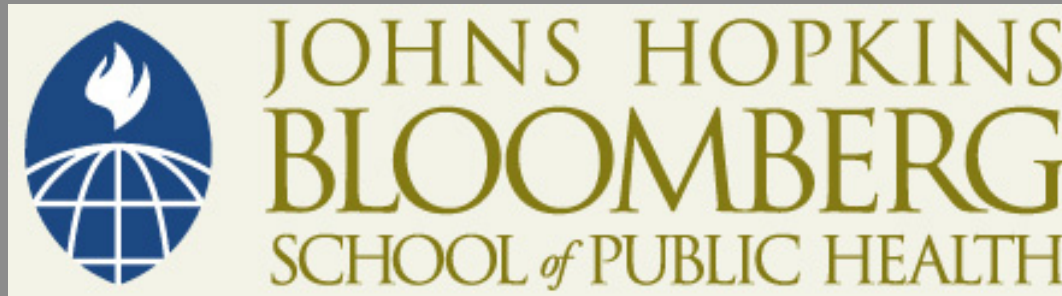


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## *Disclosure of Adverse Events and Medical Errors*

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Albert W. Wu, MD, MPH



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## *Section A*

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Why Disclose?

Sixty-five-year-old woman transferred from cardiac intensive care where she had been admitted for acute myocardial infarction and congestive heart failure

## *Case Study*

- Rapidly progressive increasing dyspnea
- Cardiac team returns, administers 100% O<sub>2</sub> via face mask
- Cardiology fellow calls for 2 mg morphine sulfate “IV push”



## *Case Study*

- Or, directs medical student to “push this”
- Medical student administers 10 mg of intravenous morphine sulfate

- Respiratory rates slows from 32 to 2

## *Case Study*

- Respiratory rate slows from 32 to 2
- Patient intubated
- Returns to cardiac intensive care





## *Flashbulb Memories*

- Vivid, persistent memories of especially important events, like the JFK assassination, or the events of 9/11, that are usually charged with emotion

# *Everyone Makes Mistakes*

- All practicing clinicians make mistakes

# *Responses to Mistakes*

- Horror, fear
- Remorse
- Anger
- Guilt
- Isolation, no place to hide
- Doubt, feelings of incompetence

## *Lawyers, Professional Organizations, and Ethicists Agree*

- The occurrence of the error must be disclosed to the patient and/or family member

# Why Disclose?

- Ethical duty to disclose

“Physicians should disclose to patients information about procedural and judgment errors made in the course of care, if such information significantly affects the care of the patient.”

— 1992 American College of Physicians’ Ethics Manual

# Why Disclose?

- Ethical duty to disclose
- JCAHO

“Patients and, when appropriate, their families, are informed about the outcomes of care, including unanticipated outcomes.”

— JCAHO Standard RI.1.1.2, July 1, 2001



# *Why Disclose?*

- Ethical duty to disclose
- JCAHO
- Institutional policy

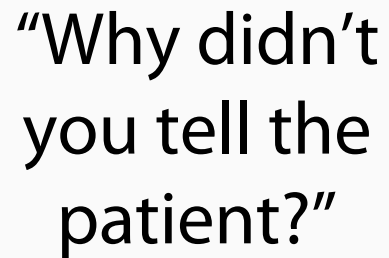
# JHH Interdisciplinary Practice Manual: Error Disclosure

- Philosophy: The Johns Hopkins Hospital (JHH) strives for safety in patient care, teaching, and research
- Policy
  - All health care professionals have an obligation to report medical errors as a means to improve patient care delivery and to help promote safety and quality in patient care.
  - Since the majority of medical errors can be linked to environmental and systems-related issues that may affect the actions of health professionals, a systems improvement focus will be used in all error analysis.
  - **Prompt reporting of a medical error in good faith will not result in punitive action** by the hospital against the involved individuals except as mandated by law or regulatory requirements. The principles concerning non-punitive reporting do not eliminate the hospital's obligations to conduct ongoing and periodic performance review, where repeated errors or other issues may lead to personnel action.
  - **It is the right of the patient to receive information about clinically relevant medical errors.** The JHH has an obligation to disclose information regarding these errors to the patient in a prompt, clear, and honest manner. This is consistent with The Johns Hopkins Hospital Code of Ethics.
- Definition of medical error: An act or omission with potential or actual negative consequences for a patient that, based on standard of care, is considered to be an incorrect course of action.

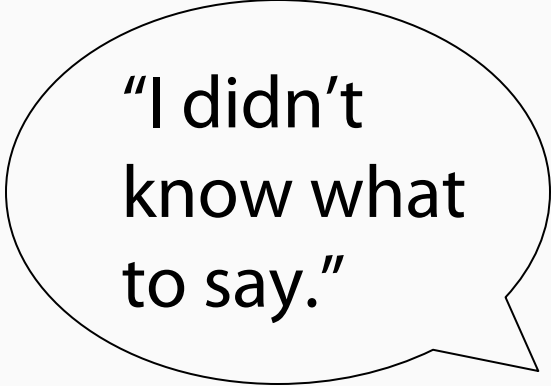


# *If You Don't Know How, You'll Avoid It*

- If you know how to do something, your threshold to do it goes down



“Why didn't you tell the patient?”



