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Medical Error Disclosure: A Quality Perspective and Ethical Dilemma in Healthcare Delivery

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ABSTRACT

Medical errors represent a significant problem for healthcare delivery and pose a considerable concern to patient safety. Disclosure of adverse events to patients and families is critical in managing the consequences of medical errors and improving healthcare quality. When errors occur, healthcare providers face considerable obstacles and uncertainty about disclosing errors. Designing an error disclosure policy requires the integration of aspects of ethical principles, physician-patient communication, patient and family-centred care, and quality improvement. It is a timely opportunity to review how healthcare providers across all disciplines and stages of training navigate the ethical, legal, societal, and systemic complexities of medical error disclosure. The purpose of this study was to review Canadian medical error disclosure policies set forth by the Canadian Provincial Colleges of Physicians and Surgeons, in addition to disclosure policies enacted by other nations, and discuss steps to navigate this ethically complex challenge. The healthcare system requires coordinated improvements to overcome this critical phase, in which quality of care is perceivably threatened. For quality improvements and patient safety initiatives to occur, the integration of various ideas and theories from human factors reengineering, information technology, organizational and management sciences, cognitive psychology, and bioethics should be utilized in the standard of care processes. We suggest that disclosure practices can be implemented as part of the standard of care and improved by creating a uniform policy that addresses errors in a nonpunitive manner while respecting patients' rights to honest disclosure.

Keywords: Medical error, Disclosure, Quality care, Patient safety, Ethical dilemma

INTRODUCTION

Avoiding harm is a central pillar of healthcare delivery. A growing body of literature and public awareness of adverse events in healthcare has made

addressing medical errors a priority in healthcare systems around the world (Kalra et al. 2005, Gallagher et al. 2007, Kalra et al. 2013, Kim et al. 2017). Adverse events are injuries to patients resulting from medical treatment rather than the underlying medical condition (Coffey et al. 2010). Existing literature cites that one in eight hospitalized Canadians is affected by an adverse event (Baker et al. 2004). Adverse events can affect patients and their families in any setting and at any time. Medical errors are a type of adverse event and are defined as unintentional acts or the failure to complete planned actions as intended (Bari et al. 2016). Medical errors are currently the third leading cause of death in North America, behind heart disease and cancer (Makary and Daniel 2016). The financial burden associated with medical errors in the United States of America (USA) has been estimated to be between 17 and 29 billion dollars per year in lost income, disability, and other healthcare costs (Institute of Medicine 1999). Disclosure of adverse events, including medical errors, is essential to maintaining patient trust and healthcare quality. Medical errors are often the result of systemic problems that are difficult to detect and measure unless appropriately reported. When there is a need for disclosure, physicians believe that disclosure is the right thing to do but face considerable obstacles and uncertainty of how to disclose errors (Gallagher et al. 2003). We have previously reported the Canadian provincial initiatives encouraging open disclosure of adverse events and have suggested its integration into a 'no-fault' model (Kalra et el. 2004, Kalra 2016). While steps have been taken by health jurisdictions across Canada to minimize adverse events experienced by patients, the issue of honest disclosure has remained largely unaddressed. Serious doubts exist if any health care provider would cede the right of self-protection without appropriate legislation to address the issue. The purpose of this study was to review Canadian medical error disclosure policies set forth by the Canadian Provincial College of Physicians and Surgeons, in addition to disclosure policies enacted by other nations, and discuss steps to navigate this ethically complex challenge.

BARRIERS AND BENEFITS OF ERROR DISCLOSURE

Several barriers currently exist to error reporting. First, there is a concern for keeping the identities of providers and organizations confidential due to the threat of legal action. Second, medical professionals may believe that the time spent reporting has been wasted because reported information may not be used. For example, new medical equipment and pharmaceuticals are rigorously tested before they are distributed to medical practitioners, who may believe that the possible risks of new technologies are already known. Risky and aggressive interventions are standard practice in healthcare because medical professionals may believe that the benefits outweigh the potential risks. Third, there is a lack of education and training in recognizing medical errors. Fourth, lack of clear standards, tools, and definitions for reporting. Finally, there is a lack of compensation for those organizations undertaking the cost of reporting. The existence of these barriers often hinders a healthcare professional's ability or willingness to disclose any adverse event that may have occurred.

