University of Montana

ScholarWorks at University of Montana

Psychology Faculty Publications

Psychology

2009

Ethics Conflicts in Rural Communities: Recognizing and Disclosing Medical Errors

Ann Freeman Cook
University of Montana - Missoula, ann.cook@umontana.edu

Helena Hoas
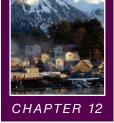*University of Montana - Missoula*, helena.hoas@umontana.edu

Follow this and additional works at: https://scholarworks.umt.edu/psych_pubs

Part of the Psychology Commons

Let us know how access to this document benefits you.

Recommended Citation

Ethics Conflicts in Rural Communities:
Recognizing and Disclosing Medical Errors

Ann Freeman Cook, Helena Hoas

DISCLAIMER

Dartmouth Medical School's Department of Community and Family Medicine, the editor, and the authors of the *Handbook for Rural Health Care Ethics* are pleased to grant use of these materials without charge providing that appropriate acknowledgement is given. Any alterations to the documents for local suitability are acceptable. All users are limited to one's own use and not for resale.

Every effort has been made in preparing the *Handbook* to provide accurate and up-to-date information that is in accord with accepted standards and practice. Nevertheless, the editor and authors can make no warranties that the information contained herein is totally free from error, not least because clinical standards are constantly changing through research and regulation. The authors and editor therefore disclaim all liability for direct or consequential damages resulting from the use of material contained in this book.

Although many of the case studies contained in the *Handbook* are drawn from actual events, every effort has been made to disguise the identities and the organizations involved.

The *Handbook for Rural Health Care Ethics* provides general ethics information and guidance. Due to complexities and constant changes in the law, exceptions to general principles of law, and variations of state laws, health care professionals should seek specific legal counsel and advice before acting on any legal-related, health care ethics issue.

Additionally, we have sought to ensure that the URLs for external Web sites referred to in the *Handbook* are correct and active at the time of placing this material on the home Web site. However, the editor has no responsibility for the Web sites and can make no guarantee that a site will remain live or that the content is or will remain appropriate.

Ethics Conflicts in Rural Communities: Recognizing and Disclosing Medical Errors

Ann Freeman Cook, Helena Hoas

ABSTRACT

This chapter explores the ethical responsibility of health care providers to administer safe clinical care. It further explores the challenges that such providers can experience in recognizing, reporting, and disclosing medical errors. Medical errors can cause serious harm (to the patient, provider and institution or clinic) and can prove to be expensive, stressful, time-consuming, and personally devastating. While rural health care providers frequently underscore their desire to provide safe care, they also report that it is very difficult to develop and implement strategies that reduce the risk of making errors. Studies show that there is limited agreement among health care providers when defining, reporting, disclosing, or resolving error. Providers who wish to actively pursue strategies that heighten safety may become inhibited by this lack of agreement. This chapter presents findings from empirical ethics studies involving rural participants from 14 states. These studies shed light on the ethics issues surrounding medical errors that occur in physicians' offices and hospitals. The two case examples that this chapter presents reflect both the experiences of rural health care providers, and the complexities that can accompany the search for ethically-attuned processes for error disclosure and resolution.

CASE STUDIES

CASE 12.1 | Addressing questionable quality of care

Dr. Bristol practices in a rural hospital where he and other physicians perform colonoscopies to detect or biopsy lesions that may indicate colorectal cancer—a common cancer in the United States, and one that has a high cure rate if found and treated at an early stage. In rural settings, family physicians sometimes conduct this procedure. Colonoscopy has provided an important source of revenue for Dr. Bristol, compared to the reimbursement rates for many other health care services, which are often inadequate in rural settings. Unfortunately, Dr. Bristol has been less thorough than other physicians when conducting the examination, and has frequently failed to reach the cecum to complete the procedure. The nurses who assist the physicians have been aware of the discrepancy and, believing that Dr. Bristol has not performed the test correctly, repeatedly have sought the intervention of the hospital administrator. The nurses have also spoken to other members of the medical staff and asked for an intervention. The administrator and the medical staff were hesitant to intervene. After two years of repeatedly lodging complaints with the hospital administration and struggling with their moral obligations to provide safe care, the nurses announced that they would no longer assist Dr. Bristol when he was performing the procedure. Faced with pressure from the nurses, the hospital administration agreed to study and respond to this clinical and ethical problem.

