DISCLOSING MEDICAL ERRORS TO PATIENTS: OVERCOMING THE CHALLENGE IN CLINICAL COMMUNICATION

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Abstract

Summary: Ethical and professional guidelines obligate doctors to disclose medical errors to patients when they occur. But very few doctors are divulging their own errors, especially in a very paternalistic doctor-patient relationship witnessed in sub-Saharan Africa where the prevalence of medical errors is unknown due to absence of error reporting and disclosing mechanisms. Doctors are not disclosing their errors because of perceived consequences when they do and the lack of disclosure skills that is not taught at all stages of the educational system including the postgraduate level. However, patients want to know and be told when things go wrong.

This article looks at the barriers to disclosure of medical errors, the benefits of disclosure for both the doctor and patient, and how doctors can begin disclosing errors based on current literature.

Key Words: Disclosure, Medical Error, Communication

Introduction

Good communication in medicine is an essential clinical skill. It is a core requirement for effective practice, fostering trust and openness between the physician and the patient[1]. Both the doctor and patient benefit when good communication exists between them[2]. The patient is healthier, more satisfied with the care received and more compliant with management plans[3–5]. Good clinical communication can sometimes be a daunting task in some situations. One challenging aspect of clinical communication is disclosing medical errors to patients and their families[6]. Disclosure of medical errors is an ethical and professional obligation and ethical guidelines worldwide enjoin healthcare professionals to disclose medical errors[7–13]. Yet, a significant number of physicians are not open and honest when mistakes happen [12,14,15]. The prevalence of medical errors and reporting in sub-Saharan Africa is unknown as there are no mechanisms for reporting and disclosing such errors[15,16]. Prevalence of medical errors is estimated to be high in resource limited settings where the vulnerability to medical errors is increased[7]. A largely paternalistic doctor-patient relationship in sub-Saharan Africa makes disclosure of mistakes exceptional[18,19].

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When medical errors occur, good and timely clinical communication is critical. How can doctors overcome this challenge of disclosing their errors considering the general absence of reporting mechanisms and training on how to communicate errors when they occur?

Methods

Barriers to disclosure

Many barriers to disclosure have been identified with fear of the consequences that may ensue after disclosure of harm being a leading inhibitory factor to disclosure[20–25]. The potential consequences of disclosure are legal action, decrease in trust and confidence, emotional reaction by patient and family, punitive measures by managers, blame by colleagues and, loss of job and privileges[25,26]. Other barriers to disclosure are lack of disclosure skills and physician personal beliefs that the patient would not want to know about the error, disclosure is unnecessary and the patient would not understand the error[23,27,28]. How Should Physicians Disclose Medical Errors? The processes of disclosing medical errors to patients can be a harrowing experience for most physicians, especially where no formal training in disclosure mechanism exist. Being an ethical and legal requirement, most physicians find themselves in a dilemma; between the devil and the deep blue sea. Though many innovative disclosure programs have been developed by institutions around the world each disclosure is unique[12,27,29–31]. Disclosure is not a one-time event (Figure 1); however, the process of medical error disclosure can be categorized broadly as follows:

