Disclosure of Medical Errors

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Medical errors are alarmingly frequent, with as many as 250,000 deaths per year being attributable to medical error. This makes medical error potentially the third most common cause of death in the United States. Approximately 1% to 3% of pediatric hospital admissions are complicated by medical error. Medication errors are frequent in children in part due to weight-based dosing, with more than 5% of medication orders containing an error. Although not every error causes death, medical errors can significantly affect the course of a patient's illness and can cause significant morbidity and alter the relationship between the family and the physician. With medical errors occurring in all health-care settings, no provider can consider themselves immune. As such, every physician, including pediatricians, should be prepared to disclose errors.

Since the Institute of Medicine's 1999 publication of "To Err Is Human: Building a Safer Health System," there has been a shift in response to medical errors from a deny and defend mindset to a philosophy of transparency. Disclosure refers to the process of communicating with a patient about an adverse event. Most physicians and professional organizations agree that there is an ethical and moral obligation to disclose when an adverse event results from a medical error, based primarily on the concepts of autonomy and justice. Failure to disclose affects a patient's autonomy to make informed decisions about his or her health. The principle of justice dictates that patients should be able to seek reasonable compensation for harm. Failure to disclose erodes trust in the physician-patient relationship; studies have shown that disclosure actually improves this relationship after an error. Research also confirms that patients expect disclosure and transparency when an error occurs and that this expectation is stronger in cases with more significant harm. Disclosure can lead to improved patient safety outcomes by increasing reporting of safety issues and providing opportunities to address problems in the hopes of preventing recurrence. Although disclosure is often stressful for physicians, long term it may help alleviate physicians' guilt and anxiety surrounding the error, protecting against second victim–related trauma.

A legal obligation to disclose has been added in several states. In addition, many health systems have policies that mandate disclosure of certain errors. Multiple professional organizations also urge error disclosure. For example, the Joint Commission on Accreditation of Healthcare Organizations requires that hospitals inform patients of unintended outcomes, and the American Medical Association Code of Medical Ethics obligates physicians to report negative outcomes that result from medical treatment. Although providers often worry that error disclosure would invite medical malpractice claims, data from the University of Michigan suggest that error disclosure may actually decrease the risk of litigation and associated costs. In addition, more than two-thirds of US states have enacted "apology laws" aimed at keeping certain statements made

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during a disclosure or apology from being used in a lawsuit. Because insurance companies may refuse to pay claims for additional costs accrued due to medical errors, providers are also contractually obligated to disclose to insurance companies if errors have occurred.

A large gap exists between recommendations on disclosure and the disclosures that front-line physicians actually deliver to patients, and many disclosures are incomplete or poorly done. Disclosing a medical error is perhaps one of the most unpleasant tasks that a physician may have to perform, and studies have cited this discomfort as a barrier to disclosure. Other barriers include fear of blame, of legal repercussions, of loss of professional standing among colleagues, and of loss of medical licensure. Physicians report a lack of role models and inadequacy of training in this domain. Recognizing this, the Accreditation Council for Graduate Medical Education's Clinical Learning Environment Review program includes resident/fellow education and experience in medical error disclosure as 1 of its 7 Patient Safety Pathways, encouraging this training for new physicians. Institutional support for error disclosure and a strong safety culture can also help physicians feel more comfortable disclosing errors. For providers working in health-care systems with a risk management department, these personnel are often able to provide just-in-time training to prepare a physician for a disclosure conversation.

Guidelines suggest that disclosure should include a clear statement that an error has occurred, details regarding that error, and how it will affect the patient's health. It is also widely recommended that disclosure include a sincere apology and a statement regarding how the health-care team will avoid similar incidents in the future. Error disclosure should be done as quickly as is reasonable after an error has been detected and the patient has been suitably stabilized, even if not all of the details of the event are available at that time. Delays before disclosure may raise concerns for a cover-up of the incident. Similar to a family meeting in other contexts, the setting should be chosen such that interruptions are minimized, with phones and pagers silenced, and the family should be given the option to have additional support persons at the meeting if desired. Individuals present at the family meeting should include the physician overseeing the patient's care (generally the attending physician); other providers who were involved (including trainees and those from other disciplines if relevant), especially if the overseeing physician was not directly involved in the error; and potentially a representative from hospital administration and/or risk management. The incident should be explained objectively, avoiding placing blame or acting defensively. The physician disclosing the error should accept responsibility (either themselves or on behalf of the health-care system), and apologize. Once events have been fully described, the conversation should then turn to the next steps in the patient's medical care. Literature shows that families also feel the need to know what is being done to prevent a similar error from occurring to somebody else. Disclosure may involve a single conversation or, more likely in the case of a serious error, may be an ongoing process.

Disclosure within pediatrics adds additional complexity due to the wide age range of patients and at what age the pediatric patient should be included. There is no consensus, but decisions should take into account the maturity and emotional stability of the patient as assessed by the provider and the parents, the patient's current health status, and parent preferences. Parents overwhelmingly express a desire to be made aware of errors, especially if harm occurred, but fewer want the child to be informed of the error, often saying that they want to protect the child from this potentially frightening revelation. There is a relative paucity of data about the perspective of older children and adolescents; in a study of pediatric patients' preferences the participants described a "right to know," especially in cases that involved harm, and that disclosure to older children showed respect for their agency but acknowledged the importance of an individualized approach. Parents who are agreeable to having the child involved in error disclosure generally want to be part of the disclosure process, and some prefer to disclose the error themselves.

There is an increasing call for error disclosure from various organizations. However, multiple barriers to disclosure continue to exist, including that many physicians feel ill-trained in the skills of disclosure. Error disclosure training is now recommended as part of residency, but more work is needed to fortify curricula in error disclosure plus support for physicians no longer in training. A nonpunitive, supportive institutional culture is important to promote error disclosure. Finally, there is a need for more pediatric-specific research in error disclosure due to the added complexities in this population.

COMMENT: One of the most significant paradigm shifts in the past few decades in the medical culture has included a

focus on patient safety and the importance of medical error disclosure. I found it inspiring to practice at an institution where my department leader was a role model in this area. It was well-known that he made a home visit to a family whose child had experienced a serious medical error, and this approach to disclosure made a lasting positive impression on all of the staff involved. His role modeling reinforced the importance of acknowledging the error, taking responsibility, apologizing, and communicating in a way that provided transparent information and comfort to the family. Recognizing that errors are usually a constellation of several events helps in addressing the systems issues that need to be changed for prevention of recurrence. Although a medical error can greatly affect a patient and family, it can also have a grave effect on the medical providers involved, or the second victims who are traumatized by the event. We need to address and minimize the second victim impact. Instead of a provider feeling guilt and shame and experiencing isolation (which can be exacerbated by the reaction of colleagues), we need to create a community of caring and provide resources where the event can be discussed, emotional support can be provided, and lessons learned from the event can be identified. This identification of ways for the error to be prevented in the future is one of the best ways to honor the patient and our profession.

– Janet R. Serwint, MD
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ANSWER KEY FOR JANUARY 2020 PEDIATRICS IN REVIEW

Calcium and Phosphate Hormones: Vitamin D, Parathyroid Hormone, and Fibroblast Growth Factor 23: 1. B; 2. E; 3. A; 4. E; 5. E.

***Mycoplasma* Pneumonia in Children and Adolescents:** 1. C; 2. E; 3. D; 4. D; 5. D.

Tumor Lysis Syndrome: 1. A; 2. D; 3. C; 4. B; 5. A.