

Disclosing Medical Mistakes: A Communication Management Plan for Physicians

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Introduction:

There is a growing consensus that disclosure of medical mistakes is ethically and legally appropriate, but such disclosures are made difficult by medical traditions of concern about medical malpractice suits and by physicians' own emotional reactions. Because the physician may have compelling reasons both to keep the information private and to disclose it to the patient or family, these situations can be conceptualized as privacy dilemmas. These dilemmas may create barriers to effectively addressing the mistake and its consequences. Although a number of interventions exist to address privacy dilemmas that physicians face, current evidence suggests that physicians tend to be slow to adopt the practice of disclosing medical mistakes.

Methods:

This discussion proposes a theoretically based, streamlined, two-step plan that physicians can use as an initial guide for conversations with patients about medical mistakes. The mistake disclosure management plan uses the communication privacy management theory.

Results:

The steps are 1) physician preparation, such as talking about the physician's emotions and seeking information about the mistake, and 2) use of mistake disclosure strategies that protect the physician-patient relationship. These include the optimal timing, context of disclosure delivery, content of mistake messages, sequencing, and apology. A case study highlighted the disclosure process.

Conclusion:

This Mistake Disclosure Management Plan may help physicians in the early stages after mistake discovery to prepare for the initial disclosure of a medical mistakes. The next step is testing implementation of the procedures suggested.

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Start out with the conviction that absolute truth is hard to reach in matters relating to our fellow creatures, healthy or diseased, that slips in observation are inevitable even with the best trained faculties, that errors in judgement must occur in the practice of an art which consists largely in balancing probabilities—start, I say, with this attitude of mind. ... You will draw from your errors the very lessons which may enable you to avoid their repetition.

—Sir William Osler, 1849–1919, physician, clinician, pathologist, teacher, diagnostician, bibliophile, historian, classicist, essayist, conversationalist, organizer, manager, and author

Introduction:

Mrs G, a woman age 54 years, was admitted to the hospital for management of a clotted femoral bypass graft. Her primary care physician, Dr A, received a telephone call to inform him of the admission. He glanced through the electronic medical record (EMR) as he discussed the patient's care with the hospitalist. In doing so, Dr A noticed a laboratory value from 1 week earlier revealing that Mrs G's international normalized ratio (INR) was subtherapeutic at 1.3. Nothing had been charted regarding any warfarin dose adjustment in response to this value. Dr A believed that promptly addressing this subtherapeutic value might have prevented Mrs G's complication and current hospitalization.¹

Much attention has focused on the management of medical mistakes in recent years.¹ Currently, there is a consensus that disclosing medical mistakes is advantageous for patients, clinicians, and medical organizations in reducing the number of medical malpractice suits and increasing patient

¹ This case is a composite developed by the authors with the specific intention of highlighting the salient features of medical mistake disclosure. Similarities to any real-life cases are purely coincidental.

satisfaction.² Although a large number of interventions have been developed to facilitate mistake disclosures, evidence remains that clinicians have been slow to adopt the practice.^{3,4} As such, one of the problems may be a need for an alternative, theoretically based model that provides a tool to guide initial conversations with patients after a mistake, which can be followed up with additional details. Thus, a more directed set of strategies may provide impetus for physicians to make a disclosure closer to the mistake event and to do so effectively. The objective of this article is to provide a streamlined two-step template for physicians to follow when disclosing medical mistakes to patients and their families using the communication privacy management (CPM) theoretical frame.⁵

Revealing medical mistakes is challenging because of a long history of feeling reticent about disclosing such information and because of physicians' strong emotional reaction to mistakes, both of which lie in tension with the inviolable ethical obligation to be truthful with patients.⁶ On one hand, there often is a culture among physicians that may lead to suppression of disclosure; on the other hand, they are ethically expected to reveal mistakes to patients and their families.⁷ These conflicting expectations can lead to a privacy dilemma for physicians who must decide whether, when, and how to disclose.^{8,9} Anxiety about disclosure of mistakes may be compounded by fears that the information surrounding mistakes will be made public, that the patient may respond by requesting cost reimbursement, or that disclosure will result in legal consequences.^{10–12} The complexities surrounding ethical disclosure of medical mistakes highlight the need for physicians to learn productive and ethically sound ways of disclosing these mistakes.¹³ Currently, evidence suggests that physicians are not adequately equipped to handle such disclosures effectively and there may be some level of defensiveness that interferes with competent disclosure.^{9–16} Conceptualizing medical mistakes as a privacy dilemma provides the basis for a different model as a framework to assist physicians in managing mistake disclosures to patients and families.^{8,9} We realize that many other medical team members are likely involved when medical mistakes take place, particularly because mistakes often result from a series of events leading to a mistake outcome.¹³ We also realize that this proposed plan will necessarily need to be tailored to fit different contexts, medical issues, and the severity of the medical mistake.

