



Ethical standards for disclosing a medical error

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Abstract

This review merges interdisciplinary perspectives from communication, law, and medical ethics to advance theoretically framed standards for error disclosure. The standards reflect ethical conduct in respect to providers' decisions to disclose and their performance of error disclosures. Furthermore, the review operationalizes a list of communicative elements that implement these standards in light of communication competence theory. This work is among the first attempts to justify ethically the disclosure of error-induced adverse events and close calls, facilitating a significant contribution to medical ethics research and practice.

Key Words: Medical ethics, ethical standards, medical error

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Introduction

Medical errors are the eighth leading cause of death in the United States, accounting for annual patient fatalities that would equivalently result from three jumbo jets crashing every two days [1]. In addition, hundreds of thousands of patients sustain preventable error-induced injuries in their medical care each year [2]. In 2001, the Joint Commission on Accreditation of Healthcare Organizations required hospitals to disclose all unanticipated care outcomes to patients and (when appropriate) their families [3]. Five years later, the National Quality Forum advanced disclosure standards for health care professionals and institutions, suggesting that providers should disclose factual information, express regret, and offer an apology in response to medical errors [4]. Although the justice system was slow to respond to these ethical advancements, at least 34 states have now adopted apology laws that allow health care workers to apologize to patients without having to fear that their apology will be used against them as evidence of negligence [5].

Unfortunately, the apology laws promise more than what they actually deliver. Different states have different statutes, and some of them are limited. For example, Indiana protects statements of sympathy but no statements of fault, even if they are made in the context of an apology [6]. The American Medical Association has attempted to alleviate this discrepancy, prescribing that “ethical obligations typically exceed legal duties” [7]. However, given the immense threats and emotional pressures providers commonly experience after a medical error, this contradictory framework may reinforce their instincts for self-preservation over their desire and professional obligation to tell patients the truth [8].

There is an apparent need for enhanced formal control over providers’ responses to medical errors, and particularly over their performance regarding error disclosure. Such efforts need to strive for clear ethical and legal vision in both disclosure intent and content. Providers should enforce the maintenance of personal and professional integrity by encouraging ethical conduct that is in the best interests of the patient, and at the same time adhere to the law despite its current ethical constraints. This review discusses the necessary disclosure components that would meet such an encompassing vision, and suggests a set of ethical standards that are specific to the context of error disclosure.

Deciding on the best trajectory for responding to critical incidents

Ethical conduct in the context of medical error disclosure requires two-dimensional considerations regarding a provider's decision to disclose an error and conduct of the error disclosure. Medical errors can cause harm (ie, adverse event), reach the patient without harmful impact (ie, harmless hit), or not reach the patient (ie, near miss) [9]. This paper adopts the standpoint that disclosure is ethically mandated in all cases. Furthermore, it is framed within communication competence theory, which posits that competent communication is both appropriate (ie, in prescribing to rules and norms) and effective (ie, in achieving goals) [10]. In light of this theoretical framework, competent error disclosure requires that providers have the knowledge, motivation, and skills to disclose an error appropriately and effectively.

Determining the need to disclose

Providers are often uncertain whether or not to disclose an error, particularly when it caused none or only trivial harm [11]. The barriers that impede error disclosure are multiple. For example, providers commonly fear litigation and being reported to the public registry [11–13]. They often perceive a lack of institutional support and do not know how to communicate to patients about an error [11,14]. Personal attitudes, uncertainties about the nature of the event, perceived helplessness, and additional anxieties are further factors that commonly contribute to nondisclosure [15]. Furthermore, providers often assess the likelihood of an error being discovered, the number of previous mistakes, patient characteristics, the culture of their work environment, the patient's state of consciousness, and the availability of family members [13]. Given the complexity of these important considerations, it is not surprising that despite legal and ethical obligations, a majority of medical errors remain undisclosed [16].

