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Matter for debate

Disclosing medical errors: The view from the USA

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ABSTRACT

Background: Disclosure is increasingly seen as a key component of efforts to improve safety, but does not yet reliably occur in all organizations in the U.S.
Approach: We describe the experience to date with disclosure in the U.S. and illustrate the issues with specific clinical examples. Both reputational and legal concerns represent substantial barriers. The evidence to date—mostly from single sites – shows that not only is disclosure the right thing to do, it also appears to decrease malpractice risk. We also discuss the related issue of compensation—practices around this vary greatly. Underlying the push for greater disclosure is also the belief that better disclosure results in an improved culture of safety, which in turn may improve the quality and safety of care.
Conclusions: Providers have an ethical imperative to disclosure error to patients, and the limited available evidence shows that doing so actually decreases malpractice risk. While disclosure is not yet routine practice in the U.S., the approach is clearly gaining momentum. Telling patients what happened is not enough. They also deserve an apology, and if harmed, to be made whole emotionally and financially. Greater disclosure may not only help individual patients, but may also help with improving safety overall.

Background

As healthcare institutions and providers seek to reduce medical error by designing better systems of care, full disclosure of errors to patients is increasingly seen as essential for improvement efforts to be successful.[1,2] Today, disclosure is often regarded as a necessary part of the transparency required to build greater patient trust and foster a stronger culture of safety.[3] In other words, by revealing our errors to our patients, we'll be better equipped to learn from our mistakes.[4] However, disclosure following a medical error does not always happen.[5,6]

The primary reasons that appear to prevent disclosure from reliably occurring are simple: reputational and legal fears pose a formidable barrier.[2] Admitting mistakes is a difficult thing for individuals to do in any setting—whether personal or professional. In the United States, the challenge to be open with patients is substantially amplified by concerns over potentially increased medical liability risk. These reputational and legal barriers may not only be impeding the safety benefits associated with disclosure of medical error, but also

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interfering with the fulfillment of ethical obligations physicians have to their patients.

Case example

A case example illustrates some of issues surrounding full disclosure. A patient undergoes laparoscopic hysterectomy for a malignancy, but during the operation the patient's colon is accidentally nicked, requiring a partial colectomy. The patient had been informed that perforation was part of the risk of the surgery. After a prolonged and painful hospital course, as well as a temporary colostomy, the patient makes a full recovery. The patient does not suspect that the injury was the result of an error and, in fact, is grateful that the cancer has been removed.

Issues raised

Disclosing the error in this case can prove difficult for both the physician and institution. Even though the patient ultimately made a full recovery, disclosure in this case could strain the physician–patient relationship as well as increase liability risk. Moreover, many may wonder what good would come of the disclosure, especially because complications like this do happen. They may worry that telling the patient in this case may bring only bad feelings that may interfere with a smooth recovery going forward.

However, by revealing the error and its cause in this case, physicians can meet their ethical obligations, which include fiduciary responsibilities (placing the patients' interests ahead of their own) as well as supporting patient autonomy (for patients to make informed decisions in their care, they need to know what happened in their care).[7,8] These ethical principles alone should be enough to warrant disclosure. In addition though, safety advocates point out that disclosure is integral to creating a broad and shared understanding that errors are very common, as well as creating an environment in which all errors are openly discussed so that they can be prevented in the future.[1] If an error like this is not revealed, discussed, and investigated, it cannot be prevented in the future.

Experience in the U.S.

Fueled by safety efforts, U.S. interest in ensuring full disclosure of errors has been steadily growing over the last decade.[2] Interest has been bolstered by the first disclosure and offer programs that have demonstrated improved liability outcomes for doing the right thing.[9,10] The first program to publish its results was a Veterans Affairs hospital that implemented a disclosure, apology, and offer program and found that it dropped from being in the top quartile of liability payments down to the bottom quartile as compared to its peers.[9] The University of Michigan program, which has received tremendous attention, also found very favorable results after implementation.[10,11] Liability payouts and legal costs associated with defense attorneys both dropped by 60 percent.[10,11] In addition, the University experienced fewer liability claims overall with a 36 percent decrease in the claims it was paying or defending. The reasons for the decrease are unclear, but what is certain is that even though the University starting disclosing errors and making offers of compensation, its malpractice experience improved, including beating actuarial predictions as well as outperforming national trends on compensation and defense costs.

Other institutions have followed suit by implementing their own disclosure and offer programs.[12–14] Yet, perhaps in part because the initial data are from only two institutions, disclosure and offer programs have not become ubiquitous. Rather, we have seen a burst of activity aimed at demonstrating what happens when disclosure and offer programs are implemented in different care delivery and liability insurance coverage models.[15] But should we need more data for wider adoption? Probably not. If disclosure is mandated by ethical principles, it should be occurring. However, more data on how best to run disclosure programs may help overcome liability fears as well as facilitate their ultimate adoption and design.

While we await more performance data, it is important to recognize that even though many institutions have implemented what they call "disclosure" programs, currently not all "disclosure" programs are necessarily the same. At some institutions, a disclosure program means that the institution simply ensures that patients know that something went wrong in their care and explains what happened. As experience with disclosure programs has developed, taking responsibility by apologizing for both the error and outcome have become part of the process.

To accomplish all of this, disclosure cannot be a one-time conversation, but is rather a process that starts when an adverse outcome or a potential error is first recognized. During initial discussions with patients about adverse outcomes or potential errors, providers should inform patients that an investigation will be conducted and that the institution will provide periodic updates. If there is concern over a particular error, reassuring patients that this will specifically be investigated is essential. Once the investigation is complete, disclosing what was learned frequently requires a face-to-face conversation, especially in the case of a severe adverse outcome or error. The value of support services for patients, families, and clinicians throughout initial conversations, investigation, and review of results should not be underestimated, as it can be a trying time for all involved. Turning back to the case example, merely telling the patient that the bowel was nicked during surgery is likely not sufficient disclosure. It is important to tell the patient not only that injury was the result of an error, but also to take responsibility and apologize for the nicked bowel.

What should also likely follow in this case is an offer of compensation. However, this is another manner in which programs in the U.S. vary greatly. Some, but not all, institutions are now also providing offers of compensation if the institution or provider was at fault. In other words, some disclosure programs are simply disclosure and apology programs and others are disclosure, apology, and offer programs. Programs that do not make offers with their disclosure and apology argue that patients are not really seeking financial compensation, but just honesty, an apology, and steps to be taken so that it will not happen again.