On the basis of previous literature and multiple applications of the evidence-based theory of CPM, we developed our management model for mistake disclosure.^{5,9,17,18} The apparatus of this theory has proved to be a useful framework to understanding disclosure and protection choices in circumstances surrounding medical mistakes and to communicating with patients about stressful information.^{9,17,19} Research using CPM predicts that people believe they own information considered private, and as such, they feel they have the right to control who has access and what happens to that information after access.^{9,20} Managing private information, according to CPM, is accomplished through the use of decision criteria about such issues as how (disclosure messages), when, whether, or whom to give private information access.

Communication privacy management shows that people grant co-ownership of private information when they confide in others and hold certain expectations about the care taken with that information.⁵ Thinking about the conditions of co-ownership according to CPM theory helps identify why both patients and physicians may feel a competing sense of ownership over information about the mistake that may further lead to the physician's own internal conflict about whether to reveal or conceal the information (Table 1).^{20,21}

Physicians' involvement in mistakes is very personal, often filled with second guessing, guilt, and self-blame.^{9,14,16} These feelings lead not only to a sense of responsibility but also to the desire to protect the information through controlling access.²² Accordingly, revealing an error means that physicians must release some control over the information and determine an appropriate and effective way to disclose the mistake. Patients, however, also claim rightful ownership to information about the mistake because the error caused, either potential or actual, harm to them and because it involves their own health care experience.^{22,23} Research of CPM suggests that a disclosure management plan can be helpful and, in this case, assist in effective disclosure of information about mistakes when there are tensions of ownership and control.^{17,18}

In most cases, it is the physician who faces the responsibility of disclosing mistakes to patients and their families.⁹ As this brief discussion suggests, offering a streamlined tool that can help physicians tell patients about medical mistakes in a straightforward, yet compassionate way likely that would help make this task a little less difficult for physicians, and more likely that the conversations will take place. In particular, a tool capitalizing on the framework of CPM theory that focuses on critical issues in mistake disclosures such as coping with emotions, information

seeking, timing, effectiveness, coordinated ownership, the context, and sequencing of the disclosure messages may set the stage for a successful mistake disclosure. The goal of this article is to offer such a disclosure management plan for physicians.

Two-Step Mistake Disclosure Management Plan

The mistake disclosure management plan (MDMP) is proposed to address the initial needs of physicians disclosing mistakes. The MDMP is a two-step process (Table 2): 1) physician preparation and 2) mistake disclosure strategies. The first step involves focusing on issues that physicians personally need to address before revealing the mistake to patients so that the needs of both physician and patient are met. This step helps physicians intellectualize and emotionally cope with the fact that a mistake has occurred “under their watch.”¹⁰ The second step involves formulating and adhering to a method of disclosing mistake messages that is geared toward preserving the integrity of the physician-patient relationship.

Rationale for Using Both Steps

Since ownership of the mistake information is perceived as “shared” by both the patient and physician, not preparing adequately in step 1 may ultimately complicate the goal of step 2. An unprepared or inappropriate disclosure prematurely delivered to patients before these processes are enacted may do more harm than good. For example, disclosure without the physician preparation step is more likely to result in the physician asking for forgiveness from the patient (tending to be more about the physician than the patient) instead of helping the patient come to terms with the mistake event.²⁰ Moreover, in an effort to rid themselves of the burden of the information, physicians troubled by the knowledge of a mistake may be more apt to engage in a communicative “hit-and-run” in which the physician quickly discloses and departs before the patient can ask questions.¹⁹ When physicians sufficiently prepare for these disclosures in advance, they are more likely to consider the needs of the patient over their own needs and to provide more successful and compassionate messages about mistakes.

