In the past two decades a patient safety movement has emerged in the US, UK, and other nations, and there has been an amendment to the Code of Ethics by the AMA to address the physicians’ obligation to disclose the truth in cases of error. US hospital and health systems have adopted new regulatory standards on patient safety that require medical providers to implement disclosure policies. This is a consequence of the greater empowerment that patients and their families feel in relation to medical care and treatment. Patients, as consumers of medical care and services, routinely access the Internet for medical knowledge, to evaluate their physicians, or to join patient advocacy groups, among other reasons. The Internet gives patients more control over their own medical decision-making.

In addition, there is also more recognition of the quality of life in relation to chronic disease, for example, lifestyle factors, such as nutrition, diet, exercise, and non-pharmaceutical treatments. Ultimately, patient safety has broadened and has become sensitive to medical errors, full disclosure, and apology. Consensus exists among hospital health systems and physicians, as well as patients and their families, that patients should be told if they are injured by medical care with full and truthful disclosure appropriate in all cases.

What is an apology? It is a communication that expresses responsibility. It is a statement that can acknowledge that an error has occurred and, as a consequence, expresses regret for having caused harm. It can decrease feelings of blame and anger. It can increase feelings of trust and improve relationships. An apology may also include a promise to refrain from engaging in similar conduct in the future. It may include an assurance that a full investigation will take place and the possibility for compensation for any harm that has been done. It may become a positive objective of expectations and intentions for future relationships between the parties.

How to Disclose
Guidelines on apology and disclosure after adverse events and errors have been in place in medical settings for over five years. The research shows that patients and their families seem to respond positively to apology and acceptance of responsibility as long as it is followed by a pledge from the physician of his commitment to continued care and optimal recovery. Although there are apology laws in many

Full Disclosure: How To Apologize For Medical Errors

Of all the bad news physicians give patients, “I’m sorry” seems the most dangerous. Here, we look at how to confront disclosure and why the gold standard treatment for a medical error should be an apology.

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states that are designed to protect physicians in the process of remediation of medical errors, these laws may not, in practice, minimize the litigation risk for physicians and the health care team.

It is difficult to apologize when the proper disclosure system isn’t set up. A study of 260 practicing pathologists and 81 academic hospital laboratory medical directors found that while nearly all “expressed near unanimous belief that errors should be disclosed to hospitals, colleagues, and patients...only about 48 percent thought that current error reporting systems were adequate.”

Even when health care providers want to disclose an error, determining how to properly do so can be a daunting task. Many doctors, understandably so, are afraid of exposing themselves, their colleagues, and their employers to unintended legal consequences by incorrect disclosure. One recent study asked residents to describe their worst medical error in an anonymous survey. It found that 31 percent reported apologizing for the situation associated with the error and only 17 percent reported disclosing the error to patients and/or family. The researchers also found that more male residents disclosed the error than did female residents (p=0.04). Surgery residents, they noted, scored higher on the subscales of safety culture pertaining to the residency program (p=0.02) and managerial commitment to safety (p=0.05).

To help physicians with revealing errors, Sorry Works, an advocacy organization for disclosure, apology, and upfront compensation after adverse medical events, has a disclosure program predicated on a three-step disclosure process.

**Initial Disclosure.** This is about empathy and re-establishing trust and communication with patients and families immediately after an adverse event. Doctors can say “sorry” but no fault is admitted or assigned. Sorry Works recommends taking care of the immediate needs of the patient/family like food, lodging, counseling, etc., and promising a swift and thorough investigation. The goal is to make sure the patient/family never feels abandoned.

**Investigation.** The investigation is to learn the truth. Was the standard of care breached or not? Sorry Works recommends involving outside experts and moving swiftly so the patient/family doesn’t suspect a cover-up. Staying in close contact with the patient/family throughout the process is important.

**Resolution.** This is about sharing the results of the investigation with the patient/family and their legal counsel. If there was a mistake, apologize, admit fault, explain what happened and how it will be prevented in the future, and discuss fair, upfront compensation for the injury or death. If there was no mistake, continue to empathize (“we are sorry this happened”), share the results of investigation (hand over charts and records to patient/family and their legal counsel), and prove your innocence. However, no settlement will be offered and any lawsuit will be contested.

Again, timing can make a difference. A study on two case reports followed the successful remediation efforts that accompanied the disclosure of medical errors to a pair of patients. It found that providers should pledge to injured patients and their relatives that they will assist and accompany them in their recovery as long as necessary and then follow through on their pledge—as soon as possible after the event.

The potential healing value of an apology can be great. It can bring a sense of relief and finality; not that this terrible event is marginalized or forgotten, but it can become a sad chapter of the past rather than a living tragedy. After being misdiagnosed, patient Trisha Torrey recounted the apology she received:
Among the dozen doctors who erred during my misdiagnosis odyssey, there was one, the director of the hematopathology lab that misdiagnosed me, who was very forthcoming after my misdiagnosis was confirmed. He took time with me on the phone, exchanged e-mail with me—and in general, helped me understand how it could have happened. It didn't make it better, but it certainly made it more understandable. [...] Today, for the first time, I met that hematopathologist, the man who was partially responsible, but was willing to explain. I attended a program which included him as a panelist, and afterwards I introduced myself. We shook hands, we even hugged—and he proceeded to tell me about all the changes they have made in his lab, based on the procedure holes uncovered during my diagnosis. I was floored. He thanked me for my post-misdiagnosis follow up that exposed the problems. He invited me to visit the lab. And then... He apologized. [...] I wept, all the way home.

