Medical Error Disclosure - A Canadian Perspective in Improving Quality of Health Care

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Abstract. Disclosure of an adverse event is an important element in managing the consequences of a medical error. The objectives of this study was to review and compare the disclosure policies implemented by individual health care authorities and hospitals in western Canada. The evaluation of the policies of individual health authorities was carried out based on the inclusion of various guidelines including avoidance of blame; support to the staff; an apology or expression of regret; avoidance of speculation; some form of patient support; and education/training to health care workers. The complexities of medical error disclosure to patients present ideal opportunities for medical educators to probe how learners are balancing the ethical complexities involved in error disclosure with other related fields. We suggest that the disclosure policies can provide framework and guidelines for appropriate disclosure that can lead to practices that are more transparent.

Keywords: Medical error · Adverse event · Disclosure · Quality · Patient safety

1 Introduction

1.1 Medical Error

The quality of health care is an emerging concern worldwide [1]. Problems surrounding the delivery of quality health care persist and require careful attention and resolution. Several studies, including “Defining Patient Safety and Quality Care” [2] and “Why quality in healthcare” [3] suggest that medical error is bound to occur if quality is mismanaged. Medical error has received substantial attention in recent years [4–6]. Disclosure of an adverse event is an important element in managing the consequences of a medical error. Bates *et al.* define an adverse event as “injuries that result from medical management rather than the underlying disease” [7]. In any health care process, exposure to an adverse event is inevitable [8, 9]. When a situation requiring

© Springer Nature Switzerland AG 2020
N. J. Lightner and J. Kalra (Eds.): AHFE 2019, AISC 957, pp. 26–34, 2020.
https://doi.org/10.1007/978-3-030-20451-8_3

disclosure arises, physicians realize that disclosure should take place. However, they face overwhelming hurdles and/or are unsure about if and how to disclose errors. It is estimated that between 98,000 and 440,000 deaths in the United States of America are caused by medical error each year, making it the third leading cause of death [10]. Baker *et al.* estimated that hospitalized Canadians have a 7.4% chance of experiencing an adverse event and that 38% of adverse events are preventable [11]. Disclosure policy is therefore a crucial component in creating a health care culture that revolves around safety.

1.2 Barriers for Disclosure

Reluctance to admit medical errors and to disclose errors to patients and their families is prevalent in the current health care system. Past research has shown that approximately three out of four physicians who have failed to disclose error to a patient [12]. This lack of disclosure may be due to various barriers faced by physicians when attempting to disclose an incident of medical error. Barriers include fear of litigation, broken patient-physician relationships, and degraded professional reputation [13]. It is common practice for hospital lawyers to advise physicians against timely admissions of errors to avoid legal ramifications. Broken patient-physician relationships create additional challenges to the process of disclosing medical errors. Perceived consequences of disclosing errors include loss of respect and trust from patients and reduced patient compliance in future encounters [14]. Modern health care culture has allowed the threat of malpractice litigation to become common practice. While these barriers may be well founded, they add difficulty and complexity to the task of disclosing adverse events in medical practice.

1.3 Benefits of Disclosure

Despite various challenges and implications, disclosing medical errors to patients and their families an essential component of quality health care on both ethical and pragmatic grounds [15, 16]. Failure to appropriately disclose medical errors is of ethical concern as it compromises the autonomy of the patient [17]. Failure to provide information to patients hinders their ability to provide informed consent and to make informed medical decisions. The fact that part of the physician-patient process involves medical consent implies that being denied information will severely impede the patient’s ability to act within his/her best interests. Policies directing appropriate disclosure of a medical error limit breaches of trust and safeguard the therapeutic relationship [18].

Although concern of litigation following the disclosure of medical error is a major concern, lack of disclosure may further increase risk. Studies have reported that failing to properly explain and communicate medical errors increases the risk of malpractice litigation [19]. O’Connor et *al.* demonstrated that honesty and openness with the patient can help improve the relationship between the two parties [20] reducing the legal strain to follow. From a practical standpoint, it has been suggested that patients expect full disclosure of harmful errors, but are concerned that health care workers will not provide this information [21]. Consequently, studies have shown that disclosing the

medical error in a prompt and open manner enhanced patient trust in the physician by fulfilling a need that the patient did not expect to be fulfilled [22].

1.4 International Disclosure Policies

Various countries around the globe have developed policies surrounding disclosure of medical error [23–25]. Canada is lagging behind in comparison to other nations when it comes to setting national disclosure policies and procedures. The United States (US) Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has mandated open disclosure of any critical event during care to either the patient or their family [26]. This has become a critical component for accreditation at medical institutions. The Australian policy integrates the disclosure process with a risk management analysis toward investigating critical events [27]. In 2003, the National Health Services (NHS) in the United Kingdom directed physicians to inform a patient of an act of negligence or error that causes harm following their "duty of a candour" declaration [28]. In New Zealand, the patients suffering a medical error are rehabilitated and reimbursed through a no-fault, state-funded compensation scheme. Patients' rights and the providers' duties are set out in a code of consumers' rights, which applies to all providers of health [29].