CASE 12.2 | The use of a wrong clinical management care plan

Dr. Simpson diagnosed his 83-year-old patient, Mr. Desrosiers, with atrial fibrillation (AF). During atrial fibrillation, the heart's two small upper chambers (the atria) quiver instead of beating effectively. Blood may not be pumped completely out of the upper chambers, and may pool and clot. If a blood clot in the atria leaves the heart and becomes lodged in an artery in the brain, a serious stroke will result. To reduce stroke risk in people with AF, physicians may prescribe anticoagulant and antiplatelet medications, which

thin the blood and reduce clotting. Long-term use of appropriate medications in patients with AF can greatly reduce the chances of stroke, but such therapy requires careful monitoring in order to avoid unanticipated events, like hematomas. Mr. Desrosiers was admitted to the hospital for evaluation, his heart rate was controlled, and he was started on two medications, Heparin and Coumadin. When Mr. Desrosiers' blood test showed that his INR (International Normalized Ratio, used to determine the clotting tendency of blood) had reached an acceptable value of 2.5, Dr. Simpson discharged him. Mr. Desrosiers was given a prescription of 5 mg/day of Coumadin, and told to return to the clinic for a scheduled visit and follow-up laboratory tests in three weeks. No tests were ordered prior to that visit. The patient arrived at the Emergency Room one day before his scheduled appointment with a dangerous INR value of 14.7, and pain from an expanding spontaneous hematoma on his thigh. The ER staff notified hospital leadership that the patient had been given an inappropriate clinical management plan.

OVERVIEW OF ETHICS ISSUES

Since publication of the 1999 Institute of Medicine (IOM) report *To Err is Human*,[1] intensive national efforts have focused on how providers and management can identify and implement error-reduction strategies in hospitals. According to that report, an error is defined either as the failure of a planned action to be completed as intended (i.e., an error of execution), or the use of a wrong plan to achieve an aim (i.e., error of planning). As noted in the report, medical errors are one of the leading causes of death in the U.S. Medical errors may rank as high as the fifth leading cause of overall death in the U.S., exceeding the number of deaths that occur from motor vehicle accidents, breast cancer, and AIDS combined. In the years since the IOM report was published, research has revealed that errors are a growing problem in the family practice setting, and upon discharge from the hospital.[2] Errors can affect anyone, but often strike the weak and helpless.[3]

While errors do not always create ethics problems, the manner in which health care providers in clinics and small rural hospitals respond to

errors may pose ethics concerns. Errors may not be recognized. Many hospitals and clinics lack mandatory reporting policies, so errors are not reported or charted. Even when policies are in place and errors are recognized, health care providers might feel such guilt and blame, or fear of retribution, that they choose not to acknowledge or document errors. In other cases, errors are discussed only behind closed doors between providers and administrators; patients and families aren't told when errors have occurred, or that corrective actions are needed. Thus, certain kinds of errors re-occur, and the risk for patient harm increases.

When health care providers do not recognize, report, or disclose errors, they fail to act in the best interest of the patient. This failure compromises patient autonomy and informed decision-making. The failure to report and disclose errors also compromises the principles of beneficence, fidelity, and justice, discussed in detail in Chapter 3 of this *Handbook*.

Seeking Safer Care: Goodness and Truth

In order to provide safe, ethically attuned care, a growing number of public, governmental and private entities have encouraged health care providers to adopt a systems approach to patient safety. Advocates suggest that a systems approach helps good caregivers give good care. Such an approach defines error, fosters the recognition of error, and promotes open discussion of errors and prevention strategies. A systems approach also promotes policies for honest reporting and disclosing of errors, offers apologies to patients and families, and seeks fair compensation for treatment needed as a result of the error(s). Since 2001, The Joint Commission has required disclosure of adverse outcomes to patients.[4] This standard reflects the national trend towards greater transparency. Indeed, initiatives like the *Sorry Works* Coalition and the Institute for Healthcare Improvement (IHI) have demonstrated the compelling need to disclose errors, and the benefits of such disclosure.[5] Patients, health care providers and the systems in which they work all benefit from such disclosure. Studies show that disclosure may help patients get treatment to offset the results of an error, may award them fair compensation, and may help restore trust in the health care provider.[6, 7] Thus, the honest, forthright disclosure of an error, including an apology, is an important component of an ethically-attuned patient-safety agenda.

