

**Disclosing Medical Errors**  
**Annotated Bibliography**  
**A selection of articles in human and veterinary medicine**  
**Institute for Healthcare Communication**  
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American College of Physicians. Must you disclose mistakes made by other physicians?  
Case Study by ACP's Ethics and Human Rights Committee and Professionalism.  
Nov 2003. <http://www.acponline.org/journals/news/nov03/mistakes.htm>

Context	Addresses the question of whether a physician has an obligation to disclose an error made by another physician if it has harmed the patient
Content	Case discussion in which a physician becomes aware of an error made by his partner who is now on sabbatical. His partner had failed to follow-up on a chest x-ray that had reported a lung nodule on a patient who had presented with breathing symptoms 18 months prior. The case discussants reaffirm the ethical obligation of a physician to provide his patient with an accurate understanding of what has happened in his care. In this case revealing that the radiologist had detected the lung nodule 18 months previous but it has not acted upon by the partner physician. The case discussant encourages contacting the original physician and inviting him to participate in making the disclosure to the patient but the current physician providing care remains obligated to see that the error is disclosed
Conclusion/ Recommendations	The article reaffirms the absolute entitlement of the patient to be told about the error that has a harmful impact and affirms the responsibility of the second physician to reveal his colleague's error.

American Society for Healthcare Risk Management (2001). "Perspective on disclosure of unanticipated outcomes information." ASHRM, phone 312 422-3980.  
[www.ashrm.org](http://www.ashrm.org)

Description of context: This paper was developed by the American Society for Healthcare Risk Management of the American Hospital Association in order to alert its members to the issues that are raised by the revised JCAHO standard requiring discussion of

unanticipated adverse outcomes. The paper is available through their website.

Description of Content: The paper provides definitions and describes concerns from the perspective of patients, professionals, and institutions. The paper offers strategies for addressing disclosure of adverse outcomes, documentation, legal safeguards, ethical consultation and support for patients and families.

Conclusions/  
Recommendations Recommends an honest approach to disclosure when investigation clearly identifies causality and encourages full coordination with risk management in working through the situation with the patient and family.

American Society for Healthcare Risk Management (May, 2003). Disclosure of unanticipated events: the next step in better communication with patients. The first monograph in a series of three parts addressing the communication and disclosure of unanticipated medical outcomes. ASHRM. Copies available at <http://www.ashrm.org/ashrm/resources/files/Disclosure.Pt1.pdf>

Description of context: The first monograph in a series that addresses the impact of the JCAHO standards, and the legal and psychological barriers experienced by individuals and organizations to more open communication with patients about unanticipated adverse outcomes.

Description of Content: Reviews the literature and describes a model organizations can use to promote constructive communication and gives examples of disclosure situations and how they were handled. Specific concerns about discoverability are addressed with a recommendation that the disclosure of the investigation of outcomes should be factual and broad. The monograph notes the consistent finding that communication issues (specifically the failure to be open, honest and empathic/apologetic) after disappointing outcomes is one of the main drivers to initiating malpractice suits.

Conclusions /  
Recommendations Patients want and should be provided an explanation, an apology when appropriate, and to be informed of the steps being taken to prevent the same type of error from recurring. Legal concerns about the discoverability of evidence should not interfere with the responsibility to inform patients about the facts of their care and be given an accurate explanation.

American Society for Healthcare Risk Management (November, 2003). Disclosure of unanticipated events: creating an effective patient communication policy. The second monograph in a series of three parts addressing the communication and disclosure of unanticipated medical outcomes. ASHRM. Copies available at [www.ashrm.org](http://www.ashrm.org)

Description of context:	This monograph describes the elements of building an effective disclosure policy.
Description of Content:	Elements include defining terms, and including healthcare staff and board in the development of the policy. The monograph places disclosure in the context of more consistent communication and informed consent throughout the treatment process. The monograph encourages a clear policy that focuses on organizational values and how they apply to disclosure situations but discourages rigidly specified policies that could constrain the flexible use of good judgment. It encourages description of events warranting disclosure, the process steps and personnel who should be involved, the content that should be included in the discussions with patients, and the follow-up steps and documentation that is necessary to resolve the situation satisfactorily.
Conclusions / Recommendations:	Organizations are encouraged to create disclosure policies that are consistent with their values, embed disclosure in a broader expectation about good clinician-patient communication and which give sufficient direction to staff while allowing flexibility to achieve the best result for all involved.

American Society for Healthcare Risk Management (February, 2004). Disclosure: what works now and what can work even better. The third monograph in a series of three parts addressing the communication and disclosure of unanticipated medical outcomes. ASHRM. Copies available at [www.ashrm.org](http://www.ashrm.org)

Description of context:	The monograph is intended as a communications guide for healthcare staff who will be involved in thinking through and communicating with patients and families about unanticipated adverse outcomes in various clinical settings.
Description of Content:	It describes the new expectations of disclosure, the goals of effective communication, provides hopeful data about the potential for open disclosure to reduce rather than increase liability costs and finally describes the specific steps in a skill based model for disclosure.

Conclusions/  
Recommendations      An open and honest approach is recommended at the outset of a disappointing outcome. Encouraging evidence is cited that honest disclosure will serve to decrease rather than increase the organization's overall liability costs.

Baker GR et al. (2004). "The Canadian adverse events study: the incidence of adverse events among hospital patients in Canada." *Canadian Medical Association Journal*, 170(11),1678-1686.

Objectives:              To estimate the incidence of preventable adverse events among patients in Canadian acute-care hospitals.

Design:                  Retrospective review of charts of discharged patients where an unintended outcome was perceived to have occurred.

Subjects:                Four hospitals of varying sizes were selected from each of five provinces for review of randomly selected charts of discharges occurring during fiscal year 2000 (with the exclusion of psychiatric and obstetrical cases).

Measures:              In stage 1, cases were screened for the possibility of one or more adverse events. In stage 2 physicians reviewed the charts selected by the screening criteria to determine the presence of unintended injuries or complications caused by medical care and the likelihood of their preventability. The methodology chosen was adapted from that used in previous studies in United States and Australia to determine prevalence of adverse events brought on by medical management and its preventability.