Step 1: Physician Preparation for Mistake Disclosures

In step 1, there are two tasks that help accomplish a more productive disclosure: 1) recognizing and talking about the physician’s own emotions and 2) information seeking.

Recognizing and Talking about Emotions

For this task, there are two issues to consider. First, it is useful to recognize that there are potential emotional barriers that physicians need to take into account to prepare for making a mistake disclosure. Second, to overcome these emotional barriers, a “talking process” is needed.

One primary issue physicians face in preparing for mistake disclosures concerns taking stock of and addressing personal needs. Often a tension exists with physicians’ inviolable obligation of truth telling and their own need to control revelations about the mistake.¹⁶ Emotions frequently surround medical mistakes, and they can become barriers to effective mistake disclosures.

Potential emotional barriers

Christensen et al¹¹ found that physicians’ fears surrounding mistakes are “related to concerns for the patient’s welfare, possible litigation, and colleagues’ discovery of their ‘incompetence.’” In general, physicians may experience four main emotional or cognitive barriers to effective disclosure of medical mistakes: 1) shame, 2) uncertainty, 3) anxiety, and 4) threat of legal liability. Each of these barriers may be anticipated, perceived, and/or real; nevertheless, having a grip on them can help alleviate the potential negative impact on both the physician’s emotional response and the disclosure process.

One major reason physicians report not talking about mistakes is because the experience negatively affects their self-esteem and they fear embarrassment.⁹ Feeling *shame* has the capacity to interfere with being able to formulate disclosure messages that help patients understand the circumstances surrounding the mistake.^{11,16} The *uncertainty* a physician feels about the reason for mistakes and the *anxiety* about the outcome also contribute to the difficulty in revealing a mistake.²⁴ Because medicine takes place in complex systems, the potential for many contributors to any given mistake is high.^{1,13,25} Ambiguity surrounding the definition of a mistake and uncertainty about when these mistakes should be revealed to patients and families add another layer of complexity to an already problematic situation.

When a mistake occurs, the *threat of legal liability* looms over decisions to disclose the information to a patient.¹² Fear of malpractice claims often pressure physicians to keep a

mistake incident a secret. However, nearly all the evidence suggests that effective disclosure to patients provides the most robust legal protection in the setting of a medical mistake.^{2,25} Despite this, some research shows that health care clinicians continue to fear that an apology could lead to legal liability and subsequent damage to their reputations.²³ Opportunities to learn effective means of disclosing medical mistakes to patients have the potential to establish a greater sense of confidence for physicians involved in an incident.^{22,26}

Talking process to overcome emotional barriers

Pennebaker²⁷ argues that “translating experiences into words forces some kind of structure to the experiences themselves.” Talking about emotions has a therapeutic effect and may provide relief when a person is experiencing guilt, shame, or inner turmoil.²⁷ For example, a physician notes, “one must be resigned to live with a lot of guilt. It was comforting to hear that other physicians felt the same way and that I was not alone.”²⁸

Consequently, physicians’ personal disclosure about their own feelings surrounding the medical mistake is important to surmount because this stressful situation can produce the emotional barriers already identified. Talking to colleagues or others the physician trusts can help physicians work through feelings and make sense of the incident before disclosing to the patient. This type of “talking process” overcomes hurdles resulting from anxiety fostered by uncertainties of how and why a medical mistake was made. A talking process also overcomes any initial tendency for secret keeping and the desire for control when events occurred on a physician’s “watch.”²⁹ Although complex to achieve, fostering an environment of openness among all health care professionals makes it easier for everyone to take co-ownership of the problems that lead to medical mistakes, thereby stemming a tendency to retreat from the problem. An environment of openness also gives a forum for the “talking process” to more easily take place.

In discovering the problem about the missing laboratory results, Dr A was able to review the case with his partners at a staff meeting. Dr A expressed his frustration about the situation and his guilt regarding the morbidity it caused Mrs G. The opportunity gave Dr A a much-needed forum in which to recognize his feelings.