While a systems approach to disclosing medical errors sounds reasonable, logistical problems can complicate such a systems implementation. The process of reporting and disclosing medical errors requires agreement among health care professionals about what constitutes an error; how errors should be reported; and when, how, and by whom they should be disclosed. A systems approach presumes that all parties involved can handle the consequences of reporting and disclosing errors. A systems approach is based on the assumption that the hospital has an ongoing willingness to keep patient safety a high priority, in spite of financial and other organizational pressures.

Lessons from Rural Empirical Ethics Studies

The empirical ethics studies that the authors have conducted over the past 12 years have shed light on conditions that can hinder the recognition and resolution of ethics-related problems that occur in rural health care settings. Rural nurses in our ethics studies reported that they lacked the vocabulary to talk about ethics issues with either peers or patients, and were, therefore, hesitant to initiate conversations about or bring attention to incidents that had ethics implications. Unclear lines of communication within the hospital further hindered the providers' identification or discussion of ethics issues. Our studies have also shown that there is little agreement among health care providers regarding how ethically challenging situations should be resolved. When rural health care providers were asked if the honest disclosure of error to patients would increase or decrease levels of trust in their institution, responses were evenly split.

Related findings emerged from the four-year Advancing Patient Safety study that the authors conducted in 30 rural health care settings in a multi-state area. This study showed that doctors' recognition and reporting of errors was selective, and tended to depend upon the type of error that had occurred, and to whom it would be disclosed. When doctors assessed cases that involved medication errors that could be attributed to nursing (e.g., overdosing of medication), most agreed that an error had occurred (97%) and should be reported on a system level (96%). But levels of agreement diminished when doctors considered disclosure of the error to the patient. Agreement among doctors was also drastically reduced when participants considered the recognition,

reporting, and disclosing of errors associated with diagnosis and treatment—and so attributable to physicians.[8]

Our research showed that even when hospitals have policies for mandatory reporting and disclosure of errors, and even if health care providers believe that there is a "no shame, no blame" approach to error in their setting, professional disagreements about what constitutes an error hinders the provider from recognizing, reporting, and disclosing any problematic events. When participating in a case-based intervention on patient safety, health care providers almost uniformly acknowledged that the case problems being analyzed had occurred, or could occur in their setting. But even when cases met the Institute of Medicine definitions of error, health care providers were still hesitant to identify problematic events as errors. Physicians, for example, often used words like "sub-optimal outcomes" or "practice variance" or "clinical judgment" when discussing the errors depicted in the case studies. Nurses used terms such as "not right" or "unfortunate" or "poor care." Administrators explained that they "lack(ed) the clinical skills to make the call as to whether an error had occurred." At times, health care providers alluded to a general sense of a bad outcome or unfortunate care, but were unwilling to tag the event as an error. If the event was not clearly recognized as an error, the provider's need to report on the system level or to disclose to the patient was thus deemed unnecessary.

When quality improvement staff from rural health care settings analyzed 13 case studies, they uniformly agreed that the issues depicted could and did occur in their settings. They also noted that these issues would probably not be recognized, reported, or disclosed. In their hospitals, these kinds of issues would also not be referred to the ethics committees, if such committees existed, nor referred to medical staff committees or to quality improvement officers. Many of the problems depicted become normalized over time; they become part of what "just happens" when delivering health care.

This "institutional hesitancy" can be reflected in policy documents developed by hospitals and clinics for reporting and disclosing errors. Policies may use words such as "incidents" or "events" when describing issues of medical errors that compromise care. The word

"error" may not be used, and the need for an apology may not be stated. So, it is not surprising that health care providers have a difficult time determining the appropriate language and disclosure practices to use when facing errors, given the fact that their own management is not clearly communicating about this topic, and the fact that specific training for providers may not be available.

CASE DISCUSSION

It is important to consider the background information given in the cases presented when trying to develop interdisciplinary strategies for providing safe, ethical care. The two cases in this chapter each depict a different kind of error. The first case depicts an error of execution, and the second case describes an error of planning. Although the cases are different in nature, both show the organizational, professional, and personal features that are in play when providers try to respond in an ethical manner.

CASE 12.1 | Addressing questionable quality of care

In the case of Dr. Bristol and his colonoscopies, the nurses lodged their complaints because they believed that Dr. Bristol was not meeting the standard of care when performing these procedures. To respond to the concerns of the nurses, the administration needed to determine whether patients undergoing this procedure had received the standard of care, and to clarify the hospital's ethical obligation to address the situation if errors had occurred.

