

To Air the Error: Lowering the Barriers to Successful Disclosure Conversations

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Clinicians are challenged to communicate unanticipated outcomes and medical errors. This article discusses how to lower the barriers to successful disclosure conversations.

Since the release of the Institute of Medicine report *To Err Is Human* in 1999, patient safety and medical errors became paramount not only to health care providers but also to patients (health care consumers).¹ The report has been likened to removing the lid off Pandora's box as it relates to safety and error.² Following this report and the heightened attention on medical errors, The Joint Commission released the standard RI.1.2.2:

The responsible licensed independent practitioner or his or her designee clearly explains the outcome of any treatment or procedure to the patient and, when appropriate, the family, whenever those outcomes differ significantly from the anticipated outcomes.³

Despite the heightened attention to patient safety and quality of care, the Agency for Healthcare Research and Quality (AHRQ) reports that patient safety continues to decline in the United States. The AHRQ estimated that in 2005 and 2006, 1 in 7 Medicare patients experienced an adverse event. The AHRQ estimated that overall measures

of patient safety declined by nearly 1% in each of the previous 6 years.⁴

The good news is that a lot of work is taking place nationally to change this.

FOCUSPOINT

Health care providers are challenged with communicating unanticipated outcomes and medical errors to patients and their families.

The Institute for Healthcare Improvement (IHI) published a white paper in 2010 entitled "Respectful Management of Serious Clinical Adverse Events."⁵

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TABLE 1. Barriers to Disclosure of Medical Errors^{13,14}

1. Fear of retribution from the patient
—Legal or physical
2. Fear of retribution from peers or colleagues
—Professional ostracism
3. Lack of experience or training in disclosure conversations
—Convey misinformation
4. Fear of handling patient emotions
—Patient anger or upset
5. Discomfort handling one’s own emotions
6. Admission of error implies inadequacy or weakness
7. Believe disclosure is not necessary
—Contradicts policy standards
8. Question the benefits in disclosure

This paper outlines the steps that our institutions can take to support the move forward to a new culture. Since to err is human, we have to accept that the practice of medicine will never reach perfection; therefore, our focus should change to one of reducing that error rate to the lowest possible level.

To do this, we have to increase awareness about the need for systems to support health care providers in delivering the best possible care to patients. We need to analyze our “bad outcomes” from this viewpoint. We also need to have increased transparency so the best minds can assist us in reaching the goal of the lowest possible errors. The IHI white paper is an excellent resource for the practical application of these principles.

With the changes noted above in the patient safety paradigm, health care providers are challenged with communicating unanticipated outcomes and medical errors to patients and/or their families. While physician-patient communication has been recognized as an important aspect of patient care (aside from clinical

outcomes and patient compliance), communication of “bad news,” especially in the context of errors, can pose for some an insurmountable challenge.⁶

Here we explore these challenges as we attempt to lower the barriers to successful disclosure conversations as well as provide models of effective disclosure.

Honest Communication

The majority of patients (98%) wish to be informed of unintended outcomes or errors: The more severe the occurrence, the higher the desire for information.⁷ Patients in particular want honest, prompt, and compassionate communication when mistakes occur.⁸

Disclosure of adverse events is associated with approval and relief by health care providers, higher ratings of quality by patients, an improved rate of recovery, a decrease in the number of malpractice suits, and a decrease in the average settlement amount.^{9,10} However, health care providers and organizations continue to demonstrate reluctance to provide full disclosure for several reasons, including fear of litigation, though the exact impact and relationship of disclosure with litigation is difficult to ascertain.^{8,11}

Full disclosure of medical errors is what patients want from their clinicians, and it is also ethically the right thing to do. Several institutions including the University of Michigan have recently implemented full disclosure programs for medical errors without any increase in liability costs or total claims.¹²

There is increased agreement that admission of a medical error is simply a factual statement.¹² So why then, with the ethical obligation to disclose, patients’ desire to be told, and evidence to suggest that litigation and malpractice costs are not increased, are clinicians reluctant and resistant to disclose medical errors? Furthermore, how do we move from “disclosure” to “communication”?

There are multiple barriers to disclosure of medical errors in addition to the fear of litigation. These barriers are psychological, legal, and based on personal

TABLE 2. Three Models to Overcome Disclosure Barriers

The “FEARED” Factor¹⁵

- F** Get all the Facts
- E** Express Empathy and Educate
- A** Search for sources of Anger
- R** Have the patient Relate back to you her understanding of your explanation
- E** Evaluate the Extended family response
- D** Document the conversation

The TEAM Approach¹⁶

- TEAM**—Whose presence is required for the conversation?
- T** =Details/Facts are relayed Truthfully
 - E** =Conversation relays Empathy and concern for patients
 - A** =An Apology (“I’m sorry”) is offered for medical mistake
 - M**= Ongoing patient Management and care are addressed

The Who, What, Where, When, and How Model¹⁰

1. Who should disclose?
 - Every effort should be made to ensure the primary provider of care involved in the error communicates disclosure
2. What should be disclosed?
 - All factual information must be communicated to patient without speculation
3. When should infractions be disclosed?
 - Disclosure should be as timely as possible to decrease speculation
4. Where should the conversation be held?
 - In a private, confidential, comfortable setting
5. How should the conversation be conducted?
 - With empathy and respect for patient dignity

experience. Table 1 lists these barriers collectively.^{13,14}

Overcoming Disclosure Barriers

The barriers are numerous, yet disclosure must occur. Several models are suggested here as a means to overcome the

disclosure barriers. They are listed in Table 2.^{10,15,16}

The FEARED factor acronym not only provides a sequence of statements but describes an emotion felt by most clinicians in these situations. All 3 models, perhaps one in particular, or an adaptation of each should assist clinicians in preparing for and conversing with patients about medical errors.

Culture Of Patient Safety

Finally, it is equally important that health care organizations recognize the importance of disclosure in medical errors. A culture of patient safety with policies and procedures that enhance open communication between clinicians and patients is essential. All health care institutions should have written policies that address disclosure as it relates to timing, content of conversation, communication, and documentation of disclosure.

Clinicians need education and training in disclosure conversations just as they receive training and competency in procedures. If communication and disclosure were viewed as a procedure, clinicians could and would receive similar procedural training and feedback. Simulation of medical error disclosure conversations is essential for clinicians to overcome many barriers, as is now done in medical education and in the airline industry. Utilizing the clinical rotations in medical school as the initial encounter for clinicians to learn how to deal with it may not be the appropriate place any longer.

Some curriculums have implemented disclosure scenarios in the initial years of training that continued through the residency program. Utilizing simulations for these unusual scenarios, as we do with other examples such as shoulder dystocia or postpartum hemorrhage, should be routine. Presenting the continuum of the clinical event and adding the disclosure of a bad outcome at the end would bring the learner full circle and develop the skills necessary to improve our responses when the real event occurs.

Institutions can support disclosure

training by making use of risk management and legal services. This helps to alleviate liability fears and thus complement the competencies we already include in our resident education, ie, professionalism, interpersonal and communication skills, and practice learning and improvement.

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