

Editorial

*Corresponding author

Jawahar (Jay) Kalra, MD, PhD, FRCPC, FCAHS

Professor
Department of Pathology and
Laboratory Medicine
Royal University Hospital
Saskatoon, SK
S7N 0W8, Canada
Tel. +306-655-2152
Fax: +306-655-2223
E-mail: jay.kalra@usask.ca

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Medical Error Disclosure: A Point of View

Jawahar (Jay) Kalra, MD, PhD, FRCPC, FCAHS*

Department of Pathology and Laboratory Medicine, College of Medicine, University of Saskatchewan and Royal University Hospital, Saskatoon, Saskatchewan, Canada

In any health care process, adverse events resulting from errors are inevitable.¹ A number of studies have estimated the rate of adverse events, in hospital patients, varied from 3.7% to 16.6%.²⁻⁶ Disclosure of an adverse event is an important element in managing the consequences of a medical and clinical error.⁷ Although, attempts have been made to minimize adverse events and medical errors, a dichotomy has developed between medical errors occurring and the disclosure of these errors by medical professionals.

In the absence of policies directing appropriate disclosure of a medical error, substantial scope exists for breaching the patient's trust if errors during the process of care are not disclosed. Failure to inform the patient of adverse events caused by a medical error compromises the autonomy of the patient, as they are unable to properly consider and consent to proposed medical decisions that may be in their best interests.⁸⁻¹¹ It also jeopardizes the opportunity to enhance quality improvement in health care, as many medical errors are the result of systemic problems that are difficult to detect unless the errors are reported. The complexities of medical error disclosure to patients present ideal opportunities for medical educators to probe how learners are balancing the ethical complexities involved in error disclosure with other related fields.¹² Effective communication between health care providers, patients and their families throughout the disclosure process is integral in sustaining and developing the physician patient relationship.¹³ We have examined and evaluated various error disclosure initiatives that are in practice in Canada and around the globe (USA, Australia, New Zealand, and United Kingdom) to analyze the progress made in this area.

In 2001, the United States Joint Commission on Accreditation of Health Care Organizations (JCAHO) mandated an open disclosure of any critical event during care to either the patient or their family.¹⁴ This was deemed to be an essential accreditation standard for a medical institution. Individual states in the USA like Pennsylvania have complemented the federal program by imposing a statutory duty to notify patients about any critical event during the process of their health care.¹⁵ In Australia, the Australian Council for Safety and Quality in Health Care (ACSQHC) offered an approach that addresses the unique interests of patients, health care professionals, administrators and management. The Australian policy integrates the disclosure process with a risk management analysis toward investigating the critical event.¹⁶ In New Zealand, the patients suffering a medical error are rehabilitated and compensated through a no-fault, state-funded compensation scheme. Patient's rights and the providers' duties are set out in a code of consumers' rights, which applies to all providers of health. This model aims to encourage health care providers towards an honest disclosure of medical errors and effectively bars medical malpractice claims.¹⁷ The National Health Services (NHS) of the United Kingdom declared a 'duty of candour' that directs the doctors and managers to inform a patient of an act of negligence or omission that causes harm. The NHS scheme offers a remedial package to the patient that includes an apology and financial compensation in return for the patients waiving their right to litigate.¹⁸ In Canada, the majority of provinces have adopted some form of a disclosure policy while others are in the process of developing such policies.¹⁹⁻²³ These Canadian provincial initiatives, though similar in content, remain isolated because of their non-mandatory nature and 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. A prime role exists for the accrediting and regulatory authorities to initiate policy changes and appropriate reforms in the area. Not only should disclosing medical error be a routine part of medical care in order to enhance quality improvement, but it would also serve to protect the health and autonomy of patients.