On the other side, there are also numerous arguments that promote disclosure. For example, providers often report that they perceive an ethical disclosure responsibility to their patient (ie, a desire to communicate honestly, show respect, and provide further medical care), to themselves (ie, a sense of duty and accountability, maintained integrity, and a desire to empathize and do the right thing), to their profession (ie, a desire to share lessons learned, serve as role model, strengthen trust, and change the professional culture), and to their

community (ie, a desire to enhance the health of future patients, sustain trust in medicine, foster the doctor–patient relationship, and help patients understand complex causes of errors) [15]. In addition, an open discussion of errors with patients and colleagues can positively affect well-being [11]. For example, providers have reported feeling a sense of relief and closure after disclosing an error [17]. Thus, arguments support each end of the disclosure decision. However, ethical standards need to be considered to justify and clarify the proper decision.

Determining the disclosure content

Empirical evidence supports that a structured and compassionate error disclosure program can be beneficial. For example, it can reduce the number of litigations and the compensation that is paid out over time [18,19]. Along the same vein, patients are less likely to seek legal advice if a physician shows himself/herself to be nonverbally involved (ie, displaying cues of immediacy, expressiveness, altercentrism, smooth interaction, composure, and positive affect) during an error disclosure [20]. However, providers often do not know what to say and how to communicate with a patient after an error [21]. Recent studies have attempted to illuminate this challenging task with empirical advice. Chan et al, for example, have proposed a five-point framework for effective disclosure, suggesting that patients prefer an objective explanation of the medical facts related to the error, honesty and truthfulness, empathy, a discussion about how future repetitions of the event will be prevented for all patients, and general communication skills (eg, listening, responsiveness, checking for understanding) [22]. Several other studies have reported that patients prefer a detailed disclosure about what happened, why it happened, the consequences, and strategies for preventing future errors [11,23–25]. Leape and Burlington were the first to summarize these findings into formal guidelines on an effective response to adverse events, suggesting that disclosure should be prompt, compassionate, honest, and continuous, containing a full account of the reliable facts, a statement of responsibility and remorse, a sincere apology, and an explanation of prevention in the future [26].

Although these accounts seem clear, their operationalization is complex. For example, root cause analyses take time and are often based on probabilities rather than facts. Therefore, an immediate disclosure may not fully account for the objective truth of the facts leading up to an event. Furthermore, the empirical findings to date do not provide any clear

operationalizations of empathy that would allow providers to translate this recommended behavior into practice. Also, discussions about how future adverse events will be prevented are difficult to conduct because they depend on many institutional factors beyond the results of a time-consuming error analysis. Last but not least, no research to date has examined if and which of the above behaviors are actually beneficial for the parties involved. Preliminary studies have shown that nonverbal involvement is significantly associated with higher patient self-reports of empathy, satisfaction, trust, closeness, forgiveness, continued care, and adherence, and with lower self-reports of distress, avoidance, doctor-switching intentions, and perceived severity of the consequences of the error [20]. However, these investigations have only touched the tip of an iceberg. More outcomes research is needed to investigate the causal effects of different disclosure components on objective health outcomes for patients and providers before “effective” disclosure conduct can be ethically advanced.

The apology component of the prescribed disclosure guidelines has evoked substantial controversy. Despite providers’ increasing legal protection in the framework of the recently advanced apology laws, physicians still abstain from apologies because they fear that they might lead to higher malpractice premiums and be admissible in court if the patient decides to sue [27]. At the same time, patients have repeatedly identified providers’ failure to apologize as one of the main reasons for filing a law suit [28]. A clear argument that advocates the use of apology during error disclosures is that it has healing effects for all parties involved, and a sincere apology can also help providers resolve their feelings of guilt and shame. At the same time, an apology can benefit patients by facilitating forgiveness and providing the basis for reconciliation [29]. However, to date, research has not provided any causal empirical associations between an apology and concrete health-related outcomes of error disclosure.

Medical error disclosure in the framework of medical ethics

Medical errors imply a boundary violation. They occur when a provider “crossed the line” and caused physical damage to the patient [30]. Thus, a competent response to medical errors is grounded in ethical conduct. Empirical findings support this argument as well. For example, the most commonly cited reason for disciplinary actions is unprofessional provider behavior rather than insufficient clinical skills [31]. Similarly, patients often report “breakdown in communication” as the main reason for pursuing litigation [32]. An application of the four principles of medical ethics can illuminate what constitutes ethical conduct in the context of

error disclosures. Given the fiduciary nature of the doctor–patient relationship, error disclosures need to accommodate respect for autonomy, nonmaleficence, beneficence, and justice.

