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Mini Review

Re-Examining the Relationship between Medical Error Disclosure and Patient Safety

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Abstract

The disclosure of medical errors is increasingly called for as a quality tool that promotes patient safety, on the grounds that more disclosure will lead to fewer errors. This article points out the problems with arguing for disclosure on the basis of its purported outcomes for patient safety. It also calls for clarity in the literature between the terms "error disclosure" and "error reporting", and urges for a return to arguing for disclosure as an ethically mandated action in its own right.

Keywords: Medical error; Patient safety; Disclosure; Error reporting

Abbreviations

HCO: Health Care Organization; MEDIC: National Medical Error Disclosure and Compensation; SHR: Saskatoon Health Region; IOM: Institute of Medicine.

Introduction

Two problems of medical care quality are the subject of increasing attention by stakeholders in the present day healthcare environment. The first problem is the prevalence of preventable medical errors made in care giving. The second problem is the lack of transparency surrounding these events, specifically in regard to those most affected by an error: namely, patients and their families. The extant literature is replete with evidence of these problems. The 2000 Institute of Medicine (IOM) report was the first of its kind to thoroughly detail the scope and magnitude of medical error [1]. Research has also emerged from various jurisdictions that displays a pattern of disconnect between preferences for disclosure (signalled by patients and physicians alike) and actual disclosure practices [2-9]. Health care practitioners, policy makers, patients, their families and the general public share a desire for respective solutions to the two problems: reduce error rates to an acceptable minimum, via systemic analysis and investigation of root causes; and eliminate the very real barriers to disclosure presently facing physicians [10], by finding a balance between physician protection and accountability [11,12].

Of late, these two problems medical errors and their nondisclosure have been treated in tandem under the push for a culture of "patient safety". Disclosure is habitually argued for in the literature as a quality tool that leads to improved patient safety, on the grounds that more disclosure will lead to fewer errors. Gallagher et al, for instance, argue for "presenting disclosure as a patient-safety challenge rather than a risk-management problem" given that "effective disclosure is a component of broad system improvement" [12]. Fein et al push for viewing disclosureas serving the higher purpose of improving patient safety, rather than merely exposing individual clinicians to blame and litigation" [7]. Kachalia et al open their empirical study with the statement, "patient safety principles support prompt disclosure of harmful medical errors" [13]. Given the prevalence of these conjectures in the medical error literature, this article will seek to re-examine the relationship between error disclosure and patient safety.

The purpose of this article is threefold. First, it is call for clarity in the literature between the terms "error disclosure" and "error reporting" with respect to arguments for patient safety. Second, it points out the problems with arguing for disclosure on the basis of its purported outcomes. These problems include the possibility that error reporting may be sufficient for patient safety, making disclosure superfluous to this end; and the lack of empirical verification linking disclosure policies to improved patient safety. Third, the authors urge for a return in the literature to arguing for disclosure as an ethically mandated action in its own right.

Error disclosure versus error reporting

The relationship between patient safety and error disclosure is not at all clear in the literature. This is due in large part to the fact that error disclosure is often conflated with error reporting. For example, Kaldjian et al employ the term "disclosure" to mean error reporting to colleagues, institutions, as well as patient disclosure [9], while Fein et al call for a "confidential disclosure system" based on the aviation industry's error-reporting [7], and Leape et al call on physicians to "learn from each other's mistakes" by disclosing [14].

This conflation is problematic because reporting errors and disclosing errors involve inherently distinct paths of information dissemination. Disclosure is directed externally towards patients and/or their families, whereas physician error reporting can be conducted internally within a Health Care Organization (HCO), either through official channels, or more informally to one's superiors. As Kaldjian et al point out, it is "important to consider how reporting errors to institutions to enhance patient safety may differ from disclosing errors to patients as part of direct patient care" [9].

The perceived interchangeability of terms can be attributed to the fact that error disclosure and reporting can be and often are connected under a single policy guided by the principles of information transparency. Many scholars propose an integrative

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approach to disclosure and quality improvement [3,10], encouraging the active involvement of patients and their families in the error investigation and corrective actions within the HCO. For example, Liang and Lovett argue for a "two-pronged approach" to error whereby an "error investigation team" and an "error disclosure team" work in parallel to achieve system quality improvement, arguing, "using the disclosure process not just to ethically inform patients but also to enhance medical system safety is our duty. We are bound to integrate learning from systems errors and responsible actions toward patients" [15]. The National Medical Error Disclosure and Compensation (MEDIC) legislation introduced by Barack Obama and Hillary Clinton includes a model that integrates procedures for preventing error recurrences into the disclosure process [16]. These disclosure models are congruent with research on patient preferences for disclosure which repeatedly suggests that patients desire, as part of the disclosure message, an assurance by the physician that she or he will take steps towards preventing repeated errors [3,17].

The problem is that while error disclosure often goes hand in hand with error reporting, many errors which are reported go undisclosed. And patient safety might very well be improved anyway. The argument in favour of error-reporting (in its mandatory, voluntary or confidential varieties), borrowed from the aviation industry and confirmed by urology literature, is quite clear: transparency with respect to the information surrounding an error will create valuable epistemic feedback loops within an HCO [7]; as a result, root causes of error and systemic flaws will be more readily identified, enabling structural adjustments that will prevent the repetition of errors. In short, reporting errors turns them into learning opportunities for the sake of improved patient safety. Kaldjian et al employ this argument, claiming "to improve patient safety, it is necessary to understand the frequency, seriousness, and causes of medical errors. Such knowledge is acquired by the analysis of data collected through error-reporting systems" [18].

