

Session 10. Malpractice and Disclosure of Errors

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Overview

Clinical errors that result in patient injury often raise concerns about medical malpractice. At its core, medical malpractice law presents a socially constructed means to compensate parties harmed in the course of receiving health care using the apparatus of the civil judicial system. However, the tort mechanism, which steers individuals and institutions into adversarial roles where the end process may be a litigated trial before a jury of peers, is recognized by all close observers as an imperfect means of addressing a social problem. Many wrongly harmed patients never receive due compensation, and many competent and capable health care professionals are harmed by even a threat of legal complaint. The negative consequences to almost all stakeholders (patient, physician, and hospital) are not trivial. Moreover, the current system sets up perverse incentives and encourages widespread distortion of priorities.

Historically, the threat of being sued and the serious difficulties that often followed from having to legally defend one's clinical conduct inclined most in the medical profession to a reluctant posture regarding disclosure of clinical errors. This formally normative pattern of behavior has begun to shift as a growing body of empirical data suggest that regardless of whether aggrieved patients intend to pursue civil litigation, they consistently voice a desire for honesty and transparency when it comes to revelations of medical error. Within the medical profession, there is increasing awareness that it is difficult to ethically justify maintaining veils of silence when errors occur.

This module will review some of the issues that arise in cases of medical error that might result in a future malpractice claim.

Instructor's Guide

- Case Summary
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Case Summary

A pediatrician is about to see a 3-year-old boy in follow-up for an elevated blood lead level. Two weeks ago at his regular checkup, a test was ordered based on parental concerns, and it came back at 55 µg/dL (normal <10 µg/dL). Before entering the room, the physician was flipping through the boy's chart and saw in the laboratory printouts a result from a level ordered at his routine 2-year visit—30 µg/dL. She cannot recall ever seeing these results.

- Should the physician tell the parents the results of the earlier test during this visit? If so, how should the oversight be communicated?
- Should a formal apology be offered? If not, why not? If not now, when, if ever, should the error be communicated to the parents?
- If the error should not be reported to the parents, why not?

Alternative Cases

1. An 18-month-old girl is admitted to the general pediatrics ward for intravenous antibiotics for urosepsis. The handwritten order for her antibiotics is misread and she is given 10 times the requested dose. She appears to have had no immediate adverse effects and is likely to have a full recovery. Should the parents be informed of this error?
2. Earlier this evening, a 16-year-old student with signs of meningitis and septic shock is admitted to the hospital. After intubation, placement of a central line, fluid resuscitation, and inotropic infusion, the student was initially stabilized and sent to radiology for a CT scan of the head. He completed the CT scan, but moments after being moved from the scanner to his stretcher, he became hypotensive. Resuscitation was attempted but he never responded, and eventually he was pronounced dead. As he was being prepared to be brought back to the emergency department, his disconnected central venous line was found in the bedsheets. None of his infusions or resuscitation medicines had actually been administered. His CT scan showed some cerebral edema and midline shift but not clear evidence of herniation. It is unclear how the patient would have fared had he survived. Should the parents be told about the problem with the central venous line?
3. A 12-year-old was transferred to your ICU after 3 days of care in a community hospital ICU, where his condition had progressively worsened. On admission an hour ago, he was in uncompensated septic shock, and he has just died. In quickly reviewing his records from the referring hospital, you see that his admission radiograph of the kidneys, ureters, and bladder from 3 days ago had obvious free intraperitoneal air, likely indicating an intestinal perforation. There is no indication in the records that this finding was noted or recognized. You are about to meet his parents. What should you say to them about why he died?

Learning Objectives

1. Understand and critically reflect on the reasons why medical errors often go undisclosed.
2. Discuss the range of possible consequences to individuals and institutions when an open disclosure policy is adopted.
3. Understand and reflect on the role of apology in the course of communicating medical errors to patients and families.

Suggested Reading for Instructor

American Academy of Pediatrics, Committee on Bioethics. Professionalism in pediatrics: statement of principles. *Pediatrics*. 2007;120(4):895–897

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Further Reading

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Case Discussion

When a medical error has occurred, what are the ethical obligations to the family? How should the error or oversight be communicated? If an error should not be reported, why not?