Operationalizing ethically and legally competent error disclosure

The ethical standards discussed above need to guide competent error disclosure. However, an operationalization of the communicative components that constitute such ethical disclosure is needed. As mentioned above, some of the ethical standards conflict with each other (eg, patient autonomy and provider beneficence), and others are constrained by legal requirements (eg, insufficient protection of apology laws) and contextual frames (ie, contractual obligations to insurers). Also, several medical issues may limit the generalizability of ethical conduct in the context of error disclosure (eg, time restraints associated with urgent care, incapacitated patients, lengthy root cause analyses). The recommended ethical disclosure standards discussed in this paper need to be viewed in light of these limitations.

All principles of medical ethics promote a positive disclosure decision. As indicated in the discussion above, disclosure of close calls and adverse events is indisputably the right thing to do. If a patient is incapacitated, providers should disclose to a third party, such as a family member or close friend. A remaining issue is the conduct of ethical disclosure. Physicians commonly want to disclose their errors, but they do not know what to say, how to conduct such a difficult conversation, and what the consequences of their disclosure might be [21]. In an attempt to alleviate this challenge, the following paragraphs suggest some communicative elements that operationalize the ethical disclosure standards discussed in this paper. Because some of the subjects remain open for future research, these communicative elements should be regarded as preliminary and incomplete.

Communicating “respect for autonomy”

Providers can optimize the ethically mandated respect for autonomy after a medical error in their post hoc communication with the patient. In order to be able to make informed autonomous decisions, the patient needs to be given a complete account of all objective information related to the critical event. Furthermore, the provider needs to ensure that the patient understands the content of the disclosure correctly. These ethical goals can only be accomplished through provider communication that is effective and appropriate. Such

communication can be expressed in various ways. For example, a provider could communicate to the patient that s/he strongly enforces the ethical imperative that patients have the right to a truthful account of what happens in their care. In addition, the provider could assure the patient that their motivation is not to control, but to empower the patient to make informed decisions about their own future medical care.

Providers would also need to deliver a full and truthful account of all known facts related to the critical event (ie, the events that led up to the incident, the consequences of the error on their health, and the treatments and side effects that are available to repair them), avoiding any discussion of incorrect or unconfirmed subjective information. Providers would need to communicate this information in a language that can be understood by patients. This requires advanced message encoding and decoding skills, suggesting that providers need to acquire the skills to translate medical information into a “language” that is understood by the patient, and to “read” the patient’s reactions to their explanation, making sure that the patient comprehended the message correctly. A helpful communicative tool to accomplish this challenge could be to verify that the patient actually understood what was said. Specifically, a provider might ask the patient in a nonpatronizing way to rephrase in his or her own words what was said, and respectfully correct any misinterpretation of the message if necessary.

Communicating “nonmaleficence”

Communication with the patient after a medical error that meets the ethical standard of nonmaleficence needs to aim at preventing further harm. As discussed above, incompetent (ineffective and/or inappropriate) error disclosures can be maleficent. For example, verbally competent disclosures may lead to nonadherence and doctor-switching if a provider communicated in a nonverbally uninvolved way [20]. Thus, to prevent additional avoidable harm, providers need to communicate with their patients in a way that shows genuine remorse and empathy. This goal requires perspective-taking skills on behalf of the provider. Specifically, providers would need to communicate with their patient from a standpoint that illustrates their complete understanding of the patient’s situation, including the ways in which the critical event impacts the patient’s occupational and personal quality of life. Messages that accomplish this goal include demonstrating a genuine motivation to correct the consequences of the error. Furthermore, the provider may show that the incident is being taken seriously,

and explain the measures that are being taken to prevent a recurrence of the same event in the future.