The problems with "outcomes arguments"

The same argument for disclosure, however, rests upon much more unstable ground. Pending evidence to the contrary, it may be the case that a purely internal investigation of an error occurrence (i.e. one conducted within an HCO without the knowledge of the implicated patient) could on its own lead to effective policy changes, making error disclosure superfluous to the goal of patient safety. Kaldjian et al suggest in another paper that while error reporting is a necessary part of "patient safety", informing patients about error is instead "part of patient care" [9]. For the link between patient safety and disclosure to be directly established, the patient's own knowledge and experience of the error must be shown to somehow play significantly into the epistemic feedback loops that contribute to systemic quality improvement.

There are hopeful examples of this. In the Saskatoon Health Region (SHR), for example, patients have the opportunity to formally share their experiences with medical error at conferences or advisory councils that incorporate patient feedback into policy-making [19,20]. Full and frank disclosure of information by physicians naturally allows for patient initiative in this respect. Patients also regularly contribute non-structural feedback to their caregivers, and in the event of an error can play crucial roles in information gathering and dissemination [10], since "the patient and family witness virtually the entire spectrum of care, whereas each healthcare provider generally is only narrowly focused on respective clinical responsibilities" [15].

Despite these opportunities for patients to actively engage in quality initiatives, the possibility remains that physician error reporting need not include error disclosure to patients to serve as learning opportunities (individual or systemic) that sufficiently improve patient safety. Since disclosure as part of error reporting systems is a relatively new phenomenon, empirical evidence opposing or supporting the link between patient disclosure and patient safety is at this point either speculative or unavailable [21]. Gallagher et al say, "Evidence of the medical and legal implications of disclosure will remain an open question for the foreseeable future" and advocate for the application of "performance-improvement tools to the disclosure process, beginning with tracking disclosure outcomes" [12]. Arguing for disclosure on the basis of its unknown consequences for patient safety leaves the notion of disclosure exposed to the possibility of its outcomes not being what we had hoped.

This is also the case with arguments for disclosure on the basis of its legal implications for HCOs. These arguments aim to convince the reader that an open and transparent relationship between physicians and patients reduces the frequency, cost, and severity of malpractice suits. However, the jury is still out on whether disclosure policies are directly productive of either quantitative or qualitative measures of disclosure outcomes, such as litigation costs and psychological impacts on physicians. Kachalia et al looked at the effects that the introduction of a disclosure-with-compensation program at the University of Michigan Health System had on litigation rates. While their "findings demonstrate that it is possible to implement a disclosure-with-offer program without increasing liability claims and costs" [13], the study was self-admittedly unable to establish a direct causal link between the disclosure program and decreased litigation rates. A disclosure program at the Veterans Affairs Hospital in Lexington, Kentucky, has likewise been linked to reduced legal and administrative costs [16]; however, the complexity of the medico-lego system is such that alternative explanations for the correlation have not been ruled out. Given the preliminary nature of the evidence, arguments for disclosure that hinge on the basis of tangible benefits have little pull, and are constantly threatened by the possibility of counteracting forces.

Another frequent "outcomes argument" linking disclosure to quality improvement in HCOs is made from the standpoint of evidence-based management practice. The argument runs as follows. The presence of organizational policies such as disclosure "may ultimately link to deeply held values of care staff" [22] such as honesty, transparency and integrity, which in turn can translate into the organizational commitment of employees to the goals of the institution they actively share in. Lamb states, "open and truthful discussion with the patient is the first stage in promoting and fostering an environment and culture that, through honest discussion, encourages the learning needed to improve systems and thus reduce medical error" [23]. Berlinger and Wu echo this sentiment, stating that "the individual who takes responsibility within a systems approach will be committed to 'prospective responsibility': discussing and analysing mistakes, improving practices, and fulfilling his or

her role obligations, including the duty to disclose" [24]. Insofar as organizational dynamics greatly impact patient care [25], it is possible that disclosure policies can lead (albeit indirectly) to increased quality of care and patient safety. Liang likewise contends that "appreciating patients' desire to know about an error's cause and prevention could encourage physicians and safety programs to examine errors more closely and to develop more effective prevention plans" [10].

It is important to notice how, in the above argument, the outcome of improved patient safety hinges on the values that underwrite the disclosure policy in the first place. That is, the disclosure policy has a primarily ethical basis, though it may lead to patient safety secondarily. Disclosure is not (always, only, or sometimes ever), called for because of its implications for patient safety or because of its legal benefits. We want disclosure despite these consequences, and should be more candid in the literature in discussing why. We can, and should, do better than argue for disclosure on the basis of its empirical outcomes.

Conclusion

It is possible that arguments based on consequences have the most weight behind policy change in a healthcare setting. The costs, stakes, processes, and outcomes of medical management are real and important to everyone involved, and finding ways to clear away barriers to disclosure physicians presently face comprises a crucial job of the medical error literature. However, framing disclosure as a patient safety issue too often involves sidestepping the fact that disclosure is justified for reasons independent of its potential benefits for the health care system. Protecting patients from harm is a worthy goal but so too is giving patients the information they deserve about their own healthcare. Let's not conflate them.

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