# Emergency Physicians and Disclosure of Medical Errors

**John C. Moskop, PhD**
**Joel M. Geiderman, MD**
**Cherri D. Hobgood, MD**
**Gregory L. Larkin, MD, MPH**

From the Department of Medical Humanities, The Brody School of Medicine at East Carolina University, Bioethics Center, University Health Systems of Eastern Carolina, Greenville, NC (Moskop); the Ruth and Harry Roman Emergency Department, the Department of Emergency Medicine, Cedars-Sinai Center for Health Care Ethics, Burns and Allen Research Institute, Cedars-Sinai Medical Center, Los Angeles, CA (Geiderman); the Department of Emergency Medicine, University of North Carolina School of Medicine, Chapel Hill, NC (Hobgood); and the Departments of Surgery, Emergency Medicine, and Public Health, University of Texas Southwestern, Dallas, TX (Larkin).

Error in medicine is a subject of continuing interest among physicians, patients, policymakers, and the general public. This article examines the issue of disclosure of medical errors in the context of emergency medicine. It reviews the concept of medical error; proposes the professional duty of truthfulness as a justification for error disclosure; examines barriers to error disclosure posed by health care systems, patients, physicians, and the law; suggests system changes to address the issue of medical error; offers practical guidelines to promote the practice of error disclosure; and discusses the issue of disclosure of errors made by another physician. [Ann Emerg Med. 2006;48:523-531.]

## INTRODUCTION

With the publication of the Institute of Medicine report *To Err is Human* in 2000, error in medicine became a high-profile national issue.[1] As a result, physicians, patients, and the general public are more aware than ever of the incidence of medical error. Responding to this increased awareness, scholars and policymakers have offered a variety of proposals for addressing the problem of medical error.[2-11]

Emergency physicians are no strangers to medical error. One recent study in a busy academic emergency department (ED) identified 18 errors per 100 ED patients.[12] In September 2003, the American College of Emergency Physicians approved a new policy statement, titled Disclosure of Medical Errors, that directs emergency physicians who discover an error to inform the patient promptly about the error and its consequences.[13] The policy recognizes that substantial obstacles, such as unrealistic expectations of physician infallibility, lack of training in communication techniques, and fear of liability, hinder the free disclosure to patients of medical errors. The policy therefore recommends several initiatives to encourage error disclosure, including the development of institutional policies on this subject, continuing education programs on error disclosure, and appropriate tort reforms and system-based changes.

This article will examine the issue of disclosure of medical errors in the context of emergency medicine. It will review the concept of a medical error, propose the professional duty of truthfulness as a justification for error disclosure, examine barriers to error disclosure, suggest system changes to address the issue of medical error, offer practical guidelines to promote the practice of error disclosure, and discuss the issue of disclosure of errors made by another physician.

## DEFINING MEDICAL ERROR

Greater attention to patient safety has resulted in a significant increase in academic discourse about what constitutes a medical error. The Institute of Medicine defines medical error as the "failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim."[1] In some cases, the application of this definition is unambiguous. In symmetry errors, for example, a procedure is performed on the wrong side[14]; in medication errors, a dosing protocol or route is incorrectly administered.[15] Other actions, particularly those involving diagnostic processes and other cognitive processes, may be much more difficult to characterize as error, particularly given the information available to the provider at the time.[16,17] See the Figure for Institute of Medicine definitions of other terms commonly used in discussion of medical errors.

Medical errors often result in harm to patients, and this explains our increased efforts to identify and minimize such errors. It is important to recognize, however, that there is no *necessary* connection between medical error and patient harm. Some errors may not harm the patient. For example, an obvious error may occur in a patient's treatment, such as administration of a medication prescribed for a different patient, but the patient may experience no ill effects from that medication. In contrast, treatments can cause serious harm to patients in the absence of any error. For example, a patient may experience severe complications from a medication even though the

Patient safety   Freedom from accidental injury. Ensuring patient safety involves establishing operational systems and processes that minimize the possibility of error and maximize the probability of intercepting errors when they occur.

