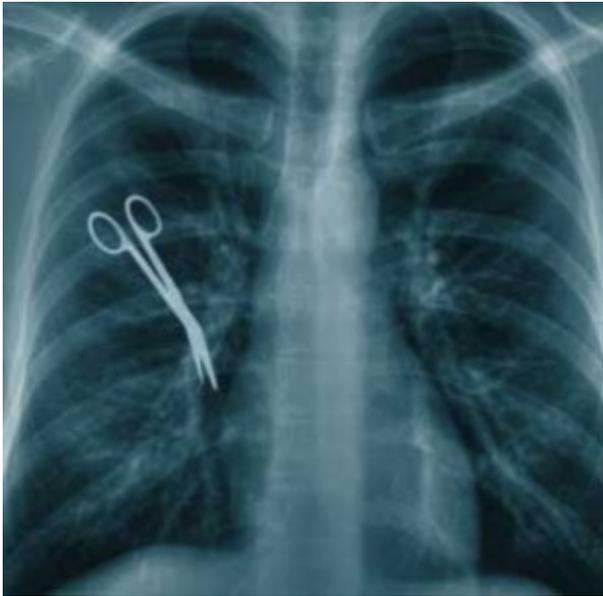


# Error, disclosure & the disgruntled patient



Anthony Beeton

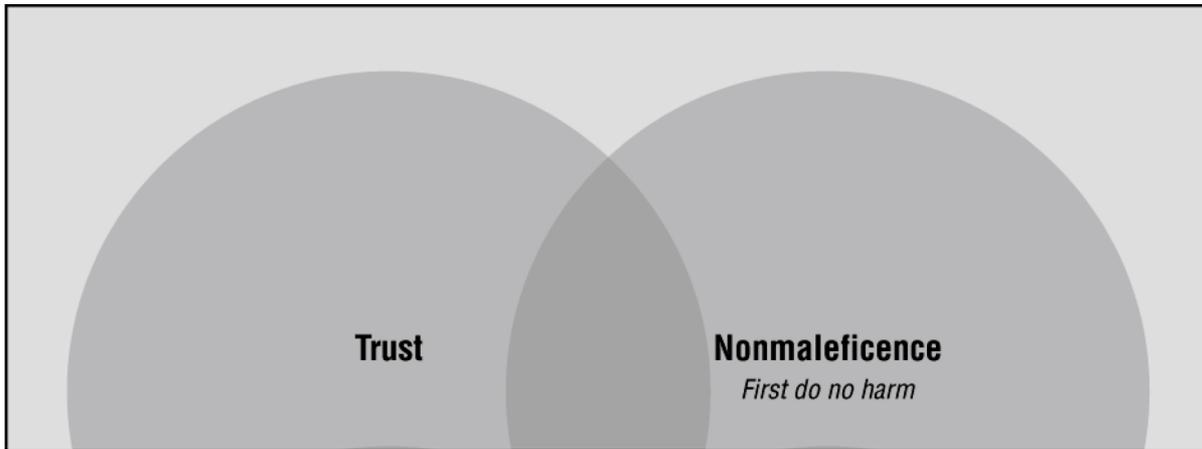


Right now we find ourselves in a profoundly threatened position

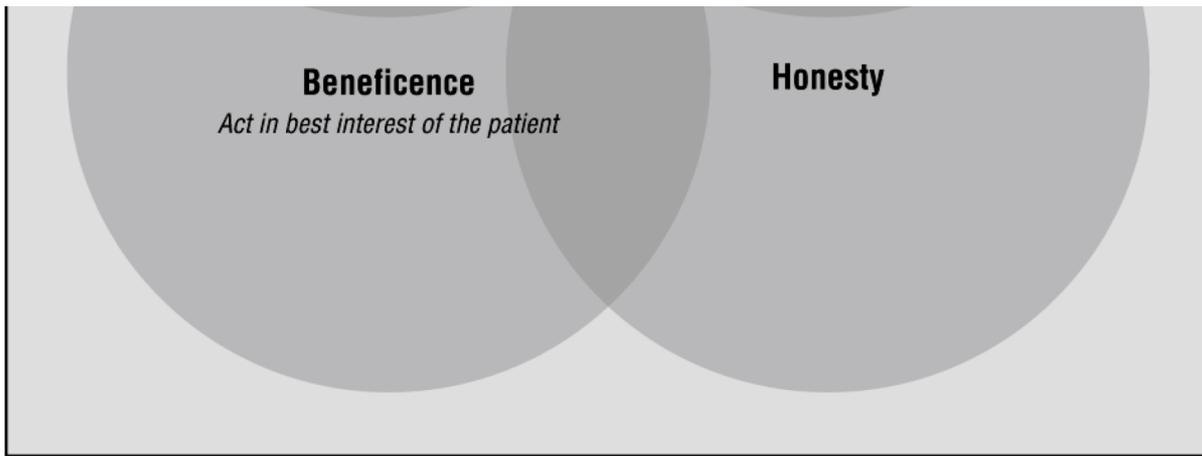


“Every (doctor) carries within himself a small cemetery, where from time to time he goes to pray”

Rene Leriche



From both parties



Cornerstones of doctor-patient care unit

# The basic premise

- Safe and patient-centred medical care
- What would I want if I or a member of my family was harmed during a medical procedure / intervention / admission?
- What is the “right” thing to do according to societal norms?



# Challenges to an open doctor – patient relationship

- Poor communication / inadequate consent
- Fear