Information Seeking

Given that medical mistakes tend not to be isolated incidents, but rather represent the culmination of a “chain of events and a wide variety of contributory factors leading up to the event”³⁰ in the early stages after a mistake, physicians are not able to do an in-depth, root cause analysis. Nevertheless, it is necessary to make sense of the events that contributed to the mistake early enough so that information can be communicated to patients. Information gathering reduces uncertainty and determines the direction that physicians should take.^{10,31,32}

Dr A closely reviewed the patient’s chart, talking with the nursing staff about how the laboratory results were scanned and flagged for review. Dr A discovered that Mrs G’s results had been faxed from the patient’s local laboratory and inadvertently scanned into Mrs G’s chart without being properly flagged for review. Dr A and his partners worked with their EMR clinician to ensure that all scanned laboratory results require physician review and signing. They also established a new mechanism for keeping track of anticoagulation levels in their clinic, whereby one physician keeps a log of all patients receiving warfarin. Additionally, the patients receiving warfarin are instructed to use the EMR patient portal to follow up on INR results and are given a card with their goal INR. Having worked out a process to correct future mistakes of this nature, Dr A felt more prepared to discuss the mistake with Mrs G and demonstrate that he took responsibility to address the problem causing her injury.

Clarifying the events leading to a mistake is often critical to telling patients about events that caused a mistake and to assure patients that concrete plans will be implemented to prevent such mistakes in the future.²²

Step 2: Mistake Disclosure Strategies

Mistake disclosure strategies are proposed to help physicians manage the relationship with patients and families and to focus on disclosure messages that are relevant to the patient. Two tasks help develop mistake disclosure strategies: 1) the context of disclosure delivery and 2) the content of mistake messages, sequencing, and apology.^{5,33–35}

Context of Disclosure Delivery

For this task, two dimensions are proposed in designing an effective message: 1) the timing of the mistake disclosure and 2) the presence or absence of other people.

Timing of the mistake disclosure

Recommendations suggest that the disclosure be made soon after the mistake occurs.³⁶ Typically, patients do not expect a medical mistake to occur. Hence, the disclosure timing is important to consider, as are general precautions and best practices surrounding disclosure of all bad news.^{37–39} Given the unexpected nature of these revelations, the physician should take into account that this information is not only a surprise but also likely represents emotionally volatile information that could include life-threatening or life-altering information.^{34,37} Research shows that disclosure timing affects how revealed information is understood, particularly in unexpected situations.^{35,36} Consequently, carefully selecting a time when patients are not engaged in distracting activities and can give full attention to the disclosure is optimal.

Presence of other people

Because mistake disclosures are unexpected and personal to patients, they may or may not wish others to be present for discussions about the mistake. It is best if physicians state that they have important information to share about the patient's case and ask whether the patient is comfortable with family members or friends present. Asking communicates both a willingness to be open and respect for the patient, family members, and others involved. In cases where the patient is not able to process the information or is incapacitated for any reason, the same considerations should be accorded to family members or guardians.

Content of Mistake Disclosure Messages and Disclosure Sequencing

For this task, two concerns are identified when developing a mistake disclosure message. They are as follows: 1) disclosure strategies affecting trust and the physician-patient relationship and 2) a logical message sequence to ensure effective mistake disclosure messages.

Fostering or hampering trust

Constructing messages to disclose mistakes should take into account the importance of both the content and the physician-patient relationship. The way that patients feel about their physicians likely has an impact on how patients interpret the mistake message.^{2,25} Consequently, there are message strategies to avoid in constructing mistake disclosures (Table 3). Avoiding the use of these strategies can help overcome roadblocks and will more likely preserve the physician-patient relationship.

Mistake disclosure message sequence

A logical message sequence is necessary to effectively communicate a mistake disclosure. Doing so is consistent with best evidence-based practice. Likewise, the ability to reach a satisfactory fit between making the disclosure and doing so in a way that patients are able to process is important.^{5,21} The suggested message sequence is 1) forecasting, 2) incremental disclosure messages, and 3) full apology.

Forecasting that something has gone awry as the initial statement in the message about a mistake is essential to allow the physician to mentally and emotionally prepare the patient to hear the mistake disclosure. For example, while setting up the meeting by phone, Dr A could say, “Mrs G, there is something important about your illness I need to talk to you about.”

