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Medical Error Disclosure in Healthcare – The Scene Across Canada

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ABSTRACT

The global focus on healthcare quality is on the rise. Despite remarkable progress in medical advancements, adverse events arising from medical errors remain a prevalent issue within healthcare systems. Disclosure of an adverse event is essential in managing a medical error's consequences. We have previously reviewed and compared various disclosure policies that are in practice in Canada and around the globe to analyze the progress made in this area and suggested a non-punitive, "no-fault" model for reporting medical errors. This study aimed to review and compare the disclosure policies implemented by individual health authorities across Canadian provinces and territories. We evaluated each policy based on the following ten criteria: apology, avoidance of blame, avoidance of speculation, immediate disclosure, patient support, provider support, provider training, team-based approach, accessibility, and documentation. The clinical significance of the study was to evaluate various health authorities' disclosure policies and report a practice model for medical error disclosure across Canada. In the face of challenges, physicians must strive to disclose medical errors to patients and their families, driven by ethical considerations and practical reasons. Disclosure policies offer a structured framework and set of guidelines for the proper communication of errors, ultimately contributing to enhanced quality of care and greater transparency within healthcare practices. We suggest that refining the disclosure process could be achieved by establishing a standardized policy that revolves around candid acknowledgment of mistakes while adopting a non-punitive approach to addressing errors.

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

INTRODUCTION

Adverse events are inevitable due to the complexity of the healthcare process. Medical errors have gained significance due to their increased prevalence, which is detrimental to the safety of patients (Aghighi et al., 2022). Medical errors contribute to increased morbidity and mortality of patients. Medical error are suggested to be the 3rd leading cause of death in the United States, after heart disease and cancer (Kalra et al., 2017; Karande et al., 2021). Disclosure of medical error is often a balance between a physician's ethical duty to disclose versus fear of repercussions. Despite the most sincere intentions and proficient skills, healthcare remains an undertaking led

by humans, inevitably prone to errors (Gorgich et al., 2016; da Silva and Krishnamurthy, 2016; Bari et al., 2016). While every conceivable effort should be exerted to curtail the frequency of errors, their occurrence stands as a sobering reality that necessitates acknowledgment for effective mitigation. The significance of medical errors lies in their potential to trigger Adverse Events (AEs), which encompass patient injuries stemming from medical interventions, independent of any underlying medical condition (Baker at al., 2004; Kalra J., 2011; Kalra and Kopargaonkar, 2017). Notably, avoidable AEs underscore a systemic shortcoming, signifying a lapse in the healthcare system's fundamental duty of safeguarding patient well-being. The Institute of Medicine's (IOM) report "To Err is Human" described medical errors as a public health risk (Insitute of Medicine, 2000). The report stresses that preventable medical errors are common in medical practice, resulting in the deaths of 98,000 people in United States hospitals annually and costing the nation $17-29 billion in health care, lost income, and other injury-related expenses (Rodziewicz, 2023). When an error occurs, a common dilemma facing physicians is whether to disclose the error to the patient. Research findings reveal that patients are keen to know about any error that causes them harm. The patient's bill of rights demands to have full disclosure of an error. Several studies report that patients prefer disclosure, enhancing their trust in their physicians' honesty and reassuring them that they receive complete information about their overall care (Kim et al., 2017; Gallagher et al., 2009). Furthermore, patients believe that humans are not perfect, they might make mistakes, and "human nature" might lead health care workers to hide errors from patients (Kalra et al., 2005).

Advantages of Transparent Medical Error Disclosure

Amidst diverse challenges and significant implications, disclosing medical errors to patients and their families is an indispensable facet of delivering high-quality healthcare rooted in ethical principles and practical considerations (Bismark et al., 2006; Mazor et al., 2004). Failing to adequately disclose medical errors carries ethical ramifications, infringing upon the patient's autonomy (American Medical Association, 2020). This withholding of information undermines the patient's capacity to grant informed consent and to engage in well-considered medical choices. The intrinsic link between the physician-patient dynamic and medical consent underscores that denying information significantly impedes patients' ability to act in their best interests. Instituting policies that guide the proper disclosure of medical errors is a bulwark against breaches of trust while also nurturing the sanctity of the therapeutic relationship (Hébert et al., 2001). Such policies play an essential role in upholding the mutual respect and understanding necessary for effective medical care, thus reinforcing the vital bond between healthcare providers and their patients.

