DISCLOSURE WITH ADVERSE OUTCOMES

OBJECTIVES:

- Define a medical error
- Identify disclosure obligations to patient and family
- Identify responsible parties relating to disclosure
- What is the purpose of an apology and why do they sometimes fail?

To Err Is Human from the Institute of Medicine’s report in 2000 has estimated that 40,000 Americans die every year because of medical errors.\(^1\)\(^2\) A survey in 2002 revealed that 42% of patients and 35% of doctors reported that an error occurred in their care or a family members’ care.\(^3\) Amazingly, most of the errors are not reported to the patient or family, with an estimate of only 30% of errors disclosed. The reasons for lack of disclosure are complex but are often related to the fear of lawsuits, lack of responsibility (or perceived lack of responsibility) and/or tarnishing of the reputation of the physician. Yet, more than ever patients want their physicians to disclose any and all errors to them.

Although it is very easy to recommend full disclosure of errors, clearly this is not occurring for the reasons mentioned above. And more confusing is that not all errors are created equal. An error is a failure of a plan to be completed as intended or the use of a wrong plan to achieve the aim.\(^4\) When an error results in no harm, the incident is called a near miss or close call. Often this is NOT disclosed to the patient. Whether or not this practice is ethically correct is debatable. When an error results in an adverse event, the error is usually more obvious to the patient, and the need for disclosure is arguably greater. Regardless of the error and its consequences, the IOM states that the standard of care is full disclosure. The Joint Commission requires hospitals to tell patients when adverse outcomes occur. The National Quality Forum requires hospitals to have safe practice guidelines on disclosure of serious errors. Several states have laws requiring disclosure of adverse outcomes.
Slide 5: Case 1

A 56 year-old undergoes a lumbar spinal fusion and during the case a pedicle screw is placed into the vertebral foramen. It is recognized and changed during the case. Postoperatively the patient has a foot drop.

Slides 6-9: Questions

What is the responsibility of the attending surgeon?
What is the responsibility of the resident physician?
Do you apologize?
What constitutes a successful apology?
Why do apologies fail?
What are the ethical issues?
What are the practical issues?
Who is responsible for the increased cost?
What are the medicolegal issues?

The physician has made an error in which serious harm has occurred. The physician in this case is directly responsible for the adverse outcome. Upon recognition of the adverse outcome, he/she should disclose all the relevant information to the patient, resisting the urge to conceal the error or shift blame to others.

Should the physician apologize?

An apology is an acknowledgement of responsibility for an offense coupled with an expression of remorse. An offense/error refers to a physical or psychological harm caused by an individual or group that could or should have been avoided by “ordinary” standards of behavior. This has long been controversial, but generally when a serious error has occurred, an apology should be offered. Not admitting the error or avoiding responsibility is unacceptable. An apology is an expected social response and a prerequisite to making amends and being forgiven. Interestingly, as physicians with encouragement apologized more frequently, an unexpected outcome occurred: a reduction in the number and cost of medical claims. Like anything else delivering a meaningful apology is a learned clinical skill. An apology consists of four (4) parts:

1. Acknowledgement of the error WITH validation that the error was not acceptable
2. Explanation of the error
3. An expression of remorse, forbearance, and humility
4. Reparation, which might include adjusting the bill with consent of all the parties, to increased close follow-up, etc.

All four are not always present or required and that is where the clinical skill is developed over time.⁶

Before offering the apology, the physician should notify the hospital risk management department and the insurer if applicable.

**How Does an Apology Work?**

Some of the ways an apology works are obvious and not all the ways are always present. An apology often begins with restoration of self-respect. The patient at this time needs to feel cared for and important. This restores power to the physician-patient relationship. Not surprisingly, a patient with a significant medical error may want to see the physician suffer. So the demeanor in which an apology is made and its perceived sincerity are very important. An apology designates fault and this often will help to comfort the patient. Being upfront and engaging the patient and/or family allows for questions to be asked and answered and for feelings to be expressed. Empathy is part of the dialogue. Finally, reparations and a commitment to the patient go a long way to re-establish confidence in the physician-patient relationship.

**Why Does an Apology Fail?**

Delay is a predictor for disaster. As soon as the error is recognized, it should be addressed. A delay tends to appear deceitful and disrespectful. Often this conversation needs to be repeated, as patients may not hear the physician the first or second time. Be specific and empathetic. If the patient does not perceive genuine remorse, the apology will surely fail. Probably the biggest reason for failure stems from the resistance of the physician to admit fault and apologize. To be successful, physicians need to regard apologies as evidence of “honesty, generosity, humility, commitment, and courage.”⁹ Avoid limited disclosure of the errors! It may come back to bite you in the future.

