# Disclosing Medical Errors to Patients:
## Recent Developments and Future Directions

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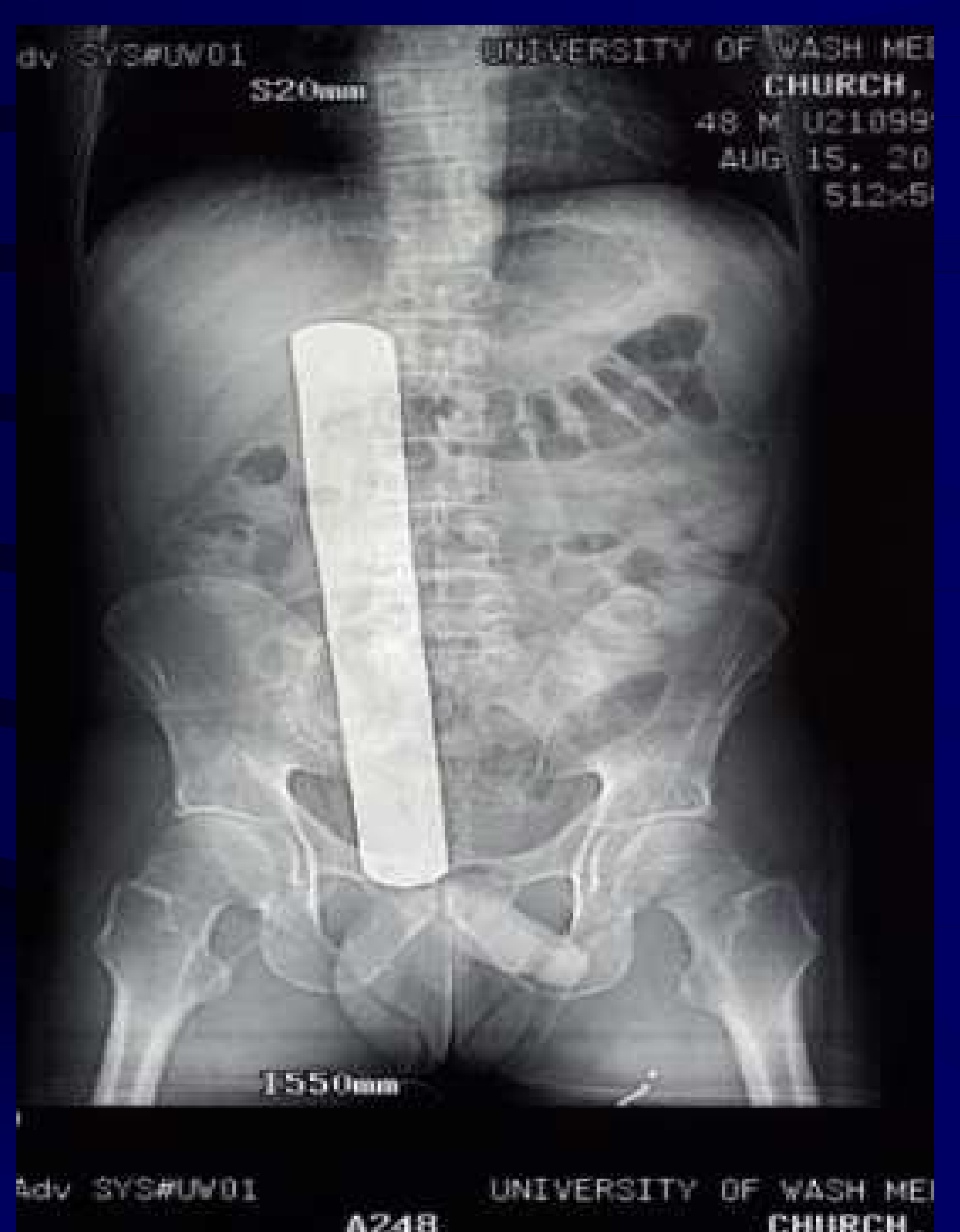
# Accelerating Interest in Disclosure

