

Enhancing the Disclosure of Medical Errors in Primary Care

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Background

- Disclosure of medical errors and adverse events recommended
 - Ethical rationale
 - Impact on patient outcomes
 - Regulatory requirement
- At present disclosure may be uncommon

Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors

- 13 patient and doctor focus groups
 - 6 patient-only groups
 - 4 physician-only groups
 - 3 joint doctor-patient groups
- 52 patients, 46 physicians
- Discussed medical errors and how they should be handled

Patients' Attitudes about Errors

- Patients conceive of errors broadly
- Desire full disclosure of harmful errors
 - Worry that health care workers might hide errors

Patients' Preferences for Error Disclosure

- Information patients want disclosed
 - Explicit statement that error occurred
 - What happened, implications for their health
 - Why it happened
 - How will recurrences be prevented
- Importance of an apology

Physicians' Attitudes about Errors

- Define errors more narrowly than patients
- Agree in principle with full disclosure
- Want to be truthful, but experience barriers to disclosure

Barriers to Error Disclosure from Physician Perspective

- Concern that disclosure could precipitate a lawsuit
- Fear that disclosure could harm patient
- Worry that disclosure would be awkward and uncomfortable
 - Difficulty in admitting to personal failure
 - No formal training in error disclosure

Choosing Your Words Carefully

- Physicians “choose their words carefully” when disclosing errors to patients
 - Avoid explicit identification of error, discussion of prevention
 - Assume interested patients will ask clarifying questions
 - Concern re: legal liability makes apologizing hard

What Would Physicians Say?

“I would be very straightforward and say you were given too much insulin. Your blood sugar was lowered and that’s how you arrived in the Intensive Care Unit. You were given some dextrose, and apologize for the events. And then if they want to know, well, how did I get too much, or why couldn’t they read your writing, or why didn’t they call you, you go into those individually, but I wouldn’t walk in saying I have sloppy handwriting and they didn’t know what they were reading.”

“You just tell the facts. You got a big bunch of insulin and your blood sugar went down, and we got that fixed up and we’re glad you’re great.”

Error Disclosure and Physicians' Emotions

- Some worried that disclosure was “dumping” on patients for physicians’ benefit

“[We are] trying to relieve the soul of some burden when we confess our sins or our errors. . . . And dumping that onto the patient is not necessarily nice.”

Forgiving Yourself Following an Error

“It helps if the patient says, “Look, I understand that this is not normal, but I am willing to go along with whatever you say ... and to give you that extra support and second chance.” Forgiveness is something that I think is tougher for the physicians to give themselves than to get from the patient.”

Error Disclosure Curriculum

- 90-minute workshop
- Combines
 - didactic material
 - trigger tape
 - opportunity for practice with standardized patient

Case

You admit a 56 year-old diabetic male for a COPD exacerbation. Two hours later the patient codes with a blood sugar of 35. The patient is successfully resuscitated and transferred to the ICU. On reviewing your admitting orders, you realize your sloppily written order for “10 U” of insulin was misinterpreted as 100 Units. The patient recovers uneventfully and returns to your team for continued care.

Overview of Error Disclosure Strategy

- What types of events should be disclosed?
 - Focus on errors or adverse events?
- All harmful errors should be disclosed to patients
- Disclose near miss if patient witnessed event
- **Get help** when deciding whether, what to disclose

Communication Strategies for Disclosure

- Plan for multiple conversations
- Seek to understand and provide information that patient wants about the error
- Respond to patient's emotions

Information to be Shared with Patient about Errors

- What happened to me, and what is the significance of this for my health?
- Why did this happen? Was it preventable?
- What are you going to do about what happened to me? Will I suffer financially?
- How will you prevent this from happening again?
- Do you care about what happened to me?
- Information does not have to be shared all at once

Additional curricular topics

- Error disclosure and blame
- Error disclosure and malpractice
- Error disclosure as quality improvement

Standardized Patient Exercise

- Error disclosure as skill that requires practice, feedback
- Standardized patient re-enacts error from video trigger tape
 - Use “volunteer” from audience to disclose error to SP
 - Audience, presenter, SP provide feedback
- Alternative is for audience to disclose error to one another in small groups

Summary

- Health care providers are not disclosing information patients want about errors
 - Minimum info to be disclosed without patient asking
- Increasing institutional support for error disclosure
- Physicians should receive specific training in error disclosure, including opportunity to practice

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