Incremental mistake disclosure messages come next in the sequence. Building on the forecasted message, CPM research on disclosing stressful events suggests communicating subsequent mistake disclosure message in increments.⁴⁰ In other words, the physician should develop a message that provides some details about the events using simple language. In an incremental way, the physician should add additional details when it appears that the patient comprehends the previous information. To be sure that the patient grasps the information about the mistake, the physician should use similar statements about the mistake while also adding other aspects over the course of making a complete disclosure. Doing so gives patients time to catch additional details that may be overlooked in previous statements. Because the stress of hearing about a mistake requires “absorption time,” offering the information in this incremental way is more likely to overcome a possible misunderstanding.⁵ Research suggests that people judge

communication on the basis of whether messages are positive or negative, meet levels of expectedness, and their degrees of message relevance.⁴¹ Disclosure of medical mistakes is typically negative, unexpected, and relevant to the person, thereby requiring patients to engage in substantial levels of cognitive processing.⁴¹ Therefore, patients should be permitted an opportunity to process the information without feeling that the physician is pressed to move on to other things.

When considering the content of the mistake disclosure, research identifies that patients want physicians to tell them about a mistake, and they tend to have a good idea of what they want to know.²² Consistent with CPM, any mistake disclosure should fully acknowledge the patient's perceived rights to know all of the circumstances surrounding the mistake incident. A detailed revelation of the harm associated with the mistake needs to be conveyed to achieve truth telling about the mistake.⁴²

Pennebaker²⁷ argues that “translating experiences into words forces some kind of structure to the experiences themselves.” Talking about emotions has a therapeutic effect and may provide relief when a person is experiencing guilt, shame, or inner turmoil.

Full apology comes last in the message sequence. Two major goals of apologizing to patients include: a) conveying that physicians have a desire to provide emotional support and b) acknowledging that the physician and/or the hospital/clinic have learned from the mistake.²⁶ The first goal illustrates the relational aspects of the disclosure message, and the second goal is outcome oriented. Consequently, full apologies include statements recognizing any inappropriate conduct or unsuitable behavior and a promise to act more appropriately or to correct the circumstance that led to the inappropriate behavior or outcome.⁴³ Genuine apologies of this nature are not excuses for mistakes, in which physicians state that the mistake was not their fault. Nor do apologies include statements of justification, in which physicians deny anything inappropriate happened. Instead, they convey accountability and culpability, a promise of corrective actions, and an explanation of circumstances leading to the mistake. One of the more important aspects of constructing the apology is resisting any temptation to embed a request for forgiveness within an apology; otherwise, the integrity of an apology may be compromised.

Asking for forgiveness places the primary focus on the physician's needs. A proper and effective apology must focus only on the needs of the patient.

Dr A called Mrs G in her hospital room and set up a time to visit her. He let her know on the phone that he had something important to discuss regarding her current illness, and suggested that if she wanted any family present at the time of their meeting that they should be alerted.

With trepidation, Dr A entered Mrs G's room knowing that the conversation might be difficult for him, Mrs G, and her family. He took a seat and revealed he had information to give her that may have contributed to her failed bypass graft. He explained to her about the laboratory value from the week earlier and how it had been filed without his being able to review it. He told her that an increase in her warfarin dose might have avoided her current situation. He also was clear in stating that the mistake occurred in his office, and he was ultimately at fault for the mistake. Mrs G asked several questions regarding the steps that led up to the mistake and asked how such a mistake could happen. Dr A did his best to answer her questions honestly. Mrs G's husband was upset with the situation and asked how such situations would be addressed in the future. Dr A outlined his office's new work-flow management for patients on warfarin and noted that their practice was working on an automated INR monitoring system through the EMR that would help alert physicians of subtherapeutic levels. He also informed Mr G about the newly established patient portal, allowing them immediate access to their laboratory values so that they could follow-up on the test results as well.

Mrs G had a successful revascularization of her femoral bypass graft the next day.