Results:                 The overall rate of adverse events in Canadian hospital patients was estimated to be 7.5%, 36.9% of which were calculated to be highly preventable. The rate of preventable adverse events across all hospitals was 2.8% and the rate of deaths from preventable adverse events was .66 %. The adverse event rate in the Canadian study (7.5%, 2.8% of which were determined to be preventable) is difficult to directly compare with those studies in United States, Australia and New Zealand as somewhat different constraints were in place for case inclusion in each of those studies. The U.S. rate of adverse events of 3.7 % in New York study and 2.9% in the Utah/Colorado study applied only to adverse events that occurred and were discovered during the index hospital and the study focused on the more restricted criteria of likely negligence where the Canadian study included adverse events detected after as well

as during the index admission and preventability rather than outright negligence was the criteria for inclusion.

Conclusions:

Since the 1999 IOM report in the U.S., Canadians have been anxiously awaiting their own “report card” of the rates of potentially preventable adverse events. In each of the countries studied, the adverse event rates and their likely translation into amounts of injury and deaths per year have indicated that there’s great room for improvement. Focus on identifying and disciplining clinicians who were closest to the incidence will not be sufficient to produce the greatest gains in improving patient safety. As a result there will be opportunity for international cooperation and understanding and experimenting with systems changes to improve patient safety.

Beckman, H. B., Markakis, K. M., Suchman, A. L., & Frankel, R. M. (1994). The doctor-patient relationship and malpractice. Lessons from plaintiff depositions. *Archives of Internal Medicine*, 154(12), 1365-1370.

Objective: To explore plaintiff depositions to gain insight into issues that prompt malpractice claims.

Design: Retrospective qualitative analysis of a convenience sample of 45 depositions randomly selected from a sample of 67 made available from settled claims between 1985 and 1987.

Setting: Large metropolitan medical center.

Subjects: Patients who had sought the services of an attorney and provided depositions to the court in medical malpractice cases.

Measures: Information extracted included responses to the following questions: “Why are you suing?” and “Did a health professional suggest maloccurrence?”

Results: Relationship problems were identified in 71% of depositions. Four

themes emerged: 32% deserting the patient; 29% devaluing patient and/or family views; 26% delivering information poorly; and 13% failing to understand the patient and/or family perspective. 54% of plaintiffs reported that other health professionals suggested maloccurrence. Of these cases, 71% named the post outcome-consulting specialist as the one who suggested maloccurrence.

Conclusions: The decision to litigate is most often associated with perceived lack of caring and/or collaboration in health care delivery. Particular attention needs to be paid to post adverse-event consultant-patient interactions.

Berlinger, N. (2005). *After the harm*. Johns Hopkins University Press. Baltimore, MD

Context Author is an ethicist and director of religions studies. She approaches the problem of disclosure and resolution of medical errors primarily from the perspective of Christian social ethics.

Content Book covers the sequence from error to forgiveness by considering disclosure, apology and repentance (compensation). Author utilizes narrative ethics in which the stories of physicians, patients and families are examined to understand the dynamics that motivate and affect each party. She focuses on Dietrich Bonhoeffer's "view from below" examining processes from the experience of the victim who must ultimately forgive. From the physician view she takes the position of what affects "truth telling", from full disclosure to concealment. She examines the "hidden curriculum" that communicates attitudes and behaviors to physicians-in-training about how to manage these situations, that has primarily favored self-protectiveness rather than treating the victim's needs for information, compassion and resolution as paramount. While honest examination is encouraged in settings such as morbidity and mortality conferences, little effort is made to explain and ask forgiveness from the patients themselves and often these settings have protections against disclosure. She offers examples of health systems and malpractice carriers who have adopted full disclosure and ethically guided resolution.

Conclusion/  
Recommendations An ethical perspective can inform healthcare providers in how best to navigate the difficult process from error recognition to forgiveness involving disclosure, apology and fair restitution.

Bonvicini, K. A., & O'Connell, D. (in press). Disclosing Medical Errors: Restoring Client Trust. *Compendium: Equine Edition*.

The purpose of this article is to help veterinarians reach a mutually satisfying resolution with clients when individual, team or system errors have resulted in an adverse outcome. A model which provides a communication protocol is presented that integrates the ethics of veterinary medicine, along with specific skills and attitudes that have been shown to promote psychological and practical resolution of these situations for both clients and veterinary practices. The article is predicated on ethical standards and values of openness and honesty as a springboard for conversations about medical errors. However, the authors caution that in veterinary practice, there is a range of opinions and approaches that may hesitate to embrace such openness for fear that it may lead to malpractice risk. While acknowledging an error has occurred has been evaluated positively leading to increased trust and lessening the possibility of negative impact, clinicians may still worry about the potential costs of openness and transparency. While such discussions are difficult and may still result in formal complaints and possible malpractice, the authors point to the evidence that tells us that disclosure can significantly reduce litigation costs, reduce bitterness and mistrust and avoids the potential of unnecessarily lengthy legal proceeding with the accompanying emotional pain for both consumers and clinicians alike. The authors encourage practitioners to engage in a conversation when joining a practice or open the conversation with colleagues about the approach and practice protocol for disclosure discussions in the event of medical error. In addition, they emphasize that it is imperative to consult with your malpractice liability insurance carrier to establish their position about how disclosure and resolution be managed.

Cupp, R. L., & Dean, A. E. (2002). Veterinarians in the doghouse: are pet suits economically viable? *The Brief*, 31(3). Retrieved January 17, 2008, from <http://www.nabr.org/animallaw/Articles/VetsInTheDoghouse.pdf>

Conclusion: Tort lawsuits against veterinarians likely will continue to expand in coming years. Animal rights are much more passionately debated today than in the past, when animals' legal status as mere property went unquestioned. At least some of the attorneys who have chosen to specialize in pet lawsuits may be motivated by a desire to increase respect for and improve treatment of animals. Courts are far more divided, however, on how to approach NED when the plaintiff is a bystander to another's injury. Because many more people witness or experience harm to others than suffer harm themselves, unrestricted bystander cases could become unwieldy. Proof of true distress also is more suspect when the primary harm is not inflicted directly on the plaintiff. Because of these concerns, courts either disallow bystander recovery or place significant limitation on such claims, requiring the plaintiff to suffer physical harm or manifestations of the distress, to be in the "zone of danger," to contemporaneously sense or experience the other's injury, and/or to be a close relative of the injured.