i. planning the disclosure

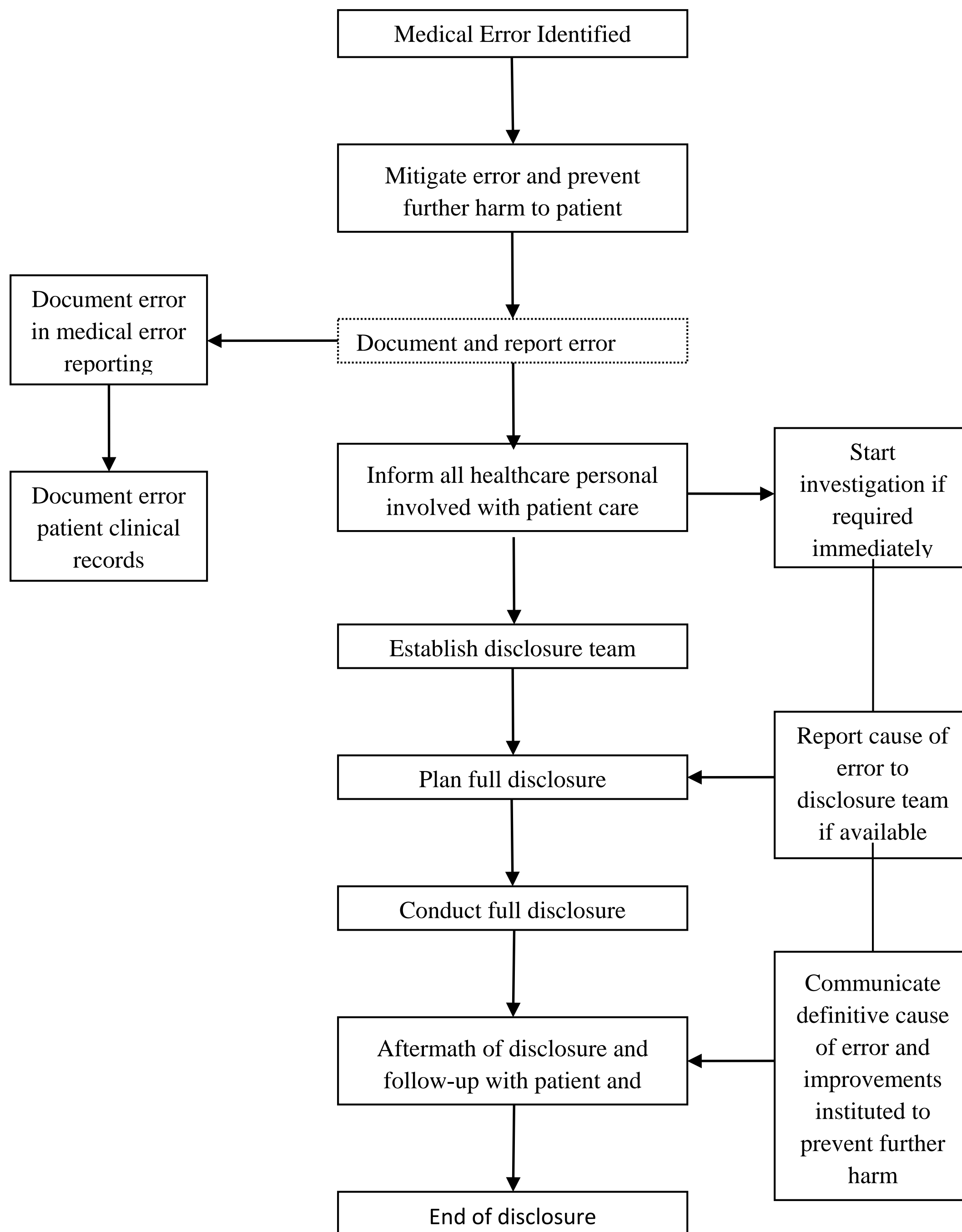

Fig 1: Algorithm for reporting and Disclosure of Medical Errors

ii. conducting the disclosure
iii. aftermath of the disclosure

Planning the disclosure

The process of planning a disclosure begins immediately an error is identified. Though patients desire full disclosure at the earliest convenience, it is important that the process is thoroughly planned [29,32,33]. Immediately an error is identified, it should be documented and urgent appropriate treatment administered to mitigate the error and prevent further harm to the patient[8]. All health care personnel involved in the event are notified and an investigation started if appropriate[34]. In planning a full disclosure, planners must determine who would lead the disclosure, who would be participating, what will be disclosed, when and where disclosure will occur. When errors occur, the attending physician or consultant bears the burden of disclosure and leads the disclosure process[35]. In situation where there is no consultant the most senior doctor bears the burden of disclosure. Nurses, trainees and other allied professionals may participate in the disclosure process[7,36–39]. Patients want to know what error occurred, how it happened, why it happened and steps taken to prevent recurrences of similar errors[20,40–42]. The disclosing physician must organise his/her

thoughts and anticipate responses and questions from patient and family[33]. Timing of the disclosure is critical[43]. Whilst most guidelines and policies suggest informing patients and family within 24 hours of knowledge that the error occurred, it should take place when the patient is stable and in the right frame of mind[20,36,39]. However, when a medical error results in the death of a patient the family must be notified immediately and given all the emotional and psychological support they need. An expedited investigative and full disclosure process is recommended to provide early closure to the bereaved family. The disclosure meeting should take place in a quiet, private setting that ensures confidentiality**.**

Conducting the disclosure

Initiating the disclosure

The lead clinician or consultant initiates the disclosure by introducing him/herself and everyone else representing the healthcare institution, the family is also politely asked to do likewise. The physician proceeds with an expression of sympathy and compassion for the circumstances.

