Medical Errors: Teachable Moments in Doing the Right Thing

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During residency training, one learns about managing complications, correcting misdiagnoses, and rectifying adverse effects from the care given to patients. However, where in residency training is one taught what and how to disclose those errors to the patient and their family? This question serves as the basis of this article.

Trust is an integral component of the physician-patient relationship. During the past 60 years, this trust has eroded to the point where physicians now trail nurses, pharmacists, and veterinarians in public reports of trust in various professions.[1] Although the reasons are multifactorial, a growing awareness of medical errors and a rise in malpractice litigation have also contributed to this erosion of trust. In 1999, the Institute of Medicine published a landmark study revealing the magnitude and impact of preventable medical errors. Each year, these errors cause between 48 000 and 98 000 deaths and result in $17 billion to $29 billion in lost income, additional care, and disability.[2]

Given the enormity of this problem, we must assess our approach to medical errors, especially in the context of medical education. Disclosure of medical mistakes to patients offers a way of preserving the trust inherent in the physician-patient relationship when unintended outcomes occur, but training in this area is lacking.

Approaches to Medical Errors and Ethical Considerations

The prevailing approach to medical errors has been to "deny and defend": deny that mistakes happened and vigorously defend against malpractice claims.[3] This adversarial approach shifts the physician-patient relationship from one of intimacy and trust to one of distance and opposition. Data suggest that this relational shift is central to why most malpractice lawsuits are filed. Indeed, the main reasons that patients sue physicians are more related to the handling of the mistake than to the actual mistake itself.[4] Vincent et al[4] found that the top reasons patients sue were to prevent the error from happening again, to get an explanation, to get an admission of error, and to have the physician realize how the victim felt. Interestingly, when asked what could have prevented a suit, the most common answer was an explanation and apology.[4] Notably absent from the most common reasons is compensation.

In contrast to the approach described above, several health systems have adopted an approach of mistake disclosure.[3,5,6] The most notable is the University of Michigan. Formerly among the "deny and defend" health systems, this university radically changed its approach in 1996. When an unintended outcome occurs, the case is quickly reviewed. If the care was inappropriate, a thorough explanation is given, and an apology is made.[3] This has led to surprising results. During a 7-year period, litigation costs were cut in half, annual new claims were down more than 50%, and claim processing time was decreased by 60%.[3]

Disclosure of errors is more consistent with the ethical obligation of physicians than "deny and defend." The American College of Physicians *Ethics Manual* states that "physicians should disclose to patients information about procedural or judgment errors made in the course of care if such information is material to the patient's well-being."[7] The American Medical Association Code of Medical Ethics echoes this in discussing situations in which patients suffer significant complications from medical errors: "In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. . .. Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient."[8] Although not all codes of ethics specifically address disclosure of errors, all emphasize honesty, integrity, assumption of responsibility, good faith, and accountability.[9]

Barriers to Disclosure

Although most physicians agree that errors should be disclosed, there is no consistent guidance on how this should be done. More than one-quarter of physicians in 1 study admitted they had made what they considered a minor error and not disclosed it to the patient or the patient's family. Eight percent reported having made a major error and not having disclosed it.[10] Other studies reported that only 24% of trainees and 21% of physicians disclosed the most significant error they made in the past year.[11]

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Barriers to error disclosure arise from several sources. It is difficult for any physician to admit error due to human nature. Additionally, physicians may fear the consequences of disclosure, including litigation, higher insurance premiums, or loss of respect.[3,12] Another barrier is that some mistakes are easily rationalized as assumed risk or downplayed as insignificant.[12] Medicine tends to embrace a culture of perfection in which errors are treated as rare events.[9] Within this paradigm, physicians are reluctant to admit errors and more likely to minimize or rationalize unintended outcomes.[3,12]

A Teachable Moment

Most medical trainees do not receive education on how to disclose medical errors despite an overwhelming interest by physicians in having this training.[13,14] Coffey et al[13] suggested that the skills set for error disclosure is similar to that for breaking bad news, another area with a need for enhanced training, and several authors have suggested guidelines on practical aspects of error disclosure.[15–19] Evans et al[15] advocate for disclosure within 24 hours and emphasize preparation for the meeting, including talking with a similarly trained colleague about the case and surrounding circumstances. Other recommendations include looking for areas of agreement and finding solutions to prevent the mistake from happening again.[17] Input from risk management is also critical to understanding state disclosure laws and the consequences of disclosure.[16,17]

Given the barriers to disclosure, it is important that medical error disclosure be an explicit part of graduate medical education. Morbidity and mortality conferences play an important role in providing a confidential forum for discussing errors and disclosure issues. However, evidence suggests that those conferences may not provide sufficient training. Even when errors are discussed, they tend not to be specifically referred to as *errors*, and conference leaders rarely admit to making errors.[20] These behaviors reinforce the notion that errors are something shameful. Instead, this culture of perfectibility should be replaced by one in which mistakes can be openly admitted and discussed.

Training in professionalism and ethics for medical students, residents, fellows, and attending physicians is a starting point in changing this culture. Modeling of appropriate disclosure by attending physicians is paramount to avoid the blame shifting, minimizing, and rationalizing of errors that will likely be emulated by trainees.

To this end, trainees should be present in error-disclosure discussions with patients and their families and in risk management team discussions. This will require recognition that there is value in trainees observing these discussions and a concerted effort to involve them. Error disclosure, especially when there is an apology to be made, is difficult and prone to failure if not done well.[21] Excluding trainees from these experiences, intentionally or otherwise, removes them from a valuable teaching moment.

Key Points

- Medical mistakes have contributed to the erosion of patient trust in physicians.
- Mistake disclosure is consistent with ethical obligations and may enhance trust.
- The culture of medicine must be changed to facilitate mistake disclosure.
- Disclosure training is a valuable addition to medical training.

Conclusion

Data suggest that trust has eroded between patients and physicians in part because of medical errors. The courage for appropriate disclosure of errors has the power to preserve the physician-patient relationship in many cases, and disclosure is more consistent with ethical obligations. It is critical that graduate medical education programs provide training regarding medical errors and disclosure and that a culture of medicine is fostered to allow for transparent discussion and assessment of errors.

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