# Disclosing medical errors: A European Perspective

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# dis·close

Verb

1. Make (secret or new information) known.
2. Allow (something) to be seen, esp. by uncovering it.

Synonyms

reveal - expose - uncover - unfold - divulge - discover

Fr: Révéler
Ge: Enthüllen
It: Svelare
Sp: revelar

# Aims of the workshop

- To explore the variation in:
  - Attitudes to disclosing medical error (‘what we think we **should** do’)
  - Behaviours of disclosing medical error (‘what we **actually** do’)

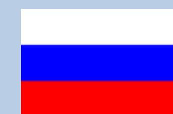
# By the end of the workshop, you should be able to:

1. To identify barriers to disclosing medical errors
2. To understand the role of disclosure in patient safety
3. To explore differences in practice between our European colleagues

# But first some tennis…

# Unforced errors – Wimbledon 2012

- First round: Fed vs Albert Ramos, 10 - 21
- Second round: Fed vs Fabio Fognini 8 - 12
- Third round: Fed vs Julien Benneteau 29 – 32
- Fourth round: Fed vs Xavier Malisse 18 – 21
- Quarter final: Fed vs Mikhail Youzhny 13 - 20
- Semi-final: Fed vs Novak Djokovic 10 - 21
- Final: Federer vs Andy Murray 38 – 25



TOTAL: 126 unforced errors!

# So what about us? – 'Superdoc'

# ‘Infallible’

- Latin: ‘In’ = not; ‘Fallere’ to deceive

- When a person is called 'infallible', this can mean any of the following:

- Some (or *all) statements or teachings made by this person can be relied on to be certainly true.*
- *This person always makes good and moral choices, and his actions may never be considered immoral or evil.*
- *This person is always right, and never wrong or incorrect.*

# ‘Infallible’

- Expectation by:
  - Ourselves
  - Patients
  - Colleagues
  - Media/national

# So what happens when we make mistakes?

- Ashamed
- Blame ourselves and blamed by our patients
- Loss of reputation with colleagues
- Isolated

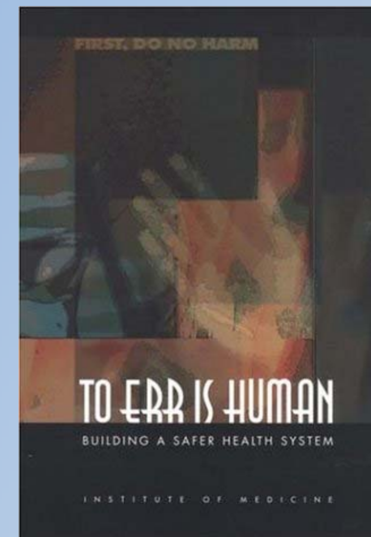
# Response to medical errors – our culture

- Error occurs
- ‘Shame and blame’

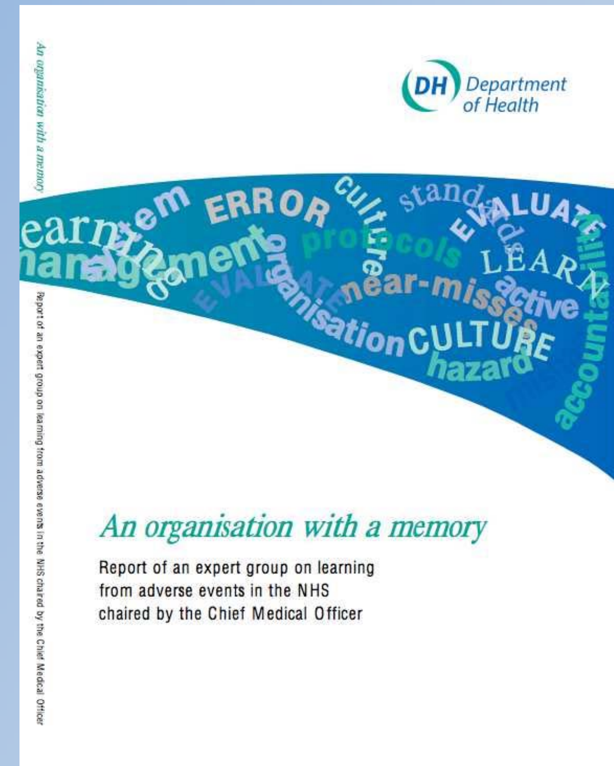
- ‘Deny and defend’
  - Rationalize the error
    - "Why disclose the error? The patient was going to die anyway.”
    - "Telling the family about the error will only make them feel worse.”
    - "It was the patient's fault. If he wasn't so (obese, sick, etc.), this error wouldn't have caused so much harm.”
    - "Well, we did our best. These things happen.”
    - "If we're not totally and absolutely certain the error caused the harm, we don't have to tell."