  - Loss of professional “face”
  - Of administrators / lawyers
  - Of offending the doctor
- Quest for perfection “error is forbidden”
- Easy access to protocols etc
- Assertive legal system

**TIME**

# 5 golden rules to reduce harm / risk

- Diligent informed consent – not just a form
- First rate record keeping – not just clinical but of discussions
- Confidentiality – the stray tongue!
- Availability (esp. when patient distressed)
- Communication
  - Manner
  - Active listening

# Adverse event

- Harm, injury or complication (or the potential for these) associated with medical treatment
- May or may not result from error



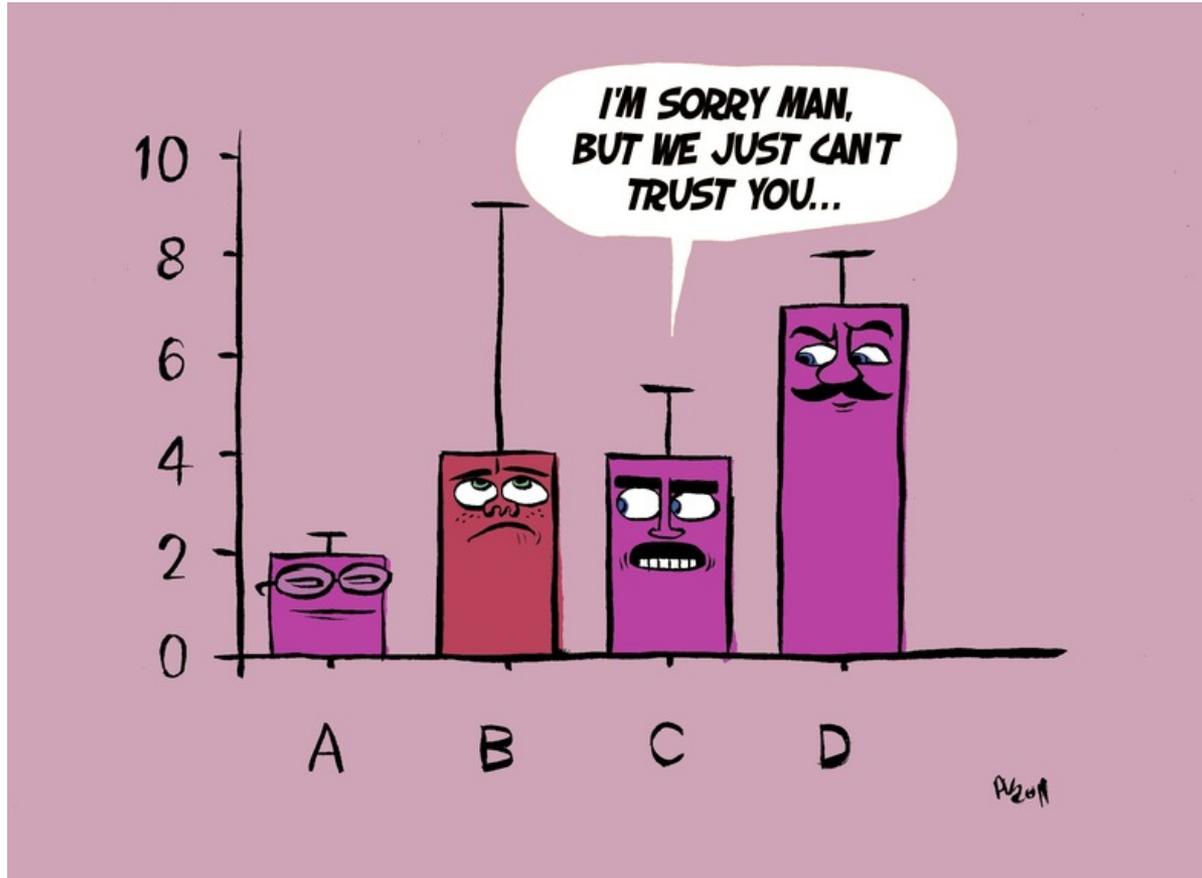
Dr Perkins' initial joy at finding his Psion palmtop is tempered somewhat by the impending medical negligence suit.