Those struggling with the colonoscopy case quickly realized that they faced a complicated situation involving hospital staff, other local physicians, individual patients, and community members. Administrators assembled a team and sought advice and assistance from the hospital's legal counsel, insurers, outside risk managers, and other medical experts, including a group of board-certified gastroenterologists. The team first needed to determine whether a problem truly existed with Dr. Bristol's procedure. Did he fail to meet practice standards, and if so, did that failure compromise the provision of safe care? The team explored a number of questions in order to better understand the scope of the problem, including those listed in Box 12.1.

BOX 12.1

QUESTIONS TO ASK WHEN GATHERING INFORMATION REGARDING QUALITY OF CARE

- What performance standards should be met when conducting this test?
- Is there any way to determine Dr. Bristol's overall success rate?
- If complaints are accurate, why did Dr. Bristol fail to reach the cecum?
- Does the failure to perform the test correctly place patients at risk or cause harm?
- If complaints are accurate, what are the hospital's ethical responsibilities?
- If there is a need for additional training, how should such training be implemented?
- If concerns are validated, does the hospital have an ethical obligation to tell Dr. Bristol's patients?
- What are the implications of disclosure for the hospital and the community?
- Who should be involved in the disclosure process and how should it be accomplished?
- If repeat examinations are recommended, who is responsible for the cost?
- What impact would disclosure have on Dr. Bristol's reputation within the hospital and the community?
- If, after additional training, Dr. Bristol continues to perform this procedure, how should his competency be assessed and monitored?
- What new policies, procedures, or guidelines are needed to ensure clinician competence?
- What policies, procedures, and guidelines are needed to create a more open and ethically attuned environment within the hospital?

As the administrative team and their legal counsel began to respond to the questions listed above, the ethical dimensions of the case became apparent. These included the professional and organizational

responsibilities associated with maximizing benefits, preventing harm, truth-telling, autonomy, and informed consent.

Maximizing Benefits and Preventing Harm

The investigation's findings suggested that Dr. Bristol's procedures had not met the clinical performance standards. That failure appeared to be linked to Dr. Bristol's skill level. The team then attempted to determine the ethical implications of that failure. Had Dr. Bristol failed to maximize benefits for his patients by failing to meet the standard of care? Had the technique used by Dr. Bristol placed patients at risk by under-diagnosing cancer or pre-cancerous conditions? Did patients have sufficient information about the skills required for this procedure and their own screening results to make informed decisions? If corrective efforts are not taken, will the levels of risk or potential harm for current and future patients escalate?

Related issues surfaced as the administrative team grappled with the implications of these questions. Since the procedure was performed in the hospital, what ethical obligations did the hospital face? If, for example, the hospital recognized an ethical obligation to require remedial training in order to prevent harm, would Dr. Bristol respond by accepting such a mandate, or would he choose to leave the community? Many rural hospitals fear losing physicians, and indeed that fear contributed to the administration's hesitation to address this problem when it was first reported. Medically underserved communities report that it can easily take two years and many thousands of dollars to recruit a new physician. The team members grappled with the notion that some care may be better than no care.

Professional Responsibility, Truth-Telling, and Informed Consent

While the administrative investigative team acknowledged that truth-telling is an important ethical principle, they did not want to unduly alarm patients or community residents. They were also very conscious of the potential financial implications, for both the physician and the hospital, of telling the truth in this case. If community members were to learn of the problems with Dr. Bristol's colonoscopy skill level, they might lose trust in him, and might seek an alternative health care provider. Dr. Bristol might not be able to maintain a financially viable practice

and the hospital could lose a source of reimbursement. However, if the hospital chose not to inform patients that their cancer screening might have been inadequate, would the hospital then be violating its ethical obligation to be truthful? When would the failure to disclose important information adversely impact a patient's autonomy? When might the lack of information about benefits, risks, and skill level compromise the informed consent process? The administrative team recognized that patients might already have been harmed, but questioned the extent to which the moral obligation for honesty and truth-telling would entail an obligation to compensate for or mitigate past failings.