Ethical and moral principles can be used to orient the policies and guide the disclosure process to ensure a patient-centered approach is utilized. Despite the obstacles, physicians should seek to disclose medical errors to patients and their families on both ethical and pragmatic grounds. Ethical principles such as veracity, fidelity, beneficence, and non-maleficence are violated when healthcare providers fail to disclose mistakes (Wu et al. 1997). Failure to adequately disclose medical errors undermines patient autonomy and compromises a patient's ability to make informed decisions (Edwin 2009). The fact that part of the physician-patient process involves medical consent entails that being denied information will severely impede the patient's ability to act within their best interests. From a practical standpoint, it has been suggestions that patients would prefer to receive full disclosure of harmful errors but are concerned that healthcare workers may not do so (Gallagher et al. 2003).

THE LEGAL LANDSCAPE

Medical error disclosure has been tied closely to the tort system surrounding patient safety issues, which focuses on providing redress for the grievances suffered by patients and families rather than punishment on wrongdoers. Healthcare providers are often fearful that disclosure or an apology can place them at risk for lawsuits (Guillod 2013). They may hesitate to apologize and disclose errors as it could increase the chances of a malpractice claim. The gap in disclosure has led many states in the USA to pass apology laws (McMichael et al. 2019). While these laws have the potential to be beneficial, they currently only protect expressions of regret and not the disclosure of error (McMichael et al. 2019). In Canada, there have been multiple legal decisions beginning in the 1980s that established if a physician made an error that harmed or had the potential to harm a patient, they have a legal obligation to disclose this fact to the patient (Hebert 1999). Beginning with *Stamos v Davies* of the Ontario High Court in 1985, where a disclosure duty was first established in Canada, the legal scene continues to evolve (Hebert 1999). Despite medical professionals' concerns about malpractice suits brought against them, the literature indicates that disclosing errors honestly and promptly may mitigate legal ramifications (Lee, 2016, MacCourt and Bernstein 2009, Studdert et al. 2006, Volpintesta 2006). Consequently, studies have shown that honesty and openness in disclosing medical mistakes reduce the risk of a malpractice suit and enhance patient trust in the physician (Heilig 1994).

DISCLOSURE POLICIES IN CANADA AND ACROSS THE GLOBE

Institutions around the world have taken different approaches to implement medical error disclosure strategies and to operationalize patients' right to know. These differences are in part attributable to differences in the cultural, legal, and economic landscape in which healthcare systems exist (Kiguba et al. 2015, Shanks et al. 2015, Turillazzi and Neri 2014). In Canada, the Royal College of Physicians and Surgeons has promoted the disclosure of adverse

Table 1. Canadian provincial college of physicians and surgeons policies on medical error disclosure.

Province	Year	Key points
British Columbia	2006	Apology Act-Prevents an apology as an admission of liability
Alberta	2011	Include an apology and acknowledge event
Saskatchewan	2002	Include an apology
Manitoba	2002	Avoid speculation
Ontario	2003	Patient can refuse discussion
Quebec	2004	Integrated in Code of Ethics
Newfoundland & Labrador	2007	Not an admission of fault or liability
Nova Scotia	2006	Implementation of a "just culture"
Prince Edward Island	2009	Includes education plan
New Brunswick	2004	Includes checklist to follow
North West Territories	2008	Includes checklist and flow chart to follow
Yukon Territories	2009	Includes algorithm and mnemonic guide

events, including medical errors, to all partners, including patients in a timely manner (National Steering Committee on Patient Safety 2002).

Almost all provincial regulatory bodies, College of Physicians and Surgeons, in Canada have adopted some form of a disclosure policy with key points to address medical errors and adverse events (Table 1) (Borsellino 2003, Kalra 2016, National Steering Committee on Patient Safety 2002) These Canadian provincial initiatives, though similar in content, remain isolated because of their non-mandatory nature and the absence of federal or provincial laws on disclosure. The designing of an error disclosure policy requires integration of various aspects, including bioethics, physician-patient communication, quality of care, and team-based care delivery. We suggest the implementation of a uniform policy centered on addressing errors in a non-punitive manner and respecting the patient's right to an honest disclosure be a standard of care.