# Errors and adverse events

- Error
  - Serious: potential to cause transient life-threatening events, injury or death
  - Minor: no potential to cause significant injury
  - Near miss: possibly serious event intercepted before it reaches patient
- Adverse event
  - Preventable – due to error or systems failure
  - Non-preventable – known risk of high risk intervention or idiosyncratic event

# Incidence of adverse events



# Incidence of adverse events

- Depends on definitions and robustness of reporting system
  - > 1/5 hospitalised patients are victims of major errors
  - ? 440 000 deaths in USA in 2013 due to medical errors (3<sup>rd</sup> most frequent cause of death)
  - 44% avoidable
  - Vast majority of physicians have been involved in an unexpected peri-op death or severe injury
  - Average 2.8 events per 10 years



HOSPITAL MEDICAL ERRORS KILL 440000 AMERICANS EACH YEAR. -- HEARST NEWS INVESTIGATION

# Considerations after an adverse event

1. Take a moment
  2. Adequate disclosure
    - Patient / family
    - Department / institution
  3. Support of patient & family
    - Beware the runaway patient / relative
    - Leopards and spots
  4. Care of self
  5. Medico-legal stuff
    - Records
    - Notification
  6. Learning, healing and returning
- Simultaneous processes



# Impact of adverse events

First and second victims

Acute trauma

PTSD

- Anxiety about future errors 61%
- Loss of professional confidence 44%
- Sleep disturbance 42%
- Loss of job satisfaction 42%
- Loss of professional reputation 13%