As this case unfolded, the obligations that physicians have to their profession became a topic of discussion. The American College of Physicians' Charter on Medical Professionalism states that, "Professionalism is the basis of medicine's contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health."[9]

Dr. Bristol's physician colleagues were aware of his performance-related problems, but were hesitant to question his procedures. They pointed out that they were "call partners" and depended upon one another in a resource-strapped environment. Losing a call partner would have major implications for the working conditions and quality of life of the remaining physicians and staff. Dr. Bristol's physician co-workers acknowledged that they operated under an unspoken code. They "did not look over one another's shoulders," and "did not look in one another's charts." Physicians explained that they "live in glass houses." They also pointed out that Dr. Bristol had provided appropriate care, and even extraordinary care, in many circumstances. Dr. Bristol was a trusted member of the community, and they did not want to jeopardize his standing. The nurses countered by referencing their professional and moral obligations to protect their patients' well-being. Thus they expressed a moral obligation to seek corrective action.

The hospital also faced the challenge of addressing organizational ethics issues, including the relationships among staff members. Ross *et al.* noted that relationships among staff are a key indicator of an

ethical environment.[10] In the authors' studies on ethics and patient safety, health care providers have often reported a lack of dialogue and respect among and between members of the various health professions, and noted that these conditions hindered recognition, reporting, and resolution of ethics problems. In the colonoscopy case, nurses expressed concern for more than a year before they were able to get attention focused on what they believed was sub-standard and improper care. As they promoted the need for corrective action, many nurses also noted that they worried about the consequences of their activities. Nurses stated that they are "not supposed to question doctors," and that they are not supposed to move beyond their scope of practice. Some feared they would lose their positions or be re-assigned. Given this backdrop, does the hospital have a moral obligation to have policies that deal with issues such as communication, reporting, and adherence to practice standards?

CASE 12.2 | The use of a wrong clinical management care plan

We have presented this case because the health care providers who participated in our studies explained that problems associated with atrial fibrillation (AF) management occur with some frequency in rural health care settings, but often go unrecognized or undetected. To support recognition, disclosure, and prevention of this type of error, the authors have proposed an information-gathering process that mirrors the one used in the colonoscopy case. Administrators may need to assemble a team, and seek advice and assistance from many departments, including the emergency room staff, quality improvement officers, and admittance and discharge personnel. The team would need to determine if practice standards have been met, benefits of treatment maximized, and harm prevented. The team would need to explore how the physicians' professional obligations and the hospital's organizational obligations might influence their recognition and resolution of this issue. They might ask: Are there procedures in place to help identify this kind of problem? If standards have not been met, can obligations for truth-telling and informed consent be honored?

The ethics issues in this case are similar to those presented in the previous, colonoscopy case, and such ethics issues are present in

most cases involving medical errors. These include issues associated with maximizing benefits, preventing harm, truth-telling and disclosure, autonomy, and informed consent. Since both cases emerged through the authors' empirical research project, we have decided to show the process by which the participating health care providers arrived at workable solutions. This "real life" approach shows how difficult it is for well-meaning people to resolve ethics dilemmas.

RESPONDING TO MEDICAL ERROR DISCLOSURE CONFLICTS

CASE 12.1 | Addressing questionable quality of care

The administrative team determined that their priority was to demonstrate a commitment to uphold the integrity of the hospital's mission—"to provide safe, quality, ethical care to patients". In addition to requiring that Dr. Bristol obtain additional training prior to performing any new colonoscopies, they initiated a monitoring process that required a photograph of the cecum to be taken during each procedure to demonstrate that the colonoscopy had been performed correctly.

The hospital recognized that this case was complicated by issues associated with staff relationships and communication, and realized that corrective actions were necessary. The concerns of the nurses should have been heeded when first lodged. The hospital also recognized the need to increase consensus among the involved health care providers, with respect to recognizing, reporting, and responding to errors so that problems of this type could be avoided in the future. Admittedly, it can be very difficult to gain consensus when trying to meet ethical obligations. This difficulty certainly emerged when health care providers analyzed this case. They noted that ongoing training is a reality of medical life, and that the hospital could announce that Dr. Bristol is seeking additional training to make sure that patients receive the best care possible. The health care providers could also envision activities like a "colonoscopy month" during which patients could schedule colonoscopies at a reduced charge.

While some health care providers felt that the gold standard of ethical conduct would have entailed contacting former patients, disclosing that

the test may not have been done correctly, and offering options for re-screening at no cost, the administrative team decided that this approach was not feasible or wise. Both the administrative team that faced this issue and the other health care providers within the hospital were reluctant to advocate such a policy, and believed that it could result in unnecessary harm or worry for patients.

