Medical errors: Meeting ethical obligations and reducing liability with proper communication

You, your institution, and the patient will benefit from your understanding of when error disclosure is required and best communication practices

Q&A with Patrice M. Weiss, MD

In her position as Chief Medical Officer, Dr. Patrice Weiss leads efforts not only to assure clinical excellence from the more than 900 clinicians at the Carilion Clinic in Roanoke, Virginia, but also to improve patient experience. She lectures extensively on one of her passions in medicine: medical errors, and the concept of the second victim. OBG MANAGEMENT has discussed with Dr. Weiss her concerns and pointers for those clinicians both involved in and in close proximity to others who have been involved in a medical error, and how this involvement can lead to personal consequences and coping challenges. (Listen to, "Medical errors: Caring for the second victim (you)" at **obgmanagement.com**.) In this current Q&A article, the conversation hones in on unanticipated outcomes with and without medical errors and how best to approach communications with patients in the context of both circumstances.

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OBG MANAGEMENT: What is the definition of a medical error?

Patrice M. Weiss, MD: Clinicians may be somewhat surprised to learn that there is no universal definition of a medical error that sets standardized nomenclature. The Institute of Medicine, in its landmark work *To Err Is Human*, adopted this definition: "failure of a planned action to be completed as intended, or the use of a wrong plan to achieve an aim."[1]

In general terms, a medical error is an act of commission or omission, meaning that something was done or not done, that has negative consequences for the patient and is judged as wrong by our peers. An unanticipated outcome can be due to a medical error or can occur without a medical error. An unpredicted side effect, for instance—one that may have a low probability of drug–drug interaction or drug reaction occurrence—is an unexpected outcome. If the incidence of a drug reaction is 1 in 1,000 and your patient is that one, it does not necessarily mean that there was a medical error.

Often, if the outcome is unanticipated, patients and their families will assume, rightly or wrongly, that a medical error did occur.

OBG MANAGEMENT: Are physicians required to disclose medical errors?

Dr. Weiss: Yes. The Joint Commission's

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standard principle states that the responsible licensed independent practitioner, or his or her designee, clearly explain the outcome of any treatment or procedure to the patient and, when appropriate, the patient's family, whenever those outcomes differ significantly from the anticipated outcome.[2]

This can even include unanticipated outcomes that are not due to an error. Specifically speaking about medical errors, however, we do have the responsibility, both from this standard and from a professional and ethical standard to disclose what, why, and how the error occurred and what we are going to do to ensure it does not happen again.

OBG MANAGEMENT: How does a physician best communicate to a patient an unanticipated outcome that was not due to a medical error?

Dr. Weiss: Usually we as health care providers are more comfortable talking about unanticipated outcomes without medical errors. It is important to, when speaking with patients, be clear and concise, describing what you best know at the time, in language that patients can understand. I often jokingly say that, at a minimum, all of us in health care are bilingual: We speak our native language, and we speak "medicine."

After describing unanticipated outcomes to patients and their families in terms they understand, affirm their understanding with a follow-up open-ended question. "Do you understand what I just said to you?" is ineffective. A better approach is saying, "Mrs. Jones, in your own words, will you describe back to me what your understanding is as to why this happened?" The answer received will allow you to know the patient's level of understanding. It also will give you the opportunity to clear up points that are not clear or were misinterpreted. Do not leave patients feeling in a "lurch," left to wonder or with a lack of understanding, or worse yet, with a sense that you are holding something back.

OBG MANAGEMENT: What is the best approach to disclosing an unanticipated outcome that was due to a medical error?

Dr. Weiss: First and foremost, you must be certain that a medical error did actually occur. There can be speculation at first, and that speculation should occur behind the scenes, with peer review or a root cause analysis on the event. Speculation should not enter into your conversation with the patient. Notional language can add to their anxiety, create mistrust on the patient's part, and perhaps make a patient feel as if you are not giving the answers that he or she needs.

When it is believed that a medical error did occur, there are several things that need to be done:

1. Gather as much information at the event as possible.
2. Notify the hospital (ie, risk management or quality or patient safety). This is important because it is an organizational approach to medical errors when they do occur.
3. Support the patient and the patient's family through the entire process. Speaking to the patient and the family may be a part of ascertaining what happened and contributing factors. Clinicians have said to me, "Well, I can't really go talk to the patient or the patient's family right now because I don't really know everything that happened." Keep in mind, however, that the longer you wait to talk to the patient and family, the more time they have to speculate and to ask other people, perhaps those not involved and with no knowledge of, what happened.