Bereaved pet owners thus may try to recover for the negligent infliction of emotional distress as parasitic to a claim for the destruction of property, or they may plead NIED as an independent cause of action. However, in most jurisdictions, owners presently cannot prevail under either theory because the majority of jurisdictions do not allow recovery for emotional distress resulting from loss of property. Because pets have property status under the law, this rule precludes recovering for the loss of a pet. A plaintiff seeking to recover for emotional distress as a bystander will encounter the various limitations noted above, as was the case in *Bobbin*, discussed earlier. The court allowed emotional distress damages under the plaintiffs' misrepresentation claim but did not allow a separate cause of action for NIED because state law required that a plaintiff be a bystander family member. Although the plaintiffs considered their pet to be a "member of the family," the court was unwilling to adopt such a "sweeping redefinition of personhood, family and personal property." Despite these concerns, a few courts have allowed recovery for NIED for the loss of a pet. For example, in *Corso v. Crawford Dog and Cat Hospital, Inc.*<sup>38</sup> a woman was able to recover after she opened her beloved poodle's casket and found a dead cat. The court analogized the case to those in which a human corpse is mishandled, stating that a pet is "not just a thing but occupies a special place somewhere in between a person and a piece of property." Similarly, in *Campbell v. Animal Quarantine Station*,<sup>39</sup> the family pet died from heat exposure in the back of a van. The court allowed family members' claims for emotional distress even though they were not present, didn't witness the tort, and were not themselves in danger.

Gallagher, T. H., Studdert, D., & Levinson, L. (2007). Disclosing harmful errors to patients. *New England Journal of Medicine*, 356(26). 2713-2719.

Description of Context	Studies are reporting high prevalence of errors and concern that there has been a professional ethos of discretion or even cover-up. Pressure from many directions is creating an environment ripe for change.
Description of Content	<p>Authors describe recent sources of guidance and disclosure requirements from JCAHO (2001), National Quality Forum (2006) and state legislatures. Where JCAHO in the US has not compelled admission of error, the NQF (2006) Safe Practice Guideline requires admission of error or system failure if known.</p> <p>The authors go on to describe prominent disclosure programs that have been on-going in the US from hospitals as well as liability carriers.</p>
Conclusion/ Recommendations	They finish by discussion of future developments with the expectation that full disclosure will be normal in 10 more years. They suggest that some tort reform will need to

accompany this change if disclosure is not to bring potentially large increases in system liability costs. This could be true if the existing pool of injured people, who may be unaware of the cause of their injury decided to seek compensation despite skillful disclosure. There are a number of organizations that are reporting lower liability costs with open disclosure but this is far from guaranteed to be the universal experience when there is widespread full disclosure.

Gallagher TH, Garbutt, GM, Waterman AD et al. (2006). Choosing your words carefully: how physicians would disclose harmful medical errors to patients. *Archives of Internal Medicine*, 166, 1585-1589.

Context	To describe how physicians would disclose errors to patients
Design	A survey was answered by 2637 physicians and surgeons in the US and Canada. Participants received one of 4 scenarios depicting serious errors that differed by specialty (surgical or medical) and by how obvious the error would be to the patient if not disclosed. Five questions measured what respondents would disclose using scripted statements.
Results	56% chose statements that mentioned the adverse event but not the error. 42% would explicitly state that an error occurred. How likely the patient was to discover the error on their own affected willingness to acknowledge that an error was made (51% with explicit apparent error and 32% with less apparent error). While surgeons were slightly more likely to disclose that an adverse event had occurred, medical specialists were much more likely to explicitly mention error (58% to surgeons 19%). Canadians physicians (who have lower risk of suit than US physicians) were more likely to acknowledge an error
Conclusions and Recommendations	Authors acknowledge that surveys of patients consistently reveal their desire for full disclosure in these situations and this is the position taken by ethicist (AMA code of ethics) and patient advocacy organizations. On the other hand, risk managers and malpractice carriers have traditionally advised limited disclosure and avoidance of disclosing that an error caused the harm. In this study only 42% of physicians explicitly mentioned that an error had occurred, even though they believed that to be the case.  The authors encourage the development of more clear

standards of behavior and training in order to better meet the stated preference of patients for full disclosure.

Henry, L. L. (2005). Disclosure of Medical Errors: Ethical Considerations for the Development of a Facility Policy and Organizational Culture Change. *Policy, Politics and Nursing Practice*, 6, 127-134.

The Institute of Medicine report, *To Err Is Human: Building a Safer Health System*, has spurred public concern over hospitals' ability to deliver safe care. The health care industry continues to struggle to address these concerns. These efforts have driven the growing expectation that health care practitioners or systems disclose unanticipated outcomes to patients and family members. Although the tort system has been cited as an impediment to medical error disclosure, some organizations and systems have successfully implemented policies calling for full disclosure of errors and unanticipated outcomes. However, most organizations have yet to develop policies concerning error disclosure. This article provides an overview of error disclosure and a model framework for an error disclosure policy. The ethical principle of respect for patient autonomy is emphasized as the driving force in developing an institutional disclosure policy and changing the organizational culture to one that supports development and implementation of such a policy.

Hughes, R. G., & Clancy, C. M. (2005). Working conditions that support patient safety. *Journal of Nursing Care Quality*, 20(4), 289-292.

Patient safety research funded by Agency for Healthcare Research Quality (AHRQ) will continue to provide key insight into how various aspects of working conditions for nurses can be changed to improve patient safety and patient outcomes. As we learn more about what causes patient safety errors, we develop an evidence base to support patient-safety-driven working conditions. The healthcare community needs to take this evidence and the evidence that is forthcoming and begin institutionalizing an organization wide commitment to safety if they have not already done so. The evidence on working conditions continues to demonstrate what needs to be done to lower threats to patient safety: proactively reduce the effect of human factors, improve the flow of information (including the use of computer-based technology), and institutionalize patient safety as something championed by both healthcare leaders and managers.

Huntington, B., & Kuhn, N. (2003 April). Communication gaffes: A root cause of malpractice claims. *Baylor University Medical Center Proceedings*, 157-161.

Do physicians have influence over the circumstances that cause patients to file lawsuits? While physicians cannot control all the stated reasons for patients' seeking legal redress, they are able to influence the quality of their relationships with patients. And, as already noted, the foundation for a good patient-physician relationship is communication. This article discusses the "art" of communication as it occurs in everyday patient encounters, the important dialogue that occurs when giving informed consent, the challenge of encountering an angry patient, and the new trend of disclosing unexpected outcomes and medical errors.

