What would YOU DO? There's been an error in care and the patient has been harmed. Is it time for you to come clean? Choose an ending to the vignette on page 19 and at www.obgmanagement.com

Robert L. Barbieri, MD
Editor-in-Chief

Do we gain when we "fully and openly" disclose our errors?

Maybe we help the patient. Strengthen the system. Or place ourselves at greater risk.

I'll set the stage for talking about so-called open disclosure of medical error with four observations on the patient–physician relationship—ones that I hope we hold in general agreement:

- Trust is the foundation of the patient–physician relationship
- Honesty, benevolence, compassion, and competence all advance that trust
- Social science research has shown that broken trust is easier to rebuild when it is caused by a failure of competence than by perceived failure of honesty
- Adverse events and harmful medical errors erode trust in the patient–physician relationship because they raise questions about the competence and honesty of clinicians.

***FAST** TRACK*

Broken trust is easier to rebuild when it is caused by a failure of competence than by perceived failure of honesty

A change in how error is disclosed

Historically, harmful medical errors were not widely or openly discussed in health systems. Patients often received a highly edited version of events that led up to an adverse outcome or medical error. There is developing recognition by physicians and patients, however, that adverse events and harmful medical errors should be discussed openly and, in many cases, reported to authorities.[1,2] And along with the recognition that disclosure is important have come better processes for communicating and recording adverse events and medical errors.

Questions from the medical team and the patient

A major adverse event or a harmful medical error raises two major questions for the care team to ask itself:

- How do we continue to best care for the patient who was harmed?
- How do we discuss and explain the events that preceded the harmful event?

Because the patient has been injured, optimal clinical care must continue to maximize the potential for full recovery; at the same time, the patient, or her family, may begin to ask: "How did this happen?" and, more challenging, "Was this injury preventable?"

A physician who is asked these questions may feel she is being placed in an awkward position: She needs to provide care and answer the patient's questions while also gathering more information about the event and caucusing with her clinical team to prepare for disclosure.

Just the facts—for now

At the inquiry stage of the disclosure process, the physician should, as needed, provide nonjudgmental, factual information to the patient and her family. Refrain from speculating on the cause–effect relationship of events that preceded the injury until the opportunity arises for the clinical team to review the situation, agree on the facts of the case, and prepare a disclosure plan. It is best, for the moment, for the

CONTINUED

A glossary of medical error

Adverse event An unfavorable or negative outcome that may have been anticipated and that may or may not have been caused by an error.

Medical error A clinical action that experienced and well-trained peers would judge to be wrong and that may or may not result in an adverse event.

Unanticipated outcome A clinical result that is very different from what was expected to occur during the course of diagnosis or treatment.

clinician to respond to the question "Was this injury preventable?" by stating that a detailed answer will be given once the case is reviewed by the care team. As rapidly as possible, the clinical team needs to meet: to identify the pertinent facts, to judge if an error occurred, and to then prepare to disclose the error.

Go stepwise in preparing for disclosure

Here are some key steps when you prepare for a disclosure meeting:

- Finalize which details will be disclosed and how they'll be presented
- Identify who on the clinical team will lead communication with the patient and her family (most often, this task falls to the attending physician)
- Find an appropriately sized, quiet place to hold the meeting
- Decide who will attend: The patient (if she is well enough)? Her family? Other clinicians on the team?
- Explore which approaches to disclosure are most likely to sustain a supportive and mutually respectful environment.

Executing these steps takes a great deal of time and effort. But the effort increases the likelihood of successful and constructive disclosure, which best protects the trust between patient and clinicians.

What's the recipe for "full and open disclosure"?

The elements of full and open disclosure include:

- clear description of the mistake that was made and the harm that occurred
- thorough discussion of the nature of the mistake
- identification of a clear cause–effect link between the mistake and any harm that followed.

