Welcome to the first of several short modules on medical error disclosure.

In this module you will review the rationale for disclosure as well as a model for how to discuss errors with family members. Our goal is to help you prepare for this difficult meeting.

Conversations around error present uniquely demanding situations for providers, patients, and families. Such conversations require a physician to not just relate the facts, but to communicate with the patient about events that neither would have wanted to occur.

Best seen as an extension of informed consent, honest and full disclosure of complications and errors lie at the heart of the physician-patient relationship. Conversations that go well are those in which the physician has command of his or her own personal emotions; has sufficient insight, integrity, and humility to present the facts in an open and honest manner; and has sufficient compassion to accept the emotional reactions of patients and families.

Honest disclosure is a cornerstone of a “safe and just culture.” Renewed focus on patient safety was triggered in the last 15 years by landmark reports from the Institute of Medicine and the Joint Commission. Many agencies, hospital policies, state laws, and professional societies’ ethics codes or guidelines now promote open and honest disclosure. Copies of the University of Minnesota Physicians and the Mayo Physicians policy on disclosure can be found on the Moodle Website.

Despite the enormous effort being devoted to enhance patient safety, providers are human beings. It is likely that you will make a mistake sometime during your career. Many residents report errors during training and most of these errors (as many as 70%) can be attributed to “teamwork failures,” such as those that occur during hand-offs, or to poor communications between junior and senior residents or attendings.

When errors happen, providers suffer as well as patients and families. This is largely because of our own intense desire to help (not harm) people, and because “being good at our job” is central to our professional identity and self-esteem. It is common to feel grief, shame, anxiety, frustration, and loss of confidence after an adverse event. In a longitudinal study conducted at the Mayo Clinic, for example, self-reported errors by residents were associated with lower quality of life, higher burnout and depression, and a decreased empathy for patients. These markers of distress, in turn, were associated with increased odds of the same residents reporting subsequent errors in the months that followed. Getting appropriate
support from peers and attending faculty, and learning the art of disclosure, are two protective measures that can really help.

The manner in which you explain an error can have profound emotional and legal consequences for you and your patients. There is near universal agreement that patients deserve open disclosure and a full apology. There is some evidence that a transparent and appropriate apology can win trust and reduce costs, but avoiding a lawsuit should not be your primary or sole reason for disclosing an error. Disclosure is not intended to stop people from suing or requesting compensation. Efforts to regain trust are never a failure, regardless of the outcome. The act of disclosure represents a commitment to learn from our mistakes. It offers an avenue for psychological healing after a terrible event. It is a marker of trustworthy healthcare.

This diagram will familiarize you with the terminology of adverse events. Research has consistently found that a very high proportion of patients (98%) want to be told the truth and many come into treatment fearing that doctors will withhold it from them. Most guidelines, including ours, state that all adverse events should be disclosed, including errors that resulted in no harm. Research finds a persistent gap in what physicians disclose and what patients and families expect to be told. Interesting research on this gap can be found in several articles by Thomas Gallagher on the Moodle Website.

Let’s now turn to a general model for framing disclosure conversations with family members. This model is based on research with patients and family members following an adverse event. Three general findings are common across studies:

- Patients want to know the facts
- They want a sincere apology, and
- They want to know what happens next

We will focus on each of these areas in subsequent modules. The first step in disclosing an error is preparing for it.

First, make sure you have all the facts. Unexpected problems can be confusing. You may not even know yet if an error caused the adverse event, so your first conversation with a family may be to let them know a complication has occurred. In that instance, you need to tell the family what’s being done to care for their loved one, and when you expect to know more. If you can confirm that an error occurred, you need to decide who should speak with the family. Guidelines indicate that a physician – preferably the one closest to the family – should be the one to explain the error. Bringing a nurse or other team member may help, but having more
than 2 people in the room can overwhelm patients and families. It is advised that the organization’s risk manager never be present at the first meeting, although they may be critical in later meetings, especially if conflict is intense.

Preparing for disclosure bears many similarities with preparing for end-of-life conversations. In addition to mental preparation and focus, you need to make sure that all of the care team members know that you are going to be talking with the family about an adverse event. If time permits, it is very helpful if everyone is on the same page concerning the facts of the case and any decisions that need to be made to treat the patient, such as consent for additional surgery.

Upon entering the room, use the same guidelines we discussed for end-of-life. Introduce yourself, sit down, look directly at the family member, know the patient’s name, and address the family respectfully.

Ok, time to go. Here is your toolkit.

In closing, disclosure should be considered an ethical obligation, not just a regulatory requirement. It should be treated not as a separate event, but a process that begins with informed consent and continues throughout care. Building relationships and being skilled in shared decision making can lessen the stress when errors happen. A collaborative approach to patient care may also increase the chance that patients can accept you are a human being, capable of making “an honest mistake.” In Module 2, we look at some examples of how some providers explain the medical facts surrounding an error.