Keyes, C. (1997). Responding to an Adverse Event. *Forum of the Risk Management Foundation of the Harvard Medical Institutions, Inc.*, 18(1), 2-3.

This brief article provides a checklist covers a range of actions to consider after an unexpected outcome. The seriousness of the event and the relationship between the parties involved will dictate which steps need to be carried out in full, and their sequence. Running through the list will help organize thorough, appropriate, and consistent responses. The checklist is premised on the belief that clinicians should do what is best for their patients, after adverse events or otherwise. These actions will not prevent all claims and suits, but will prevent some, mitigate others, and ensure that risk management is aligned with good medicine. The following checklist covers a range of actions to consider after an unexpected outcome. The seriousness of the event and the relationship between the parties involved will dictate which steps need to be carried out in full, and their sequence. Running through the list will help organize thorough, appropriate, and consistent responses.

Lazare, A. (2006). Apology in medical practice: an emerging clinical skill. *Journal of American Medical Association*, 296(11), 1401-1404.

Context	Author acknowledges emerging interest in full disclosure of medical errors. He described how effective apology is an essential part of making disclosure constructive
Content	Author describes an apology as an acknowledgement of responsibility for an offense coupled with an expression of remorse. He described the 4 parts of effective apology, which includes acknowledgement of the offending behavior and validation that the behavior was unacceptable. Next is an explanation of the offense (not to excuse but to help the victim understand the situation). Third is an expression of shame,

remorse and promise to prevent recurrence and fourth is reparation. He described how apologies may have their healing impact, including restoration of the victim's damaged self esteem, restoration of power to the victim by humbling of the offended, clear validation that offense and fault occurred, reassurance that there are shared values and therefore trust can be restored about the future of the relationship, and finally reparation to compensate for damages victim experienced through no fault of their own.

Leape, L. L. (1994) Error in medicine. *Journal of American Medical Association*, 272, 1851-1857

Description of Context: The author argues that the error rate in medicine is much higher than that permitted in other safety sensitive industries.

Description of Content: He cites the expectation of infallibility that leaves errors buried and unacknowledged and so does not plan ahead for their reduction in a systematic way. He reports that human errors are inevitable, that punishment only reduces its frank reporting and so prevents efforts to understand, and reduce the potential harm to patients. Human factor research and cognitive psychology offer insights into how and why errors occur. He differentiates slips, small errors in automatic routines made more likely by multitasking and distraction, from mistakes resulting from misapplication of rules and miscalculation or inability to accurately weigh and sort among multiple factor patterns and their implication. He describes the "latent" errors in systems; those aspects of the way work is structured that predisposes individuals to make "active" errors in situations. Examples could be design factors of the equipment, work schedules, communication patterns that inhibit flow of information or are too autocratic to allow input from others.

Possible solutions are described for each source of error. Forcing functions could require that necessary steps be completed before an activity (e.g., a prescription being filled) can occur. Reducing distractions and scheduling appropriately and using standardization and checklists or "expert computer systems" could all help with the weakest aspects of human cognition namely short term memory, planning, and problem solving when multiple factors must be integrated. He compares the aviation and the medical models in terms of the

openness to error reporting and the proactive stance of the industry to take evidence of “acute errors” and find and correct the underlying latent errors that make them more likely to occur. Thus corrective action is taken for the industry rather than merely for the individuals involved.

Conclusions /  
Recommendations

The author supports the view that, while errors may be expected, we can reduce the harm they cause to patients by building checks and redundancies into our work design. He argues strongly that blaming individuals for errors will not lead to meaningful improvement in patient safety.

Leape, L. (2006). Full disclosure and apology – an idea whose time has come. March-April 2006. *The Physician Executive*. 16-18.

Context

Author is one of the most respected researchers on medical errors

Content

Author lays out the case for full disclosure, apology and restitution in the clearest terms. He outlines the ethical as well as the therapeutic reasons for disclosure, noting the trauma experienced by both patients and providers, who are part of harm caused by error and who have not experienced apology and chance for forgiveness. Leape states that appropriate restitution is an essential part of resolution. He gives examples to show that it can be affordable for the healthcare system if a sensitive and timely offer allows compensation to address out of pocket costs and disability in a timely manner.

Conclusion and  
Recommendations

This is a clear and succinct statement of the ethical and therapeutic imperative for full disclosure, apology and timely restitution. Leadership must set expectation, provide support and training and provide early settlements for injured patients in order to make this work.

Levinson, W., & Gallagher, D. (2007). Disclosing medical errors to patients: a status report in 2007. *Canadian Medical Association Journal*, 177(3), 265-267.

The patient-safety movement has highlighted the importance of disclosing medical errors, and many organizations are developing policies and procedures to support these efforts. In Canada, new laws and guidelines are rapidly being developed. Australia, the United Kingdom, New Zealand and the United States have somewhat more experience

in implementing programs to help health care professionals meet the challenge of disclosing medical errors. Physicians now have an opportunity to change the historical paradigm of never discussing medical errors with patients. The environment is clearly changing toward supporting physicians in effective and full disclosure. We anticipate that in the near future disclosing medical errors will be a routine part of medical care, allowing honest communication between health care professionals and patients, and facilitating quality improvement when things go wrong.

Liang, B. A. (2002). A system of medical error disclosure. *Quality and Safety in Health Care*, 11, 64-68. Retrieved December 2, 2007 from <http://qhc.bmjournals.com/>

External mandates for medical error disclosure are often justified by potential cost savings, the belief in individual moral obligations in health care, and the concept that patients have rights and providers have responsibilities. Such an approach does not recognize the systems nature of error and outcomes and the important quality role disclosure can play in a system of medical error disclosure. Systems concepts, the patient-provider partnership, and overall quality of care can be enhanced using a system of disclosure that provides for education about the systems nature of error, fulfills the delivery system philosophy of mutual respect, and integrates the patient and his/her family as a partner in the error reduction enterprise. Such a system can result using clear disclosure policies and procedures sensitive to patient and family needs, open communications with concerned, committed, and compassionate system representatives, and use of mediation methods that foster communication, allow for venting, and are flexible in their approach to resolving conflict, including using apology. Although a system may also result in conflict resolution costs, more importantly it may foster and solidify a team approach to reducing errors and promoting patient safety.