(A comment about partial disclosure: Typically, it fails to explicitly identify a possible link between the mistake and the harm, and it's characterized by obfuscating or misleading statements.[3])

Fein and colleagues have provided an example of full disclosure after a medical error:

> *Because of an error on my part, you got your diabetic medications when you should not have. I apologize for that. It caused you to have very low blood sugar which caused you to have a seizure, at which time you fell out of bed and broke your hip.*

An example of "nondisclosure" of the same incident?

> *I am so sorry you had a seizure. Let's get you to surgery to repair your hip.*

A main goal of openly disclosing adverse events and medical errors is to preserve trust in the patient–physician relationship. In a survey of patients, full disclosure was associated with, first, a greater likelihood that a patient would retain the physician who "made the mistake," and, second, an increase in the patient's trust, positive emotional response, and overall satisfaction.[1] In that survey, however, patients reported that full disclosure would not significantly reduce

CONTINUED

***FAST** TRACK*

A main goal of disclosing adverse events and medical errors is to preserve trust in the patient–physician relationship

their desire to seek legal advice about pursuing a malpractice claim if they had been seriously injured during the course of treatment.

Full disclosure often identifies problems in the health system that could cause a similar error to recur. During the disclosure process, it's common for physicians and patients to identify improvements in systems and processes that might reduce the risk of error. Many patients and their families want action taken that might prevent a similar error from occurring in the future.

Most health-care leaders believe that open disclosure and reporting of medical error may motivate members of the health system to more rapidly identify and make changes that improve the safety and reliability of health-care processes.

Does "coming clean" suppress the risk of being sued?

Many authorities believe that disclosure and rapid response to patient injury that arise from adverse events or medical error will, ultimately, reduce physicians' risk of liability claims. For example, high-visibility disclosure and rapid-response programs are in place at various Veterans Administration facilities,[4] the University of Michigan, and through the COPIC Insurance Company in Colorado that writes malpractice policies in that state.[5] The hope is that disclosure/rapid-response programs will preserve the trust in some patient–physician relationships and, overall, reduce the risk of liability.

But some experts worry about a rebound effect: Disclosure programs that may soothe the anger of some patients might prompt others to investigate whether they have a plausible liability claim for what they consider harm during their care.[6] On balance, disclosure programs might have a net modest overall impact on liability risk. A more profound effect of open disclosure and reporting is that health systems may more rapidly improve their processes as they recognize, first, the magnitude of system-based errors and, second, the opportunity to improve their systems.

Considering the human condition

Full disclosure of medical error often causes emotional turmoil—for patients and physicians alike.

Patients may be anxious, sad, or angry when they first hear about an error; often, they fear that additional errors might occur while they are receiving care to recover from their original injury. As patients recover from injury, they may become angry that an error has harmed their health and prolonged their recovery.

A patient who becomes emotionally mired in a cycle of anger and blame might find it difficult to rebuild trust in the patient–physician relationship.

Reassuringly, many patients have reported that their emotional recovery is hastened when a physician honestly discloses an error. Patients, and families, often welcome from the physician an empathic response and a willingness to express sympathy.

Physicians often feel upset and guilty when an error occurs. Sometimes, following an error, physicians experience a prolonged interval of anxiety, sleeplessness, and difficulty concentrating.

Two troubling observations: First, the professional venues in which a physician can explore her feelings after a medical error are often limited. Second, physicians, by personality and training, may find it difficult to forgive themselves.[7]

Say "sorry"?

A major challenge for physicians is how to weigh risk against benefit in considering whether to offer formal apology for a harmful medical error.[8] Many malpractice defense attorneys express caution: Making any formal statement could be perceived as acceptance of responsibility for a harmful medical error. Some medical authorities advise that you not apologize for an event beyond your control.