# Scale of the problem: Patient Safety

- TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (1999) Institute of Medicine USA:
  - Estimate 40000 to 98000 preventable deaths due to error per year in US hospitals
  - Not a ‘bad apple’ problem
  - Errors are caused by **faulty systems, processes, and conditions**
  - Recommend reporting systems

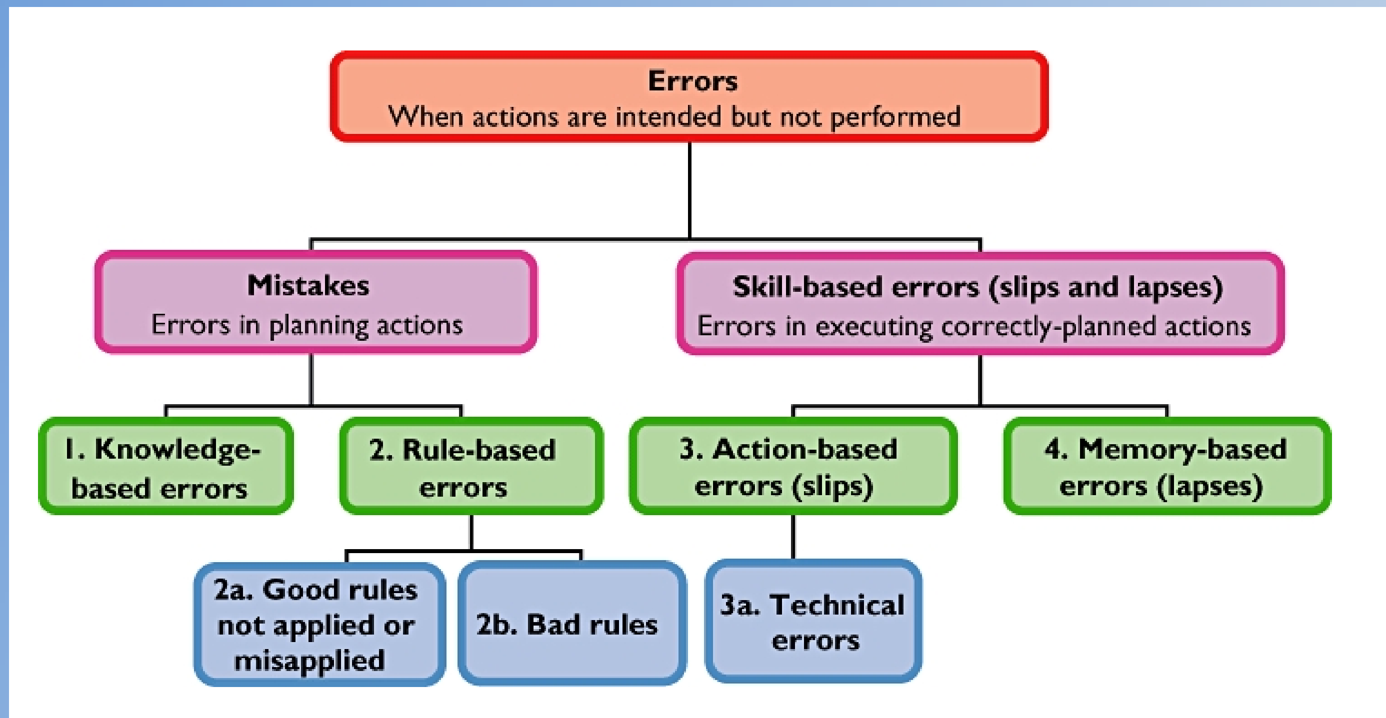


- AN ORGANIZATION WITH A MEMORY (2000) Department of Health UK
- change error reporting in the NHS to a more open culture
- wider appreciation of the value of the system approach in preventing, analysing and learning from errors



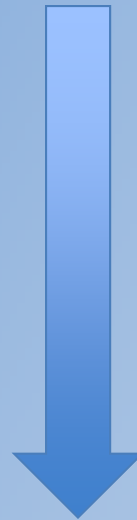
# Types of error

- A medical error is a preventable adverse effect of care, whether or not it is evident or harmful to the patient



# Severity of error outcome

- ‘Near miss’
- ‘Error, no harm’
- ‘Error, some harm’
- ‘Error, serious harm’
- ‘Error, death’



# Medical errors

- Largely accepted that they occur as a result of:
  - human fallibility
  - compounded by poor system designs in healthcare that allow for error.

