

Disclosure: A Beacon in the Storm

Moving Forward with a
Policy of Disclosure

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Conclusions

- A policy of error disclosure is only part of a wider effort to improve patient safety
- Must address the obstacles to openness
- Encouraging disclosure can improve reporting and encourage learning
- Disclosure is a central spoke in a wheel of learning

Who is an errorist?

- *Errorist*
- “*One who is inclined to error; one who encourages and propagates error.*”
 - *Complete Oxford English Dictionary 2002 on CD Rom, v.3*
- “*Prudent men should doe well not to ingage themselves in conference with Errorists.*”
 - *Ward. Simple Cobler 1647*

Natural human tendency?



- “There are few who are ready & willing to admit error, & perhaps even fewer among doctors & lawyers.” (Anderson J. *Sehmi v Vasadani*. OJ 1993)

Case 1

Calman N. *Health Affairs* Mar/Apr2001:243.

- 60 year-old male, recent aortic valve repair. Admitted with high fever; Dx = endocarditis
- Has surgery to replace infected valve. Infection may have been due to contaminated CV catheter
- Arrests post-op; K⁺ = 7.8. CPR unsuccessful.
- Staff: *“Nothing good will come of telling the family...No one needs to*

Case 2

- An eager surgical clerk has excelled during the rotation & impressed the faculty with his dexterity and wit
- In his last OR, just as they are about to close up the site, the chief urologist *deliberately* transects the patient's ureter & says to the clerk, "OK, show me how you'll fix that... One day, you'll do it & there'll be nobody to supervise you."
- How should the clerk respond?

Case 3

- A 45 year-old woman is transferred from a medical ward. A tricyclic O/D, she is 'medically cleared' for psychiatry.
- Seen by the intern on her 1st night on call, the patient is drowsy & sweaty but seems otherwise OK. The senior resident is notified but is "too busy" to provide advice.
- Later that night the patient suffers an arrhythmia and dies.

Questions:

- 1. Would you want to know about these events?
- 2. What are the obstacles to learning about them?
- 3. What can a hospital disclosure policy do?
- 4. Are you confident you have systems in place that would encourage their disclosure & reporting? What adjunctive policies / practices would help?

1. Would you want to know
about these events?

Of course!

1. The Cases

- **Case 1:** the high K+ level.
- Was the outcome avoidable? What should the family have been told?
 - Likely preventable: infection control? High K+ treatable
 - Disclose “complications” that lead to poor outcome
 - Silence impeded learning & system improvement

1. The Cases

- **Case 2:**
- Deliberate harm to a patient: not just an AE, a deliberate action: 'sabotage'
 - Surgeon must be reported
- What should patient be told?
- **Case 3:**
- A failure to provide supervision of interns
- Open to litigation

What went wrong?

**Who should
know?**

**What can be done
to prevent it?**

2. Obstacles to openness

- **Old views:** Retribution
- **Fears, emotions:**
Humiliation, pride
- **Policies:** ineffective, not known
- **Educational:** No teaching, no models
- **Structure:** Professional power gradient
- **Philosophy:** utilitarian view of disclosure (“*Why tell, if no point...?*”)

Whither errorists?

- “The medical profession seems to have no place for its mistakes....”

Hilfiker D. Facing our mistakes. *NEJM* 1984

- Really: no place for erring professionals
- Ergo, *if you err, don't mention it...; if you do mention it, don't expect our support...*

Old way of thinking

- Somebody's to blame, at fault
- Somebody's got to pay
- = Old Testament
'an eye for an eye'
justice

“Throw ‘em into the sea”

- Adverse events caused by individual acts of negligent or careless health care professionals
- Identification of these individuals, followed by remediation or vilification, will improve patient safety

Public attitudes

-- Complaint letters to CPSO - range of expectations. "*.... do not want occurrence to happen to others*"

-- Demand: discipline / revocation / public humiliation

-- Overall, demands for greater accountability

Does duck discipline

Hearings on less than 1% of complaints

By **DAVE RIDER**
Toronto Sun

Ontario doctors accused of making mistakes are far less likely to be disciplined than their colleagues in other provinces, say the parents of a baby who died in 1994.