Accident   An event that damages a system and disrupts the ongoing or future output of the system.

Error   Failure of a planned action to be completed as intended (error of execution) or use of a wrong plan to achieve an aim (error of planning).

Active error   An error that occurs at the level of the front line operator and whose effects are felt almost immediately.

Latent error   An error in design, organization, training, or maintenance that leads to operator errors and whose effects typically lie dormant in the system for lengthy periods of time prior to their appearance.

Adverse event   An injury caused by medical management rather than by the underlying disease or condition of the patient.

Adverse medication event   An injury related to medication administration rather than the underlying disease or condition of the patient.

Preventable adverse event   An adverse event attributable to error or equipment failure.

Near miss   An event that could have resulted in an accident, injury, or illness but did not, either by chance or through timely intervention.

Negligent adverse event   An adverse event that meets the legal criteria for negligence.

*IOM = Institute of Medicine. (Data from Kohn LT, Corrigan JM, Donaldson MS, editors. To Err Is Human: Building a Safer Health System. Washington [DC]: National Academy Press; 2000: 210-1; Quality Interagency Coordination [QuIC] Task Force. Doing what counts for patient safety: federal actions to reduce medical errors and their impact. Available at: www.quic.gov/report/index.htm. Accessed 23 Mar 2004.)*

**Figure.** IOM nomenclature for patient safety.

medication is a standard treatment for the patient's condition and was administered correctly.

## MEDICAL ERROR AND THE DUTY OF TRUTHFULNESS

Truthfulness is widely recognized as a central professional responsibility of physicians. The American Medical Association's "Principles of Medical Ethics" include the principle that "a physician shall . . . be honest in all professional interactions . . ."[18] Similarly, the American College of Emergency Physicians' "Principles of Ethics for Emergency Physicians" direct that "Emergency physicians shall communicate truthfully with patients . . ."[19] In pledging to be truthful with their patients, physicians acknowledge that patients are moral agents who deserve to be treated with dignity and respect.

To make important health care choices, patients expect and are entitled to accurate information about their medical condition and treatment alternatives. In addition to enabling patients to make informed treatment choices, open and honest communication between physicians and patients fosters the trust and cooperation essential for a successful therapeutic relationship.

Although there is strong consensus that physicians owe a duty of truthfulness to their patients, the scope and limits of

that duty are less well established. Some limits of the duty of truthfulness are, however, reasonably clear. Because the physician-patient relationship is a professional (and not a personal) relationship, the duty applies only to information about the patient's medical condition and its treatment.[20] Moreover, the duty does not require disclosure of all medical information. Physicians need not, for example, provide purely technical or insignificant information to their patients, because total disclosure is neither practical for physicians nor desired by (or advantageous for) patients.[21]

How, then, can physicians determine what information is and is not owed to their patients? A potential source of guidance about disclosure of information to patients can be found in the legal doctrine of informed consent. As that doctrine evolved in law and ethics during the past half-century, standards have been adopted about the amount of information that should be disclosed to patients to enable them to give an appropriately informed consent. One widely accepted legal standard appeals to the concept of the reasonable person, asserting that the physician should disclose what a reasonable person in the patient's position would want to know to make an intelligent and informed treatment decision.[21] This standard could be extended beyond the consent process to direct physicians to share with their patients the information a reasonable person in the patient's position would want to know about his or her medical condition, including the diagnosis, prognosis, course and outcomes of treatment, complications, and errors in their care.

How might this standard of disclosure be applied when medical errors occur? If disclosure is based on what the reasonable person would want to know, it clearly cannot be a "fair-weather" phenomenon, required only when the information is benign and the patient's outcome is excellent. Rather, physicians should also share bad news with their patients, including the news that an adverse event was the result of an error made in their care. Only in this way can physicians demonstrate that they remain committed to the patient's well-being and are willing to work to correct the problem and improve the patient's condition. The alternative, attempting to hide or cover up the error and hoping that the patient will not discover his or her misfortune, potentially transforms physicians from patient advocates into patient adversaries. At the very least, nondisclosing physicians are placing their own interests ahead of the interests of their patients.

