

Open School

Case Study: (AHRQ) The Wrong Shot: Error Disclosure

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Learning Objectives: At the end of this activity, you will be able to:

- Describe the rationale for disclosing harmful errors to patients.
- Describe the specific information that patients want disclosed following a harmful error.
- Define the "disclosure gap" and the barriers that contribute to the difficulty health care workers experience in disclosing errors to patients.
- Recognize the emotional impact that errors have on health care workers and how these emotions can impair the disclosure process.
- List specific steps that institutions can take to enhance the disclosure of harmful errors to patients.

Description

A child is mistakenly vaccinated for hepatitis A, rather than B. Despite forthright disclosure and no evident harm to the child, the father becomes incredibly angry at the providers.

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- [PS 105: Communicating with Patients after Adverse Events](#)
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Key Topics

Engage patients and families in care, patient- and family-centered care, transparency, communication, satisfaction: patient and family, adverse event, culture of safety.

Case & Commentary: Part 1

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A 10-year-old child from India presented to his pediatrician's office for a school physical. The child had no past medical history, was in excellent health, and all immunizations were up to date with the exception of Hepatitis B. The physician discussed the issues around vaccination with the patient's father and obtained consent. The nurse drew up the vaccine and the physician administered it. After administration, the physician went to record the lot number and discovered that a dose of vaccine for Hepatitis A had been given instead of Hepatitis B.

Adverse drug-related events are common in both the inpatient and the outpatient setting. Studies of hospitalized patients find that up to 6.5% had an adverse drug event and about 25% of those were preventable.(1) While less is known about adverse drug events in outpatients, a recent study demonstrated that over 25% of outpatients had experienced a recent adverse drug event, with 40% of those being either ameliorable or preventable.(2)

Ethicists have long recommended that patients be told about all harmful errors, to demonstrate respect for patients and foster honesty in the patient-provider relationship.(3,4) Increasingly, hospital policies and regulatory agencies also require disclosure of "unanticipated outcomes." (5) Yet disclosure of errors, particularly discussion of the details of the event, continues to be uncommon. In one recent national survey of both the public and physicians, only one-third of respondents who had personally experienced a medical error said that the involved health care professionals had disclosed the error or apologized to them.(6)

When a harmful error takes place, patients first want an explicit, jargon-free statement that an error occurred and a basic description of what the error was and why it happened.(7) Patients dislike explanations that seem evasive. Second, patients want to understand the implications of the error for their health and how their health care workers will deal with the consequences. Third, patients want to know how the physician, other health care workers, and the health care system will learn from this error; understanding how future errors will be prevented is more important to patients than many physicians appreciate. Fourth, patients want their physician to apologize, which demonstrates that the physician genuinely cares about what happened.

However, health care workers may hesitate to provide this information to patients. Studies of physicians' attitudes have identified several important barriers to disclosure, such as physicians' fear of litigation, concern about whether the information might harm patients, and discomfort with how to share the information.(7-9) These barriers can lead physicians to "choose their words carefully" when talking to patients about errors, mentioning the adverse event but avoiding explicitly stating that an error occurred. In addition, physicians want to apologize to patients but worry that doing so will increase their legal liability. Physicians further wonder whether to take personal responsibility for an

error, especially given the patient safety movement's emphasis that most errors are not failures of individual providers but rather breakdowns in the system of care.

This "disclosure gap"—namely the mismatch between recommendations that all harmful errors be disclosed to patients and the evidence that, in practice, such disclosure is uncommon—has two potential interpretations. Clinicians may appreciate that error disclosure is "the right thing to do" but experience insurmountable obstacles in their attempts to tell patients about errors. Alternatively, this disclosure gap may reflect under-appreciated but morally relevant complexities in the decision about whether and how to disclose errors to patients. For example, the patient in this case suffered minimal if any harm; it is even possible that the inadvertent administration of a dose of Hepatitis A vaccine may have helped the patient. Little is known about whether disclosure of errors that cause minor harm or disclosure of near misses is desirable from either patients' or physicians' perspectives.

Case & Commentary: Part 2

Without hesitation, the physician informed the father that the wrong vaccine had mistakenly been given to the boy. He explained the usual indications for Hepatitis A vaccination and emphasized that this vaccine would not bring any harm to the boy and may even protect him from illness in the future. He suggested that the boy still receive the Hepatitis B vaccine. The father became extremely angry. He refused to allow further vaccination and proceeded to report the incident to the clinic administrator.

Patients' reactions to hearing about such an event depend in part on the content of the disclosure as well as the communication skills used to deliver this information. Patients especially value understanding how an error happened and how recurrences will be prevented, information physicians (as in this case) often fail to share with patients. We believe that an essential component of narrowing the disclosure gap is for physicians to begin conceiving of error disclosure not as "service recovery" but rather as an integral component of quality improvement.⁽¹⁰⁾ The father might have been less angry had he learned that, as a result of this error, such vaccines were now being stored in separate and clearly labeled spots in the physician's office. Furthermore, the need to tell the family about an error's cause and prevention may stimulate the physician to think more critically about why the error happened and develop a robust prevention plan, thereby enhancing the quality of future care. Determining exactly how an error happened and formulating a plan for preventing recurrences can be especially challenging in the outpatient setting, where the resources to conduct formal error analyses may be absent.

