# Taking the Fear Out of Error Disclosure

KEHINDE ENIOLA, MD, MPH, AND CHRISTINA GAMBINO, MD

## What if we could talk about medical mistakes without fear of judgment or punishment?

Our residency clinic admitted a patient to the family medicine inpatient service for sepsis, likely from pneumonia. On the day of admission, the patient was placed on intravenous (IV) antibiotics. His vital signs began to improve, and he was no longer febrile on day two of hospitalization. On day three, the patient developed a fever again. On day four, the patient was falling back into sepsis. The inpatient team reviewed the differential diagnosis list looking for something it might have missed. Why was the patient declining? A thorough review of the patient's medications revealed that antibiotics were not continued after day one. The inpatient team had to explain to the patient that it failed to notice that the antibiotics were not ordered. Once the antibiotics were resumed, the patient recovered.

## EASING ERROR DISCLOSURE

Although medical errors cause approximately 251,000 deaths annually in the United States, less than 10 percent of medical errors are reported.[1,2] Common barriers include fear of litigation, lack of peer support, inadequate training, and lack of a structured reporting system.[3] Although it can be difficult, medical error disclosure to patients and families is ethical and can improve the patient-physician relationship and patient safety.[4,5] Identifying errors is key to preventing their recurrence. To encourage proper reporting, physicians, colleagues, and organizations should take the following steps.

**Physicians** should model transparency by providing prompt, empathetic, and supportive communication with patients and families when a medical error occurs. Patients' perceptions of poor or insensitive communication may increase the likelihood of litigation; however, offering a direct apology can reduce the potential for litigation.[4,6] Physicians should also offer to continue providing care to the patient or to facilitate a transition of care to a different physician or setting if appropriate.[5]

**Colleagues** should help foster an environment of support, devoid of judgment, when a physician is involved in a medical error. This will encourage transparency and prompt disclosure.[4,5] Attendings, supervisors, and advisors should create an atmosphere of openness and easy communication so the physician is not met with punitive action when disclosing a medical error.[4] Instead, they should offer direction and guidance to the physician and encourage appropriate reporting to patients, leadership, and their ethics committee if applicable.[5]

**Organizations** should develop clear medical error policies that provide disclosure guidance to physicians and staff as well as a confidential reporting process that fosters transparency and leads to future error prevention.[4,6] Institutions should have designated individuals such as an ethics committee member who can facilitate disclosure conversations between patients/families and physicians.[5,6] Institutions should also provide a form of immunity and support to physicians by ensuring the availability of malpractice insurance and a medical malpractice attorney.[4] Medical training institutions should incorporate medical error disclosure training into their curriculum, with a focus on communication with peers, patients, and institutions.[4,6]

By taking these steps, we can all create an environment in which physicians willingly disclose errors without feeling judged or unsupported or fearing punishment. FPM

**ABOUT THE AUTHORS**

Dr. Eniola is an assistant professor of family medicine at Cone Health Family Medicine residency program affiliated with the University of North Carolina in Greensboro, N.C. Dr. Gambino is a third-year resident at Cone Health Family Medicine residency program. Author disclosures: no relevant financial affiliation disclosed.

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