Liebman, C. B., & Hyman, C. S. (2005). *Medical error disclosure, mediation skills, and malpractice litigation*. Retrieved November 16, 2007, from <http://medliabilitypa.org/research/liebman0305/LiebmanReport.pdf>

From the Executive Summary: In the past decade, the cost of medical malpractice insurance has skyrocketed in Pennsylvania. Physicians in high-risk specialties are reported to have moved out of the state, closed their practices, or retired, particularly in eastern Pennsylvania. Liability insurance companies have pulled out of the state. At the same time, serious medical errors continue to occur. Doctors and hospital officials, afraid of lawsuits and loss of insurance coverage, often stonewall patients and relatives, offering only barebones explanations of serious medical errors. Research shows this situation creates a vicious circle in which frustration, anger, and a search for information often motivate patients or their families to file medical malpractice suits. Against this backdrop, the Project on Medical Liability in Pennsylvania, an independent initiative financed by The Pew Charitable Trusts, developed the Demonstration Mediation and

ADR Project in 2002 to explore the value of mediation and open, frank communication about medical errors as a means to avoid bitter and protracted lawsuits. The demonstration project, designed and conducted by faculty of the Columbia Law School in New York, involved three hospitals in eastern Pennsylvania and was based on an extensive review of existing research. Shortly after the demonstration project began, its potential findings gained significance because Pennsylvania enacted Section 308 of the Medical Care Availability and Reduction of Error Act. This law, the first of its kind in the United States, requires hospitals to give written notice to patients or their family after a "serious event." In effect, the state now obligates health care providers to explain the circumstances and repercussions of serious health complications caused by inpatient medical errors.

Liebman, C. B., & Hyman, C. S. (2004, August). A mediation skills model to manage disclosure of errors and adverse events to patient. *Health Affairs*, 22-32.

In 2002 Pennsylvania became the first state to impose on hospitals a statutory duty to notify patients in writing of a serious event. If the disclosure conversations are carefully planned, properly executed, and responsive to patients' needs, this new requirement creates possible benefits for both patient safety and litigation risk management. This paper describes a model for accomplishing these goals that encourages health care providers to communicate more effectively with patients following an adverse event or medical error, learn from mistakes, respond to the concerns of patients and families after an adverse event, and arrive at a fair and cost-effective resolution of valid claims.

Manser, M., & Staender, S. (2005). Aftermath of an adverse event: Supporting healthcare professionals to meet patient expectations through open disclosure. *Acta Anaesthesiol Scand*, 49, 728-734.

An important element of how adverse events are handled is effective communication between health care providers and patients and their families. This review addresses the main questions: What do patients expect in the aftermath of an adverse event? What is known about the practice of open disclosure? How can organizations support health care providers in the aftermath of an adverse event, both professionally and personally? Patients clearly expect open disclosure to include an explanation of what happened, an apology for harm done, that appropriate remedial action will be taken and an explanation of what will be done to learn from the event and to prevent recurrence. Research has found that open disclosure is not very common although the ethical duty to disclose is widely acknowledged. Barriers to open disclosure include discomfort and a lack of training how to disclose, a fear of litigation, a culture of infallibility among health professionals, and inadequate systems for analysis, discussion and learning from mistakes. Significant commitment is required from health care organizations and

managers to develop frameworks for open disclosure to occur, to assure its quality and to support health care providers in this process. Organizations also need to address the emotional needs of health care professionals in the aftermath of an adverse event. Last but not least, adequate systems for debriefing and incident analysis need to be in place to learn from adverse events and to avoid recurrence.

Mazor, K. M., et al (2006). Disclosure of medical errors: what factors influence how patients respond? *Journal of General Internal Medicine*, 21(7), 704-710.

Objectives	To determine whether full disclosure, an existing positive physician-patient relationship, an offer to waive associated costs, and the severity of the clinical outcome influences the patients' responses to medical errors.
Subjects	407 health plan members
Design	Subjects were randomly assigned to experimental condition in which they viewed video depictions of 2 medical errors (overlooking an allergy to penicillin-type antibiotic and failing monitor an anti-epileptic medication adequately) and full and partial disclosure. Conditions varied in type of medical error, level of disclosure, reference to prior positive physician-patient relationship, an offer to waive costs, and severity of outcome (life-threatening vs. less severe). 16 versions of the video scenarios were utilized to create the different conditions. Each subject viewed only one version.
Results	Non-disclosure increased the likelihood of changing physicians and reduced satisfaction and trust in both error conditions. Nondisclosure increased the likelihood of seeking legal advice and was associated with a more negative emotional response in the missed allergy error condition, but did not have a statistically significant impact on seeking legal advice or emotional response in the monitoring error condition. Neither the existence of a positive relationship nor an offer to waive costs had a statistically significant impact. Overall, full disclosure had either positive or no impact on patient and family members. There was no evidence that it increased the risk of negative consequences for the physician. In contrast to previous literature (Kraman and Hamm Lexington VA reports), the offer to waive fees did not improve the subject's reaction to the situation.
Recommendations	Study provides evidence that full disclosure is likely to have positive effect or no effect on how patients respond to medical

errors. Severity of clinical impact affects likelihood of changing physicians and seeking legal advice. Impact of existing positive physician patient-relationship or waiving fees associated with the cost remains inconclusive in this study. Both these last results are counter to previous research and need further exploration. It may be that waiving fees is insufficient when harm has occurred, raising the idea of financial consequences but not adequately addressing patients entitlement to more compensation of some kind for other consequences of the harm they have experienced.

Mazor, K. M., Simon, S. R., & Gurwitz, J. H. (2004). Communicating with patients about medical errors: A review of the literature. *Archives of Internal Medicine*, 164:1690-1697.

**Background:** Ethical and professional guidelines recommend disclosure of medical errors to patients. The objective of this study was to review the empirical literature on disclosure of medical errors with respect to (1) the decision to disclose, (2) the process of informing the patient and family, and (3) the consequences of disclosure or nondisclosure.

**Methods:** The authors searched 4 electronic databases (MEDLINE, CINAHL, PsycINFO, and Social Sciences Citations Index) and the reference lists of relevant articles for English-language studies on disclosure. From more than 800 titles reviews, we identified 17 articles reporting original empirical data on disclosure of medical errors to patients and families. They examined methods and results of the articles and extracted study designs, data collection procedures, populations sampled, response rates, and definitions of errors.

**Results:** Available research findings suggest that patients and the public support disclosure. Physicians also indicate support for disclosure, but often do not disclose. The authors found insufficient empirical evidence to support conclusions about the disclosure process or its consequences.