Sincerity matters. The University of Massachusetts Medical School crafted guidelines on apology and disclosure after adverse events and errors, hopes high that their policy could produce the same patient satisfaction. Five years later, they examined the impact they had on 78 patients who felt there was an error in their care. “Patients' valued apology and expressions of remorse, empathy and caring, explanation, acknowledgement of responsibility, and efforts to prevent recurrences, but these key elements were often missing,” researchers wrote. “Clinicians preparing to talk with patients after an adverse event or medical error should be aware that patients expect their actions to be congruent with their words of apology and caring.”

Truth telling is a practice that exists within human relationships, in a social context, usually involving a dynamic of tension between an individual or group and an authority. There can be various perspectives from both sides of the equation with regard to what is ethical, expedient, reasonable, and responsible. Telling the truth means something different according to the particular context in which one stands, taking into account the nature of the relationship between the parties involved at specific times during the relationship. The action involved in truth telling is in “speaking.”

Telling the truth when a medical error occurs means the practice of full disclosure, i.e. giving the patient and family a complete and truthful account of what happened, why it happened, who is responsible to prevent this error in the future, what will be the treatment, an expression of apology, and a discussion of fair compensation. It is context- and time-specific.

Medical Culture
There exists among the medical culture a resistance to admit mistakes despite hospital policies and protocols for disclosure and despite the “sorry laws” in many US states. This resistance is part of the “hidden curriculum” in the process and hierarchy of medical training, i.e. learning by example. Senior physicians may model behavior that conceals errors. Research shows that the values of physicians include telling the truth to patients about errors they may have made. But the practice may lead them to take a “don’t ask, don’t tell” position and practice avoidance.

Physicians are expected to honor the perspective of those who suffer. However, if the physicians view themselves as the victims in the scenario, due to the impact of the error, disclosure, and apology on their self-esteem, self-image, career, income, and reputation among their colleagues, then they are putting their suffering ahead of the patient’s and will refuse to understand and embrace full disclosure and apology as an ethical norm.

One obstacle might be that physicians are unaware of the exact protections they are afforded. The Patient Safety and Quality Improvement Act (PSQIA) of 2005, inspired by the Institute of Medicine’s (IOM) 1999 report “To Err Is Human,” gives federal protections in exchange for error disclosures. Tasked with assessing the quantity of publications regarding this protection within the medical literature, one study found few published studies in clinical journals describing the PSQIA.

Evaluating 2,060 safety-related articles through a
PubMed search, researchers separated articles into pre-IOM report (1990-1999) and post-IOM report (2000-2008) literature. They found no articles to be "on topic" in the pre-IOM period (n=624), while “27 articles were considered ‘on topic’ in the post-IOM period (n=1436), constituting 1.8 percent of the period total (95% confidence interval, 1.2%-2.6%).” Of the 27 articles, seven appeared in practice-related journals, while the remaining 20 were in journals with a health policy or health care administration focus.

Another study found 31 percent of US physicians are reluctant to report colleagues, while 12 percent fear retribution from their colleagues for doing this.7

Health Systems
The larger picture of how health systems respond to errors and what kind of environment they foster is immensely important, since they have the power to set a high example of what it expects from its staff. A 2008 study documenting hospital adverse-event-reporting systems pointed to needed improvements in reporting processes.8 Surveying 1,652 non-federal hospital risk managers using a mixed-mode (mail/telephone) questionnaire, the authors found that virtually all hospitals reported they have centralized adverse-event-reporting systems, although characteristics varied. Scores on four performance indices suggested that only 32 percent of hospitals had established environments that support reporting, only 13 percent had broad staff involvement in reporting adverse events, and 20-21 percent fully distribute and consider summary reports on identified events. Interestingly, the authors guessed that because survey responses were self-reported by risk managers, these may have been optimistic assessments of hospital performance.

In part to monitor errors and attitudes of health systems, the “Hospital Survey on Patient Safety Culture 2010 User Comparative Database Report” is filed yearly by the federal Agency for Healthcare Research and Quality (AHRQ). It details results of 885 hospitals and 338,607 hospital staff respondents. It found three areas for systemic improvement:9

Nonpunitive Response to Error. This is an area with potential for improvement for most hospitals.
Nonpunitive response to error was defined as the extent to which staff feel that their mistakes and event reports are not held against them and that mistakes are not kept in their personnel file. This area was one of the two patient safety culture composites with the lowest average percent positive response (44 percent). The survey item with the lowest average percent positive response was: “Staff worry that mistakes they make are kept in their personnel file” (an average of only 35 percent).