While each country struggles to navigate unique social and legal landscapes, lessons can be learned from other healthcare systems around the world that have made progress in different domains of implementing national disclosure policies. The feasibility of medical error disclosure guidelines is enhanced when enacted in conjunction with strategies to reduce barriers to disclosure. In Australia, barriers to medical error disclosure have been reduced by policies that protect healthcare providers by making such disclosures free of implied liability and inadmissible in legal proceedings (Kalra et al. 2020). In New Zealand, no-fault compensation policies are funded by physicians' insurance premiums. They entitle patients affected by adverse events related to medical care to be compensated and rehabilitated while protecting providers from individual legal liability and tort claims. Similarly in the United Kingdom, the National Health Service in 2003 implemented the a 'duty of

candour,' whereby doctors and managers must inform a patient of an act of negligence or omission that causes harm (Dyer 2003). This offers the patient a package in the form of remedial care, apologies, and monetary compensation without the need for litigation. If patients accept the compensation package, they waive their right to litigate. In the USA, open disclosure of any critical event during medical care to either the patient or family is required for accreditation of medical institutions (Paradise 2004). Further research is required to better understand how healthcare providers across all continents, disciplines, and stages of training navigate the ethical, legal, societal, and systemic complexities of medical error disclosure (Kalra 2016). Only through collaboration and shared goals to improve patient care can progress be made to strengthen the quality and transparency of healthcare.

NEXT STEPS IN NAVIGATING MEDICAL ERROR DISCLOSURE DILEMMAS

The genesis of medical errors lies in both system and human failures. There is little to be achieved by forcing these reporting systems on healthcare professionals. Nonpunitive reporting and confidential handling information are the foremost requirements in a successful reporting system. This information is provided to protect patients against a future occurrence of similar events and, therefore, should be used solely for this purpose. Unless reporters are assured of indemnity from liability on reporting, few will step forward to report critical incidents. Inappropriate blame attribution will merely alienate professionals and discourage them from participating in system improvement, which is essential for maintaining and enhancing health care quality. Cultural changes to support reporting of errors should be fostered. Increasingly unrealistic expectations of patients, society, and healthcare industries for flawless healthcare delivery despite outdated practices of sleep deprivation, time restraints and factors known to precipitate burnout, must be addressed. These factors drive many professionals away from their ethical duty and responsibility of honest disclosure of mistakes. Error reporting systems should be built on the focus of systems-oriented change rather than individualistic targeted reforms. For medical error and patient safety to be addressed in any form, there needs to be appropriate leadership in all realms, including physicians, organizations, and other related authorities. The executive responsibility includes providing clear and specific guidelines for others to follow must be handled by leaders in the profession. The designing of error reporting systems requires the integration of various reporting principles, quality-oriented approaches, and appropriate leadership to make significant contributions to the improvement of quality care and patient safety across all healthcare disciplines.

Implementing a uniform and nonpunitive national policy to address medical error disclosure is no simple task. Improving patient safety requires striking a delicate balance between competing interests to create a culture of safety for both patients and healthcare providers. Although some medical errors may be unavoidable, healthcare systems must remain diligent in reducing the prevalence of errors by identifying causes and developing systematic

measures to adverse events. Effective communication between healthcare providers, patients, and their families throughout the disclosure process is integral to developing and sustaining the therapeutic relationship. The focus on enhancing quality care should be supplemented by increased honesty and openness policies with patients. It is imperative for the sake of patient safety and continuous quality improvement in health care that disclosure, reporting, and discussion of errors committed or witnessed be a standard procedure. Only through appropriate disclosure and open attitudes can the cause of errors be identified, and healthcare delivery systems be improved.

CONCLUSION

Medical errors are a growing public health concern in healthcare systems across the world. As the prevalence of medical errors and adverse events continues to grow, healthcare systems are tasked with forming policy and systematic approaches to mitigate these potentially preventable harms. The correction of flaws in the medical system and the subsequent protection of patients' health should be a top priority. When an adverse event occurs, there is a need for open and honest communication with patients and families. Policy creation, revision, and adaptation can be utilized for systematic transformation. Disclosure policies can provide a framework and guidelines for appropriate disclosure, leading to more transparent healthcare practices. An effective disclosure policy for adverse events is crucial in creating a safety culture.

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