Empathic communication techniques can also help physicians respond to patients' anger.⁽¹¹⁾ Empathy refers to the process of understanding and explicitly acknowledging patients' feelings, and listening carefully as patients share their distress. As in other difficult communication situations, such

as delivering bad news, the health care professional must listen attentively and offer support when a patient is expressing a powerful emotion, whether the emotion is sadness, anxiety, or even anger.(12) Usually, the intensity of the patient's feeling will diminish as the physician listens, acknowledges, and, when appropriate, validates the feeling in a caring fashion. Communicating empathically can be especially challenging in the setting of an error, when the patient's upset emotions may be explicitly directed at the physician.

For some patients, anger following a medical error leads them to file a malpractice claim. Considerable debate currently exists about whether full disclosure of medical errors makes malpractice claims more or less likely. Many have argued that skillful disclosure may assuage such anger and lessen the chances of a malpractice claim.(13-15) However, skeptics argue that the reason few injured patients actually sue is because they were unaware that the error occurred, and that more open disclosure could actually precipitate lawsuits.(16) Even a remote chance that error disclosure could prompt a malpractice suit is worrisome to physicians, given the impact such a claim could have on physicians' already skyrocketing malpractice premiums, as well as the need to report successful claims to the National Practitioner Databank and hospital credentials committees. Wholesale tort reform and adoption of a no-fault malpractice system would clearly facilitate full disclosure of errors to patients. Yet, the current political climate is unlikely to support such dramatic tort reform.(17) In the meantime, individual clinicians must still decide what to tell patients about medical errors. Overall, we recommend that clinicians respond to medical errors with an underlying assumption of full disclosure, but work closely with experienced risk managers throughout the disclosure process to minimize unanticipated legal risks.

Case & Commentary: Part 3

After the vaccine incident, the physician in this case felt responsible for the loss of trust and the missed opportunity to administer an important vaccine to a child.

Physicians frequently experience powerful emotions following a medical error.(7,18-20) As highly responsible individuals, it is not surprising that most physicians will feel a sense of shame and culpability for errors, disappointment about failing to practice medicine to their own standards, and fear about possible law suits. For some physicians, the emotional aftermath of an error can include physical symptoms such as sleeplessness, difficulty concentrating, and anxiety.

We believe that addressing health care workers' emotional needs following errors is critically important. The presence of such emotional distress can diminish physicians' well-being and impair the disclosure process. Some distraught physicians may mistakenly assume that an adverse event was due to an error and disclose this information to the patient, when on closer analysis the adverse event was actually not preventable. For other physicians, feelings of guilt and embarrassment can prevent

them from disclosing a serious error to the patient. While physicians may desire to discuss the circumstances of the error and their feelings with a trusted colleague, many risk managers warn that such conversations between physicians can be subpoenaed in a court of law.

Institutions can take several steps to improve error disclosure. First, they can provide emotional support for health care workers as an explicit component of their patient safety program. In addition, they should offer communication skills training and the opportunity for physicians to practice disclosing errors, analogous to workshops that teach physicians to discuss other difficult topics such as end-of-life care. We have used standardized patients to allow surgeons to practice disclosing a major error and to receive feedback; to date, these surgeons report this to be a valuable and novel learning experience. Finally, education of physicians and other health care workers about the causes and prevention of errors can dispel the misperception that errors are usually the fault of individual providers.

Take-Home Points

- Harmful errors should be disclosed to patients. Such disclosure should include an explicit statement that an error occurred, basic information about the error's cause and prevention, and an apology.
- Physicians should seek help from institutional risk managers or others skilled in disclosure before discussing an error with a patient.
- Greater attention should be paid to the relationship between error disclosure and quality improvement.
- Institutions should support error disclosure both by providing communication skills training and by implementing programs to support health care workers' upset emotions following a medical error.
- Further research is needed about the relationship between disclosure and malpractice, as well as on the factors that influence physicians' approach to error disclosure.
- Effective error disclosure could enhance patient safety and improve the quality of care.

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Discussion Questions

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1. Now that the doctor has recognized the mistake, what should he/she do and/or say to the nurse, and the patient and family?
2. What action(s) should the medical team take to understand why this error occurred? What changes can they make to ensure that this error does not occur again?
3. What barriers in medicine make full disclosure challenging?
4. What are the ramifications of disclosure on:
 - The doctor-patient relationship?
 - The relationship between the patient and the medical care system as a whole?
 - The relationship(s) between members of the medical team?
5. Is it more or less important to practice full disclosure for errors that have led to harm than for those that have not? Why?
6. Should full disclosure include an apology for the error that occurred? If so, how should the apology be phrased to the family (i.e., should it be an apology for the fact that an error occurred, or a personal apology for causing the error)?
7. Do you feel that you have adequate training to practice full disclosure with your patients? If so, what training has helped you to feel this way? If not, what preparation would be most useful?

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