- Rarely medical errors are the result of personal negligence or criminal activity.

# Changing our culture

- Move away from ‘defend and deny’ culture
- Disclosing errors:
  - To patients
  - To the our colleagues & hospital
- Openness and honesty is considered better for patients and health professionals

- BUT:
  - Are we always disclosing errors to patients?
  - Is it always in the patient’s best interest to disclose errors?

# Breakout groups

- Groups according to Page 16 of handout.
- Elect one speaker.
- Report back on what different responses in the group.

ESIM survey:

# **Attitudes and behaviours to medical error Disclosure amongst European Doctors 2012**

- Electronic survey sent to ESIM summer residents in 2011 and 2012:
  - 31 respondents in 21 countries:

| | | | |
|---|---|---|---|
| – Finland | - France | - Netherlands | - Tunisia |
| – Belgium | - Germany | - Norway | - Turkey |
| – Canada | - Israel | - Romania | - UK |
| – Czech Republic | - Latvia | - Serbia | |
| – Denmark | - Lithuania | - Spain | |
| – Finland | - Morocco | - Switzerland | |

ESIM survey:

# Attitudes and behaviours to medical error Disclosure amongst European Doctors 2012

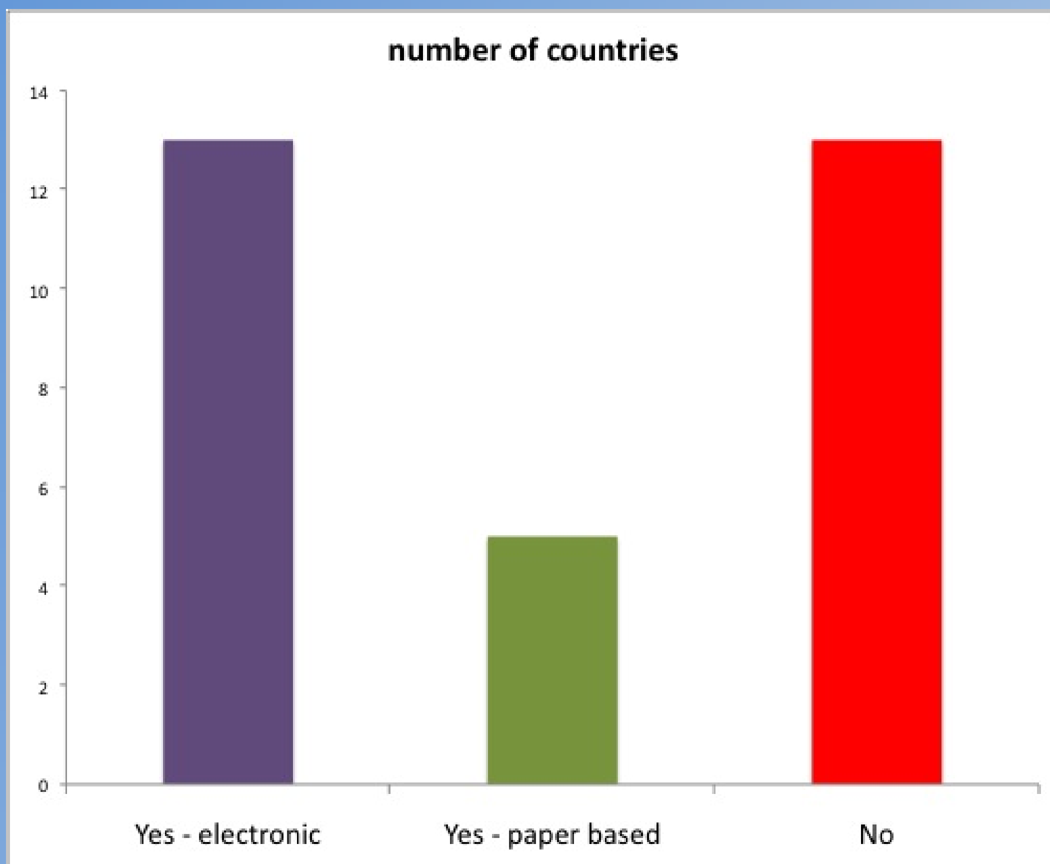
(Behaviour)