In this case, it is clear that a medical error has occurred that may have a lasting negative health consequence for the child. Not surprisingly, when asked, adult patients and parents of pediatric patients almost universally express a desire to receive information about medical errors despite its unsettling nature. Further, a solid body of research shows that an overwhelming majority of surveyed physicians believe serious errors should be disclosed to patients and families. However, ideals do not match practice. Several studies collectively sampling thousands of physicians have demonstrated that although nearly all respondents acknowledge serious errors as such, significantly fewer appear prepared to disclose the same specifically as “error” to patients and families.

There is a temptation in cases like this to jump to conclusions that would hedge on the question of whether the physician should disclose based on concerns about a torrent of negative immediate and long-term consequences to the physician, including but not limited to risk of liability. The focus here should be on the basics, the “right thing to do” question. One way of getting at the ethical concern is to ask participants to ask themselves, “If you were a parent of this child, what would you think is reasonable *to expect* to be told?”

Most agree that, as an ethical matter, physicians ought to disclose medical errors to patients and their families, especially when there is any basis to be concerned about lasting harm. Yet it is the case that most practitioners initially hesitate in their willingness to be forthcoming and transparent. Why might physicians hesitate to disclose medical errors?

The framing of the basic problem is important. If the primary narrative that a physician or institution selects to understand medical error is one that casts medical error in terms of risk of legal liability, a resolute nondisclosure policy quite predictably follows. The physician's or institution's posture is immediately defensive. In this approach, adopting a “circle the wagons” mentality is common; as such, any patient-supportive activity that might increase the risk of malpractice exposure will be discouraged.

Numerous explanations have been offered for the professional wall of silence that relate to and are distinct from fear of legal liability. It is important to acknowledge that the current system of tort-based compensation is dysfunctional. It can and does occasionally unfairly devastate a physician's career, and it costs insurers and institutions money. Even though civil litigation is

generally not organized to be punitive, it can have that effect on clinicians forced into defending themselves. Formal findings of malpractice potentially have negative downstream consequences in terms of credentialing, obtaining hospital privileges, and securing affordable insurance coverage. As such, clinicians quite naturally might focus on how the error affects them personally, rather than thinking of disclosure as a respectful, patient-centered, professional duty.

What structural, sociologic, and psychological barriers exist that make breaking the wall of silence difficult?

Physicians are acculturated into a system that poorly prepares them to deal with their mistakes; the training of medical professionals takes place in a hierarchical system, within which trainees must perform to the satisfaction of their superiors. Trainees are socialized early to use certain coping mechanisms in the face of error, such as denial, discounting, and distancing.

Acknowledging vulnerability and the possibility of mistakes is not encouraged or rewarded. This often translates into a need to project confidence, even in the face of uncertainty, and appear objective, even in situations that engender confusion and distress. Thus, it becomes easier not only to hide errors from patients and colleagues but also to develop strong psychological defense mechanisms and not recognize them as such as time goes by. Admitting error becomes akin to acknowledging a personal failing, which risks triggering strong feelings of inadequacy, let alone guilt and remorse. There is also a preoccupation with professional perfection, which sets up a false expectation that clinicians who are well-trained cannot and do not make mistakes. Some believe that imagining the physician as infallible may provide comfort to a vulnerable patient, but there is an important difference between appropriately having confidence in a professional's competency and mistakenly believing doctors are infallible.

Are the collection of potentially serious negative consequences (legal and nonlegal) to medical professionals enough to partially or completely justify nondisclosure in cases of clear medical error on the part of individuals or systems?

What is important is to notice that rather than being a given, it is debatable whether any of the accurate descriptive explanations mentioned previously are adequate to serve as ethical justification. There is a clear conflict of closely held and important values. On the one side are the professional self-interests of physicians and health care institutions; on the other are patients' claims to be treated with respect (ie, honesty and transparency). For the purposes of case discussion, participants will hopefully recognize that the harmful consequences that may flow to individual physicians are in competition with best patient care practices, and these latter considerations deserve much more attention than they typically receive.

Offering an apology after one has played a causal role in an accident or error that harms something of value to another person not only seems polite and courteous, it also expresses respect and empathy. Typically, it is the decent thing to do. Yet in cases of medical error in which a patient is harmed, as in this case, many physicians feel ambivalent about offering an apology. Why is this so?