CASE 12.2 | The use of a wrong clinical management care plan

While health care providers who discussed the atrial fibrillation (AF) case were hesitant to use the word "error," they acknowledged that the problem was one that occurred with some frequency in clinics and in hospitals. They had many suggestions for preventing the problem in the future. These recommendations included assigning responsibility to pharmacists for management of blood thinners, designing new hospital discharge policies, and enhancing patient education. Even though harm had occurred, most agreed that the patient probably would not be told that the complications he suffered were related to the failure to prescribe an appropriate treatment plan. This failure to disclose could be linked to a number of issues already discussed in this chapter, including lack of agreement of definitions of error, lack of policies for reporting and disclosing errors, concerns about consequences of disclosure, and lack of agreed-upon discharge standards.

Thus the real ethical stumbling block for those addressing this case was the issue of disclosure: what exactly would the patient be told, by whom, and how? In order to uphold the ethical principles and concepts associated with maximizing benefit, preventing harm, truth telling, protection of autonomy, and informed consent, a disclosure plan should be carefully planned and implemented.

ANTICIPATING RECOGNITION AND DISCLOSURE OF MEDICAL ERRORS ETHICS CONFLICTS

An ethically attuned disclosure process requires that health care professionals and institutions implement a change in orientation and culture. The emphasis moves from placing blame on individual providers and health care organizations to developing systems that improve the quality of care. In order to accommodate such a cultural change, health

care settings have to promote recognition of error in a manner that engages all stakeholders, including patients. Hospitals can no longer perceive themselves as powerless when errors occur, unable to direct the behavior of physicians, or unable to control the economic impact of errors. Both hospitals and clinicians fear lawsuits, which may tarnish their reputations and lead to lost revenue. These fears have discouraged the use of words such as "error" and "I'm sorry," but practices are gradually changing.

In the AHRQ patient safety study,[8] participants were presented with case examples and a standard set of companion questions that were structured to reinforce recognition of error, foster the use of a common language in discussing error, and provide common experiences when trying to resolve problems. When developing this intervention, the authors considered the use of other error analysis models such as the Root Cause Analysis Model (RCA) and the Failure Mode Effects Analysis (FMEA) model. Many of these models, however, required substantial training, time, and resources, and were less appealing to project participants as a result. Some who had used the RCA process, for example, described it as difficult and unsatisfactory. Participants expressed the need for a model that was accessible, and that provided practical guidance for safer care. We developed the patient safety model illustrated in Table 12.1 as a result of these requests.

This case study methodology proved to be a cost-effective and time-efficient way to disseminate information throughout clinics and hospitals and to enhance the level of dialogue. Responses to the case studies were shared among all team members, shaped into case summaries, and distributed to staff. Hospitals used the case studies to provide continuing education programs for nurses and physicians. The case examples given in this *Handbook* were discussed at staff meetings, and copies, including summaries, were posted at nurses' stations and in clinical staff lounges. The majority of participants reported that the weekly case studies were relevant (92%), useful (92%), valuable (94%) and resembled situations that happen in their hospital(s) (74%). The majority of the participants also reported that the case studies and their summaries had a positive impact on interdisciplinary collaboration, and contributed to a change in the organizational safety climate.

TABLE 12.1

PATIENT SAFETY ERROR ANALYSIS MODEL	
Topic and description of problem	Is the diagnosis correct? Is the prognosis/treatment plan correct?
Issues that need to be addressed	Was the treatment provided properly? Were appropriate procedures used?
Ethics Considerations	Explore issues including: • autonomy • justice • beneficence • nonmaleficence • truth-telling • impartiality • publicity • shared decision-making
Learning Points	What are the learning points?
Guides/Standards	What clinical guides could be suggested to solve this problem and avoid future problems? Is there a system plan for reporting, disclosure, and remediation?
Strategies for Improvement	What steps for improvement should be considered? What issues should be disclosed?

This case-based intervention and the use of the Patient Safety Error Analysis Model helped health care providers recognize differences in their professional beliefs and practices; showed how these differences influence recognition and resolution of error; and showed that change is necessary, desirable, and possible. Since the case studies helped build staff-wide support for patient safety initiatives, they became the basis for implementing new standards and practices. Over the four-year course of the project, health care providers gained skills in addressing the issues in the case studies, and they became more willing to discuss ethically problematic issues that occurred in their own settings. The study manual, *"From good intentions to good*

actions: A patient safety manual for rural health care settings," is available online.

