Disclosing errors to patients and parents, and apologizing

The traditional medical approach to dealing with healthcare-related errors is characterized by error concealment, opprobrium and punitive measures against those who commit them. These common issues and shortcomings, still being faced today regarding patient safety, are mainly related to the fact that this fundamental cultural change is difficult to achieve.¹ The attitude of hiding an error to patients and parents does not uphold the ethical principles of our profession, since by not telling them the truth we are not being honest to our patients. Among the current challenges related to patient safety, this is a complex problem, and even today, many healthcare professionals are still concealing errors to patients or parents.

However, in those institutions that strove to have the traditional culture changed by creating measures to which everybody is held accountable (including the authorities), error concealment is being reduced. Multiple initiatives, special programs and publications contribute to bringing about a change in the attitude of physicians who undoubtedly are reluctant to disclose an error to patients and children's parents.²⁻⁵

Several reasons justify reporting the mistakes made and I believe that the most important reason is that it respects the inalienable right of every man and woman to know about their health or that of their children's, and about the outcome of the treatment performed. Many surveys have shown that the vast majority of people wish that when an error has been made, they receive explicit information about how it happened and what its consequences were.

Dr. Gallagher et al., published a survey submitted to over 2600 physicians to find out how many disclosed errors to patients and how they did so.³ Only 42% would actually use the word "error," and there was a significant difference in the information provided based on the specialty: 58% of internists versus 19% of physicians from surgical disciplines endorsed the need to disclose serious errors to patients. The huge impact of this study led the *New York Times* to publish an editorial entitled "*When Doctors Hide Medical Errors*" where published data was mentioned and the consequences that this unfair attitude could cause were described, as it had a negative impact on patients and the medical profession alike.

Causes that lead to not reporting an error are several. In the first place, as we pointed out before, there is the persistence of the traditional culture of secrecy and denial which, in our country, occurs in most of medical institutions. This behavior is related to factors present in physicians such as

fear of legal liability, punitive measures, damage to reputation and loss of patient's confidence. In practice, a defensive attitude might develop leading to the denial of the error. This situation is complex and harmful for physicians because, as long as they do not accept their fallibility, and that they may make mistakes like every human being, they will not be able to communicate these errors nor learn from them. The lack of self-criticism in our profession is one of the negative aspects that prevents physicians from practicing good medicine because it maintains the aura and does not whittle away the false belief that we are infallible.

Another aspect to be considered is that many healthcare professionals assume that the error made will not leak out and, therefore, the patient will never know what happened. This speculation is undoubtedly wrong; chances are that sooner or later parents or relatives will eventually find the error out. This is due to situations where patients or parents will ask what happened, for example, if a change in treatment is required, if the patient is transferred to a special or intensive care unit and if changes in symptomatology occur. Additionally, at present, healthcare is provided by a multidisciplinary team involving a wide range of health professionals. An error may inadvertently be disclosed to patients or to their relatives by a team member causing problems to the health professional involved since it will result in violation of trust and loss of confidence.

Medical errors are frequently hidden up and concealed because of fear of malpractice liability. This attitude is generally observed when errors occur in the operating room, in obstetrics and in diagnosis, especially if they have inflicted harm.

However, the most important cause of litigation is when an error is intentionally concealed by the health professional involved. There are several surveys published pointing out that the number of lawsuits significantly decreases when errors are reported. Contrary to what many assume, the most important factor when people make the decision to bring a lawsuit to court is not negligence, but a poor physician-patient communication leading to error concealment. When physicians are dealing with an unexpected adverse event, their lack of empathy, being reluctant to give an explanation or not being honest when describing what happened might trigger a lawsuit. The lack of an open and honest communication fuels anger among patients, inevitably causing a loss of confidence, which is one of the main factors motivating malpractice claims.

Regarding communication in the field of Pediatrics, several studies have shown that over 95% of parents want to be informed about a medical error, whether it has caused actual or potential harm. Besides, they frequently request their children receive the appropriate information when they are at the right age to understand.

This approach has been in place for many years at the Department of Pediatrics at Hospital Italiano de Buenos Aires. Most of the times, once parents have overcome the initial impact of having an error disclosed to them, they express gratitude for the honest and detailed information they have been provided. There have been no legal actions taken since errors started being reported to parents over 15 years ago.

Another important aspect to be considered is to apologize after disclosing an error. This attitude, unthinkable until not long ago, has been steadily increasing but it is not as frequent; the hope is that it becomes more and more popular among physicians.⁶⁻⁸ Apologies help mitigate the impact of disclosing an error to parents and allow us not to hide the feeling and shock related to what has happened. Expressing our emotions is extremely valuable; we are disclosing feelings of what has occurred and consequently, the humanization of the message we convey is enhanced. Likewise, it produces a positive reaction in parents who appreciate our openness and transparency, and acknowledge we are also distressed for what happened.

When reporting an error that caused a severe adverse event in a child, faced with the crying or despair of the parents, we should remain silent; many times, words are worthless. In this setting, emotions also play a critical role by expressing our feelings without the need of speaking. It might be appropriate to use non-verbal acknowledgement; for instance, to put the hand on the mother's or father's shoulder.

Finally, I would like to underscore a strategy that can really improve the culture of safety including communication and apologizing. It is all about developing effective partnerships with patients and parents to improve the quality of care and to optimize the physician-patient relationship. This originated in USA by means of a program called Partnership for Patients, (<http://www.healthcare.gov/center/programs/partnership/resources/index.html>).

Basically, it implies to share with patients the most adequate and greatest amount of information so that they can take part in their own care or in that of their children's.^{9,10} This approach has resulted in evident changes, especially in pediatrics, since parents are true caretakers of their children and when being supported by physicians they are remarkably encouraged and

relieved. Different observations have shown that parents detect errors before nurses and other healthcare professionals do. A recent study revealed that almost 60% of parents reported errors during their children's hospitalization.¹¹

This strategy will have significant benefits for parents as well as for physicians and nurses who will change their attitude of working alone and will relate more appropriately with patients and parents. If we consider them our "partners," communication with them will significantly improve.

The effects of this partnership go beyond hospital discharge. Necessary recommendations are provided to prevent complications from occurring during the post-discharge transition period.

In closing, issues described in this article show that physicians should hold a different attitude after making a mistake. Concealment and dishonesty are morally wrong;¹² we should bear in mind that error-reporting is an unavoidable ethical obligation to us all.

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