“I didn't know what to say.”

# House Officer Survey

- Anonymous survey about worst mistake
- Serious adverse outcome 90%, death 31%
- 24% told patient and/or family

“Why is it that when things go wrong, everyone clams up?”

— *Lucian Leape on behalf of an anonymous patient*

# Summary

- Mistakes are inevitable
- We are obligated to disclose mistakes to patients and their family members
- More training and experience is needed



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## *Section B*

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How to Disclose

# *What?*

- Any incident which causes harm to the patient or which requires a change in their care

# *When?*

- As soon as possible after the incident is recognized
- Update the patient or family when more information is learned

# Who?

- Attending physician
  - In conjunction with other caregivers
    - ▶ Physician in training
    - ▶ Nurse
    - ▶ Administrative representative?



# Where?

- The physician's office
- A room off the waiting room
- The most important thing—
  - Ensure privacy for the patient/family



## *What Patients Want*

- The facts
- Responsibility taken
- Actions to prevent the same event happening to others
- An apology

# *What to Disclose*

- As much as you know up to the time of the disclosure
- Disclosure is part of an ongoing dialog between patient and physician

# *What to Say?*

- Treat it as an instance of “breaking bad news”

How to  
Break  
Bad  
News

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*A Guide for Health  
Care Professionals*

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ROBERT BUCKMAN, M.D.  
*with contributions by Yvonne Kason, M.D.*

# *What to Say?*

- Begin by stating you regret to say that you have made a mistake
- Describe the course of events, using non-technical language

## *What to Say (cont.)*

- State the nature of the mistake, consequences, and corrective action
- Express personal regret and apologize
- Elicit questions or concerns and address them
- Plan the next step

## *Planning and Following Through*

- Make a list of the patient's top priorities
- Devise and explain a plan to address them
- Identify the patient's coping/support mechanism
- Plan the next contact—this is just the initial conversation





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## *Section C*

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Case Examples

# *Chemotherapy Overdose*

- Mr. Smith, a healthy 71-year-old, has chemotherapy after successful surgery for early colon cancer
- Hospitalized two days later with multi-organ failure
- Physician discovers she miscalculated chemo dose, resulting in a 10x overdose
- Discloses adverse event to patient's son

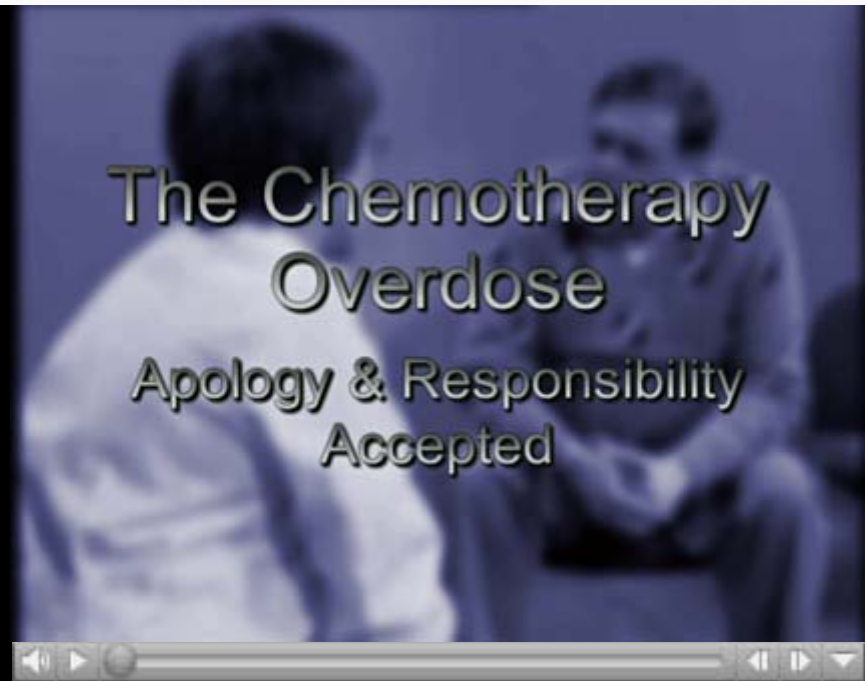
# *Chemotherapy Overdose*

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# *Chemotherapy Overdose: Responsibility Accepted*

At this point in the presentation, you will view an online video that will appear in another browser window.

Follow Steps **1** and **2**, below, to view the video and then return to this lecture.



**Click to Play**

# *The Overlooked Mammogram*

- Ms. Merrill is a 45-year-old woman visiting her doctor for an annual physical
- One year ago she complained of a painless breast lump
- Dr. Rubach ordered a mammogram
- Ms. Merrill never received the results

## *The Overlooked Mammogram (cont.)*

- Dr. Rubach reviews chart before the physical and notes results are not in the folder
- Results on the computer from a year ago show a 2 cm lesion with high probability of malignancy
- Dr. Rubach begins the disclosure to Ms. Merrill in her office

- “Anything you say can be used against you”

*Medical Contrition*

Doctors' New Tool  
To Fight Lawsuits:  
Saying 'I'm Sorry'

Malpractice Insurers Find  
Owning Up to Errors  
Soothes Patient Anger

"I found out he was a real person," Ms. Kenney says. "He made an effort to seek me out and say he was sorry I suffered." Moved by the doctor's contrition, Ms. Kenney dropped her plans to sue.