Although litigation following medical error disclosure is a significant concern, lack of disclosure may further increase risk. Studies have reported that failing to explain and communicate medical errors adequately increases the risk of malpractice litigation (Guillod, 2013). It has been demonstrated that

honesty and openness with the patient can help improve the relationship between the two parties, reducing the legal strain to follow (O'Connor et al., 2010). From a practical standpoint, it has been suggested that patients expect full disclosure of harmful errors but are concerned that healthcare workers will not provide this information (Fein et al., 2007). Consequently, studies have shown that disclosing the medical error promptly and openly enhanced patient trust in the physician by fulfilling a need that the patient did not expect to be fulfilled (Anwer and Abu-Zaid, 2012).

Global Landscape of Medical Errors

National and international initiatives and advances to address disclosure following medical errors show a range of attitudes toward patients' right to know and institutional and healthcare providers' immunity and responsibility. Differences in legal, social, economic, and health care systems, social and cultural factors, and access to health services have historically differed among nations, underpinning patient experiences of care and expectations of quality and disclosure. Across global studies, the prevalence of adverse events among hospital patients has exhibited a range of disparities, with rates spanning from 3.7% in New York to 11% in the United Kingdom and reaching 16.6% in Australia (Kalra et al., 2005; Kalra et al., 2020; Australia Council for Safety and Quality in Health Care, 2002). Within the Canadian context, these figures vary between 5% and 7.5% (Louie et al., 2010). The significant variability in reported adverse event rates can partly be attributed to dissimilarities in research methodologies and patient cohorts. We have previously proposed a 'no-fault' model whereby disclosing adverse events to patients is integral to accreditation (Kalra, 2011). The United States Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recommends that the doctor conduct the disclosure. Although research continues to grow in error disclosure and patient safety, it is evident that a patient-centered model supported by a culture of safety will significantly reduce error rates.

A Canadian Perspective

Canada's current medical error disclosure scene reflects a growing emphasis on transparency, accountability, and patient-centered care. Canadian healthcare organizations, guided by ethical principles and patient safety imperatives, actively promote open communication between healthcare providers and patients when errors occur. Policies, guidelines, and training programs are being developed to equip healthcare professionals with the skills and tools for effective disclosure conversations. Legal protections such as Apology Acts in certain provinces foster an environment where healthcare providers can express empathy and apologies without fear of legal consequences (Robbennolt, 2009; MacDonald and Attaran, 2009). Patient engagement is a central tenet, recognizing the importance of involving patients and families in the disclosure process and subsequent decision-making (Abo-Glele et al., 2021). While challenges and variations in practices persist, there is a concerted effort to shift the culture towards honesty, learning, and continuous improvement. The evolving landscape of medical error disclosure in Canada

reflects a commitment to patient safety, transparency, and building trust in the healthcare system.

Canadian Policies

Medical error disclosure policies were reviewed from individual health authorities in Canadian Provinces and Territories. Disclosure policies were obtained through email, telephone, and documents from the health authorities' website. Upon receipt of the disclosure policies, the contents were evaluated based on the ten key criteria. The study excluded the province of Quebec due to a lack of complete data availability. In reviewing and comparing the medical error disclosure policies across the Canadian provinces and territories, most policies did not differ regarding who should disclose and when the disclosure should be done.

The criteria chosen to compare within medical error disclosure policies were: apology, avoidance of blame, avoidance of speculation, immediate disclosure, patient support, provider support, provider training, team-based approach, accessibility, and documentation. These ten criteria were identified as critical components for any medical error disclosure policy. Although these are all essential features, we have ranked them in order of importance, as summarized in Table 1. This is done to provide the best guidelines for developing current and future medical error disclosure policies.

Table 1. Key criteria of disclosure policies in order of importance.

Key Criteria	Order of Importance
Apology	1
Patient Support	2
Immediate Disclosure	3
Avoidance of Speculation	4
Avoidance of Blame	5
Provider Support	6
Team-Based	7
Approach Documentation	8
Provider Training	9
Accessibility	10

CONCLUSION

With the escalating concern and economic implications tied to preventable medical errors and adverse events, it has become imperative to institute well-defined protocols. To foster a climate of transparent communication with patients, it is crucial to cultivate a comprehensive understanding of the intricate landscape of medical errors. As such, sharing knowledge about this complex topic and developing practical approaches is essential to foster a culture of candid disclosure. Appropriate processes must be executed as preventable medical errors and adverse events become a growing concern and

cost. Sharing knowledge and learning about the complex topic of medical error and how to approach it is necessary to encourage honest disclosure with patients. The disclosure of a medical error is an ethical dilemma that requires deliberative thinking and reflection by the health care providers. Healthcare providers must be aware of the legislation enforced in the jurisdiction under which they practice making disclosure easier and less daunting. Improving the process of healthcare is not a mandate for physicians alone. It is a collective effort of healthcare institutions, policymakers, providers, and patients working toward a common goal. Only through such collaboration can medical error disclosure become a standard, achievable, and informative practice in healthcare improvement.

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