

Virtual Mentor

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Vignette 1: Physician-to-Patient Communication

Disclosing Error to a Patient

Commentary by Geoffrey H. Gordon, MD

You are halfway through a busy clinic afternoon and seeing Mr Osler, a middle-aged man with hypertension. His blood pressure diary indicates that he is above your therapeutic target, and you decide to add a new antihypertensive drug to his regimen. You write a prescription, the nurse faxes it to the pharmacy, and you move on to the next patient.

Two days later you are called by the emergency room about Mr Osler, who became dizzy while getting his morning paper. He fell on his porch, sustaining a forehead laceration. A careful evaluation showed only postural hypotension, and his laceration was closed. You arrive to say hello to him and see his medication bottles at the bedside. You are shocked to find that the hospital pharmacy dispensed the new drug at 10 times the dose you intended. You step out of the room to collect yourself and decide what to do.

Commentary

Medical errors are the eighth leading cause of death in the US, and medication errors alone cause more than 7000 deaths per year. Error can be generally defined as the flawed execution of a sound plan or the wrong plan to achieve a particular aim. Not all errors result in adverse outcomes (for example, a patient with a recorded medication allergy tolerates an erroneous dose without difficulty), and not all adverse outcomes are the result of error (for example, a pneumothorax as a known complication of subclavian vein catheterization, discussed during informed consent). A “near miss” is an error that is caught before it harms the patient.

Errors are ubiquitous and, even though we are all accountable for our performance, no one is perfect 100 percent of the time. Errors arising from one individual’s action (or inaction) are normally caught by safety checkpoints designed to identify and stop them. Errors can slip undetected, however, through “holes” in the checkpoints, such as faulty information technology, diffusion of responsibility, or poor communication. Learning when and how our patient safety systems *don’t* work is critical. This requires open communication of information, without “shame and blame” and with the goal of reducing preventable harm due to error.

Error: The Human Experience

Physicians typically respond to error with anger, shame, and fear. Mostly they fear a malpractice suit, in which patients accuse them of medical negligence and substandard

care in order to be compensated for economic losses. As a result of this fear, physicians may avoid or hide the error, become defensive, or blame others. In the long term they can experience sadness, self-doubt, and guilt.

Patients want to know that an error occurred, what happened, and how. They want the physician to express concern or offer an apology and, if appropriate, compensation for economic losses. Patients and attorneys cite communication breakdown and loss of trust, rather than substandard care, as the most common cause of a lawsuit.

Rationale for Disclosure

For decades, professional societies have endorsed disclosing errors to patients and families. This is based on the ethical principles of honesty and integrity. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) adopted error disclosure as a standard in 2001. Paradoxically, error disclosure may reduce overall malpractice costs, probably because patients often sue when they feel their physicians are avoiding them or hiding information. In Oregon, a 2003 “apology law” states that a general apology or expression of regret cannot be construed as an admission of guilt or error, and a few states are enacting laws mandating medical error disclosure.

On the other hand, disclosing errors makes patients more aware of problems and could increase the number of malpractice claims. Causality may be hard to assess. Also, it’s a difficult conversation to have.

Steps in Disclosing and Reporting an Error

1. *Make sure the patient is stable and ensure optimal care.*
2. *If you are under supervision, notify the attending physician immediately.*
3. *If the harm is severe (a patient death or wrong surgery) report it immediately to a quality assurance team or administrative official.*
4. *Gather the basic facts available at the time.* What happened and why? How did it affect the patient? What was done? What is the patient’s current condition?
5. *Consider getting help talking with the patient or family.* If you are worried, angry, or defensive it will help to have someone with you. Ideally this person would be able to speak on behalf of the hospital to offer sincere regret, support, and services.
6. *Disclose the error to the patient, his or her family, or both.* State the facts without blame or conjecture. That is, give an account of what happened, the consequences, what treatments are being given to correct the error, and the results of treatment. Let them know that you will update them as you learn more.
7. *Express empathy.* Patients are normally frightened, angry, and distrustful if harmed by a medical error. Your behavior and response to the error affects their perception of what happened. Explain that the event was not expected or intended, that their feelings are understandable given the circumstances, that they are doing the right thing by seeking information, and that you are there to support them. Express regret for what happened and offer a personal apology if appropriate.

8. *Let the patient know that your goal is to make sure that he or she gets the very best care possible.* Tell the patient that you are doing everything you can to learn how the error happened and to make sure it doesn't happen again to him or her or to anyone else.

9. *Express a desire to continue providing care* and hope that the patient can trust you and your team to do so.

10. *Report the error to your quality management department* (usually with an incident report). If this was not a severe harm case, this can take place in the first 24 hours. The result may be a critical event review, or "root cause(s) analysis," to find and repair the "holes" in the patient safety system. Unfortunately many still view these as disciplinary actions rather than as means to improve patient safety.

11. *Write a note in the medical record documenting what happened, the impact on the patient, treatment provided, and results.* You can include who was told about it, what they were told, and when. The clinical record is the wrong place to guess what happened or to blame others.

12. *Items that should not be disclosed or documented in the clinical record include names of individuals or disciplinary actions taken, results of critical events or peer reviews, and consultations with attorneys or insurers.*

A primary goal of error disclosure and reporting is preventing future harm to future patients. Patient safety is an ethical duty, as important as duty to individual patients. However, fear of blame and malpractice suits often suppresses error reporting and disclosure and drives it underground. National and regional efforts are under way to remove blame from considerations of patient injury and compensation [1, 2].

Coda

You call the pharmacy, and hear that they dispensed the dose that was on the prescription, and they fax back the prescription to prove it. You see that you wrote a decimal point that you think is clear, but the pharmacist and ER nurse disagree. You are angry that no one questioned the prescription or called you about it. You call the patient advocate for advice.

The patient advocate arrives, empathizes with you about the situation, and says Mr Osler should be told what happened. She offers to help with the conversation and accompanies you to the bedside. When you return to Mr Osler's room, he is relaxed and comfortable, and his blood pressure is normal. You tell him that you wrote a prescription that some people were unable to read, and that, as a result, he received more of the medicine than you intended. Mr Osler is furious and blames you for almost killing him. You tell Mr Osler that his dizziness and fall were most likely side effects of the higher-than-intended dose but that no further side effects are anticipated. There are no long-term consequences of the unintended high dosage, you say. You apologize and tell him that you didn't intend for this to happen.

The patient advocate empathizes with Mr Osler, reassures him of your good intentions, and asks what other concerns he has now. He is worried about his dogs that are home alone and about the bill for the ambulance ride. The patient advocate

says that she will call a neighbor to care for the dogs and promises to see if the hospital can help with the bill. You explain to Mr Osler that what happened to him has shown the hospital it must speed up implementation of computer-entry orders, which should reduce these kinds of errors. When Mr Osler is calm, you express interest in continuing to be his physician. He thanks you for being honest and says he will give you another chance. You carefully rewrite his prescription, explaining the new dose and follow-up.

References

1. S.544 – A bill to amend title IX of the Public Health Service Act to provide for the improvement of patient safety and to reduce the incidence of events that adversely effect [sic] patient safety. *Bill Summary & Status for the 109th Congress*. Available at: <http://www.congress.gov/cgi-bin/bdquery/z?d109:SN00544:@@L&summ2=m&>. Accessed July 25, 2005. Congress passed S 544 on July 27 and sent it to the President to sign into law.
2. SorryWorks, for example, is an Illinois initiative to provide compensation for patients injured by care without resorting to lawsuits. Available at www.victimsandfamilies.com/Sorry.phtml. Accessed July 26, 2005.

Suggested Readings

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