A Call for Disclosure

In order to honor and respect patients, and to maximize benefits, reduce harm, and reflect honesty and truthfulness in the patient/clinician relationship, health care organizations are morally obligated to develop and implement a disclosure policy that promotes open and honest communication. When even minor errors happen, patients and families want to be informed in a timely manner. Failure of professionals to communicate effectively, and to honestly admit to the error in a timely manner, can potentially undermine the hospital's reputation and heighten the risk of litigation.

The disclosure process should be delineated in the institutional policies, and should include issues that are addressed during and after disclosure, including follow-up and remediation. Follow-up and remediation should include a system for fair compensation. While there is no foolproof way to disclose a bad outcome and error(s) in care, the recommendations from a growing body of literature suggest that the issues listed in Box 12.2 be discussed during a disclosure meeting.

It is noteworthy that patient safety advocates stress the importance of disclosure even in situations where there is no error, but when a bad outcome nonetheless occurred. Under that scenario, the steps include:

Step 1: Set up a meeting with the patient, family and attorney
Step 2: Show empathy, answer questions, open records, and prove innocence
Step 3: Look for genuine resolution; honesty and disclosure can mitigate the likelihood of unnecessary tension and litigation

Maintaining the Commitment to Disclose Medical Errors

Health care providers may experience a certain relief when disclosure policies have been crafted and are in place. The goal of patient safety, however, can still remain quite tenuous in many health care facilities. Implementing a disclosure process requires a significant change in previously accepted attitudes, beliefs, and processes.

BOX 12.2

ISSUES TO ADDRESS WHEN DISCLOSING A MEDICAL ERROR[11]

- Express regret, and apologize
- Explain the nature of the error, including time, place, and circumstances
- Explain the proximal cause
- Explain the known consequences for the patient, and the potential or anticipated consequences
- Explain any actions taken to treat the medical error
- Identify those who will manage the ongoing care of the patient
- Discuss any planned investigation or review of the error
- Explain who else has been, or will be, informed of the error
- Identify actions taken to identify system issues that may have contributed to the error
- Discuss who will manage ongoing communication with the patient and his or her family
- Provide the names and phone numbers of individuals with whom patients and families can address concerns and questions
- Explain how to obtain support and counseling regarding the error
- Explain that any charges directly related to the error will be removed from the patient's account
- Offer a commitment to assist the patient and his or her family in identifying resources to help obtain compensation if actual damages are warranted

It is important to realize that change is a complex process, involving stages that include pre-contemplation, contemplation, planning, action, maintenance, and sometimes relapse.[12-15] These stages do not necessarily occur in a sequential fashion. Certainly the pre-contemplation stage precedes contemplation, but if one's experience is unpleasant, one could easily revert from the contemplation stage, or even the planning stage, back to pre-contemplation. Consider the experiences of the nurses who spent two years in a pre-contemplation phase and then over a year in a contemplation phase as they tried to focus attention on Dr. Bristol's colonoscopy procedures. Such a

stressful experience might cause a provider to reconsider identifying an event as an error, or decide not to file a report when encountering a subsequent error. Indeed, change theorists caution that only 10-15% of persons who think they are in a change phase are actually in the action process.[14] And even when change has been successfully achieved, the maintenance of new behaviors is an ongoing challenge. When change is hard to maintain, people can easily backslide and revert to old behaviors and patterns. Stages of change are outlined in Box 12.3.

BOX 12.3

STAGES OF CHANGE

Pre-contemplation
Is the stage at which there is no intention to change behavior in the foreseeable future. Many individuals in this stage are unaware or underaware of their problems.

Contemplation
Is the stage in which people are aware that a problem exists and are seriously thinking about overcoming it but have not yet made a commitment to take action.

Preparation
Is a stage that combines intention and behavioral criteria. Individuals in this stage are intending to take action in the next month and have unsuccessfully taken action in the past year.

Action
Is the stage in which individuals modify their behavior, experiences, or environment in order to overcome their problems. Action involves the most overt behavioral changes and requires considerable commitment of time and energy.

Maintenance
Is the stage in which people work to prevent relapse and consolidate the gains attained during action.

Health care professionals need ongoing support in order to recognize problems, handle the consequences of recognition, and work for change.[12-15] As part of the Advancing Patient Safety study, the authors developed an interdisciplinary curriculum that was rooted in change theory.[16] The curriculum employed weekly case studies that depicted unsafe situations that actually occur in rural hospitals and clinics. Every week the cases were delivered via email to three- or four-member interdisciplinary teams in each participating setting. Even with this level of support, health care providers noted that it was still hard to disclose errors, and easy to backslide. So, hospitals and clinics have to cultivate a high level of vigilance.