If we assume that patients would want to know about medical errors that significantly affect their medical condition and its treatment, are there also errors about which they may not want to know? If an error is minor or is quickly corrected and therefore has only a minimal or no effect on the patient's condition or ongoing treatment, there may be no strict duty to disclose it to the patient. Physicians may, nevertheless, choose to inform their patients about these inconsequential errors and reassure them that the error has been corrected and has not had any adverse effects.

Patients' expectations for error disclosure continue to be explored, and most of the available evidence suggests that patients want to be told about all errors that occur in their medical care.[22-24] For example, 91% of members of a New England health maintenance organization who responded to a survey on medical errors agreed with the statement "Patients should always be told if an error is made—even if the patient is not injured or harmed."[22] In a survey of ED patients, 88% stated they wanted to "know everything" about errors that occurred in their health care, whereas 12% wanted to be informed of a mistake only if it affected their health.[23] In a prominent study using focus groups, patients unanimously agreed that they should be informed about any error that caused them harm.[25] These focus group patients, however, expressed mixed opinions about whether patients should be told about near misses, and the study authors recommend limiting such disclosures.

In rare circumstances, it may be appropriate for emergency physicians to limit disclosure of information to their patients on the basis of "therapeutic privilege." Like the reasonable person standard of information disclosure, the doctrine of therapeutic privilege has its origins in the law of informed consent. According to this doctrine, if a physician judges that the disclosure of certain information will in itself be highly detrimental to the patient, as, for example, disclosing the occurrence of a serious error to a medically unstable or emotionally fragile patient, the physician may refrain from providing that information.[26] Commentators caution that such situations "should be rare and based on well-delineated reasons that outweigh and therefore supersede the presumption to disclose and apologize."[26]

## BARRIERS TO ERROR DISCLOSURE

For a variety of reasons, many physicians have sought to avoid the difficult topic of medical error.[27] Recent studies of the frequency of medical errors, however, have forced institutions and individual professionals to confront this problem directly. One obvious way to respond to medical errors is to identify them when they occur, to disclose them promptly to interested parties, and to seek out and correct the causes of errors. There are, however, a number of barriers to implementing a practice of error identification, disclosure, and investigation. This section will examine, in turn, significant barriers to error disclosure posed by health care systems, patients, physicians, and the law.

### System Barriers

Despite recent calls for improved error surveillance and disclosure, health systems in the United States are generally not designed to reward, compensate, or otherwise encourage the processes of error recognition, disclosure, investigation, and remediation. Although legal histories, malpractice awards, and letters from the National Practitioner Data Bank are basic components of hospital credentialing, hospitals rarely require members of their medical staff to engage in error disclosure activities.

In academic medical centers, institutional practices may often inhibit error disclosure. Teaching sessions, such as ward rounds or mortality and morbidity conferences, may indeed identify and discuss medical errors.[28,29] When they do focus on medical errors, however, these sessions may be used to embarrass "guilty" physicians or to examine the sequelae of errors rather than to teach about the importance of identifying key errors and developing constructive ways to prevent or respond to them.

Health care systems, like individual professionals, have a strong interest in avoiding malpractice liability, and they may view medical errors as a major liability risk. Systems may, therefore, assign to risk managers rather than physicians the task of responding to reports of medical error. If risk managers respond by trying to deny, minimize, or cover up the error, physicians may draw the conclusion that the system has no interest in acknowledging or disclosing medical errors.