**Conclusions:** Empirical research on disclosure of medical errors to patients and families has been limited, and studies have focused primarily on the decision stage of disclosure. Fewer have considered the disclosure process, the consequences of disclosure, or the relationship between the two. Additional research is needed to understand how disclosure decisions are made, to provide guidance to physicians on the process, and to help all involved anticipate the consequences of disclosure.

McDermott, M. (1997). Responding to an adverse event: A case study. *Forum of the Risk Management Foundation of the Harvard Medical Institutions, Inc.*, 18(1), 10.

At the start of the meeting, various family members were sad, angry, or suspicious that the hospital was trying to cover up its failure to conduct sufficient tests. However, the willingness of the health care providers at the meeting to discuss the case, explain the clinical aspects, and weigh the pros and cons of conducting further tests allied the clinicians with the family in their search for answers. The family left the meeting with a copy of the medical record, provided by the hospital, planning to discuss the matter further among themselves. Indeed, they called the pathologist on a later occasion to ask more questions, but initiated no further action.

Mellanby, R. J., & Herrtage, M. E. (2004). Survey of mistakes made by recent veterinary graduates. *The Veterinary Record*, 155, 761-765.

To investigate the incidence and types of mistakes made in veterinary practice, and to assess the impact the mistakes had on the veterinarians involved, a questionnaire was sent in November 2002 to all the veterinary graduates of the Universities of Bristol, Edinburgh, Glasgow, London and Liverpool in 2001. One hundred and eight (27 per cent) of 402 questionnaires were returned completed; 87 of 106 respondents (82 per cent) worked frequently or always unsupervised and only 46 (43 per cent) could always rely on support from other veterinarians in the practice. Since starting work, 82 of 105 respondents (78 per cent) stated that they had made a mistake, defined as an erroneous act or omission resulting in a less than optimal or potentially adverse outcome for a patient, and in many cases these mistakes had had a considerable emotional impact on the veterinarians involved. The survey highlights that a large number of recently graduated veterinarians work with little supervision and that many veterinarians beginning their year in practice do not always have access to assistance from other veterinary colleagues.

Milani, M. (2007). The art of apology. *Canadian Veterinary Journal*, 48, 195-197

The author provides a thoughtful yet brief overview of the role of apology, medical error and responsibility taking in veterinary medicine. She reports how many practitioners intuitively recognize that the “admit-no-wrong” approach is more likely to lead to legal action than prevent it. Further, she recommends that veterinary professionals follow the following steps, identified by a coalition of 14 hospitals associated with Harvard Medical School:

1. Tell the patient and family what happened, providing all known facts.
2. Take responsibility. For veterinarians who own the practice, this means that the “buck stops with you,” even if the error was committed by someone on your

staff. Most certainly, any subordinates also should accept responsibility for their roles, but the ultimate responsibility still rests with the owner.

3. Apologize at once.

Nunalee, M. M. M., & Weedon, G. R. (2004). Modern trends in veterinary malpractice: how our evolving attitudes toward non-human animals will change veterinary medicine. *Animal Law, 10*, 125-161. Retrieved on July 28, 2007, from [http://www.animallaw.info/journals/jo\\_pdf/vol10\\_p125.pdf](http://www.animallaw.info/journals/jo_pdf/vol10_p125.pdf)

The magic of Lassie is not just a movie script made in magicland USA, but for many a young boy and girl it may well be the theme song for their feelings about a little dog that just happens to live at home with them, and for most of these persons who have dogs at home, the greatest problem, pooperscooper notwithstanding, is that these dogs believe quite honestly that they are human beings and members of the family. In a sense this decision might be dedicated to just such a four-legged member of the family. The facts are, at least at the beginning, not uncommon to many a home, where a pet permits his owners to live with him. As often happens, the pet took ill on the weekend and the owner was unable to reach a veterinarian. To those who are not indoctrinated in this field of unusual medicine, a veterinarian may, with no disrespect meant to either medical specialty, be referred to with love and affection as a “pet’s family pediatrician.”

O’Connell, D., & Reifsteck, S. W. (2004) Disclosing unexpected outcomes and medical error. *Journal of Medical Practitioner Management*, 317-323.

Description of Context:

The article outlines a suggested educational approach for organizations and clinicians interested in developing their skills in interacting constructively in situations where there has been an unexpected adverse outcome, including those situations where investigation has indicated that a medical or systems error was responsible for the injury.

Description of Contents:

Clinicians and organizations are encouraged to proactively address questions such as, “What do their patients and families expect from them in these situations?” and “What do their medical groups, malpractice carrier, health-care institutions and the legal system consider in determining an appropriate response?” The authors describe the range of reasons why patients and families may be disappointed with the outcome of care and how they can be understood and addressed. They describe what can be done before, during and after a potentially disappointing outcome to increase the chances that the situation can be resolved sensitively, ethically, and

equitably in the eyes of all parties. The authors encourage clinicians and organizations to rethink the appropriate role of legally protected venues (i.e., quality assurance and peer review committees) so they are not misused to conceal from the patient facts that relate directly to their injury. The public is now much more sophisticated about the extent to which individual medical and systems errors and equipment failures cause injury and has a much wider array of information sources from which to launch their own investigation should they feel that health-care providers are withholding crucial information from them. There is a large and active plaintiff's bar that is aggressively marketing to individuals who feel they have been wronged by the health-care system. The article frames patients' motivation to seek legal advice in the context of their perceived needs to protect their personal financial security, to assure fairness and equity, and to counter the blows to their self-esteem that can come both from medical injury and insensitive response to the injury that health-care system.

Conclusions/  
Recommendations

The authors recommend an open and honest approach to disclosure of adverse outcomes. To address this, the authors encourage discussion in which patients and families' questions are elicited and answered and where disputes about facts and interpretations are referred to mutually agreed upon the third parties for review. Where an injury is clearly caused by individual or systems errors a proactive offer of assistance (including compensation) before the upset patient has turned to a plaintiff's attorney may enable the situation to be resolved satisfactorily in the patient-family-provider-organization relationship.

Silversides, A. (2007). National guidelines in the offing. *Canadian Medical Association Journal*, 177(11), 1343.

National Guidelines for the Disclosure of Adverse Events to patients and families are promised by the Canadian Patient Safety Institute by year's end, having been under development by a National Disclosure Working Group since the spring of 2006. The Canadian Medical Protective Association, which insures doctors in Canada, is also playing a key role in developing the national guidelines.

