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Patient Safety Tip of the Week

July 11, 2023

Error Disclosure in the Real World

We've done many columns on error disclosure and apology (see list below). We've advocated disclosure since the early 1990's because it is the right thing to do and, in the long run, tends to make something positive come from something negative. Disclosure and apology has now become accepted on a widespread basis.

But how is it actually working in the real world? Researchers in France studied this in a neonatal ICU (NICU) setting (Passini 2023). They analyzed data from a randomized controlled trial "Study on Preventing Adverse Events in Neonates" (SEPREVEN). Note that disclosure was not intended to be related to the intervention tested in that study.

Errors in the 10 participating French NICU's were reported in the study. The professional who discovered the error used a self-administered questionnaire created for the study, to report disclosure/non-disclosure, or gave it to another staff member who might have been more likely to disclose it. The form covered both the reporter and the discloser (if any) and their involvement in the process leading to it and also assessed their perception of how the parent(s) reacted to disclosure.

The analysis included 1822 medical errors in 1019 patients. Of these, 752 (41.3%) were disclosed to parents. When evaluated by severity (whether harm occurred or not), errors in the subgroup where harm occurred were disclosed in 58.7% of events. Harmless errors were disclosed less frequently than moderate or severe errors (27.7%, 54.8%, and 79.3%, respectively).

They looked at factors related to non-disclosure and found that shorter interval between NICU admission and error, type of error, milder consequences, night-time error discovery, and units with fewer beds were independent predictors of non-disclosure.

When professionals were asked about factors that led to their disclosing errors, the top 3 responses were by perception of a professional obligation (63.3%), the error's visibility (51.7%), and its severe consequence (27.0%). The top three reasons for non-disclosure

were parental absence at error observation (68.6%), non-severe or unknown consequences (53.8%), and fear of stressing the parents (34.5%).

Perceived parental reactions were most frequently empathy towards the professional (34.8%), followed by anxiety (25.3%), resignation (24.4%), and surprise (11.9%). Mothers' and fathers' reactions were similar. 14.1% of reactions were perceived as mixed (negative as well as positive). Negative reactions (anxiety, resignation, surprise, anger/aggressiveness, or sadness) were associated with time between NICU admission and error, a severe error, disclosure by a physician rather than a nurse, and a previous disclosed error in the NICU for this child.

It was clear to the authors that the influence of parental involvement was a key factor in the professionals' attitudes regarding disclosure. That a weak professional–parent relationship might be negatively associated with the decision to disclose was suggested by the finding that non-disclosure was associated with parents' absence at the error discovery, error discovery at night, and a shorter interval between NICU admission and the error.

Two of the common reasons for non-disclosure (protecting the parent from further stress, and fear of undermining trust in the relationship) may be false assumptions. It is difficult to quantify the impact of parental stress or anxiety. And, while disclosure of an error can in some cases reduce trust in the physician-parent relationship, the fact that the perceived parental response to disclosure was empathy towards the professional in 34.8% is reassuring. And, when an error comes to the attention of a parent via other mechanisms, the failure to disclose has a much more negative impact on trust in the relationship.

Interestingly, fear of the parents' reaction—aggression, anger, a lawsuit or demand for compensation—was very rarely the motive reported for non-disclosure. The authors note that the French legal system is substantially less litigious than in countries like the US, and provides faster and more certain (although less generous) compensation in the event of medical errors, without the need for families to sue healthcare professionals or hospitals.

In an accompanying editorial, Gallagher et al. (Gallagher 2023) note that we often have programs to support clinicians after error disclosure, m but we need much more attention to understanding what support patients and families need. They suggest the most important first step is simply asking the patient and family early and often what can be done to help them cope with the disclosure and any associated harm, and then striving to meet these needs. They note many organizations are developing a liaison role distinct from the clinical team that can support patients and families after error disclosure. They go on to discuss many elements of Communication and Resolution Programs (CRP's) that have been developed to proactively support patients and families following medical errors.

There are several other important elements to include in communications with patients, parents, and families that we discussed in our Patient Safety Tips of the Week for June

22, 2010 "Disclosure and Apology: How to Do It" and March 9, 2021 "Update: Disclosure and Apology: How to Do It". Patients and families also want to hear that you will be using lessons learned from the event to ensure similar errors do not occur in the future and impact other patients. One of the most important points, from our perspective, is letting them know that you will be having multiple conversations with them, periodically keeping them up to date with regards to the status of your investigation and RCA (root cause analysis) and the steps you take to prevent recurrence of such errors. You also want to let them know about continued care for the patient (assuming it was not a fatal error), what harm the error may have caused, and how what will be done about that harm.

The contribution made by Passini et al. in their study is much welcomed. Despite all that's been written and discussed about disclosure, theirs is the first study we know of to actually show us what is happening in the real world.

Some of our prior columns on Disclosure & Apology:

July 24, 2007	"Serious Incident Response Checklist"
June 16, 2009	"Disclosing Errors That Affect Multiple Patients"
June 22, 2010	"Disclosure and Apology: How to Do It"
September 2010	"Followup to Our Disclosure and Apology Tip of the Week"
November 2010	"IHI: Respectful Management of Serious Clinical Adverse Events"
April 2012	"Error Disclosure by Surgeons"
June 2012	"Oregon Adverse Event Disclosure Guide"
December 17, 2013	"The Second Victim"
July 14, 2015	"NPSF's RCA2 Guidelines"
June 2016	"Disclosure and Apology: The CANDOR Toolkit"
August 9, 2016	"More on the Second Victim"
January 3, 2017	"What's Happening to "I'm Sorry"?"
October 2017	"More Support for Disclosure and Apology"
April 2018	"More Support for Communication and Resolution Programs"
August 13, 2019	"Betsy Lehman Center Report on Medical Error"
September 2019	"Leapfrog's Never Events Policy"
March 9, 2021	"Update: Disclosure and Apology: How to Do It"
November 2021	"When a Radiologist Recognizes He Committed an Error"
May 31, 2022	"NHS Serious Incident Response Framework"

Other very valuable resources on disclosure and apology:

- IHI's "Respectful Management of Serious Clinical Adverse Events" (Conway 2010)
- The Canadian Disclosure Guidelines (Canadian Patient Safety Institute 2008)
- The Harvard Disclosure Guidelines (Massachusetts Coalition for the Prevention of Medical Errors 2006)
- The ACPE Toolkit (American College of Physician Executives)

- Oregon Patient Safety Commission Oregon Adverse Event Disclosure Guide.

References:

Passini L, Le Bouedec S, Dassieu G, et al. Error disclosure in neonatal intensive care: a multicentre, prospective, observational study. BMJ Quality & Safety 2023; Published Online First: 14 March 2023
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