- Growing experimentation with disclosure approaches
  - Healthcare organizations
  - Malpractice insurers
- New standards-NQF and others
- State laws re disclosure, apology
- Increased emphasis on transparency in healthcare generally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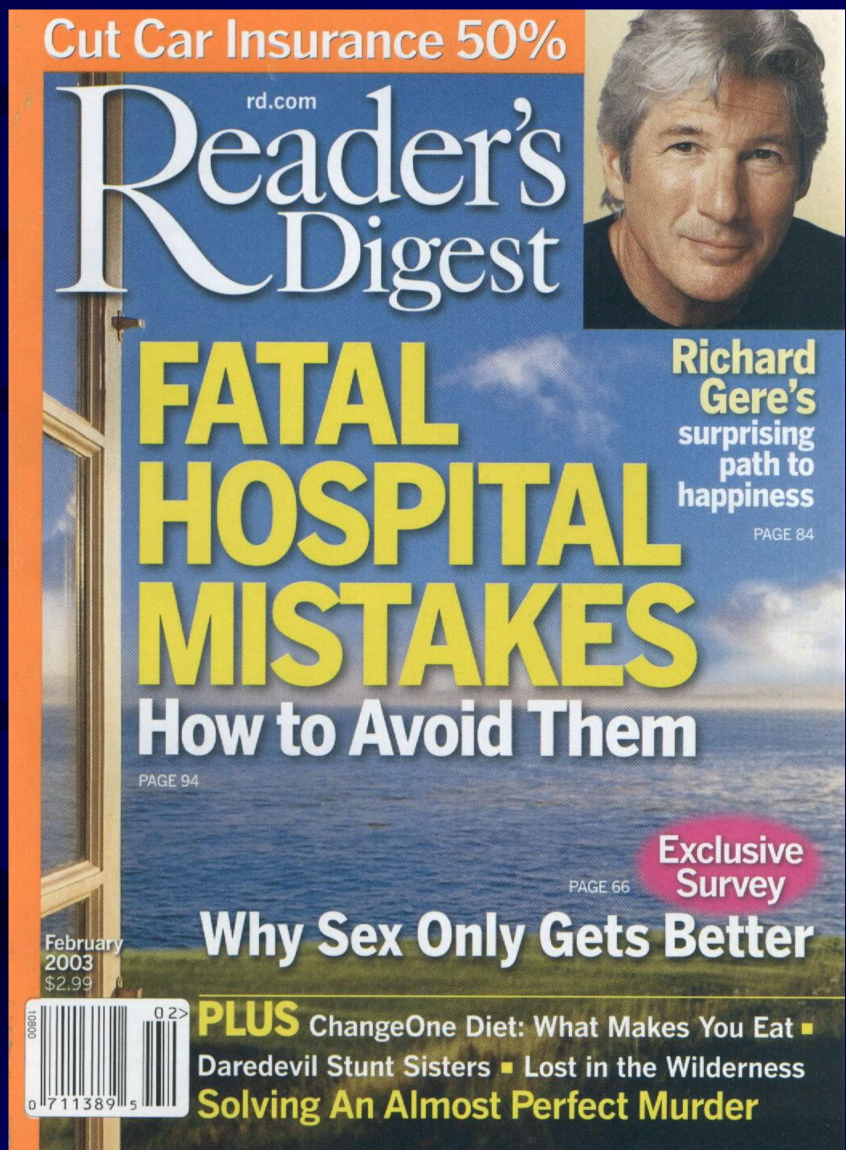
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# Disclosure Performance Gap Also Increasingly Evident

- Harmful errors often not disclosed
- When disclosure does take place, often falls short of meeting patient expectations
- Little prospective evidence exits regarding what disclosure strategies are effective
- Impact of disclosure on outcomes unclear

*"Listen up, my fine people, and I'll sing you a song 'bout a brave neurosurgeon who done something wrong."*

# Disclosure: From Bedside to Health Policy

- Individual doctor-patient conversation
- Interprofessional issues
- Institutional issues
  - Policies
  - Reports from the field
- Health policy issues
- Future developments

