Dealing with Medical Errors
What should I say?

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Presented in 2010 by gurdev Singh, Director, UB Patient Safety research Center
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‘Health’ Warning: This talk may raise
more questions than it answers !!
The Six ACGME Core Competencies

Patient Care

Communication

Knowledge

Professionalism

Practice Based Learning

System Based Practice

Safety Transcends all Competencies
Safety is a fundamental system property. Without safety there can be no quality of care. IOM

Patient Safety Is
“freedom from accidental injury due to medical care or medical error”
And then there are other adverse Events!!

US Healthcare

National Burden of Systemic Errors in the Health Care

1.5 Million/year Incidents of Harm

2-5 Jumbo jets of the Health Care Industry drop out of the sky every day
(Analogy after Leape: the Safety Guru of USA)

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# International Rankings and National Health Expenditure (Through Patient’s Lens)

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Money vs. Health. No relationship

Better health

Worse health

Individual U.S. states

Our Goal

Less state spending

More state spending

Congressional Budget Office Head, Peter Orszag: Times Nov 08
If this is not a MAJOR National Disaster my name is not gurdev
This constitutes nearly 50% of the surgical “Never Events”

Wrong body part: 30%  
Wrong procedure: 16%  
Wrong patient: 4%

COST About 20Billion/yr

CMS press release 2006 (Minnesota Study)
Patient Safety Awareness Week

March 7-13

Let's Talk

FOR SAFER HEALTHCARE

www.NPSF.org

Singh 10
Currently we live in Fear

Scherkenbach’s Cycle of Fear, 1991
Currently we live in Fear

Kill the messenger
(denial; shift the blame)

Scherkenbach’s Cycle of Fear, 1991
Currently we live in **Fear**

- **Kill the messenger**
  - (denial; shift the blame)

- **Filter the data**
  - (game the system)

Scherkenbach’s Cycle of Fear, 1991
Currently we live in **Fear**

- **Micromanage**
  (Barking up the wrong tree)
- **Kill the messenger**
  (denial; shift the blame)
- **Filter the data**
  (game the system)

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Scherkenbach’s Cycle of Fear, 1991
Currently we live in **Fear**

- **Micromanage** *(Barking up the wrong tree)*
- **Filter the data** *(game the system)*
- **Kill the messenger** *(denial; shift the blame)*

Scherkenbach’s Cycle of Fear, 1991
“From January to May, I work for the government to pay for my income tax and from May to October to pay for my malpractice insurance”
There are increasing calls for Error Disclosure from various directions with increasing disclosure protection.
Overview

• Background
  – Current culture of blame and non-disclosure
  – Ideal culture of safety with open disclosure

• Ethical principles

• What do patients want?

• What do physicians think?

• Risks and Benefits of Disclosure

• A practical approach to disclosure

• Conclusions
Errors are common
Harm sometimes occurs – it is preventable
System problems are usually at the root
Humans are often unfairly blamed
– To err is human
Current culture is conducive to hiding errors to avoid repercussions
When errors are hidden we cannot learn from them
Example: System for ordering labs and obtaining results
(a small sub-system!)

Doctor

Lab Slip

Lab

Specimen collection

Patient

Test Log

Doctor’s In-Box

Doctor

Patient

Chart

To be filed

Clerk

Report

To be filed
Background 2/3

• When errors are hidden we cannot learn from them
  – We need to change the culture !!

• In a Culture of Safety:
  – People are able to discuss errors openly without fear of repercussions
  – Attention is focused on faulty systems rather than blaming individuals for all problems
  – This includes disclosing errors to patients and families where appropriate
Background

Disclosing errors to patients and families

How can we decide whether it is appropriate to disclose or not?
Ethical Principles that can guide our disclosure decisions

*Beneficence* – act in the best interests of the patient

*Nonmaleficence* - do no harm

*Patient Autonomy* – protect and foster a patient's free, uncoerced choices

*Justice* – fairness of healthcare in society
If it’s often the “right thing to do” why not just do it?
The doctor is in court on Tuesdays and Wednesdays."
“From January to May, I work for the government to pay for my income tax and from May to October to pay for my malpractice insurance”
What do patients want? 1/3

Gallagher et al JAMA 2003 289(8)1001-7

Patients wanted disclosure of all harmful errors and information about:

* What happened
* Why the error happened
* How the error's consequences will be mitigated
* How recurrences will be prevented.