**Handoffs and Transitions.** The extent to which important patient care information is transferred across hospital units and during shift changes was the other patient safety culture composite with the lowest average percent positive response (44 percent). The survey item with the lowest average percent positive response was: “Things ‘fall between the cracks’ when transferring patients from one unit to another” (an average of only 41 percent).

**Number of Events Reported.** On average, most respondents within hospitals (53 percent) reported no events in their hospital over the past 12 months. It is likely events were underreported. Event reporting was identified as an area for improvement for most hospitals because underreporting of events means potential patient safety problems may not be recognized or identified and therefore may not be addressed. However, responses varied widely, ranging from one hospital where 82 percent of respondents had not reported a single event over the past 12 months to a hospital where only 14 percent had not reported an event.

One outcome of underreporting is that it “creates a reservoir of information that is plagued with epidemiological bias. This leads to inaccurate rates of errors and an inability to generalize results to whole patient populations. It leaves reporting incidents, in epidemiological terms, comparable to nonrandom samples from an unknown universe of events.”

**Systemic Changes**

To address the larger picture of how health systems respond to medical errors, the AHRQ released guidelines of the efforts hospitals can make to reduce them. Changes in organizational culture, particularly creating a positive safety culture, are an essential element can improve patient safety. These changes primarily focus on human resources management procedures and practices relative to the supervision and discipline of individuals reporting events to institutions and leadership. Organizations found that to encourage reporting of medical errors, it was important to adopt a culture that eliminated the blame and shame associated with medical errors. When these changes were made and employees felt safe to report medical errors, harm, no harm, or near miss events, the organizations often found that their reporting rates increased—in some instances to incredible levels.

**Involvement of Key Leaders.** When organizational leadership, both administrative and clinical, actively engages in patient safety improvement, it can have an exceptionally beneficial impact on all employees and staff of the organization. An example of this involvement is an “Executive Safety Round.” While it’s important this not stray into a lecture session, it can be a routine visit to clinical units by an organization’s senior leaders to discuss patient safety issues. This technique is increasingly used to involve senior leadership in actively promoting safety and discovering the risks and hazards to patients.

**Education of Providers.** Provider education is used nationwide to orient professionals about various aspects of patient safety and how errors are identified. Education is also often used to introduce or reinforce safe practices that are proven to eliminate or minimize harm to patients. Some AHRQ-supported researchers note that the process of collecting and analyzing medical error information also results in increased patient safety.

When key personnel are trained in and understand the use of root cause analysis, the quality of information obtained from the medical error reporting systems is enhanced. Root cause analysis (RCA) is an error analysis technique for determining the contributing causes of adverse events that have already happened. It takes into account the severity and likelihood of occurrence of the adverse event to ensure that significant problems are addressed and
then identifies contributing factors and mitigating actions. Failure modes and effects analysis (FMEA) is a proactive analysis technique for identifying potential failure modes, determining their effect on the product or service under examination, and identifying actions to mitigate the failures. While RCAs focus on what could go wrong. FMEAs focus on what went wrong. FMEAs are often similar to those developed by the Institute of Safe Medication Practices (ISMP).

When complete root cause analysis is performed, a more precise corrective action can be implemented, that the types of changes that are initiated move away from the usual employee counseling to the modification of organizational processes and procedures. Being able to link corrective actions to root causes is much more effective.

Establishment of Patient Safety Committees. Many organizations participating in reporting systems, particularly in Georgia, describe establishing special patient safety committees made up of physicians, nurses, pharmacists, and other health care providers to examine medical error reports. The establishment of these committees helps the organizations identify more effective corrective actions and to implement safe procedures that involve all stakeholders.

Development and Adoption of Safe Protocols and Procedures. Health care facilities and hospitals report that they have been able to develop and adopt safe protocols and procedures to effectively reduce medical errors. These protocols and procedures are often similar to those developed by the Institute of Safe Medication Practices (ISMP). Examples include alerts for medications with a high potential for harm if not managed appropriately and guidelines on the use of standard abbreviations.

Conclusion
Silence from the doctor provokes confrontation, feelings of abandonment, cover-up, and lack of accountability from patients and families. They believe that an apology is not necessarily an admission of guilt. States’ disclosure laws in general seek to protect the doctor by allowing him or her to express sympathy, regret and condolence without the liability of blame in malpractice litigation.

Disclosure and apology can have beneficial aspects of healing and positive rewards for all those involved in the medical error context. Doctors can learn from their mistakes through continued training and self-reflection. They have the opportunity to forgive themselves. Patients and families can forgive them for their “human error.”

Within western societies, the Judeo-Christian traditions of confession, repentance, and forgiveness surround the many social contexts of errors, including medical errors.

Patients and families expect this from their physicians. They feel it is the professional and ethical thing to do. Research suggests that medical education should include teaching trainees how to disclose errors, apologize to injured patients and families, and reinforce the commitment to continued care and repair of trust. The education should also stress confronting the emotional dimensions of the errors by the physician trainees, with the full acceptance by the senior attending medical staff.

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