Studdert, D. M., Mello, M. M., Gawande, A. A., Brennan, T. A., & Wang, Y. C. (2007). Disclosure of medical injury to patients: An improbable risk management strategy. *Health Affairs*, 26(1), 215-226.

Pressure amounts on physicians and hospitals to disclose adverse outcomes of care to patients. Although such transparency diverges from traditional risk management strategy, recent commentary has suggested that disclosure will actually reduce providers' litigation exposure. We tested this theory by modeling the litigation consequences of disclosure. We found that forecasts of reduced litigation volume or cost do not withstand close scrutiny. A policy question more pressing than whether moving toward routine disclosure will expand litigation is the question of how large such an expansion might be.

Waterman, A. D., Garbutt, G., Hazel, E., Dunagan, W. C., Levinson, W., Fraser, V. J., & Gallagher, T. H., (2007). The emotional impact of medical errors on practicing physicians in the United States and Canada. *The Joint Commission Journal on Quality and Patient Safety*, 33(8), 467-476.

**Background:** Being involved in medical errors can compound the job-related stress many physicians experience. The impact of errors on physicians was examined.

**Methods:** A survey completed by 3,171 of the 4,990 eligible physicians in internal medicine, pediatrics, family medicine, and surgery (64% response rate) examined how errors affected five work and life domains.

**Results:** Physicians reported increased anxiety about future errors (61%), loss of confidence (44%), sleeping difficulties (42%), reduced job satisfaction (42%), and harm to their reputation (13%) following errors. Physicians' job-related stress increased when they had been involved with a serious error. However, one third of physicians only involved with near misses also reported increased stress. Physicians were more likely to be distressed after serious errors when they were dissatisfied with error disclosure to patients (odds ratio [OR] = 3.86, confidence interval [CI] = 1.66, 9.00), perceived a greater risk of being sued (OR = .28, CI = 1.50, 3.48), spent greater than 75% time in clinical practice (OR = 2.20, CI = 1.60, 3.01), or were female (OR = 1.91, CI = 1.21, 3.02). Only 10% agreed that health care organizations adequately supported them in coping with error-related stress.

**Discussion:** Many physicians experience significant emotional distress and job-related stress following serious errors and near misses. Organizational resources to support physicians after errors should be improved.

University of Michigan Disclosure Policy and Procedures (2002). Accessed 2007 at [www.med.umich.edu/patientsafetytoolkit/disclosure](http://www.med.umich.edu/patientsafetytoolkit/disclosure)

Context	University of Michigan Health System has been a leader in the open disclosure and timely resolution of medical errors with its clinicians, patients and their families.
Content	This document lays out their policy, procedures, rationale, and defines important terms and their implications. It describes fallacies about consequences of disclosure. It describes the levels of harm that require disclosure and specific steps to be taken by clinicians and the organization.
Conclusion Recommendation	This is one of the best and most useful documents for Thinking about and carrying through effective disclosure of medical errors that cause harm.

Weber, D. O. (2006 March-April). Who's sorry now? *The Physician Executive*, 6-14.

Context	The American College of Physician Executives conducted surveys of members and the general public on the question of whether physicians and healthcare organizations should apologize for medical errors
Content	<p>The author provides numerical data as well as individual comments made by survey participants. More than 25% of general public reported experience in their family with medical error. 90% reported they would be more likely to sue if there was a cover-up although 25% reported considering suing simply to obtain compensation for the harm caused by an error.</p> <p>Only 50% of the 1019 physician executives reported that their organizations are currently encouraging apologies for medical errors. The individual comments reported throughout the piece show the range of feelings of executives re: the role of plaintiff's attorney's in driving claims, the need for tort reform, and their differing acceptance of the ethical and legal requirements for honesty in the face of adverse outcomes vs. their feeling that their physicians and organizations are entitled to be self-protective.</p> <p>Embedded in the article is a case study by Rick Boothman, Director of Risk management for the University of Michigan Health System. He reports on the rationale and success that they have had in early recognition and resolution of cases where error has caused patient injury coupled with vigorous defense in situations where their own review of care does not</p>

find error/negligence. The program has resulted in initial liability cost savings for U of M and had salutatory benefits on their patient safety program as well.

#### Conclusions

More than half of physician executives remain reluctant to encourage apology and full disclosure in the current climate of tort litigation although there has been a substantial movement in this direction in recent years.

West, C. P., Huschka, M. M., Novotny, P. J., Sloan, J. A., Kolars, J. C., Habermann, T. M., & Shanafelt, T. D., (2006). Association of perceived medical errors with resident distress and empathy a prospective longitudinal study. *Journal of the American Medical Association*, 296(9), 1071-1078.

**Context** Medical errors are associated with feelings of distress in physicians, but little is known about the magnitude and direction of these associations.

**Objective** To assess the frequency of self-perceived medical errors among resident physicians and to determine the association of self-perceived medical errors with resident quality of life, burnout, depression, and empathy using validated metrics.

**Design, Setting, and Participants** Prospective longitudinal cohort study of categorical and preliminary internal medicine residents at Mayo Clinic Rochester. Data were provided by 184 (84%) of 219 eligible residents. Participants began training in the 2003-2004, 2004-2005, and 2005-2006 academic years and completed surveys quarterly through May 2006. Surveys included self-assessment of medical errors and linear analog scale assessment of quality of life every 3 months, and the Maslach Burnout Inventory (depersonalization, emotional exhaustion, and personal accomplishment), Interpersonal Reactivity Index, and a validated depression screening tool every 6 months.

**Main Outcome Measures** Frequency of self-perceived medical errors was recorded. Associations of an error with quality of life, burnout, empathy, and symptoms of depression were determined using generalized estimating equations for repeated measures.

**Results** Thirty-four percent of participants reported making at least 1 major medical error during the study period. Making a medical error in the previous 3 months was reported by a mean of 14.7% of participants at each quarter. Self-perceived medical errors were associated with a subsequent decrease in quality of life ( $P=.02$ ) and worsened measures in all domains of burnout ( $P=.002$  for each). Self-perceived errors were associated with an odds ratio of screening positive for depression at the subsequent time point of 3.29 (95% confidence interval, 1.90-5.64). In addition, increased burnout in all domains and reduced empathy were associated with increased odds of self perceived error in the following 3 months ( $P=.001$ ,  $P=.001$ , and  $P=.02$  for depersonalization, emotional exhaustion, and lower personal accomplishment, respectively;  $P=.02$  and  $P=.01$  for emotive and cognitive empathy, respectively).