# Patients' Attitudes about Errors

- Patients conceive of errors broadly
- Desire full disclosure of harmful errors
  - Worry that health care workers might hide errors

# Patients' Preferences for Error Disclosure

- Information patients want disclosed
  - Explicit statement that error occurred
  - What happened, implications for their health
  - Why it happened
  - How will recurrences be prevented
- Importance of an apology

# Physicians' Attitudes about Errors

- Define errors more narrowly than patients
- Agree in principle with full disclosure
- Want to be truthful, but experience barriers to disclosure

# Choosing Your Words Carefully

- Physicians "choose their words carefully" when disclosing errors to patients
  - Avoid explicit identification of error, discussion of prevention
  - Assume interested patients will ask clarifying questions
  - Concern re: legal liability makes apologizing hard

# Physician Surveys

- Survey of:
  - 2,000 physicians at Washington University/BJC HealthCare, University of Washington, Group Health Cooperative
  - 2000 Canadian physicians
- Topics: Communicating about medical errors with patients, colleagues, and health care institutions
- Response rate: 63%

# Disclosure Scenario Overview

- Respondents randomized to one of four specialty-specific disclosure scenarios
  - Overt error: insulin OD/ retained surgical sponge
  - Unapparent error: hyperkalemia/bile duct injury during lap chole due to unfamiliarity with new surgical tool
- Five questions measured content of disclosure
  - each question presented actual disclosure language representing no information, a little information, or full disclosure

# Scenario 1: Insulin Overdose

*You have admitted a diabetic patient to the hospital for a COPD exacerbation. You handwrite an order for the patient to receive "10 U" of insulin. The "U" in your order looks like a zero. The following morning the patient is given 100 units of insulin, ten times the patient's normal dose, and is later found unresponsive with a blood sugar level of 35. The patient is resuscitated and transferred to the intensive care unit. You expect the patient to make a full recovery.*

# How likely would you be to disclose this error to the patient?

| Response | US Medicine | Canadian Medicine |
|---|---|---|
| I would definitely not disclose this error | 0.5% | 0.6% |
| I would disclose this error only if asked by the patient | 3.0% | 1.3% |
| I would probably disclose this error | 31.8% | 22.8% |
| I would definitely disclose this error | 64.8% | 75.3% |

# What would you most likely say about what happened?

| Dialogue | US Medicine | Canadian Medicine |
|---|---|---|
| Your blood sugar went too low and you passed out. | 1% | 1% |
| Your blood sugar went too low because you received more insulin than you needed. | 28% | 21% |
| Your blood sugar went too low because an error happened and you received too much insulin. | 71% | 78% |

# How much detail would you most likely give the patient about the error?

| Dialogue | US Medicine | Canadian Medicine |
| --- | --- | --- |
| I would not volunteer any specific information about the details of the error unless asked by the patient. | 11% | 8% |
| You received more insulin than you needed. | 36% | 31% |
| You received 100 units rather than your usual 10 units of insulin. | 54% | 62% |

# What would you most likely say regarding an apology?

| Dialogue | US Medicine | Canadian Medicine |
|---|---|---|
| I would not volunteer that I was sorry or apologize. | 3% | 3% |
| I am sorry about what happened. | 54% | 48% |
| I am so sorry that you were harmed by this error. | 43% | 49% |

# Scenario 2: Hyperkalemia

*You start an outpatient with hypertension on a new medicine with a common side effect of increasing the potassium level. The patient's baseline potassium level is normal (4.0). You order a repeat potassium blood test to be drawn the next week, but forget to check the lab results. Two weeks after the patient begins this new medicine they start feeling palpitations and go to the emergency room. In the ER the patient experiences an episode of ventricular tachycardia requiring cardioversion. The patient's potassium level at the time of this event is 7.5. The patient is hospitalized for four days, and makes a full recovery. The patient returns to your office for a follow-up visit. On reviewing the patient's chart you see the overlooked labs, which showed the patient's potassium had risen substantially from 4.0 to 5.6. Had you seen this elevated potassium earlier, you would have stopped the new medicine and treated the hyperkalemia, likely avoiding the life-threatening arrhythmia.*