An apology need not be an admission of guilt or causal responsibility, although it is hard to control whether it is interpreted as such. For this reason, it may be useful to distinguish saying, "I'm sorry for what has happened to you," from an apology that entails personal or institutional accountability for error. Arguably, the act of saying, "I'm sorry," allows physicians to reclaim

their natural capacity for caring and kindness. Of note, numerous state legislatures have passed so-called apology laws that are intended to encourage formal acknowledgment while simultaneously insulating such statements from use in subsequent malpractice litigation. However, it is at least possible that such laws actually detract from the perceived sincerity of an apology in this context.

What evidence exists concerning the effect of apologies or admissions of error on risk of liability?

The data are equivocal. Several small lines of evidence suggest that an open disclosure policy may reduce the risk of liability under the current tort system and save hospitals and insurers money. The most impressive example of this comes from the University of Michigan. There, it was found that poor communication and a failure of accountability were the root causes of initiating local malpractice suits. In 2002, the hospital adopted a new approach that included acknowledging cases in which a patient was hurt because of medical error and quick and fair compensation of those patients, defending cases thought to be without merit, and studying adverse events to determine how procedures could be improved. In a 4-year time frame, the university was able to demonstrate a drop in its annual litigation costs from \$3 million to \$1 million and a drop in the number of claims and lawsuits from 2001 to 2005 from 262 to 114.¹

On the other side, there is an obvious concern that if more patients and families are informed about potentially actionable errors, more will decide to sue. The basic point is that there are a huge number of claims out there that have never been filed because patients were never made aware of them. Once this can of worms is opened, even if only a minority of patients end up suing, the potential overall costs to the system may increase. One group of investigators has concluded based on its modeling studies that a widely adopted open disclosure policy would at least double the number of claims and lawsuits, open disclosure would reduce the size of awards by an average of 40%, and the overall effect of disclosure would be an increase in compensation costs from \$5.8 billion to \$7.0 billion per year.²

Even if overall malpractice claims and costs increase, is that a sufficient ethical reason to discourage the practice of open disclosure?

This is a final opportunity to challenge the participants to think through the range of negative financial, professional, and personal consequences that might follow from being sued or losing a civil suit in court, and ask if all of those undeniable bad outcomes are enough to warrant nondisclosure of errors or prevent an apology that is heartfelt and empathetic and need not amount to an admission of guilt.

What approaches might be reasonable in this specific case of medical error?

Most participants should agree that disclosure is obligatory in this case. There may, however, be a genuine debate about the optimal timing of the disclosure. Because the physician is just about to see the family, it may seem reasonable to wait to disclose until a follow-up visit. More information might be useful to gather, including determining how the error occurred. Discussion of a possible medical error could distract the parents from attending to the immediate medical needs of their child at this time. Because the immediate need is to make a treatment plan for the elevated lead level, it may make sense to address the issue of the missed laboratory result in a separate, dedicated meeting with the parents.

Alternatively, one could disclose the laboratory result at this visit, perhaps after a plan for workup has been developed and agreed on. The physician could say something like, “There is something else I need to tell you. Before I came in the room today I noticed that the screening lead level we performed last year was also elevated. I’m really sorry about this; I don’t know why I didn’t see it, and indeed at this time I can’t even be sure that there wasn’t an error in labeling the result such that it is not even yours. But in any case, I wanted you to know this as soon as possible, and I will follow up and have more information for you as soon as I am able to gather it. This is a priority for me, and I also want to prioritize arranging to have your child seen by the appropriate developmental pediatric specialist as soon as possible.” However uncomfortable this approach may initially seem, it also has some advantages—it establishes with the parents that you are taking this problem seriously and that you are immediately responding to it as best as you are able.

Conclusions and Suggestions

Disclosing medical error with an apology remains a thorny problem for physicians despite little disagreement about the ethical merit of such activity. The threat of medical malpractice litigation and its host of negative consequences clearly influence professional behavior and present a formidable social and structural barrier to opening better lines of honest and empathetic communication between stakeholders. There is increasing empirical evidence to suggest that genuine acknowledgments of mistake and regret, coupled with diligent efforts to compensate those harmed, offer a path forward that can mitigate the risk of legal liability.

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