Conclusion

Disclosures of medical mistakes require preliminary considerations to effectively and compassionately disclose these events to patients. The ethical requirement to disclose mistakes and physicians' personal desires to conceal mistakes create a privacy dilemma surrounding disclosure. Use of a CPM perspective offers a potential way of coping with privacy dilemmas of this nature through developing and following management strategies to overcome maladaptive ways of telling patients about mistakes.^{5,19,21} As this discussion underscores, before physicians are able to tell patients about problematic medical situations, it seems best to reduce the

emotional tension that a physician likely feels. By talking through possible feelings of guilt or shame with colleagues, physicians are more likely to personally come to terms with the mistake. In addition, considering specific types of disclosure strategies to help patients in these situations is useful in preserving credibility and the patient-physician relationship.

Following the MDMP provides an ethically sound, evidence-based process for dealing with disclosure events surrounding medical mistakes, with a focus on preserving physician integrity and trust in the physician-patient relationship. Whereas this plan is generated out of observations, based on theory, and grounded in research, the next step is to test the implementation of the procedures suggested in this article. Having a more streamlined approach may help address physicians' slow adoption of mistake disclosures in the future.

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Table 1Principles of communication privacy management theoretical perspective¹ mistake disclosures

Principles	Description	Application to medical mistake disclosure
Privacy ownership	People believe they own their private information	Patients believe that any information about their health care is private to them
	Giving access to that private information creates co-owners	Physicians are given access to the patient's private health information as their caregiver and are therefore authorized co-owners, but because they make decisions, they may feel a greater sense of ownership than patients want
Privacy control	People believe ownership means right to control access	Patients always believe they should have continued control over their information even when physicians are co-owners
	People use privacy rules developed to control their private information	Patients have a set of privacy rules they use to control access to their medical information
	Giving access rights to authorized co-owners assumes that co-owners will use the original owner's privacy rules for dissemination	Patients assume that physicians know how they want them to treat their information
Privacy breakdowns	People assume their privacy rules will be properly used by co-owners; in reality, mistakes can be made by co-owners in management of this information	Physicians often receive their patients' private health information (eg, test results) before the patient and can confuse this information as theirs to control and regulate; when involving medical mistakes, the need to control information flow becomes more challenging for physicians, whose sense of self may be perceived to be on the line

¹Petronio S. Boundaries of privacy: dialectics of disclosure. New York, NY: SUNY Press; 2002 Oct 1.

Table 2

Components of the Mistake Disclosure Management Plan

Step	Primary beneficiary	Components	Issues addressed
1. Physician preparation for mistake disclosure	Physicians	Task 1: Recognizing and talking about emotions	<ul style="list-style-type: none"> • Overcoming shame • Overcoming uncertainty • Coping with anxieties • Coping with threat of liability
		Task 2: Initial information seeking	Gathering preliminary scope of problem
2. Formulating and delivering mistake disclosure messages	Patient/family members, physicians	Task 1: Context of disclosure delivery	<ul style="list-style-type: none"> • Timing of mistake disclosure • Presence of other people at disclosure
		Task 2: Content of mistake disclosure messages and disclosure sequencing	<ul style="list-style-type: none"> • Fostering trust • Message sequencing • Forecasting • Incremental disclosure • Full apology
1 and 2: Used jointly	Patient/family members, physicians		<ul style="list-style-type: none"> • Addressing information-ownership conflict • Meeting ethical obligations • Giving compassionate care

Table 3

Mistake disclosure message strategies to avoid

Message strategy	Examples
1. Blocking avenues to questions	“Let’s not worry about that now.”
2. Redirecting the conversation to less relevant aspects of the mistake	“What I want to focus on is getting better, not what caused the problem.”
3. Neglecting to answer questions	“Don’t worry about that. Tomorrow we will start treatments.”
4. Placing the blame on the patient/family	“Unfortunately, if your weight and diabetes had been under control, it is unlikely this mishap would have happened.”
5. Overloading the patient/family with information	“During the operation the bile duct, which carries the bile from the liver down to the gallbladder, was injured because you had inflammation there for so long that I had to peel everything apart, and because of your diabetes you did not heal well, and the bile duct started leaking.”
6. Blaming the system	“Because the hospital is under pressure to serve so many patients, we don’t have the staffing we need to watch out for these problems. If we had more staff, this mistake would never have happened.”