**Abstract:**
Despite our best efforts, medical errors remain an unavoidable reality in the field of medicine, and bring with them sensitive and often-challenging communication issues. This is particularly significant in the emergency department (ED), where health care providers must stabilize, diagnose, and treat patients very quickly, all while establishing rapport and developing trust with the patient and family. The patient and family rely on the ED physician not only to provide appropriate treatment but also to alleviate anxiety. Difficult conversations in the ED span a variety of topics, including adolescent sexuality, child abuse, a new or life-threatening diagnosis, or a medical error that occurred in the course of the child's care. Ultimately, it is the physician's responsibility to ensure that communication is effective, honest, and complete. This review article aims to guide clinicians through the issues surrounding one of the most difficult conversations that can arise in the ED: the disclosure of medical errors.

**Keywords:**
communication; difficult conversation; disclosure; medical error

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# Difficult Conversations in the Emergency Department: Spotlight on the Disclosure of Medical Errors

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A 12-year-old boy with history of multiple food allergies presents with hives on his face, swollen lips, and is complaining of a hoarse voice and progressive throat tightness after exposure to an unknown allergen at school. He received no treatment at school and was brought directly to the emergency department (ED). He ambulated to a room in the ED and is speaking in full sentences. He received 25 mg of oral Benadryl in triage. His past medical history is significant for multiple food allergies, and he has had anaphylaxis on two separate occasions. He is not on any medications, but he has an EpiPen at home for use as needed. There are no known drug allergies. Vital signs on presentation: temperature 37.3°C, heart rate (HR) 82 beats per minute, respiratory rate (RR) 20 breaths per minute, blood pressure (BP) 111/68 mm Hg, SpO2 99% on room air, weight 30 kg. In general, the patient is alert and in mild acute distress. His airway is patent, although his voice is hoarse. His breathing is unlabored, with clear lungs notable for no

wheezing or stridor. He is warm and well perfused with strong central and peripheral pulses; capillary refill time is less than 2 seconds. The skin exam is notable for hives to his face and trunk, and swollen lips.

The patient begins vomiting as the nurse places the intravenous (IV) line. The physician gives the following verbal orders: epinephrine 1:1000 0.3 mL intramuscular, methylprednisone 2 mg/kg IV, ranitidine 1 mg/kg IV. The nurse draws up the medications and gives the IV medications first. However, when she is ready to give the intramuscular epinephrine, she realizes that only the ranitidine remains in her hand—the epinephrine was already administered via the peripheral IV. The patient immediately begins to complain of severe chest pain and appears diaphoretic. Vital signs are now: HR 183, RR 42, BP 202/104 mm Hg, SpO2 100% on room air. The nurse quietly pulls the physician aside to explain what happened, as the patient's mother asks, "Why is his chest hurting? We have been through this many times, and this has never happened before!" A 12-lead electrocardiogram is performed and reveals ST segment elevation. Serum electrolytes and troponin are drawn, and pediatric cardiology is consulted due to concern for acute myocardial ischemia. The patient is placed on supplemental oxygen, given aspirin to chew, and 0.2 mg of sublingual nitroglycerin. The patient reports slight improvement in chest pain after these interventions. Reassessment reveals a patent airway, unlabored respirations, and resolved angioedema. Five minutes after these interventions, vital signs are: HR 78, RR 22, BP 92/51 mm Hg, SpO2 100% on nonrebreather mask. The patient's mother is visibly upset and repeatedly questions the physician and nurse as to what happened.

The case outlined above is an example of a serious medical error from which a patient experienced actual and immediately apparent harm. This case does not represent an actual patient, but rather is based on several patient experiences encountered by the authors. Although this may be an extreme example of a patient safety event, medical errors such as these occur frequently in the care of patients. Despite our best efforts, medical errors remain an unavoidable reality in the field of medicine and bring with them sensitive and often challenging communication issues. This is particularly significant in the ED, where health care providers must stabilize, diagnose, and treat patients very quickly, all while establishing rapport and developing trust with the patient and family. In the ED, clinicians with little or no knowledge of the patient or family background frequently must have deeply personal and sensitive conversations on a range of issues that arise, often with little or no time to prepare. These topics include adolescent sexuality, child abuse, a new or life-threatening diagnosis, or a medical error that occurred in the course of the child's care. The patient and family rely on the ED physician not only to provide appropriate treatment but also to alleviate anxiety. Ultimately, it is the physician's responsibility to ensure that communication is effective, honest, and complete.

This review article aims to guide clinicians through the issues surrounding one of the most difficult conversations that can arise in the ED: the disclosure of medical errors. Specifically, our goals are to: (1) outline the prevalence of medical errors; (2) describe current attitudes toward error disclosure; (3) describe perceived barriers to full disclosure of medical errors; and (4) describe methods for error disclosure and existing methods for training clinicians in error disclosure. We believe that the principles we will discuss can be applicable in other difficult conversations clinicians encounter in daily practice.

## SCOPE OF THE PROBLEM

To date, most of what has shaped our understanding of medical errors, patient safety events, and error disclosure originate from the 2000 Institute of Medicine (IOM) report, *To Err is Human: Building a Safer Health* System.[1] This report defined medical errors and patient safety events of varying severity (Table 1), described their prevalence, and outlined comprehensive strategies for preventing and reporting medical errors. The IOM report estimated that nearly 100 000 patients died each year from safety events attributed to preventable medical errors.

**TABLE 1. Types of patient safety events.[1]**

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| Patient safety event | Unplanned, undesired events, which potentially or actually result in harm to an individual |
| Error | Failure of a planned action to be completed as intended (ie, error of execution) or the use of a wrong plan to achieve an aim (ie, error of planning) |
| Adverse event | An injury caused by medical management rather than the underlying condition of the patient.<br>*An adverse event attributable to error is a "preventable adverse event"<br>*Negligent adverse events represent a subset of preventable adverse events that satisfy legal criteria used in determining negligence |