CONTINUED

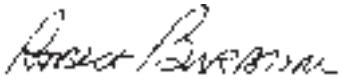
***FAST** TRACK*

Many patients have reported that their emotional recovery is hastened when a physician honestly discloses an error

In contrast, as I noted earlier, some experts believe that apologizing is 1) an important part of "full disclosure" and 2) vital to preserving trust and reducing the risk that the patient will sue the physician. The role of the apology in open disclosure is likely to continue to evolve.

We'll be asked to change for a higher purpose

Memory tells me that, in the 1970s, open disclosure of harmful medical error was not widely practiced by physicians or hospitals. That is changing: Open disclosure and consistent reporting of harmful medical error and adverse events is becoming an important part of the health-care system and, as better processes evolve for disclosure and reporting of error, we're likely to see continuous improvement of that system. What does this change require of physicians? We will find ourselves placing our professional liability risk in balance with the potential for system-wide improvement in how health care is delivered to our patients.



obg@dowdenhealth.com

References

1. Mazor KM, Simon SR, Yood RA, et al. Health plan members' views about disclosure of medical errors. Ann Intern Med. 2004;140:409–418.
2. Kaladjian LC, Jones EW, Wu BJ, Forman-Hoffman VL, Levi BH, Rosenthal GE. Disclosing medical errors to patients: attitudes and practices of physicians and trainees. J Gen Intern Med. 2007;22:988–996.
3. Fein SP, Hilborne LH, Spiritus EM, et al. The many faces of error disclosure: a common set of elements and a definition. J Gen Intern Med. 2007;22:755–761.
4. Kraman SS, Hamm G. Risk management: extreme honesty may be the best policy. Ann Intern Med. 1999;131:963–967.
5. Gallagher TH, Studdert DM, Levinson W. Disclosing harmful medical errors to patients. N Engl J Med. 2007;356:2713–2719.
6. Studdert DM, Mello MM, Gawande AA, Brennan TA, Wang YC. Disclosure of medical injury to patients: an improbable risk management strategy. Health Affairs. 2007;26:215–226.
7. Gallagher TH, Waterman AD, Ebers AG, Fraser VJ, Levinson W. Patients' and physicians' attitudes regarding the disclosure of medical errors. JAMA. 2003;289:1001–1007.
8. Lazare A. Apology in medical practice: an emerging clinical skill. JAMA. 2006;296:1401–1404.

INSTANT POLL

There's been an error. Is it time to come clean with the patient?

Postoperatively, a woman is administered extra doses of her diabetes medication. She develops hypoglycemia, has a seizure, falls out of bed, and fractures a hip.

The clinical team reviews the case. Physicians, nurses, and pharmacists all confirm the causal set of events—beginning with inappropriate administration of medication and resulting hypoglycemia to seizure, fall, and fracture. The hospital proceeds to focus its efforts at improvement on 1) greater standardization of the treatment of patients who have diabetes and 2) fall-prevention strategies.

Your task is to speak with the patient. What would you say?

☐ "There was an error in the way your diabetes medication was ordered and administered, and you received an extra dose. That caused you to develop low blood sugar, which caused you to have a seizure. Because of the seizure, you fell out of bed and fractured your hip. I'm sorry all this happened."

☐ "You had a seizure. We'll do more tests to determine why, but it might have happened because your blood sugar was low—remember, you were postop and not eating. The seizure caused you to fall out of bed and fracture your hip."

☐ "Your diabetic condition caused you to have a seizure. The seizure caused you to fall out of bed and fracture your hip."

☐ "I'm sorry you had a seizure. We need to get you to surgery so that we can fix the fractured hip. We'll keep close watch on your other medical problems."

Which approach would you take?
Weigh in at www.obgmanagement.com

Are your peers of like mind?
Find out when INSTANT POLL RESULTS are published in an upcoming issue.

Editor's note: This Instant Poll is adapted from a scenario in Fein SP, Hilborne LH, Spiritus EM, et al. The many faces of error disclosure: a common set of elements and a definition. J Gen Intern Med. 2007;22:755–761.