# How likely would you be to disclose this error to the patient?

| Response | US Medicine | Canadian Medicine |
|---|---|---|
| I would definitely not disclose this error | 0.8%<br>0.5% | 1.2%<br>0.6% |
| I would disclose this error only if asked by the patient | 12.5%<br>3.0% | 6.5%<br>1.3% |
| I would probably disclose this error | 52.7%<br>31.8% | 47.8%<br>22.8% |
| I would definitely disclose this error | 34.1%<br>64.8% | 44.4%<br>75.3% |

# What would you most likely say about what happened?

| Dialogue | US Medicine | Canadian Medicine |
|---|---|---|
| Your potassium level got too high, which led to a dangerous heart rhythm. | 6%<br>1% | 1%<br>1% |
| The new medicine we started caused your potassium level to become too high, which led to a dangerous heart rhythm. | 55%<br>28% | 57%<br>21% |
| You had a dangerous heart rhythm because an error happened and we did not notice that the new medicine had caused your potassium to become too high. | 40%<br>71% | 41%<br>78% |

# Scenario 3: Retained Sponge

*You are seeing a patient 3 weeks post-elective splenectomy for ITP. The splenectomy was technically challenging due to the patient's obesity, but appeared to be uncomplicated. At this follow-up visit, the patient complains of vague, persistent LUQ pain. You send the patient for an abdominal x-ray, which shows a foreign body consistent with a retained surgical sponge in the patient's LUQ. You remember that the sponge count was correct at the end of the procedure. However, you also remember that you packed off a small bleeding vessel near the stomach with a sponge, and now do not recall removing this sponge. When you review the post-operative records, you observe that a math error was responsible for a falsely correct sponge count. You believe a re-operation to remove the retained sponge is indicated, and expect the patient will make a full recovery.*

# How likely would you be to disclose this error to the patient?

| Response | US Surgeons | Canadian Surgeons |
|---|---|---|
| I would definitely not disclose this error | 0.6%<br>0.5% | 0.3%<br>0.6% |
| I would disclose this error only if asked by the patient | 0.0%<br>3.0% | 0.0%<br>1.3% |
| I would probably disclose this error | 3.2%<br>31.8% | 2.4%<br>22.8% |
| I would definitely disclose this error | 96.2%<br>64.8% | 97.3%<br>75.3% |

# What would you most likely say about what happened?

| Dialogue | US Surgeons | Canadian Surgeons |
|---|---|---|
| The x-ray showed an abnormality that could be serious. Another operation will be required to investigate and correct this problem. | 3%<br>1% | 2%<br>1% |
| During the surgery, a sponge was inadvertently left in your abdomen. Another operation will be required to remove the sponge. | 83%<br>28% | 79%<br>21% |
| We will have to do another operation because an error happened and a sponge was left in your abdomen. | 14%<br>71% | 19%<br>78% |