Georgina and James Hunter released the figures yesterday, hoping to pressure Health Minister Elizabeth Witmer into striking a task force to investigate the situation.

Less than 1% of investigations by Ontario's College of Physicians and Surgeons are referred to a disciplinary committee, according to data compiled by the couple.

Rates in other provinces range from 4% in Newfoundland to 31% in Manitoba

Madeleine, died from severe dehydration, brought on by gastroenteritis, in a Toronto hotel room. The coroner at an inquest that yielded 46 recommendations for change, said: "I've never seen a case where so many things went astray."

The Hunters lodged a complaint with the college against Dr. Giannoula Klement, a resident physician at the Hospital for Sick Children who, on the eve of Madeleine's death, pronounced her "well-hydrated" and discharged her. The college investigated but administered no discipline, telling the Hunters they were partly to blame for the death.

College spokesman Jim Maelean refused to comment on the figures. He said



MADELEINE HUNTER
Inquest into death

From a Malpractice website

- “Make it clear to the medical personnel that you need the container, the remaining medication and all paperwork back when they have finished. This is important evidence, which you will need to preserve. If you leave it with the doctor or emergency room, it might be discarded.”
 - [..\Error\NZ\If You're involved in a Pharmacy or Medical Error.htm](#)

To disclose or not to disclose?

Blendon et al. NEJM Dec 12, 2002: 1933

- Physicians should be required to tell patients when errors are made in their care:
 - Physicians: **Yes: 77%**; No: 22%
 - Patients: **Yes: 89%**; No: 9%

Error disclosure

Wu *JAMA* April 24, 1991; 265:2089

- Housestaff discussed mistakes with patients in only 24% of cases

Views on error reporting

Blendon et al. *NEJM* Dec 12, 2002

- Ought outside agencies be told about serious medical incidents?
- No?
- Yes?

Views on error reporting

Blendon et al. *NEJM* Dec 12, 2002

- Ought outside agencies be told about serious medical incidents?
- No? **Physicians: 20%**
- Yes? **Patients: 70%**

Risks of reporting

Liang B Risks of reporting sentinel events. *Health Affairs*
2000; 19:112-20

- The main risk: legal discoverability of incident reports / 'sentinel-event' materials
- Most provinces / states do not protect QI activities from legal scrutiny

What should happen to erring physicians?

Blendon et al. *NEJM*. Dec 12, 2002; 347:1938

Doctors

Patients

Suspend their licenses	3%	
Increasing lawsuits	1%	
Fine erring clinicians	2%	

What should happen to erring physicians?