# Stress / trauma related symptoms

**Physical** Exhaustion, throbbing headaches, dizziness

**Emotional** Grief, anger, depression, irritability, fear, anxiety, suicide

**Cognitive** Confusion, nightmares, poor concentration, memory loss

**Behavioural** Restlessness, withdrawal from environment, drug/alcohol abuse, change in appetite, loss of libido



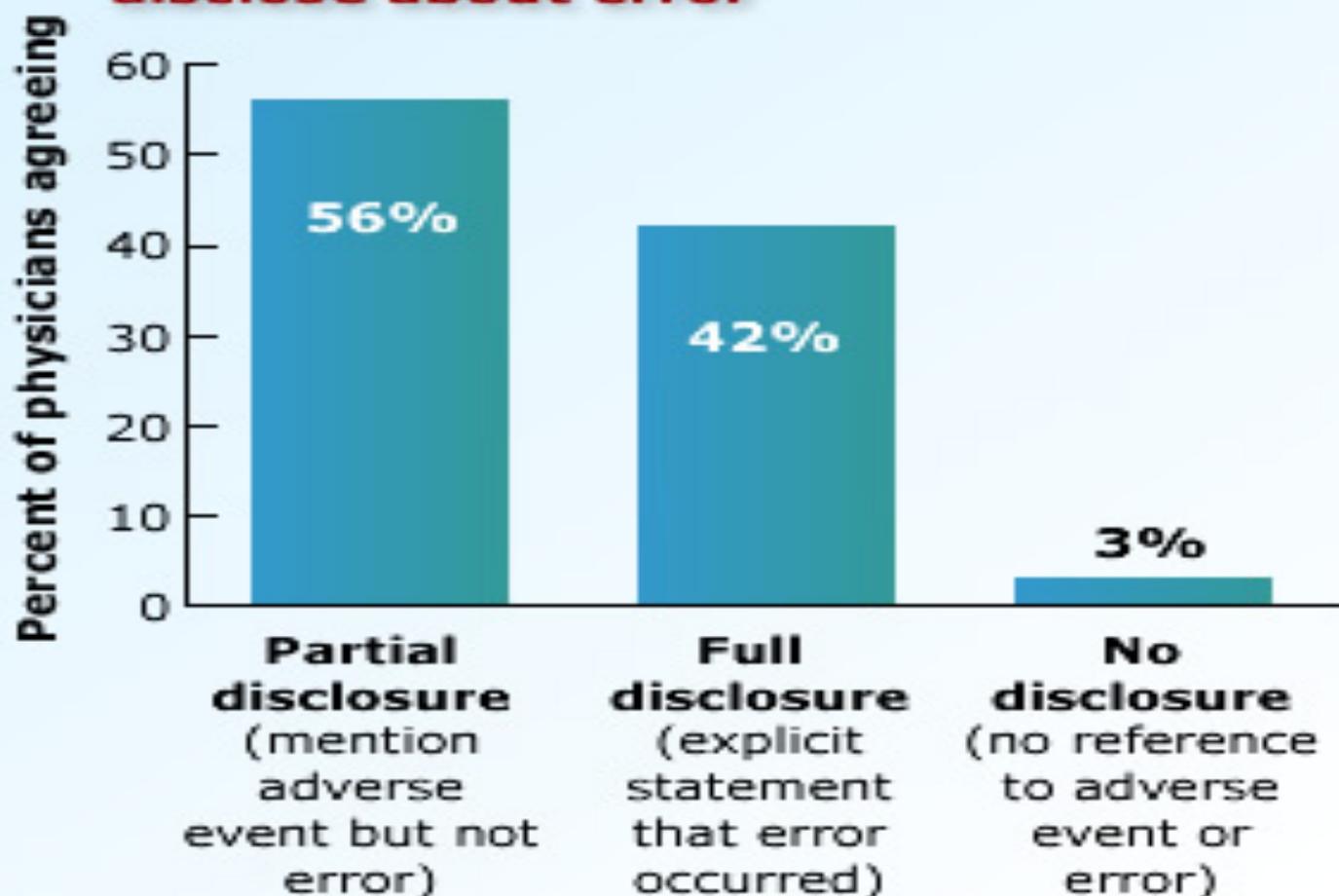
# Attitudes to disclosure

- Patient and doctor demographics
- Error or near miss?
- Damage or not?
- Perceived culpability?
- Potentially recurrent adverse event?

# Rates of disclosure

- About half of non-injurious errors are disclosed in North America (fully?)
- Serious errors
  - Limited consequences – 95% disclosure
  - Severe consequences / death - ~ 80% disclosure
- “Adequate” disclosure from physician perspective in 85% of cases
- PTSD following inadequate disclosure

## What physicians would disclose about error



“You don't want to be accused of scaring people. I've had patients tell people that I was scaring them when I thought I was simply being informative and, you know, not being dramatic or anything. But clearly in those cases, I was telling people more than they wanted to know.”

“My job is to relieve anxiety, not to create it. And to a certain extent when an error occurs that doesn't get to the patient, it's not their problem, it's my problem.”

“I think if we were held to disclose all of those [near misses], I think that happens so often we wouldn't have the opportunity to practice medicine.”

# Impact of disclosure

- 92% of patients desire full disclosure of all errors
- 60% of patients would change doctors even after full disclosure of a non-injurious event
- 12% state they would sue in these circumstances
- 20% would sue with identical outcome but if they discover non-disclosure
- Numbers much higher with poor outcomes

# Impact of disclosure

- It's not just going through the motions of disclosure
- If regarded as complete / honest by patient / family and includes an apology
  - Higher physician quality ratings
  - Enhanced perception of recovery
  - Decreased number and value of malpractice suits

*“If you develop a good relationship over time with the patient and his family, if you are sincere and honest about it from the start, if you appear to be a caring human being, they will excuse almost anything. If you are abrupt and short and you are dishonest, if you try to hide or you seem duplicitous and you seem uncaring and detached, then you are going to be in real trouble.”*

“I was really surprised to hear the doctors talk like that. I saw a lot more caring than I expected. Caring means communications, their feelings. You know, most of the time when you see the doctor you don't get their feelings—yeah, I was surprised.”