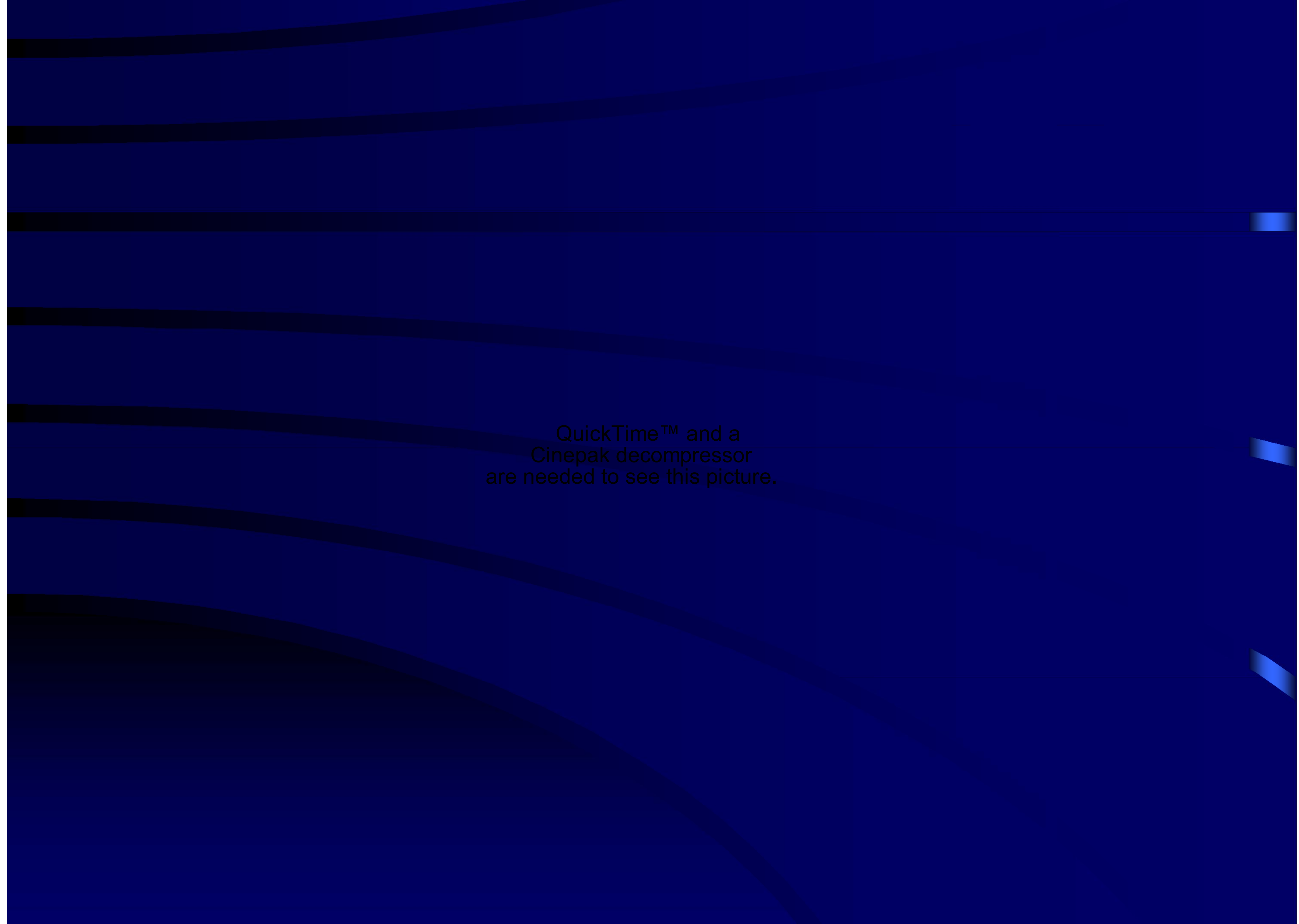
# What would you most likely say regarding an apology?

| Dialogue | US Surgeons | Canadian Surgeons |
|---|---|---|
| I would not volunteer that I was sorry or apologize. | 19%<br>3% | 13%<br>3% |
| I am sorry about what happened. | 72%<br>54% | 69%<br>48% |
| I am so sorry that you were harmed by this error. | 9%<br>43% | 18%<br>49% |

# Preliminary Survey Conclusions

- Physicians support concept of disclosure
- Little agreement exists regarding the core content of disclosure
- Less information disclosed for errors that would not be apparent to patient
- Medical and surgical physicians may approach disclosure differently

# Patient-Centered Disclosure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# Interprofessional Issues in Disclosure

- Disclosure conceptualized as doctor-patient conversation
- We make errors as teams--should we disclose them as teams?
- Team disclosure complicated by power dynamics

# Nurses' Disclosure Attitudes

- 9 focus groups at 4 institutions
- Support disclosing errors that cause serious harm or require further intervention
- Worry that disclosing minor errors would scare patients and family
- Eager to participate with MD in disclosure conversations, in part so they won't be blamed
- "Walking on eggshells"

# Challenges in team disclosure

- When is team disclosure helpful? Harmful?
- What do we owe other team members?
  - Absolute loyalty?
  - Falling on sword?
- What are roles of different team members in the disclosure process?