1. Reporting practices in your healthcare institution
2. Views on the usefulness of error reporting systems

(Attitudes to medical error)

1. Response to no harm error
2. Response to major harm error
3. Response to a colleague error

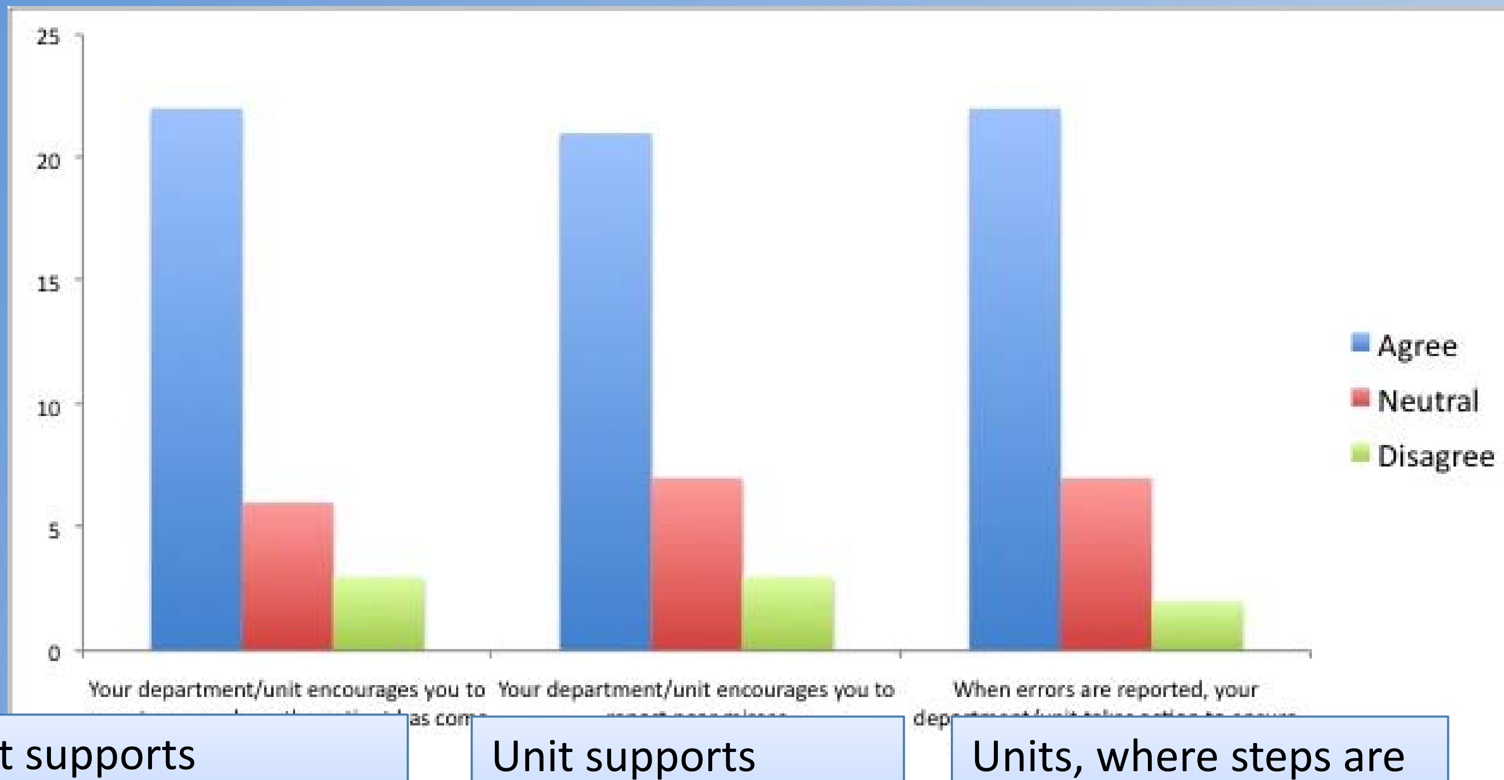
# ESIM Survey Result:
# Reporting practices in the healthcare institutions




Countries without reporting systems included:

- Belgium
- Czech Republic
- France
- Germany
- Latvia
- Lithuania
- Morocco
- Romania
- Serbia
- Tunisia