Communicating “beneficence”

Active contributions to the patient’s welfare after the occurrence of a medical error can also be accomplished through effective and appropriate interpersonal communication. A truthful account of what happened, for example, can decrease patient anxiety and uncertainty about unexplained symptoms. Granting the patient access to counseling services, discussing fair compensation for injuries the error may have caused, and offering various forms of social support (eg, emotional care, tangible assistance, affectionate expressions, and companionship) are direct merciful acts that translate beneficence into practice. Empathic nonverbal displays during these interactions can reinstate the dignity of the patient. For example, providers are advised to show themselves attentive and involved during their interactions with the patient, and allow the patient to talk without interruption. In the event of harm, a provider may ask the patient whether s/he would allow them to assist in making important choices regarding corrective follow-up care. Finally, to demonstrate their investment in preventing additional harm, providers may invite the patient to contribute to their institution’s quality improvement efforts by sharing his or her experiences.

Communicating “justice”

The provider-patient relationship is generally unequal in respect to decision-making power and medical knowledge. In the context of an error disclosure, the power relationship changes. Providers are at the mercy of the patient to forgive them and not to pursue legal action, humbling themselves onto the “level” of the patient. At the same time, patients are at the mercy of the provider to find out what happened in their medical care. In an attempt to meet the ethical imperative of justice, competent error disclosure needs to include communicative elements that optimize a fair distribution of these scarce resources. Providers can contribute to accomplishing this goal by offering their medical expertise to the patient. At the same time, patients need to recognize and respect the provider’s difficult situation and the fallibility of the medical profession as a whole. In the midst of finding out about an error in their medical care, patients will likely not experience this empathy for the provider on their own. Thus, competent provider communication is necessary to facilitate this ethical goal. Specifically,

providers could be assertive by stating that their job is to cure, and that having to face a harmed patient is very difficult for them. They could apologize to the patient for having transgressed boundaries, and express that they would like to reinstate the patient's privacy and trust. They should also solicit support from their institution to be able to offer financial assistance and provide fair compensation for injuries that the error may have caused to the patient.

In sum, according to communication competence theory, error disclosures need to be appropriate (ie, follow cultural rules and norms) and effective (ie, achieve desired goals) [10]. This outcome is attained when providers are motivated to disclose an error effectively and appropriately, have the knowledge about how to disclose an error effectively and appropriately, and have the skills to conduct the disclosure effectively and appropriately. Additional factors such as complexity of the event, for example, may intervene with a successful outcome. However, in a nutshell, the communicative elements discussed above can be viewed as a heuristic guide for the operationalization of ethical conduct during disclosures of medical errors.

Limitations and suggestions for future research

Ethical conduct can be displeasing and difficult, particularly in the context of disclosure of medical errors. However, it can also promote a learning experience. This paper applies the principles of medical ethics to the context of error disclosure, suggesting that providers have an ethical obligation to disclose errors in their medical care competently. The discussion yields a set of communicative disclosure elements that operationalize the advanced ethical standards.

It is important to note that ethical disclosure standards come with certain limitations. First, the literature suggests that patients prefer a sincere apology. Thus, providers may face an ethical conflict if their apology is not genuine. Future research is needed to elaborate this tension. Second, a causal link between the apology element and positive error disclosure outcomes has not been empirically established. In light of the legal controversy on this disclosure element, future studies need to provide causal data on this association and also test for potential mediators, such as nonverbal involvement. Third, the operationalized communicative elements assume that the error disclosure is initiated by the provider. Most of the existing

literature approaches error disclosures from this standpoint. However, future research needs to evaluate to what extent a patient-elicited disclosure may be different. Fourth, multi-disciplinary approaches to error disclosure that include all protagonists in the system are needed, including all patients and professionals involved. Such a systemic approach can promote partnership in this relationally challenging context and facilitate more reliable patient safety.

In sum, this work provides ethically framed disclosure standards and an operationalized list of communicative elements that providers may use when disclosing a medical error to a patient. As mentioned, these elements need to be considered in light of several limitations. However, it is hoped that they provide a valuable starting point for future investigation

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