# Institutional Disclosure Issues

- Vast majority of institutions have adopted formal disclosure policies
- Policies range from restatement of JCAHO standard to detailed disclosure procedures
- Translating policy into action can be difficult

# NQF Safe Practices

- 30, consensus-based standards
- Harmonized with JCAHO, CMS, IHI, Leapfrog, AHRQ
- Disclosure 1 of 2 new Safe Practice
- Used in pay-for-performance
- Hospital-specific performance on each Safe Practice available on Leapfrog website

# Leapfrog Hospital Ratings

Search Results: **Zip:** 98105 **Radius:** 10 Miles

Below are the results of your search. Click on the "leaps" and the circles for more details.

Survey Info | Scoring Info | Start Over

| | | | Leap1 | Leap2 | Leap3 | | | | | | | | Leap4 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | High Risk Treatments | | | | | | | | | | | | |
| Click to Compare | Hospital Name | City | CPOE | ICU | CABG | PCI | AAA | Esoph. | Panc. | Bariatric | Aortic Valves | NICU | Safe Practices Score | Transparency Indicator | Adherence to Never Events Policies | Leapfrog Hospital Insights Reporting Hospital | Survey Results Submitted |
| | EVERGREEN HEALTHCARE | Kirkland, WA | | | | | | | | | | | | | | | 6/25/2007 |
| | HARBORVIEW MEDICAL CENTER | Seattle, WA | | | NA | NA | | | | NA | NA | NA | | | | | 6/06/2007 |
| | UNIVERSITY OF WASHINGTON MEDICAL CTR | Seattle, WA | | | | | | | | | | | | | | | 6/15/2007 |
| | VIRGINIA MASON MEDICAL CENTER | Seattle, WA | | | | | | | | | | NA | | | | ✓ | 7/23/2007 |

Compare hospitals above: GO!

# Safe Practices Score

The Safe Practices score consists of individual scores on the following 27 health care practices. The number to the right of each bar below indicates the total number of points possible for meeting each practice. The gray portion of each bar indicates the extent to which the hospital has met the standard for each practice.

(more info on scoring)

**UNIVERSITY OF WASHINGTON MEDICAL CTR** (website)
**1959 Ne Pacific St/box 356151, Seattle, WA 98195**

| Practices | |
|---|---|
| **Safety Culture** | |
| Element 1: Establish leadership structures and systems | 120 |
| Element 2: Invest in performance improvement | 20 |
| Element 3: Teamwork training and skill building to promote patient safety | 40 |
| Element 4: Identify and mitigate risks and hazards | 120 |
| Nursing staff meets patients' needs | 100 |
| Non-nursing staff meets patients' needs | 20 |
| **Communication Among Health Care Workers** | |
| Timely clinical information for other caregivers and patients | 84 |
| Repeat verbal orders and critical test results | 25 |
| Prevent mislabeled x-rays | 15 |
| Discharge summary available for follow-up care | 25 |
| Use standardized abbreviations and doses | 11 |
| **Doctor and Patient Communications** | |
| Patient can repeat details of condition and treatment | 4 |
| Patient preferences are prominent in chart | 4 |
| Patient notified of problems in care delivery | 25 |

# Overview of Disclosure Safe Practice

- Emphasizes transparency as core value
- Links disclosure with performance improvement
- Articulates process of disclosure
- Details institutional disclosure support system
  - Background education for healthcare workers
  - Just-in-time coaching
  - Emotional support for patients, families, healthcare workers

# Content of Disclosure

- Empathic communication of <u>the facts regarding the outcome</u> and its preventability
- Expression of regret (all unanticipated outcomes)
- Commitment to investigate and prevent future occurrences

# Apology

- Expression of regret appropriate for all unanticipated outcomes
- Apology when unanticipated outcome clearly caused by unambiguous error or system failure