**Slide 10: Case 1-Altered**

*What if the resident was left to close the wound and a sponge is left in the patient that is recognized on a post-op film in the office at two weeks?*
Slide 11: Question

Is there a change in responsibility?

Let’s assume that no nerve injury resulted and the surgery was without complications. You left the case once the instrumentation was complete, and the resident closed. On the two-week follow-up radiographs, a sponge left in the patient is noted. Often the house officers are reluctant to disclose errors to their supervising attending. In this case, however, it is unavoidable. The ultimate legal and ethical responsibility falls to the attending surgeon. The error in this case will result in another surgery and must be disclosed. Ethically the most appropriate medical-legal response would be to have the hospital risk manager offer reparation, which often is an out-of-court settlement. If there is a good physician-patient relationship, the reparation could be as little as waiving all medical charges for the previous and upcoming surgeries.

The resident’s error also needs to be addressed at a different level. This is the opportunity for the resident to understand disclosure and learn the skill of communicating an apology. Finally, a case such as this should be discussed in a Morbidity and Mortality conference to help others avoid such an error. It should also be reviewed at the hospital level as a quality improvement issue and procedures revised to avoid such a complication.

Slide 12: Case 2

During a routine decompression for a herniated disc, the surgeon inadvertently tears the dura. It is a small tear easily repaired and does not change the post op course.

Slide 13: Questions

Is this error different?
Does the surgeon have a responsibility to disclose?

This situation is a bit different in that potentially there is no adverse outcome to the patient. Yet an error occurred; albeit it is one that is a known risk and usually is discussed with the patient prior to surgery. Often there is a temptation not to disclose the complication, especially in a case where no harm occurred. In this case the patient sustained a known complication that occurs with this procedure, which otherwise was performed well. As long as the “standard of care” was followed and the patient agreed to the risks, the physician is not to blame for this complication in a punitive sense. Yet, to
maintain a strong bond with the patient, it should be disclosed and the physician should express regret over it even though it was a known risk. Finally, there is little risk to the physician in disclosing an error to a patient when there is no adverse outcome or harm done. In this scenario, the patient is less likely to get angry. Ultimately your bond to the patient is strengthened.

**Slide 14: Case 3**

*Your office nurse calls you about a post-operative wound that looks infected, and you ask him to begin antibiotics. The nurse writes a prescription for a sulfonamide antibiotic. The patient gets it filled and does not recognize that he is allergic to the medicine as he has a documented sulfa allergy. He ends up in the ER, is treated, released, and changed to an appropriate antibiotic.*

**Slide 15: Questions**

*What is the responsibility of:*
  - The physician?
  - The medical system (i.e. pharmacist)?
  - The nurse?
  - The patient?

Several medical errors occurred in this scenario. Errors such as this occur frequently. Although they might be blamed on deficient knowledge, effort, or conscientiousness, they are now thought to be due to inherent limitations in human cognition and attention, and to system failures. A lapse of concentration can happen to the best of doctors, and multiple system failures had to occur for this to happen. The nurse failed to recognize the allergy documented clearly in the patient’s chart. The pharmacist made the same mistake. Finally, the patient, although he might have been unfamiliar with the medicine, failed to question anyone or remind them of his allergy. System problems are frequent. Focusing on improving the healthcare system rather than attempting to blame individuals will result in higher quality of healthcare for all. But remember, as the attending physician you are still responsible for this error, and an apology is required. You might argue that this was “not your fault”, and indeed it may not have been.

Changing the case to make it even more clearly not the physician’s “fault,” you asked the nurse about allergies, and he stated none were noted on his chart. A strong argument can be made not to hold the physician responsible for actions or conditions beyond his control. Yet, this still does not remove the responsibility from the physician. The physician is the primary person involved in the patient’s care and needs to take responsibility and apologize.
Second and maybe of more importance, medical professional liability holds the individual physician responsible for an error. If it results in a judgment or settlement, the physician will be reported to the National Practitioner Data Bank, even if the error was beyond the physician’s control.

**Slides 16-17: Summary**

The decision to admit or acknowledge an error should be based on ethical guidelines. Disclosure is often difficult, but failure to do so can damage credibility and compromise integrity, destroying the physician-patient relationship. Although disclosing an error does not protect the physician from legal liability, the lack of disclosure might increase the legal risk, and several states have enacted laws that mitigate liability for physicians related to the disclosure of unanticipated outcomes of care. By learning from and admitting errors, the quality of medical care is enhanced for all.

**References**

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