CONCLUSION

There are no easy road maps for providers who face a complex problem like medical error disclosure. Errors can trigger feelings of shock and anxiety among all parties involved. Indeed, the health care providers we have interviewed report that they carry the pain of past errors for years. As one physician explained, "The guilt from that event has been on my shoulders for 15 years."

Given the personal and professional pain that may ensue when a serious medical error occurs, a provider might be tempted to look away, and so avoid the moral reflection and actions that are needed to acknowledge, report, and then truthfully disclose the error(s).

Health care providers also noted that, in spite of their best intentions, it was often hard to keep patient safety on the "radar screen." Any number of organizational issues, such as renovating or building new surgery suites or emergency rooms, dealing with staff attrition and replacement, or the need to rely on temporary employees, can divert attention away from recognition and disclosure and toward what seem like more pressing issues. Thus, it is critical to create an environment in which professionals continually evaluate and reinforce ethically-attuned responses to patient-safety issues.

REFERENCES

1. Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err is Human: Building a Safer Health System.* Washington, DC: National Academy Press; 2000.

2. Clark PA. Medication errors in family practice, in hospitals and after discharge from the hospital: an ethical analysis. *J Law Med Ethics.* Summer 2004;32(2):349-357, 192.

3. Wachter RM, Shojania KG. *Internal Bleeding: The Truth Behind America's Terrifying Epidemic of Medical Mistakes.* New York, NY: Rugged Land; 2005.

4. Devers KJ, Pham HH, Liu G. What is driving hospitals' patient-safety efforts? *Health Aff (Millwood).* Mar-Apr 2004;23(2):103-115.

5. Sorry Works! Coalition. http://www.sorryworks.net/. Accessed Dec. 6, 2008.

6. Wu AW, Cavanaugh TA, McPhee SJ, Lo B, Micco GP. To tell the truth: ethical and practical issues in disclosing medical mistakes to patients. *J Gen Intern Med.* Dec 1997;12(12):770-775.

7. Boyle D, O'Connell D, Platt FW, Albert RK. Disclosing errors and adverse events in the intensive care unit. *Crit Care Med.* May 2006;34(5):1532-1537.

8. Cook AF, Hoas H, Guttmannova K, Joyner JC. An error by any other name. *Am J Nurs.* Jun 2004;104(6):32-43; quiz 44.

9. ABIM Foundation, American Board of Internal Medicine, ACP-ASIM Foundation, American College of Physicians-American Society of Internal Medicine, European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med.* Dec. 6, 2008 2002;136(3):243-246.

10. Ross JW, Glaser JW, Rasinski-Gregory D, Gibson JM, Bayley C. *Health Care Ethics Committees: The Next Generation.* Chicago, IL: American Hospital Publisher; 1993.

11. Morath J, Hart LG. Partnering with families: disclosure and trust. Paper presented at: National Patient Safety Foundation/ JCAHO Patient Safety Initiative 2000: Spotlighting Strategies, Sharing Solutions; October 6, 2000; Chicago, IL. http://www.npsf.org/download/Morath.pdf. Accessed Dec. 13, 2008.

12. Emmons K. Commentary: The transtheoretical model of behavior change: Application to clinical practice. *Adv Mind Body Med.* 2006;1:221-223.

13. DiClemente CC, Prochaska JO, Fairhurst SK, Velicer WF, Velasquez MM, Rossi JS. The process of smoking cessation: an analysis of precontemplation, contemplation, and preparation stages of change. *J Consult Clin Psychol.* Apr 1991;59(2):295-304.

14. Prochaska JO, Norcross JC, DiClemente CC. *Changing for Good: The Revolutionary Program that Explains the Six Stages of Change and Teaches You How to Free Yourself from Bad Habits.* New York, NY: W. Morrow; 1994.

15. Lebow J. Transformation now! (or maybe later): client change is not an all-or-nothing proposition. *Psychotherapy Networker.* 2002(Jan/Feb):31-32.

16. Cook AF, Hoas H, Guttmannova K. From Here to There: Lessons From an Integrative Patient Safety Project in Rural Health Care Settings. *Advances in Patient Safety: From Research to Implementation.* Rockville, MD: Agency for Healthcare Research and Quality; 2005. Available at: http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=aps.section.1290. Accessed Dec. 6, 2008.