# Institutional Disclosure Support System

- Emotional support for patients, families, healthcare workers
- Disclosure education/skill building
- Provide disclosure coaching 24/7/365

# Impact of Disclosure on Outcomes

- Reports from the field
  - University of Michigan
  - COPIC
- Disclosure and malpractice

# University of Michigan

- Full disclosure program:
  - Disclose cases of harmful error
  - Compensate patients quickly and fairly
- In five years since implementing full disclosure program:
  - Annual litigation costs:
    - $3 million ⇒ $1 million
  - Average time to resolution of claims:
    - 20.7 months ⇒ 9.5 months
  - Number of claims and lawsuits
    - 262 ⇒ 114

# COPIC

- Large Colorado malpractice insurer
- Developed “3Rs” Program in 1998
- Program seeks to promote disclosure, early offer following unanticipated outcomes
- Program is “no-fault”
- Exclusions-patient death, attorney involvement, complaint to BME
- Patient not asked to sign waiver
- Payments not reportable to NPBD

# 3Rs Processes

- Event reported
- Physician and COPIC in accord as to intervention
- Doctor engages in disclosure process, tells patient about program, and puts patient in touch with 3Rs administrator
- 3Rs Administrator reimburses patient upon obtaining receipts for out of pocket expenses and lost time up to $30,000

# 3Rs Program Highlights – 50 Month Financial Results (10/1/00-12/31/05)

| | | |
|---|---|---|
| Participants | 2532 | 310 for all 50 months; 1713 for 38/50 months |
| Reported Incidents | 4674 | Cornerstone = Early Incident / Event Reporting |
| 3Rs Criteria Met | 2174 | No incident with 3R criteria met has proceeded to full litigation |
| Closed with no $ Paid | 1622 | 1235 of 2174 closed and 387 about to close with no $ paid, simply satisfactory communication |
| Closed with payment | 500 | 259 closed and 241 about to be closed with payment |
| Sent to Claims | 52 | 4 of 52 settled w/o lawyers, indemnity paid, & docs reported; 12 also with 3R payments (no offset, not reported) |
| Spent so far | $2,908,137 | About 50/50 spent so far for reimbursable expenses and loss of time |
| Average paid per incident | $5,680 | Compared to avg. severity in 2003 of $88,056, and in 2004 of $74,643, and in 2005 of $77,936 |
| Dollar range per incident | $95 -$30,000 | $30,000 maximum allowed |
| Operational Costs | $975,899 | Two FTE administrators; 1 P/T physician, 1 secretary, managerial consulting |
| Total Program Cost | $3,884,036 | All costs (reimbursement $, time loss $, & Administrative $) over 63 months |

# Role of Compensation in Disclosure Process

# Health Policy Initiatives

- State apology laws
- State disclosure laws

# Apology Laws

- 35 states have adopted apology laws to date
- Protection varies widely
  - 25 laws protect “expression of remorse” only
  - 6 protect remorse plus explanation
  - 4 protect entire disclosure statement

# Disclosure laws

- 8 states mandate disclosure of serious adverse events
- Disclosure burden usually falls to institution
- 2 states (PA, OR) require written notification

# Impact of Apology and Disclosure Laws

- Even broadest apology laws provide only limited protection
  - Disclosure might still trigger litigation
- Laws difficult to interpret
  - Will compound inertia related to disclosure
- Laws don’t view disclosure and apology as integrated process
- Key developments likely to continue taking place at institutional level

# Leading Disclosure Organizations

- Early, deep involvement of medical staff
- Tackling challenging disclosure issues
  - Acceptance of responsibility
  - Disclosure of events that patients were not aware of
- Training disclosure coaches
- Disclosure as team sport
- Tracking disclosure outcomes

# Future Directions

- Ongoing experimentation with disclosure by healthcare organizations, insurers will continue
  - Will yield useful information on impact of disclosure on outcomes
  - Additional research sorely needed
- Challenges of effective disclosure will become increasingly evident
- Additional disclosure standards will be released
  - Likely to remain voluntary
  - Link with P-4-P may prove important