OBG MANAGEMENT: What is the best timing and location for the disclosure conversation?

Dr. Weiss: The person who is responsible for the patient who was involved in the medical error needs to have the disclosure conversation. The conversation with the patient, and the family if the patient so desires, should occur as soon as possible. However, take into consideration the patient being awake, coherent, and not under the influence of medications. With those caveats, the best time to speak is when it is convenient for the patient. Do not plug this conversation into a

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When a medical error is suspected, gather as much information at the event as possible, notify the hospital, and support the patient throughout the process

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10-minute opening in your busy schedule. The conversation could take an hour, or it could take 15 minutes. It should not be conducted as a matter of convenience to the clinician.

In addition, often times the recovery room is not the best location—it is not private and confidential, and the patient is still groggy and will be unable to remember most of what is said or ask questions as needed.

OBG MANAGEMENT: You advocate a "TEAM" approach when speaking with the patient. What is TEAM?

Dr. Weiss: Disclosure conversations are not easy to have. The patient and the patient's family are often upset. Medical errors challenge a physician's humility and integrity, and they can lead to questioning of one's own ability. I adopted the helpful pneumonic TEAM after first learning about it at what is now known as the Institute for Healthcare Communication. It refers to what parties need to be notified and who needs to be present with you when having a disclosure conversation. Of course, you want someone there who not only can serve as a witness but also can help facilitate the gathering of answers for questions that will be asked. The best person for this job could be the lead physician involved in the care of the patient, a hospital risk manager, a colleague, or the patient safety officer.

The "T" stands for truthful. When you begin the conversation, tell the patient at that point what you know to be true and what you know may have happened or definitely did not happen that contributed to the outcome. Again, do not speculate in answering the patient's questions. A good approach is to say, "This is what I know happened. As of right now, this is what I know may have contributed or did contribute. We are going to be looking into this more thoroughly. As I learn more, you will be the first to know."

These are not one-time conversations. As you do learn more, circle back and talk to the patient and family. This can be a dialogue that goes on for weeks or even months.

"E" equals empathy. Allow the patient and the patient's family to ventilate. Try to understand what is it that they are most upset about, and try to soothe these upset feelings. For example, do not make the assumption that they are most upset about paying for a surgery in which there was a medical error. In fact, they really may be most upset about staying in the hospital 2 additional days, and they are going to now miss the visit of a relative, their child's graduation, or something important to them.

Let patients talk. Do not interrupt them. Do not stand over them while they are in the bed; sit down at eye level with them. Talk in a voice and tone that the patient understands and try to soothe and empathetically relate to what is being said.

The "A" is important: Apology. There are 2 things that patients want when a medical error occurs: 1) to hear the clinician say, "I'm sorry"—and you should be sorry if a medical error occurred, and you should say that you are sorry this happened—and 2) what you or your organization is going to do so that this does not happen to the next person. Incorporate these 2 factors into the apology piece.

OBG MANAGEMENT: Can saying, "I'm sorry" expose a clinician unnecessarily to malpractice risk?

Dr. Weiss: Saying "I'm sorry," of course, has come under a lot of scrutiny. There are various state laws, and you should be aware of your state's apology laws. In many states an apology, with "I'm sorry," cannot be used against a provider. However, there is not 100% absolution of the event if an apology occurs. In other words, "I'm sorry" cannot be held against you, but saying "I'm sorry" does not negate the error that occurred.

Even when practicing in a state in which there is not an apology law, however, and a clinician does apologize and that apology comes up in the legal setting of a true medical error, we would need to ask, is it really that bad that an apology was made on behalf of the medical error that was committed? Isn't that compassion? Isn't that empathy? Isn't that showing that I as the physician care

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Important points to the medical error disclosure conversation include: be truthful, empathize, apologize, and manage the ongoing process with the patient

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for the patient and the medical team cares for the patient?

Finally, abide by the disclosure policy and standards of your organization.

OBG MANAGEMENT: What does the "M" in TEAM stand for?

Dr. Weiss: Management. There may be times when a medical error occurs that the patient or the patient's family are angry and upset to the point that they no longer want you to continue to care for them. Be empathetic and helpful by offering to assist them in finding someone else to continue to provide their care. Also let them know that you are more than happy to continue to care for them and assist them in their healing and restoration to health in any way that you can: "Of course the ongoing management of your care is your decision, and we will do whatever your wishes are."

References

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