# Disclosure

- Challenges
  - Customisation of disclosure
  - Training
  - Support for both parties

# Content of disclosure

- Explicit statement that an error has occurred
- Truth about the nature of the error and strategies to prevent recurrence
- Facts relevant to future care
- Include a sincere apology
- Avoid speculation or taking / directing blame until full investigation
- Promise a follow up discussion after investigation
- Contact person & details

*Baldwin*



“Something that says I’m sorry without admitting liability.”

# Style of disclosure

- Early
- Team (the catastrophic stray comment)
- Quiet, private venue
- Factual and truthful
- Empathetic and apologetic
- Listening and answering
- Non-futile
- Keep lines of communication open

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“Botched attempt is correct. But can anyone suggest a more family-friendly way of describing what happened?”

What are the main reasons you might not disclose a non or minimally damaging error?

1. Admission of failure
2. Loss of patient trust
3. Shame and guilt
4. Don't want to create anxiety for no reason
5. Fear of loss of professional esteem
6. Litigation fears
7. Loss of work / income
8. Fear of punishment
9. Hostile environment – culture of blame
10. I know I can get away with it!

# Reasons for non-disclosure

- All of the aforementioned
- Pressure from MCOs; hospital trusts; hospital management; insurers
- Ignorance of how to disclose
- Loss of professional detachment
- Fear of loss of job / financial losses
- The concept of “moral luck”
- Legal concerns
  - Worse outcomes of claims with non-disclosure
  - Tendency of doctors to accept and over-estimate degree of blameworthiness
  - Once bitten, twice shy

*I've had one doctor for 23 years and I have a great rapport with him and he could pretty much tell me anything and I would...feel a lot better about it because we've gone through so much together. And, as opposed to another doctor, who I've had for just a couple of years—since I had my heart attack—who is a classic “I've-got-exactly- 7-minutes-because-I'm-such-a-specialist” and he's 2 hours late to the appointment, to boot. If he told me something like that, I would be absolutely livid and it would be totally different.*

You are supposed to give full disclosure. Don't hold anything back. And it is almost a religious experience. You get up, you confess your sins. They assign a punishment to you. You sit back down and you are forgiven for your sins.



# Why disclose?

- Honesty to self
- Truthful relationship with patient
- Personal learning
- Institutional learning
- Standards of care

# Conclusions

- Informed consent
- Record keeping
- Training in disclosure
- Non-punitive reporting and compensation system
- **DON'T BE YOUR OWN JUDGE AND EXECUTIONER!**

“It’s not the successes I remember but the failures”.  
Henry Marsh, neurosurgeon

“The medical profession seems to have no place for its mistakes. Indeed one would almost think that mistakes are sins. And if the medical profession has no room for doctors’ mistakes, neither does society... We see the horror of our mistakes, yet we cannot deal with their enormous emotional impact. Perhaps the only way to face our guilt is through confession, restitution and absolution.” David Hilfiker MD, 1985.

“Mistakes should be examined, learned from and discarded; not dwelled upon and stored”

Tim Fargo, writer & entrepreneur

# Communicate! Communicate! Communicate!

- Good doctors have adverse events and get sued
- Nice doctors have adverse events but don't get sued
- Be a humane being
- Don't be afraid to let the patient / family and your colleagues see that you are hurting

# Pay your professional indemnity insurance with a smile



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edgar wigo

# Failure to defuse

- That's why you have indemnity insurance
  - Don't keep trying to go it alone
    - Esp. when social media involved
  - Tell the patient you are getting legal advice and refer all communications to counsel
  - Mediation works in 90% of cases
  - Cannot fix a relationship that never existed
  - Legal process
    - Mandatory to have good records of consent; clinical features and discussions

# Standard of care (SOC)

- 50:50 split between claims where SOC is judged adequate and inadequate
- Adequate care – still some successful claims but small payouts
- Inadequate care
  - Produces higher rate of claim success irrespective of severity of outcome
  - 32% inadequate monitoring – highest claim value
  - Care more likely to be judged inadequate where outcome most adverse (outcome bias)

# Peer support

I hope that this never becomes relevant to any of you. Please be there for colleagues who are on the receiving end...