**NOTE:** they don’t want to know who’s fault it is

Patients also desired emotional support, saying that they would be less upset if the physician:

* Talked honestly
* Showed compassion
* Apologized

Qualitative study (13 focus groups of patients/physicians)
What do patients want?

Schwappach Int J Qual H Care 2004 16(4):317-26

- Internet survey 1017 citizens of Germany
- In cases with a severe outcome, if the physician was:
  - Honest
  - Empathic
  - Accountable
- Then, there was a 59% decrease in support for strong sanctions (e.g., lawsuits) against the physician
What do patients want?


• 149 outpatients at an academic medicine clinic
• 98% wanted to be informed, even of a minor error
• For errors of various severities, patients reported that if they were informed of the error by the physician (vs. finding out from another source) then they were:

  Error of Moderate Severity
  – Less likely to change doctors (60 vs. 92%)
  – Less likely to report the physician (23 vs. 52%)
  – Less likely to file a lawsuit (12 vs. 20%)
Why do people sue?

• Of course, every case is different.
• Studies have shown that there is little, if any, correlation between quality of care and likelihood of malpractice claims.
  – Many suits are filed even when no lapse in quality has taken place.
  – In cases where medical negligence has taken place, only a small minority of patients or families file suit (perhaps as low as 3%)

• So, why do people sue??
Why do people sue?

Hickson et al JAMA 1992;268(11):1413-4

• Interviewed 127 mothers who had sued due to perinatal injuries to their infants.

• **Reasons for filing suit included:**
  – Advised to sue by knowledgeable acquaintance (33%)
  – Recognized a cover-up (24%)
  – Needed money (24%)
  – Needed information (20%)
  – Wanted to protect others from harm (19%)

• Respondents believed that their physician(s):
  – Tried to mislead them (48%)
  – Did not talk openly (32%)
  – Did not listen (13%)
What do physicians think?
Gallagher et al JAMA 2003 289(8)1001-7

• Qualitative Study
• Physicians agreed that harmful errors should be disclosed but
  – "choose their words carefully" when telling patients about errors.
  – often avoided stating that an error occurred, why the error happened, or how recurrences would be prevented.
• Physicians were upset when errors occurred and expressed a desire to apologize but worried that an apology might create legal liability.
Benefits and Risks of Disclosure

Benefits to the Patient

* Opportunity to receive corrective treatment
* Helps them to make informed decisions
* Promotes trust in the physician
* Alleviates worry – why did that happen to me?
* Acknowledges fallibility – encourages patient to take greater responsibility for their own care
* Opportunity to receive fair compensation

Benefits to the Physician

May be less likely to be sued

* If sued, the fact that you disclosed may help your case
* May help alleviate stress
* Fulfills your moral obligation to tell the truth
Benefits and Risks of Disclosure

• Risks to the Patient
  – Anxiety / Confusion (but pt’s in Gallagher’s study did not report this)
  – Loss of trust in the system
  These risks may justify non-disclosure of inconsequential errors

• Risks to the Physician
  – Risk of being sued (if the patient wouldn’t otherwise know about the error)
  – Risk of disciplinary action
  – Possible loss of reputation
  – Loss of patients
Joint Commission Requirement
(Endorsed by most Patient Safety and Risk Management organizations)

• As a requirement of Joint Commission certification, hospitals must develop policies on disclosure of unanticipated outcomes to patients/families.
• Disclosure only required for unanticipated outcomes – ie when there is harm
• Don’t have to disclose an error if no harm results
• But:
  – Does this meet the ethical standard?
  – Who is to decide what harm is?.....
Was there harm?

• Differing perceptions of harm.
• Is it harm if –
  – Treatment is delayed slightly?
  – Hospital stay is prolonged?
  – Patient undergoes unnecessary tests?
  – Patient has to incur additional costs?
  – Hospital or health plan has to incur additional costs?
• Harm may not be apparent until after discharge.
  – Therefore the patient may need to be informed of warning signs for potential harm.
• These and other practical issues need to be resolved.
• As a student – do nothing by yourself!