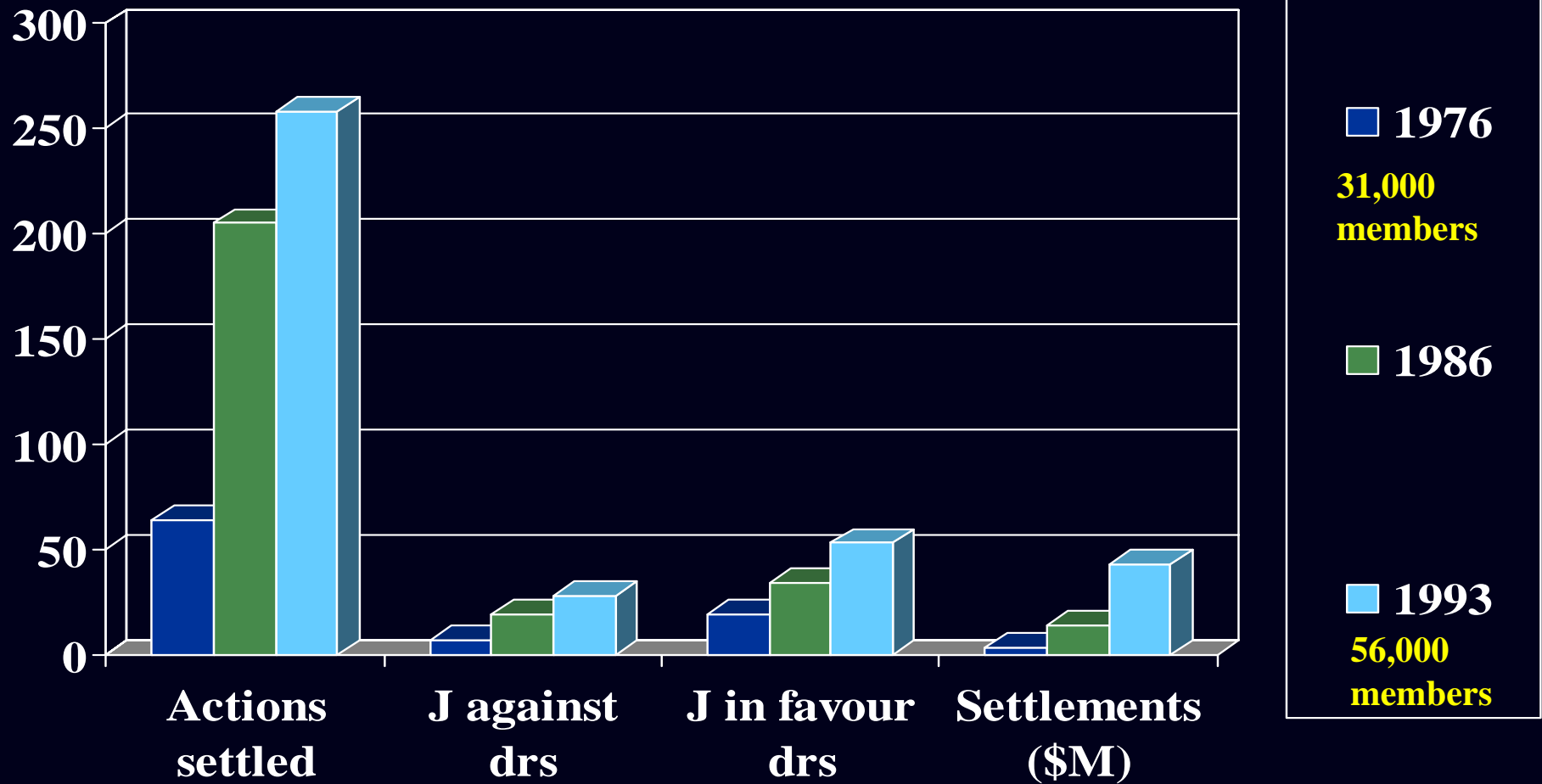
Blendon et al. *NEJM*. Dec 12, 2002; 347:1938

Doctors

Patients

Suspend their licenses	3%	50%
Increasing lawsuits	1%	23%
Fine erring clinicians	2%	40%

CMPA Review of Legal Actions



Ratio of actions started/ settled = 3.7:1 in 1976 & 4.7:1 in 1993

Ratio of membership / actions started = 130:1 in 1976 & 46:1 in 1993

Cost of total settlements / member = \$84 in 1976 & \$759 in 1993

How Can Patients Be Safer?

3. The role of a disclosure policy

What patients do

Vincent C et al. *Lancet* June 25, 1994

- Some seek legal redress
- Seek *explanation, accountability*, and are concerned with *standards* of care, not just with compensation

What is to be done?

- What can your institution do to lessen gap between reality & ethics?
- Must make disclosure less risky for clinicians and the easiest thing to do...

Why more lawsuits?

- “The most frequent factor is *a lack of adequate communication* between the physician and the patient. Patients are most likely to sue when they feel they have been given the runaround and have not been kept informed about their progress or complications.”
 - *CMPA. A Medico-Legal Handbook for Physicians in Canada. 2002:21*

Malpractice evidence

Daniel et al *Med J Australia* 1999; 170: 598.