1.5 Canadian Disclosure Policies

In Canada, through the Colleges of Physician and Surgeons, various provinces have adopted some form of a disclosure policy while others are in the process of developing such policies. Many provinces have failed to enact legislation that enforces the disclosure of adverse events, and even fewer offer protection against malpractice lawsuits after a medical error. The Royal College of Physicians and Surgeons has endorsed the disclosure of adverse events, including medical errors, to all partners including patients [30], but no uniform Canadian guidelines are yet in place. Provinces of western Canada have adopted various forms of a disclosure policy and though these initiatives are similar in content, they remain isolated because of their non-mandatory nature and absence of federal or provincial laws on disclosure. The College of Physicians and Surgeons of Saskatchewan requires the physician to disclose any medical error to the patient or his or her family as soon as possible during care [31]. Manitoba's provincial government has complemented the province's medical policy by legislating that physicians have a duty to notify patients or their families of critical incidents resulting from medical errors [32]. British Columbia is the only province that has adopted laws that prevent apologies for medical errors from being referenced in courts for proving liability, although doctors are not obligated to disclose adverse events [33]. The purpose of this study was to examine and compare the medical error disclosure policies implemented by the individual health authorities and hospitals in the western Canadian provinces; Saskatchewan, Manitoba, Alberta, British Columbia, and to identify trends and possible areas of quality improvement.

2 Methodology

Disclosure policies for adverse events in the health authorities and hospitals in western Canada were collected and compared. Contact information was obtained from the health authority websites. A standard email was sent to every health authority in western Canada requesting a copy of their disclosure policy or a reply stating there was no policy in place. Various authorities responding indicated that there would be changes to their policies in accordance with the Canadian Patient Safety Institute (CPSI) upcoming release of revised guidelines. Of the authorities that replied, only one did not have any policy in place.

The aspects we chose to compare within medical error disclosure policies were: who should disclose, when disclosure should take place, whether an apology was included in the policy, mention of provider support, mention of provider training, mention of avoidance of blame, avoidance of speculation, support for the patient, as well as any unique characteristics of individual policies. Six components were identified that are critical for any medical error disclosure policy. Although these are all important features, we have taken the liberty to rank them in order of importance as summarized in Table 1. This is done in the hopes of providing the best guidelines for the development current and future medical error disclosure policies.

Table 1. Critical components of disclosure policies in order of importance

Feature	Order of importance
Expression of regret or apology	1
Patient support	2
Avoidance of blame	3
Support for health care provider	4
Training	5
Avoidance of speculation	6

3 Results

In reviewing and comparing the medical error disclosure policies across the western Canadian provinces, most policies did not differ regarding who should disclose and when the disclosure should be done.

In the province of Saskatchewan there are 13 health authorities. We received policies from 92% (12/13) of the health authorities. Of the policies we received, 82% mention the absence of blaming statements, 45% state that health care providers and staff involved in the disclosure process should have support available to them, 73% include an apology or expression of regret in the disclosure process, 100% mention some form of training or education for the staff, and 77% of the policies included patient support. Only 18% of policies made mention of training or education for the members involved in the disclosure discussion. During the study period in 2012–2016, there were 13 health authorities in the province of Saskatchewan. Currently, the 13 authorities have amalgamated into a single unified Saskatchewan Health Authority.

In Alberta, there is only one health authority that governs all hospitals in the province. We found this policy described regret as a critical component of the disclosure discussion. Overall, the policy was found to be quite complete, including mention of support for providers and training, the avoidance of blame, training or education for the staff, avoidance of speculation, and patient support (Fig. 1).

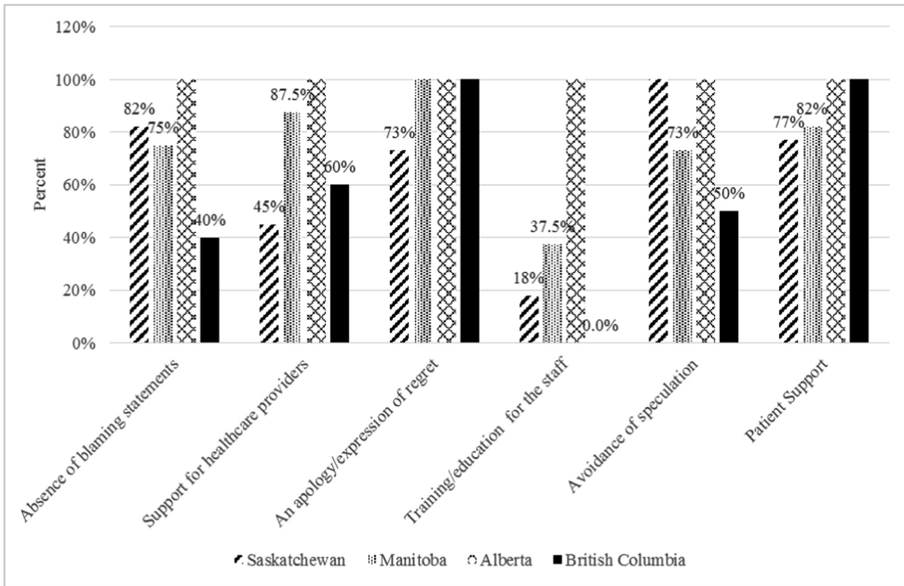

Fig. 1. Percentage of each component found in the disclosure policies of each of the western Canadian provinces.

