**FAST FACTS AND CONCEPTS #194**
**DISCLOSING MEDICAL ERROR**
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**Background** Discussing an adverse outcome related to medical error is challenging under the best of circumstances—for both the clinician and the patient or family. Errors can damage a clinician's self-esteem, confidence, and reputation, and lead to costly and unpleasant legal action. Timely disclosure of error is now considered a standard of quality patient care. An empathic, open discussion can help restore trust while respecting a patient's autonomy and right to justice. Hospice and Palliative Care clinicians may themselves be the source of medical error, or be asked to comment on other clinician's actions by patients or families concerned that medical errors have led to a dying trajectory. This *Fast Fact* will address how to disclose error with a patient/family; *Fast Fact* #195 will discuss responding to a colleague's error.

**Types of Error** No single definition of error exists. For practical purposes error can be thought of being due to a) an isolated or series of clinician mistakes (providing care below a reasonable professional standard such as by failing to prescribe an indicated medication or injuring the common bile duct during routine cholecystectomy), b) a system failure (inadequate checks on pharmacy medication dispensing), or c) both. Unanticipated outcomes of medical care also occur and can be perceived as errors by patients/families even if not the consequence of a 'mistake.'

**Discussing Error – Preparation**
- Whoever committed the error (attending physician, advance practice provider, or resident), the clinician with the final responsibility for the patient's care should lead the discussion. Invite trainees to attend – this is an important learning opportunity. Limit the discussion to just those healthcare professionals directly involved.
- Have the discussion in a timely manner – as soon as possible after the error is identified – but make sure the appropriate people are there (including an incapacitated patient's legal decision maker). Set aside ample time and have the meeting in a distraction-free environment.
- Review the pertinent facts of the case so that you are prepared to answer any detailed questions that the patient/family might have.
- Discourage other consultants/ancillary staff from discussing the error with the patient/family – multiple accounts of the events will likely confuse rather than clarify.
- Notify and seek the advice of your institution's risk manager. In addition to informing you of policies and procedures specific to your institution, they will then be aware of the case should legal inquiries be made. **Note:** while it is wise to seek risk management input, remember that discussing errors with patients/families is a *clinical* task – part of clinicians' obligation to openly share medical information – not a *legal* task.

**Discussing Error – Content** (see *Fast Facts* #6, 11 for general breaking bad news principles)
- Be clear, concise, and honest. Avoid medical jargon or lengthy explanations.
- Give the patient and family time for questions, emotional reactions, or silence.
- If you believe the adverse outcome was a result of error (either individual or system-wide), specifically apologize for the error and its outcome.
- If the outcome was unanticipated, but not clearly avoidable express regret and sorrow. Avoid blame: *"I am sorry this has happened*" is not an admission of error or liability.
- Commit yourself and your institution to investigating and remedying any individual or systematic deficiencies.
- Commit to providing ongoing, appropriate care, including comfort-oriented care for a dying patient. Involve the appropriate services as indicated such as chaplaincy, social work, and consultants including palliative care.
- Document your discussion; refer legal inquiries to your institution's risk manager.

**Summary** Discussing error requires professionalism and openness, sometimes at the expense of vulnerability. Not only is it an ethical imperative, it is a requisite skill that is key to maintaining a healthy clinician-patient relationship.

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