The distinctive environment of the hospital ED may create its own specific barriers to addressing medical errors. High patient volume, high acuity, and the largely episodic nature of care in the ED may increase the risk of errors and inhibit their identification and disclosure. Errors may occur more frequently in the ED than in other treatment settings because physicians must often act quickly and with only limited information about the patient's condition and medical history.[30] The ED is also characterized by multiple transitions in care, from one attending physician to another, one resident to another, one nurse to another, an emergency physician to a consulting specialist, and so on. These frequent transitions can increase the risk of medical error as a result of incomplete, inaccurate, delayed, or poorly organized transfer of information and failure to reevaluate a previous physician's assessment or treatment plan.[31]

ED patients are eventually either admitted to the hospital or discharged, and emergency physicians typically do not provide ongoing or follow-up care. Thus, unless a medical error manifests itself rapidly, the emergency physician will not have an opportunity to identify, disclose, or investigate it. Because emergency physicians generally do not have a long-term relationship of trust with their patients, they may fear that injured patients will have few qualms about taking legal action against them and so may be reluctant to disclose an error in their care.

Care in the ED is typically provided by multidisciplinary teams of health care professionals. The Institute of Medicine has identified a team approach to health care as a key strategy for improving patient safety, through increased communication and cooperation among the team members and better coordination of care.[32] To achieve this outcome, team members must embrace the goal of improving patient safety and be willing to work together to achieve it. Based on a survey of emergency physicians, nurses, and emergency medical technicians in one ED, however, Hobgood et al[33] conclude that "providers have limited insight into their own error pattern, rarely assist others with error identification, and when errors are identified, often

do not inform others, including the patient, of these events." Improving patient safety and care systems in the ED setting will therefore require specific education on teamwork skills, coordination of care, and communication.

## Patient Barriers

Physician efforts to disclose medical errors may also be frustrated by an inability to contact patients once they leave the ED. Many ED patients are unable or unwilling to provide contact information because they are undocumented immigrants, fugitives from the police, travelers, or visiting foreigners who lack a telephone, a stable or verifiable address, or, in some cases, a legitimate identity. Other patients grow tired of long waits in the ED and may leave before physicians have an opportunity to discuss a medical error with them or obtain their contact information.

Emergency physicians are unable to disclose medical errors to many ED patients because of the patient's condition. Even if an error is quickly identified, the patient may already be dead or may be unable to receive the information because he or she is unconscious, demented, intoxicated, or otherwise mentally impaired. As immigration and travel increase, language and cultural differences between patients and physicians are becoming more common barriers to engaging in sensitive, nuanced discussion of medical errors.

## Physician Barriers

Widely held beliefs and attitudes of physicians also create strong barriers to the disclosure of medical errors. Physicians are taught the foundational principle *primum non nocere* (first, do no harm) early in their medical careers. This basic tenet has become both a professional and a societal expectation of physicians. When an error occurs, physicians, as leaders of the health care team, often feel a profound sense of failure. In the aftermath of medical errors that have caused serious harm to patients, physicians acknowledge feeling shame, a sense of professional inadequacy, and grave doubt about their competence.[23,34-36] Feelings of shame, guilt, incompetence, and fear of exposure may make physicians extremely reluctant to disclose the occurrence of a medical error. In emergency medicine residents, negative emotions such as remorse, guilt, inadequacy, and frustration were associated with lack of experience, job overload, and lack of institutional support surrounding error.[37] To mitigate these negative emotional responses, physician-educators must attend to the experiences of trainees and develop constructive strategies to enable residents to acknowledge and disclose their medical errors.

Residents and attending physicians may believe that they should disclose medical errors to patients but be reluctant to do so because they lack the training and skills to communicate this sensitive information. In one recent study, only 12% of a sample of residents and attending physicians working in the ED of an academic medical center reported that they had received any formal instruction on how to inform patients about a

medical error.[33] The recent inclusion of interpersonal and communication skills as a core competency for all residency programs may encourage efforts to provide formal training in the disclosure of medical errors.[38]

Physicians with anxiety, depression, lack of self-confidence, or lack of confidence in due process may also be reluctant to disclose errors. Character defects such as arrogance or narcissism can make some physicians believe that duties of disclosure and honesty do not apply to them, because such physicians may view the interests of others as subordinate to their individual concerns.[39] Other (hopefully rare) physicians who are slothful or avaricious or who abuse drugs or alcohol may also be unwilling to disclose medical errors.

