Disclosure of Medical Error: A Necessary Step in Healthcare Improvement

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Abstract. Medical error has become a major issue around the globe. When errors occur, healthcare practitioners are faced with the ethical dilemma of if, and to whom to disclose the errors. This dilemma of disclosure is faced by healthcare providers across all disciplines, countries, and generations and has far-reaching implications on the progress of healthcare quality. Medical error disclosure is a necessary step to foster a culture of transparency, strengthen partnerships, and improve the quality of healthcare. Although the principle of medical error disclosure is widely acknowledged and endorsed by providers and patients, disclosure is far from common practice. We reviewed Canadian and global disclosure policies and discuss what steps should be taken to remedy the status quo. We suggest the implementation of a uniform policy centered on addressing errors in an ethical and non-punitive manner while respecting the patient's right to an honest disclosure be a standard of care.

Keywords: Medical error · Disclosure · Medical ethics · Quality care · Patient safety

1 Introduction

Despite best intentions and competencies, health care remains a human endeavor in which mistakes will inevitably be made. While every attempt must be made to minimize the rate of errors, their occurrence is an unpleasant reality that must be acknowledged if it is to be properly mitigated. Medical error has been defined as a problem that arises during patient management [1]. The two broad categories of medical error are errors in performance and errors in planning [2–4]. In errors of performance, the correct medical treatment for a patient does not go as planned or is left incomplete. In errors of planning, the wrong medical treatment has been chosen for the patient, or the correct treatment has been chosen for the wrong reason. Medical errors are a major concern because they have the potential to cause Adverse Events (AEs). Adverse events are defined as injuries to a patient that are the result of medical

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treatment, not due to any underlying disease [2–5]. Avoidable AEs represent a failure of the healthcare system to fulfill its cardinal purpose of ensuring the safety of its patients.

The Institute of Medicine's (IOM) report "To Err is Human" described medical errors as a public health risk [6]. The report stresses that preventable medical errors are common in medical practice, resulting in the deaths of 98,000 people in United States hospitals annually and costing the nation $17–29 billion in health care, lost income, and other injury-related expenses [7]. Self-reported survey data has shown that 95% of physicians have witnessed a medical error, and 61% of health care professionals believe errors are a routine part of medical practice [8]. Because medical errors have a large impact on patient care, it is important to consider the ethical issues regarding disclosure that arise when health care providers make or witness errors. Recognition of the staggering impact of medical error and a focus on preventable harm has helped bring attention to errors and error disclosure, a trend that has accelerated with the more recent emphasis on health care quality. However, there remains a dichotomy between medical errors occurring and disclosure of those errors to patients and their families. While the healthcare industry has taken actions to minimize adverse events experienced by patients, the issue of honest disclosure has yet to be addressed.

When an error occurs, a common dilemma facing physicians is whether to disclose the error to the patient. Research findings reveal that patients are keen to know about any error that caused them harm. The patient's bill of rights demands to have full disclosure of an error. Several studies report that patients prefer disclosure and that this would enhance their trust in their physicians' honesty and would reassure them that they are receiving complete information about their overall care [9–11]. Furthermore, patients believed that humans are not perfect, they might make mistakes, and "human nature" might lead health care workers to hide errors from patients [12]. We examined the ethical dilemma facing physicians in regard to disclosing errors and the benefits that open and honest disclosure will bring to the healthcare industry. We reviewed Canadian disclosure policies, in addition to disclosure policies enacted by other nations, and discuss what steps should be taken to remedy the status quo.

2 Medical Error and Adverse Event

The rate of adverse events in hospital patients from studies worldwide has varied from 3.7% in New York to 11% in the United Kingdom and 16.6% in Australia [13–15]. In Canada, the rate varies between 5% and 7.5% [16, 17] and the "Health Care in Canada 2004" report states that about 5.2 million Canadians have experienced a preventable adverse event either in themselves or in a family member [18]. The wide variation in reported adverse event rates is due in part to differences in study methods and patient selection. We have previously proposed a 'no-fault' model whereby disclosure of adverse events to patients is integral to accreditation [19]. The United States Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recommends that the doctor should conduct the disclosure, though on occasion some other member of the team will be more suitable [20].