**Conclusions** Self-perceived medical errors are common among internal medicine residents and are associated with substantial subsequent personal distress. Personal distress and decreased empathy are also associated with increased odds of future self-perceived errors, suggesting that perceived errors and distress may be related in a reciprocal cycle.

White, A. A., Pichert, J. W., Bledsoe, S. H., Irwin, C., & Entman, S. S. (2005). Cause and effect analysis of closed claims in obstetrics and gynecology. *Obstetrics and Gynecology, 105*(5), 1031-1038. Retrieved March 26, 2006, from EBSCOhost database.

**Background:** Identifying the etiologies of real or perceived adverse clinical events and undesired outcomes is an important step in improving patient safety and reducing malpractice risks. Systematic analysis of obstetrics and gynecology–related risk management files allows a more complete examination of ways that human and systems factors may contribute to adverse events.

**Objective:** To learn the medical complaints of patients who experienced apparent adverse events, the general causes of those adverse events, and the significant specific causal factors involved in obstetrics and gynecology–related risk management cases.

**Methods:** This was a retrospective analysis of 90 consecutive obstetrics and gynecology–related internal review files opened by a medical center’s risk managers between 1995 and 2001. Each file was analyzed to identify factors that may have contributed to or caused unanticipated adverse events. The main outcome was the pattern of contributing factors when they were aggregated into categories.

**Results:** Fifty percent of cases were associated with inpatient obstetrics. Factors that may have contributed to adverse events were identified in 78% of cases, and most had more than one contributing factor. Thirty-one percent of adverse events were associated with apparent communication problems. Clinical performance issues were identified in 31% of cases, diagnostic issues in 18% of cases, and patient behavior contributed to 14% of adverse events.

**Conclusion:** Diagnostic, therapeutic, and communication issues were the most common factors identified. Although the generalizability of these data are unknown, all obstetrics and gynecology departments face multiple challenges in assuring consistent quality care. Analysis of claims files may help identify opportunities for improvement.

Wilson, J., & McCaffrey, R. (2005). Disclosure of Medical Errors to Patients. *MEDSURG Nursing, 14*(5), 319-323.

This literature review explores the feelings of patients and health care providers regarding the disclosure of medical errors. Findings from these studies illuminate patients’ desires for information about medical errors and what they are likely to do with the information once they are informed.

Wilson, J. F. (n.d.). *The Law of Professional Negligence*. Priority Management Veterinary Consultants Website, Retrieved January 18, 2008, from <http://www.pvmc.net/index.html>

This publication discusses the important aspects of professional liability, and basic elements of a suit for negligence. Included are specific areas where additional knowledge and discussion would be most valuable, including the areas of animal restraint, informed consent, and several new client consent forms. The paper covers the Origin of Client Complaints and the resultant refusal to pay for services rendered to include

1. Breakdowns in communications about medical care and fees.
2. The failure to provide satisfactory quantity and quality of veterinary care.
3. The failure to offer timely referrals - not at all or too late to be of value.
4. The failure to show adequate compassion.
  - a. When a patient dies.
  - b. At the time of euthanasia.
  - c. When providing a mechanism for disposal of the patient's body.
  - d. When a client is injured.
5. Aggravating the potential for complaints.
  - a. The egotistical veterinarian.
  - b. Making a diagnosis too quickly.
  - c. Filing a small claims court action to collect on an unpaid account.
6. Avenues for addressing grievances.
  - a. Talk with clients on a regular basis!!!!!! Do not pass this job on to a receptionist or office manager. Meet with them in person whenever possible.
  - b. VMA ethics committees or peer review committees.
  - c. State boards of veterinary examiners and courts of law.

The material in the paper is covered in-depth in Chapter 6 of the *Law and Ethics of the Veterinary Profession* textbook, available from Priority Press, Ltd., (215) 321-9488, Yardley, PA 19067.

Wisch, R. F. (2003). Overview of Veterinary Malpractice. Animal Legal and Historical Center, Retrieved on July 28, 2007, from <http://www.animallaw.info/articles/qvusvetmal.htm>

As veterinarians are professional licensed by the states in which they practice, negligence or malpractice may result in the revocation of one's license to practice veterinary medicine. As with other professionals, veterinarians are responsible for the maintenance of certain standards in order to have their licenses renewed. Improper actions, such as a failure to communicate with the pets' owners, the failure to inform the owners of their pets' deaths, or the failure to improperly administer treatment may

result in suspension or revocation of a veterinary license. Unfortunately, the biggest bar to a negligence lawsuit in veterinary malpractice cases is the lack of any significant monetary damages for the owner. But, for many owners, pets are more than mere animal companions and a legal action affords some assurance that the negligent veterinarian is held responsible. Owners should be aware of the necessary steps to take to properly preserve their claims.

Witman, A. B., Park, D. M., & Hardin, S. B. (1996). How do patients want physicians to handle mistakes? A Survey of internal medicine patients in an academic setting. *Archives of Internal Medicine*, 156:2565-2569.

Patients now play a more substantive role in medical decision making. As a consequence, they desire more information. These findings illustrate that patients expect their physicians to communicate openly and honestly. Any anonymous survey is a relatively crude instrument that cannot account for the more subtle nuances of the physician/patient relationship. Patients may, in fact, be less likely to sue physicians than the responses received from this small, relatively homogenous group of participants indicate. Physicians have a number of reasons to acknowledge their mistakes. Besides a moral imperative for truth telling are more practical reasons. These findings suggest that openness strengthens the physician/ patient relationship: patients are more likely to stay with their physicians if told honestly of their mistakes. And, finally, telling the truth may reduce the risk of litigation and other punitive actions.

Wojcieszac, D., Banja, J., & Houck, C. (2006) The Sorry Works Coalition: making the case for full disclosure. *Journal of Quality and Patient Safety*, 32(6), 344-350.

Context	Sorry Works ( <a href="http://www.sorryworks.net">http://www.sorryworks.net</a> ) is a leading organization promoting full disclosure and early resolution of adverse outcomes involving error
Content	The author describe the Sorry Works history, rationale and approach and provide evidence for its ethical rightness as well as its effectiveness in reaching reasonable resolutions with patients and families. They use a challenge-response format to address key concerns and objections.