• If you discover an error:
  – Inform your supervisor(s)
  – Discuss possible disclosure options
  – Ultimately the physician has to decide whether to disclose and what to say
What should I say?

- As a physician
  - If no or mild harm
    • Consider informing (weigh the risks and benefits)
  - If significant harm
    • Consult with risk management / malpractice carrier
    • Consider informing (weigh the risks and benefits)

- If you decide to disclose:
  • What should you say?
"Good news! The exploratory surgery turned up negative!"
"We sincerely regret the unnecessary surgery, and we’re going to put back as much as we possibly can."
Consider doing the following (in a timely fashion):
(after weighing up the risks and benefits)

1. **Acknowledge** the error
2. **Apologize** and empathize
3. **Accept some responsibility**
4. **Commit to investigate & prevent**
5. **Set the tone**
6. **Address adverse consequences**
7. **Address any other concerns**
8. **Arrange follow-up**
Error disclosure protocol: 2/6

1. Set the tone
   - in person
   - eye-level
   - private & respectful
   - consider participants
   - check comfort
   - allow time for the patient/family to react to what you say
   - listen
2. **Acknowledge the error**
   - Be direct
   - Use words such as “error” or “mistake”

   “I think you received the wrong medication by mistake”

   “You are right - you were supposed to get the MRI today. Sounds like an error was made.”
3. Apologize and empathize

- “I’m sorry that this happened to you”
  - is not an admission of guilt
  - it’s not a true apology either!

- “I certainly understand your anger about the unnecessary delay in your discharge”
  - an expression of empathy

- “I’m sorry I made a mistake”
  - is a true apology
  - however, it is an admission of guilt – may create legal liability in some states
  - may be premature (most harm is multi-factorial and involves system failures)
Error disclosure protocol: 5/6

4. **Accept some responsibility** for the error and its consequences

- If you are sure it was your error, consider saying so:
  “It was my mistake. I forgotten to write the order.”
  *Note that this can create legal liability*

- If it is possible you may have contributed to the error, consider saying so:
  “I’m not sure how this happened. I may have written the wrong order, or maybe it was illegible, or maybe someone else made a mistake in following the orders.”

- Don’t be too sure about your personal responsibility without some pause for reflection and supervision. Guilt can influence your words.
5. Commit to investigate and prevent
   • Commit to investigate the error to find its causes
   • Commit to inform the patient of the findings
   • Commit to attempt to prevent the error from happening again

6. Address adverse consequences
   • Screen & work up as needed
   • Educate/advise patient as needed

7. Address any other concerns

8. Arrange Follow-up
Tips for “safe” disclosure

Don’t be evasive
*Make yourself available
*Don’t say “No comment”

Don’t jump to conclusions prematurely – some questions require further investigation before they can be answered. Say that you are not sure rather than blaming someone else or denying responsibility immediately.

Don’t use jargon – the patient may think you are trying to confuse them.

Don’t promise something unless you can deliver.
Conclusions - Theory

- **Ethical arguments** in favor of full and honest disclosure of all errors, regardless of harm caused, are widely recognized.
- **JC** requires that errors be disclosed if harm occurs.
- Most patients desire full disclosure and an apology.
- **Fear of litigation** makes many physicians feel uncomfortable disclosing information and apologizing.
- The desire to find out what happened, and to prevent recurrence are the cause of many lawsuits.
- Disclosure may decrease the risk of litigation since it helps to meet these needs – further studies are needed.
Conclusions - Practice

• Don’t despair (it’s not all doom and gloom!)
  – Most errors have relatively mild effects
    • as a physician, *errors will happen* in your practice
      but you can manage them effectively if you communicate well with your patients
  – For errors that cause serious harm
    • you are not alone
    • help is available
Final Thought

“Treat other people the way you would want to be treated.”
Thanks

and from Ranjit Singh
Pursuit for Safety is a NEVER ENDING Journey