Full disclosure

Disclosure must take into account the patient's personal, social religious and cultural background[7]. The Harvard Teaching Institutions' "When Things Go Wrong" has outlined four essential steps to full disclosure[9].

- Tell the patient and family what happened
- Take responsibility
- Apologize
- Explain what will be done to prevent future events

The disclosing physician tells the patient and family what happened in a clear and simple language avoiding medical jargons. He or she must also refrain from being defensive, speculative and laying blame[23]. The lead physician makes a clear statement of responsibility to the patient and family, even though he/she might not have committed the error and proceeds to render a formal apology with show of genuine remorse[9]. It is also noteworthy to state that whenever an obvious error occurs, the primary care giver must apologize and show genuine remorse before and during disclosure proceedings. Apologizing is an essential aspect of taking responsibility and it preserves the therapeutic relationship between the doctor and patient. Apologies heal both the patient and provider[9,23,44]. The patient is informed about measures implemented to prevent harm to other patients in future and concludes the meeting by asking if anyone still has questions or some clarifications. Informing patients about measures implemented to prevent such errors in future offers some reprieve to their suffering, knowing others will not experience their suffering[23].

Closing the disclosure

As indicated earlier disclosure is an on-going process, and not a single event. Patients and family must be informed about plans for follow-ups and updates of new information as they emerge. A contact person for follow-up by the patient is then introduced to the patient and channels of communication also made available[45].

Results

Aftermath of the disclosure

This stage of disclosure occurs after the definitive cause of the error and improvements made to prevent harm to other patients. The disclosure team communicates the cause of the medical error to the patient and makes known improvements instituted[46].

Benefits of Disclosure

The doctor and patient benefit when medical errors are disclosed, even though the opposite might seem to be the case for both parties especially for the doctor. Foremost is the trust of the public in the institution of the doctor. When doctors disclose their errors the public trust in medicine is bolstered because the patient's wellbeing is seen to be preserved over narrow and selfish professional interests. This leads to the development of more trust and an open relationship between the doctor and their patients and family[36]. The physician also upholds his ethical duty to tell the truth hence, boosting his or her self-esteem and restoration of self-respect [27].

Clinicians also develop disclosure skills and become less anxious about disclosing their errors when they occur. Aside from error disclosure skills, routine clinical skills, safety skills and clinical knowledge is enhanced due to institutional improvements and policy implementation subsequent to investigations and audits that happen when errors are discovered. Disclosures programmes particularly from US institutions have laid bare the tremendous benefits due to disclosure of medical errors. Disclosures have led to reductions in malpractice claims and legal action against healthcare professionals and institutions with attendant benefits of improved clinical care and patient safety resulting in lesser errors and patient injuries [36,47,48]. The healing and coping process for both the doctor and patient is augmented when telling the truth, both become liberated allowing healing to occur with the patient knowing what went wrong and satisfied that it will not happen to another patient. Improving Statistics of Medical Errors in Sub-Sahara Africa The absence of medical error reporting mechanisms and databases in healthcare institutions in sub-Saharan Africa has contributed largely to the under-reporting of medical errors[16,17]. This continues to undermine quality improvement and patient safety, hence the need

for healthcare institutions to urgently develop and implement medical error reporting and disclosure mechanisms that are voluntary, non-punitive and ensure confidentiality. The Minimal Information Model for reporting patient safety incidents proposed by the World Health Organization (WHO) may be adapted by institutions. The model is easy to use and looks at the core elements of any reporting system (Table 1)[49].

Table 1: Minimal Information Model for Patient Safety Data Categories

Data Categories of the Minimal Information Model	
Incident identification	
• Patient	*Sex, age*
• Time	*Date and time of day*
• Location	*Physical setting error occurred*
• Agent (s)	*Product, device, person,*
Incident type	*Describes incident*
Incident outcomes	*Impact to patient and institution*
Resulting actions	*Disclosure, ameliorating or preventive actions*
Reporter	*Person who collects and writes about the incident*

An improved and reliable statistics on medical errors in the sub-region will in the long run improve the quality of care and patient safety.

Conclusion

Disclosing a medical error yields several benefits for both the patient and doctor and more importantly, it is an ethical and a professional obligation to the patient. Doctors must make a determined effort to learn how to disclose medical errors and fulfil their ethical obligation to patients by making disclosing of errors a routine habit. This will provide a learning platform for acquiring the skills and dissolve the barriers that make it difficult to be open when errors occur.

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