Hickson et al *JAMA* June 12, 2002; 287: 2951

- *Suits have to do with:*
- Poor communication skills
- Failing to meet expectations of patients
- Inability to establish rapport
- Lack of courtesy – rude, inconsiderate

Clinician concerns

- “shooting oneself in the foot”
 - *Provide help with disclosure*
- “putting oneself out on a limb”
 - *Provide a strong tree*
- “being a sacrificial lamb”
 - *Don’t sacrifice individuals*
- “what is error anyway?”
 - *Don’t sweat the small stuff*

The role of a policy of disclosure

- Shows community we take the issue seriously and openly
- Can encourage reporting & disclosure
- Protect & reward those who tell
- Provide guidance & support to clinicians

Error / AE policy

- *“S&WCHSC requires the full & frank disclosure of adverse medical events to patients”*
- Applies to *all* hospital staff & employees
- The obligation to disclose & report increases as the (risk of) harms increase
- Promises protection for employees

Rules of disclosure

- **To whom:** affected patient
- **When:** “in a timely way”
- **Who:** most responsible clinician
- **Failure to comply:** hospital will inform patient

Protect staff

- No reprisals for reporting/disclosing
- Cannot protect the criminally negligent
- Help provided by Risk / Safety Committee
- **How to do so:** guidelines to clinicians

Implications for hospital

- *Take errors seriously -- somebody must be listening.*
 - What will be done to ensure this won't happen again?
 - What lessons can be learned for others?

Implications for hospital

- Need support for clinicians:
 - help re-disclosure (how, when)
 - reassurance re-reprisals
- Institutional change:
 - support to reporters
 - training programmes for disclosure & reporting; post-event counseling

Implications for hospital

- Requires supplementary reporting policy
- Institutions should be particularly interested in hearing about 'near misses', latent errors, & hazardous situations
- Major commitment to patient safety
- Be prepared to take responsibility for mishaps & not blame individuals

New medicine

- Society's expectations about medicine is changing
- What was acceptable conduct yesterday (*"the law does not condemn the doctor when he does only what a wise doctor so placed would do"* *) may not be so today

*Action for negligence fails. *BMJ* 1954; ii: 105-6.

Cultural revolution

Luther K. Breakthru' change concepts 2001

Attitudes / Beliefs	Old	New
Human Performance	I am perfect	Humans are fallible
Care Delivery	I work alone	I work with others
Error Origin	Individual failure	Team failure
Peer Monitoring	Offends me	Protects me & my patients
Disclosure / openness	Avoided	Encouraged

NASA Maintenance Worker and the Golden Bolt

- Left bolt in a liquid O₂ tank?
- Simulated in empty tank
- Two places a bolt could be left
- Called launch director
- Recovered bolt
- Launch day



The tale of a RAT

- A specific anti-antigen serum
- In-house production using human tissue, not screened for HIV, no REB approval; used for years
- Risks noted by pharmacist
- Took 1.5 years before acted on
- Patients notified on direction of *CEO*
- Pharmacist never received recognition

What residents would do

M Green et al. Lying to each other *Arch Intern Med* 2000;160:2317

- 14% would fabricate a laboratory value to an attending physician
- 5% would lie about checking a patient's stool for blood to cover up a medical mistake
- ***Why would they act deceptively?***

What staff do

Vincent C et al. Reasons for not reporting....*J Evaluation Clin Prac* 1999; 5: 1321

- Staff reported < 25% incidents
- Reasons:
 - Didn't know details of reporting system
 - Fears that junior staff would be blamed
 - High workload
 - Wasn't needed
 - Litigation worries

What clinicians do

Hingorani et al. *BMJ* 1999; 318:640

- Asked eye patients & ophthalmologists whether patients should always be told about complications of surgery (e.g., eye capsule rupture with 10% risk vision being affected).
- *Patients: 92% yes*
- *Physicians: 60% yes*

Does disclosure prevent complaints?

- No guarantees
- Can take the 'sting' out of legal action if error & injury happens
- Must be combined with other efforts

Only one study....