## *"I'm Sorry" ... "I Am Guilty"*

- Make an appropriate apology
- In the case of system failure or no obvious fault—
  - “I am so sorry that this happened”
- In the case of personal responsibility—
  - “I am sorry that I did this”

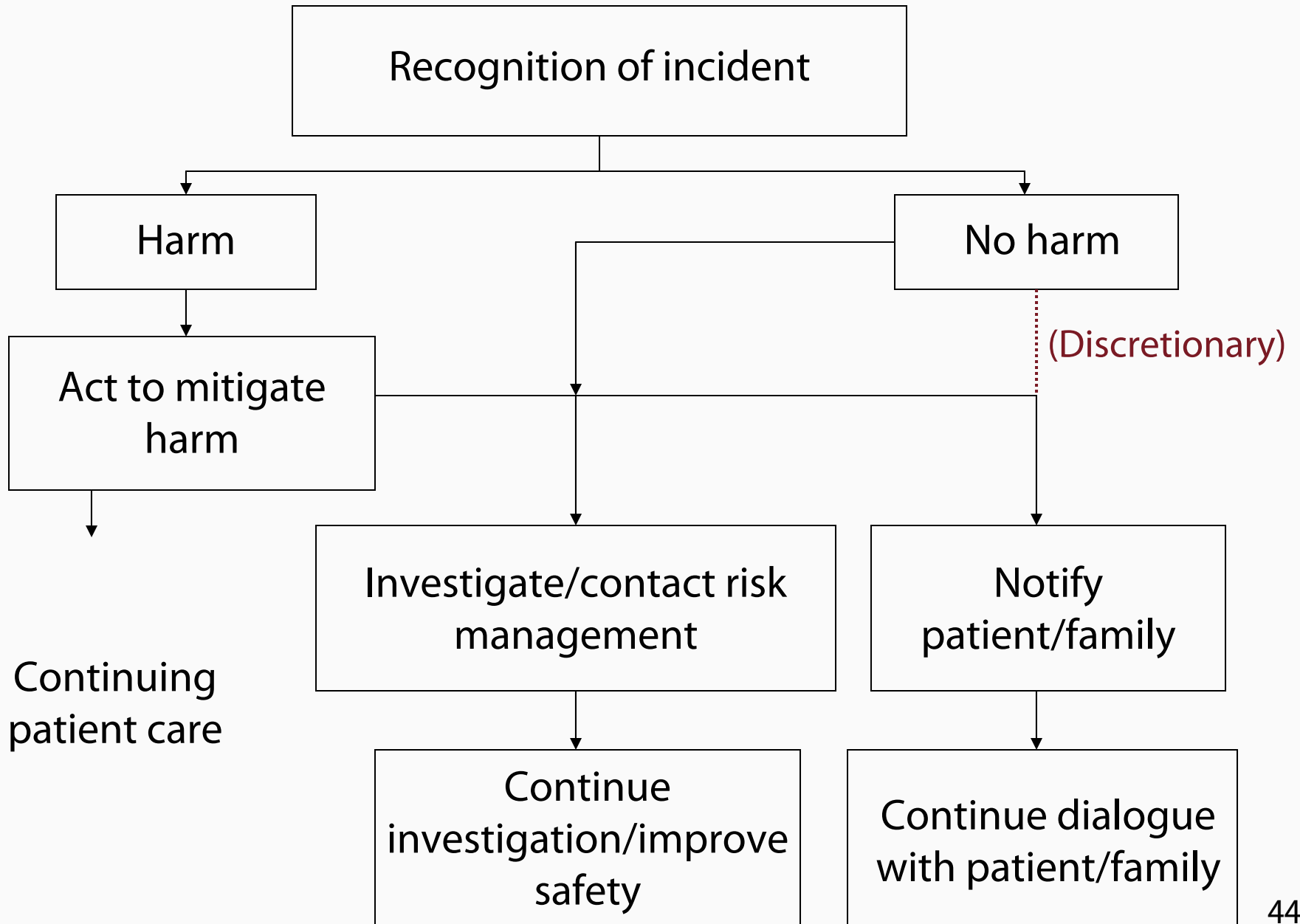
# *Responsibility*

- In general, responsibility for the error should be accepted on behalf of the health care team and the institution
- Those involved with the care should not be personally named, blamed, or criticized

# *Managing Your Own Emotions*

- Avoid
  - Anger
  - Defensiveness
  - Detachment

# The Disclosure Process



# Removing Insult from Injury

- For information on obtaining the video, go to: [www.jhsph.edu/removinginsultfrominjury](http://www.jhsph.edu/removinginsultfrominjury)