3 Medical Error Disclosure Scene Worldwide

The majority of provincial regulatory bodies in Canada have adopted some form of disclosure policy [21]. However, these Canadian provincial initiatives remain isolated because of their non-obligatory nature and the absence of federal or provincial laws on disclosure [22]. In Australia, disclosure policy integrates the disclosure process with risk management analysis towards investigating the critical events [23]. In New Zealand, in any adverse event, patients are rehabilitated and compensated through a no-fault state-funded compensation scheme [24]. This disclosure model supports health care providers and strengthens the policy of honest disclosure. The United States JCAHO mandated an open disclosure of any critical event during care to the patient or their families [20]. By following an open disclosure policy, patient's autonomy can be preserved, and malpractice claims can be effectively reduced [25]. Healthcare providers should reflect on the patient's expectations concerning disclosure and the factors that hinder disclosure so that the gap between theory and practice can be bridged.

4 Disclosure Barriers

Although disclosure of medical errors is, in principle, the correct course of action [4, 5, 26, 27] many well-documented barriers prevent this from happening [27]. These include fear of legal repercussions from patients or their families and fear of loss of reputation among colleagues. Uncertainty about who is responsible for errors involving multiple caregivers or systemic factors can delay or prevent disclosure. In cases where errors are minor or go unnoticed, there are concerns that disclosure could cause unnecessary psychological stress or strain the relationship with the patient, ultimately resulting in more harm than benefit. Overcoming these barriers will require a fundamental change in the perception and handling of medical errors. Some centers have introduced policies where disclosure of medical error is part of the standard of care where physicians will face professional and legal consequences if they fail to disclose. Others have implemented "no-fault" or "no-blame" models for error disclosure, where the institution shoulders the blame, rather than the individual caregivers [4, 5, 26].

5 Disclosing Error – Professional and Ethical Responsibility

There is universal agreement in western medical culture that errors resulting in serious harm must be disclosed to the patient [28]. Physician organizations, such as the American Medical Association, Canadian Medical Associated (CMA), and the Canadian Medical Protective Association (CMPA) emphasize the need for physicians to inform patients about medical errors so that patients can understand the error and participate in informed decision making about subsequent management of their health care [29]. Opinion 8.12 of the Code of Medical Ethics of the American Medical Association states that "physicians should at all times deal honestly and openly with patients" [30].

6 Principles of Beneficence, Non-maleficence, Autonomy, and Justice

Four overarching ethical principles currently guide modern medicine. The principle of beneficence in medical practice refers to avoiding and preventing errors by doing what is in the best interest of the patient [31]. The principle of non-maleficence emphasizes that one should not cause harm to oneself and others [32, 33]. When patients come to a health care system to seek care, they place a great deal of trust in the system and health care providers. They expect competency and believe that physician will provide the best treatment in accordance with the principles of beneficence and non-maleficence. Autonomy is defined as the ability of an individual to make an informed, un-coerced and rational decision [32, 33]. The principle of justice is described as the moral obligation to act on the basis of fair adjudication between competing claims. According to the principles of autonomy and justice, it is the patient's right to be provided with complete information regarding treatment and any adverse events that may have occurred. In light of these principles, disclosure of error to patient and management is justified as the only defendable course of action.

7 Conclusion

As preventable medical errors and adverse events become a topic of growing concern and cost, appropriate processes must be executed. Sharing knowledge and learning about the difficult topic of medical error and how to approach it is necessary to encourage honest disclosure with patients. The disclosure of a medical error is an ethical dilemma that requires deliberative thinking and reflection by the health care providers. It is suggested that disclosure of medical error should be encouraged keeping in view the principles of medical ethics including beneficence, non-maleficence, patient autonomy, and justice. It is important that healthcare providers are aware of the legislation that is enforced in the jurisdiction under which they practice in order to make disclosure an easier and less daunting process. Improving the process of healthcare is not a mandate for physicians alone. It is a collective effort of healthcare institutions, policymakers, providers, and patients working toward the common goal. Only through such collaboration can medical error disclosure become a common, achievable, and informative practice in healthcare improvement.

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