REFERENCES

1. Committee on Quality of Health care in America, Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.
2. Brennan TA, Leape LL, Laird NM, et al. Incidence of adverse events and negligence in hospitalized patients: Results of the Harvard Medical Practice Study I. *N Engl J Med*. 1991; 324: 370-376. doi: [10.1056/NEJM199102073240604](https://doi.org/10.1056/NEJM199102073240604)
3. Wilson RM, Runciman WB, Gibberd RW, et al. The quality in Australian health care study. *Med J Aust*. 1995; 163: 458-471.
4. Vincent C, Neale G, Woloshynowych M. Adverse events in British hospitals: Preliminary retrospective record review. *BMJ*. 2001; 322: 517-519. doi: [10.1136/bmj.322.7285.517](https://doi.org/10.1136/bmj.322.7285.517)
5. Forster AJ, Asmis TR, Clark HD, et al. Ottawa hospital patient safety study: Incidence and timing of adverse events in patients admitted to a Canadian teaching hospital. *Can Med Assoc J*. 2004; 170: 1235-1240. doi: [10.1503/cmaj.1030683](https://doi.org/10.1503/cmaj.1030683)
6. Baker GR, Norton PG, Flintoft V, et al. The Canadian adverse events study: The incidence of adverse events among hospital patients in Canada. *Can Med Assoc J*. 2004; 170: 1678-1686. doi: [10.1503/cmaj.1040498](https://doi.org/10.1503/cmaj.1040498)
7. Kalra J, Kalra N, Baniak N. Medical error, disclosure and patient safety: A global view of quality care. *Clin Biochem*. 2013; 46: 1161-1169. doi: [10.1016/j.clinbiochem.2013.03.025](https://doi.org/10.1016/j.clinbiochem.2013.03.025)
8. American Medical Association Council on Ethical and Judicial Affairs. *Code of Medical Ethics: Current Opinions*. Chicago, USA: American Medical Association; 2000.
9. Hebert PC, Levin AV, Robertson G. Bioethics for clinicians: 23. Disclosure of medical error. *Can Med Assoc J*. 2001; 164(4): 509-513. Web site: <https://repository.library.georgetown.edu/handle/10822/943911>. Accessed August 30, 2016
10. Gallagher TH, Waterman AD, Ebers AG, et al. Patients' and physicians' attitudes regarding the disclosure of medical errors. *JAMA*. 2003; 289: 1001-1007. doi: [10.1001/jama.289.8.1001](https://doi.org/10.1001/jama.289.8.1001)
11. Robertson GB. Fraudulent concealment and the duty to disclose medical mistakes. *Alberta Law Rev*. 1987; 25: 215-223. Web site: <https://repository.library.georgetown.edu/handle/10822/728947>. Accessed August 30, 2016
12. Crawshaw R, Rogers DE, Pellegrino ED, et al. Patient-physician covenant. *JAMA*. 1995; 273: 1553. doi: [10.1001/jama.1995.03520430089054](https://doi.org/10.1001/jama.1995.03520430089054)
13. Sutcliffe KM, Lewton E, Rosenthal MM. Communication failures: An insidious contributor to medical mishaps. *Acad Med*. 2004; 79: 186-194. Web site: <https://psnet.ahrq.gov/resources/resource/1940>. Accessed August 30, 2016
14. Joint Commission on Accreditation of Health care Organization. *Comprehensive Accreditation Manual for Hospitals: The Official Handbook*. Illinois, USA: JCAHO; 2004.
15. Medical Care Availability and Reduction of Error (Mcare) Act. 2002. 13 Pa C S §308.
16. Australian Council for Safety and Quality in Health care. Draft Open Disclosure Standard. Standards Australia, XX 1234-2002, Draft v5.2.
17. Bismark M, Dauer E, Paterson R, et al. Accountability sought by patients following adverse events from medical care: The New Zealand experience. *CMAJ*. 2006; 175: 889-894. doi: [10.1503/cmaj.060429](https://doi.org/10.1503/cmaj.060429)

18. Dyer C. NHS Staff should inform patients of negligent acts. *BMJ*. 2003; 327: 7. doi: [10.1136/bmj.327.7405.7](https://doi.org/10.1136/bmj.327.7405.7)
19. National Steering Committee on Patient Safety. Building a Safer System—a National Integrated Strategy for Improving Patient Safety in Canadian Health care. NSCPS, 2002. Web site. http://www.royalcollege.ca/portal/page/portal/rc/common/documents/advocacy/building_a_safer_system_e.pdf. Accessed August 30, 2016
20. Physician disclosure of adverse events and errors that occur in the course of patient care. Web site. www.quadrant.net/cps/index.html. Accessed October 15, 2004
21. Physician disclosure of harm that occurs in the course of patient care. Web site. www.umanitoba.ca/colleges/cps/Guidelines_and_Statements/169.html. Accessed October 15, 2004
22. Borsellino M. Disclosure of harm to be standard of practice. *Medical Post*. 2003; 39.
23. Code of Ethics of Physicians. Web site. www.cmq.org/UploadedFiles/cmqcodeontoan.pdf. Accessed October 15, 2004