For the province of Manitoba, there are 11 health authorities. We received 81.8% (9/11) of the health authorities' policies. Of these policies, 87.5% included support for providers, 100% included an apology or expression of regret, 75% included avoidance of blame, 73% included the avoidance of speculation, and 82% included patient support in the policy. Only 37.5% of the received policies include training for those involved in disclosure. In one of the policies in Manitoba, it listed to address the clinical and emotional needs of the client and staff involved as priority on the procedure process, making it the only policy in all of western Canada to do so.

British Columbia has six health authorities. We received 83% (5/6) of the policies from these health authorities. All (100%) of the health authorities responded to our email and have a policy in place. However, one policy was under revision and was not sent to us. All of the policies included the need to apologize or express regret, 60% included provider support, 40% included avoidance of blame, 50% included the need to avoid speculation, and 100% included some form of patient support. None of the policies in British Columbia included providing some form of training or education for the staff.

4 Discussion

We have previously reported various Canadian provincial initiatives in medical error disclosure and have suggested that adequate policies be an integral part of the institutional accreditation process [31, 34–36]. The results of the present study have allowed us to identify six components that are critical for any medical error disclosure policy. Although we believe that they are all important features, we have taken the liberty to rank them in order of importance to establish the best guidelines for current and future medical error disclosure.

The expression of regret or an apology to the patient and their family is the most important component of medical error disclosure policies. The CPSI guidelines indicate that when a patient receives a statement of apology, it often leads to a restoration of the patient-physician trust [37]. It is important to begin the disclosure of a medical error with an apology or expression of regret as it allows for a better relation to be established serving as a gateway to open and honest discussion.

The second most important component of a medical error disclosure policy is support for the patient. This is particularly important following the occurrence of a medical error as patients are in their most vulnerable state. Provision of support for a patient offers a chance to strengthen the patient-physician relation.

The avoidance of blame and support for the provider go hand in hand and have been grouped together as the next most important components of a medical disclosure policy. Health care providers receive little support after an adverse event [38]. The CPSI advises support to anyone involved in an adverse event and/or disclosure discussion [37]. Lack of support for health care providers can potentially have similar negative consequences as the lack of support for patients [39]. The avoidance of blame is another way in which to provide support for those involved. By providing support for those involved, we can foster a culture that is non-punitive and adheres to a no-fault model of care.

The inclusion of training for those involved is critical to medical error disclosure policy. We encourage facilities to develop disclosure discussion and training workshops for new and current staff to attend. Many policies in western Canada do not currently include the provision of training for their staff. Provision of training is necessary to avoid the re-occurrence of a medical error. Currently, the inclusion of training for those involved in disclosure is the feature most often omitted in disclosure policies of the health authorities in western Canada.

Lastly, the avoidance of speculation is crucial to disclosure policy. Physicians and patients should both avoid speculation as it might create unwanted and avoidable strain. Only sufficient and correct knowledge should be used to speculate the cause and factors leading to a medical error. In this way, no individuals will be wrongfully blamed for an error which adheres to a non-punitive and no-fault model.

The inclusion of these critical components in medical error disclosure policies will allow for more uniform policy creation and the avoidance of medical error ramifications. These consequences include the possibility of malpractice litigation, broken patient physician relationships, and ethical implications on the health care team [40, 41].

5 Conclusion

Malpractice continues to be a growing issue for those practicing in health care [42]. Legal action being taken against these individuals is usually ill intended and relies solely on the gains of monetary compensation creating an inappropriate use of the tort system. Although justice for an error is required, the method through which it is carried out must promote honesty and full disclosure. This makes the disclosure to patients an ideal opportunity for medical educators to probe how learners are balancing the ethical complexities involved in error disclosure. The designing of an error disclosure policy requires integration of various aspects including bioethics, physician-patient communication, quality of care, and team-based care delivery. It is important to provide support to health care workers and emphasize an expression of regret within disclosure policies. Moreover, the training for proper disclosure is crucial and staff members must be made aware of the resources and training available to them. We suggest a greater inclusion of the Canadian provincial initiatives in the hopes of implementing a uniform policy that is directed towards disclosure of error through an honest and non-punitive approach. Making disclosure of error a pillar in the health care industry, will raise the quality of care being given which will in turn protect the health and autonomy of patients. The other challenge lies in achieving a balance between a non-punitive approach to error and the need for a process that includes accountability and suitable compensation for patients. We suggest that this balance can be achieved by a system-based error disclosure programme which would better allow us to serve as the protectors of the health and autonomy of patients. We believe that the disclosure policies can provide framework and guidelines for appropriate disclosure that can lead to practices that are more transparent. We suggest the improvement of disclosure practice by creating a uniform policy, centered on addressing errors in a non-punitive manner and respecting the patients' right to an honest disclosure and as part of the standard of care.

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