

APPENDIX 4. HOW TO DISCLOSE MEDICAL ERRORS—Tips for Learners

To A Supervisor

Make a full and prompt disclosure to the supervisor, allowing him/her the time to determine (1) if any action is needed to prevent further harm to the patient and (2) how the error will be discussed with the patient and family.

- Choose an appropriate setting for the discussion.
- Make an explicit statement that an error has occurred and provide a description of what you know (or suspect) happened *and* why or how it happened
- Describe any consequences to the patient that have already occurred and that are likely to occur
- Summarize your knowledge of any treatment that was given or that may yet be required
- Offer to accompany the supervisor when he/she discloses the error to the patient.
- Accept responsibility for the incident and the outcome, but avoid placing *blame* on yourself or others.
- Request a follow-up meeting with the supervisor to discuss how to prevent a similar incident in future.

Talking Tip

“I am having a tough time dealing with this patient’s case. I feel I made a mistake in his/her management and feel guilty. I’d like to sit down and go over the case with you to see how I could have handled things better, and how to avoid this situation in the future.”

To A Patient

Whenever possible, you and your supervisor should disclose to the patient together. The following summarizes the important steps.

Promptly advise the patient about the error. Do not wait to see if the patient knows or suspects anything; although delaying disclosure may be appropriate if the patient is not physically or emotionally stable.

- Choose an appropriate setting for the discussion and be prepared for strong emotions.
- Make an explicit statement that an error has occurred and indicate your regret. Apologize, if appropriate.
- Use clear, unambiguous, non-technical language to provide a basic description of:
 - what you know (or suspect) happened
 - why or how it happened
 - what you are still investigating
- Describe:
 - any consequences that have already occurred and that are likely to occur
 - any treatment that was or may yet be required
 - how you plan to prevent a similar incident from happening again
- Offer:
 - to address any questions or concerns
 - the option of a family meeting, follow-up meetings
 - to arrange for a prompt second opinion, where appropriate
- Accept responsibility for the incident and the outcome, but avoid placing *blame* on yourself or others.
- Thoroughly document the incident, its consequences and management, and all important discussions with the patient.

Talking Tip

A physician mistakenly prescribed a medication to a patient allergic to that class of drug.

- “Mrs. Jones, I’ve discovered what has caused you to become so ill. I’m sorry that I didn’t realize you were allergic before I prescribed the new medication. The symptoms that you now have are due to the allergy. We’ve stopped the medicine, and I’m giving you something (e.g., an antihistamine) to help you feel better. You should improve gradually over the next few days.”

<Pause. Wait for the patient to respond or ask a question.>

- “I’ll do what I can to make sure this doesn’t happen again. I’ll make a special note of your medication allergies in your chart. I also suggest that we arrange for you to order a MedicAlert bracelet.”

<Pause. Wait for the patient to respond or ask a question.>

- “Do you have any questions?”

Sources:

- Gallagher TH, Waterman AD, Ebers AG, Fraser VJ, Levinson W. Patients' and physicians' attitudes regarding the disclosure of medical errors. *JAMA* 2003; 289(8):1001-1007.
- Hebert PC, Levin AV, Robertson G. Bioethics for clinicians: 23. Disclosure of medical error. *CMAJ* 2001; 164(4):509-513.
- Jacobson L, Elwyn G, Robling M, Tudor Jones R. Error and safety in primary care: no clear boundaries. *Family Practice* 2003; 20(3):237-241.
- Crook ED, Stellini M, Levine D, Wiese W, Douglas S. Medical errors and the trainee: ethical concerns. *Am J Med Sci* 2004; 327(1):33-37.
- Hevia A, Hobgood CD, Weiner BJ, Rivello RJ. Resident Error in Emergency Medicine: The REEM Study. *Acad Emerg Med* 2003; 10(5):457.