# ESIM Survey Result:
# Reporting practices in the healthcare institutions




Unit supports reporting of errors where patients were harmed

Unit supports reporting of near misses, no harm

Units, where steps are taken to improve patient safety

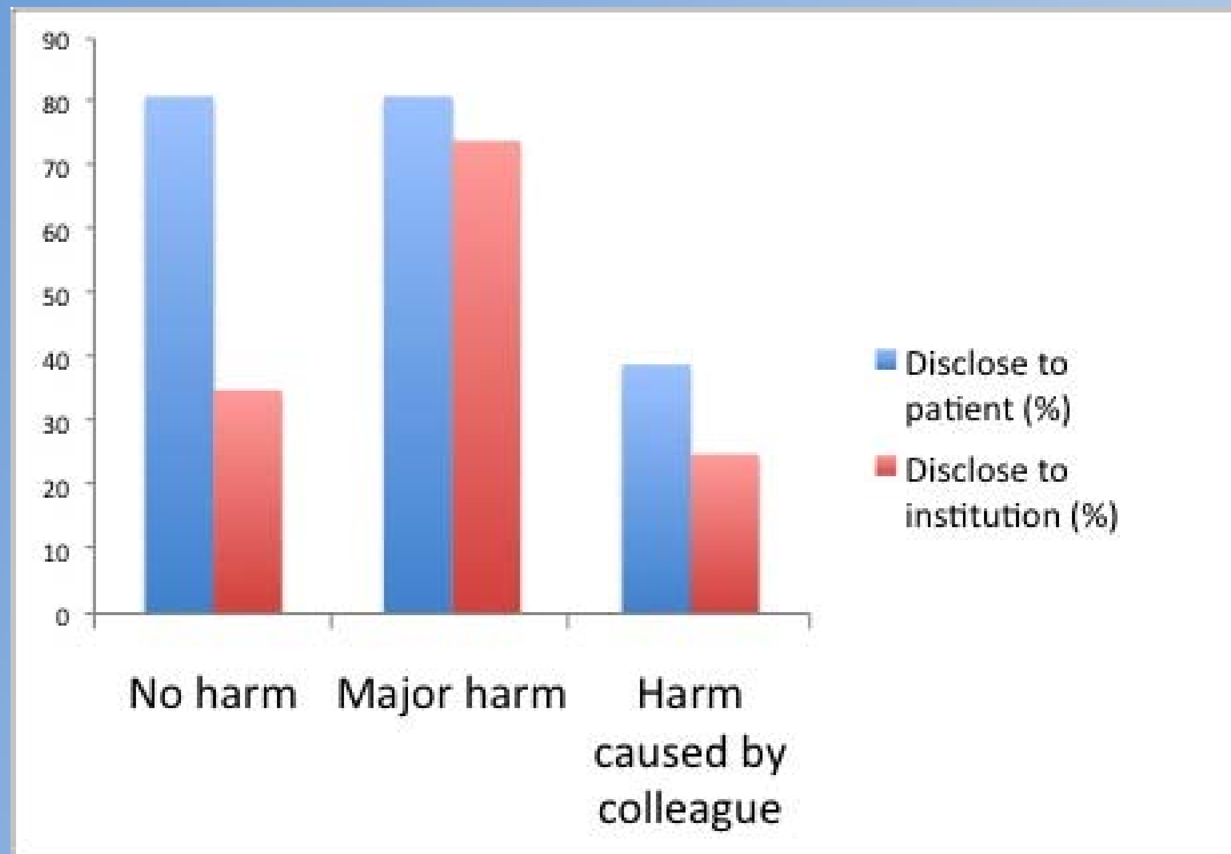
# ESIM Survey Result:
# Views on the Usefulness of Reporting Systems

- 74% respondents agreed that open & non-blame approach to errors is more helpful than anonymous written reports.

- 45% of respondents believed that error reporting is too complicated/time consuming

- 90% of respondents believed that speaking about errors within a team can help to prevent errors in the future

# ESIM Survey Result:
# Responses to error scenarios



# Summary

1. We considered the advantages and disadvantages of disclosing medical errors
2. We have identified barriers to disclosing medical errors
3. We looked at the role of disclosure in patient safety
4. We have explored the reporting practices and beliefs of our colleagues

# Summary

- He makes errors, so do we.

- Let’s talk about them.
- Thanks for taking part