Kraman, Hamm. *Ann Int Med* Dec 21, 1999;
131:963

- Reported on VA hospital in Ky that actively informs patients / families of negligent care & offers help in filing claims (1990-96)
- Resulted in more local, out-of-court settlements.
- 8th **lowest** total \$ claims out of 36 comparable VA hospitals

4. Beyond Disclosure

What needs to be done? What other policies and practices to support disclosure?

Driving out fear

- VA Hospitals in the US have been among the leaders in patient safety efforts
 - New reporting system to identify “near misses” run by NASA
 - Non-punitive error reporting system greatly increases numbers of errors reported

Create a Culture of Safety

- Drive out fear!
 - Everyone makes mistakes every day
 - Have a comprehensive safety programme
- Create a non-punitive environment
 - Reward error reporters
 - Confidential reporting system
 - Make reporting easy and worthwhile

What can be done

Levinson W. *JAMA* 1997

- What distinguishes non-sued from sued clinicians: *not better outcomes, but better processes of care*
- Listen, inform, provide opportunities for questions & dialogue
- ⇒ **more patient satisfaction**

What can be done?

- Teach professionalism
- Teach safety and how to deal with it
- Teaching modules

Helpful response

- “I wish things had turned out differently....”
- “I know this must be very hard for you.”

Less helpful:

- "I sure made a mess out of things today" (*Wickoff v James*, 324P2d 441 Cal App 1958)
- "Yes, I know it is not your fault...it is all my own." (*Lashley v Koerber*, 156 P2d 441 cal 1945)
- "I made a mistake and got over too far." (*Robertson v LaCroix*, 534 P2d 17 Okla App 1975)
- "The events are entirely my own fault...." (A Rest Home & Hospital, HDC 13293 1999)

What can be done?

- Teach about the policy
- Everyone's responsibility to report untoward outcomes
- Make it easy to do

General surgery service

Wanzel et al. *CJS* 2000; 43:113-117

- 80% of errors not presented at MMR; 66% not in discharge summary
- “We did not detect any reluctance...to discuss complications.”
- *“The lack of an effective system to record and present complications explains the poor compliance with the requirement that all complications be presented.”*

Error Detection Systems

Method	AE/1000 admissions
Incident Reports	5
Retrospective Chart Review	30
Stimulated Voluntary Reports	30
Computer Flags	55
Daily chart review	85
Computer Flags and Daily review	130

Jha J Am Med Inf Assoc 1998;5:305

O'Neil Ann Int Med 1993;119:370

What can be done?

- Teach and support activities against the authority gradient

Pharmacy Ethics

- 1952 APhA: “if there is any question in the pharmacist’s mind [re-Rx error]...he tactfully discusses it with the dr 1st...”
- 1994 APhA: “A pharmacist places concern for the well-being of the patient at the center of professional practice.”

To tackle error

- Clinicians, like the pharmacist, must be prepared to pursue unsafe situations
- Things don't have to be the way they always have been
- The essence of professionalism is to ensure patient's 'best interests' are never compromised

What can be done?

- Encourage system improvement
- Any project will do!

Understand the Safety Issues

Thanks to Ed Etchells

- Study the system
- Method 1 (expensive)
 - get degree in engineering or management consulting
- Method 2 (cheap)
 - ask “why did that happen?” 3-5 times
 - avoid blame words

Study / Do / Learn / Act

- Find an area of concern
- Focus on a programme / a problem
- Study baseline (mis)functioning
 - Elicit error /near miss reports
- Seek improvement ideas
 - What are we trying to do?
 - When is change an improvement?
 - What changes will result in improvement?
- Apply them & measure the difference
- Reward teams / individual efforts

Addressing the barriers requires:

- Effective and *known* reporting systems
- Non-punitive systems of reporting
- Making error discussion part of regular rounds
- Education in the 'how-to's' of error disclosure
- Re-training for faculty
- Resources for staff and trainees
- A well-resourced ethics programme to support all of the above....

Conclusions

- A policy of error disclosure is only part of a wider effort to improve patient safety
- Must address the obstacles to openness
- Encouraging disclosure can improve reporting and encourage learning
- Disclosure is a central spoke in a wheel of learning