Many physicians report a fear that acknowledging an error will result in an irremediable erosion of patient trust both in them as individuals and in the medical profession as a whole. This loss of trust may harm patients by decreasing their adherence to treatment plans, creating undue anxiety about their treatment, or deterring them from seeking future care.[23,36,40,41] Other commentators, however, argue that error disclosure does not in fact erode but rather enhances patient trust. These authors maintain that honesty is a cornerstone of the physician-patient relationship, and full disclosure of errors fosters communication, trust, and openness between patients and their physicians.[23,36,40,42]

As noted in the above discussion of system barriers to error disclosure, emergency physicians generally do not have a longstanding relationship with their patients. In addition to a concern that injured patients will be more likely to take legal action against a physician who is a virtual stranger to them, emergency physicians may also feel less inclined to disclose medical errors because the physician-patient bond is new and tenuous and because they are not concerned about protecting and preserving long-term relationships with their patients.

## Legal Barriers

In addition to physician concerns about competence, communication skills, and erosion of patient trust, the threat of malpractice liability poses a substantial barrier to disclosure of medical errors.[23,43-46] Without disclosure, most patients will have no knowledge that an error in their care resulted in some harm to them. Physicians' disclosures of error can thus reveal to patients that their injury was a result of the error, not of the disease itself or of an unavoidable complication of treatment. This knowledge may induce patients to take legal action to receive compensation for the harm they have experienced. A physician's disclosure of error and apology may also be admissible as evidence against him or her in a malpractice trial.[47] For these reasons, defense attorneys frequently counsel physicians not to speak with patients and families about medical errors.

One obvious way to remove this legal barrier to error disclosure would be to replace the current medical malpractice system with a no-fault approach to compensating injured patients or an enterprise liability system that ascribes

responsibility for errors to institutions rather than individual practitioners.[10,48] Under these alternative approaches, physicians could identify, report, disclose, and investigate errors without fear of opening themselves to severe adverse consequences. Enacting a comprehensive restructuring of the tort system in the foreseeable future, however, appears to be an uphill political battle.

A number of medical and legal commentators have challenged the widespread perception that disclosure of errors to patients increases the physician's risk of liability.[49-55] These commentators argue that voluntary disclosure of errors and apologies by physicians may, in fact, reduce the likelihood of legal action. Patients and families who have filed malpractice suits cite a variety of reasons for doing so.[56,57] Financial compensation is one reason, to be sure, but so are a desire to learn what caused their injuries, a sense of abandonment by their physician, a perception that the physician is indifferent to their misfortune, and a desire to prevent future errors. Most of these interests can be satisfied without legal action if physicians give patients a full explanation of the reasons for their injury, offer sincere apologies, strive to correct or ameliorate the injury, and describe what is being done to prevent similar errors in the future.

There are, thus, 2 conflicting accounts of the likely effect of disclosing errors and offering apologies on the risk of liability. Unfortunately, there is a dearth of published empirical data to support either account.[58] Proponents of disclosure commonly appeal to a 1999 article reporting the results of 7 years' experience with an aggressive error disclosure policy at the Lexington, KY, Veteran's Affairs Medical Center.[53] With this disclosure policy in place, the Lexington center had a relatively high number of malpractice claims and out-of-court settlements but a low level of overall payments compared with 35 other VA medical centers in the eastern United States. Critics of this study, however, have claimed that it is methodologically weak and is not generalizable, because the VA system does not permit suits against individual physicians.[44,46]

In an effort to overcome one legal obstacle to physician apologies to patients, 18 states have in recent years enacted statutes making physician apologies inadmissible in civil suits.[59] A 2004 North Carolina statute, for example, declares that "statements by health care providers apologizing for an adverse outcome in medical treatment, offers to undertake corrective or remedial treatment or actions, and gratuitous acts to assist affected persons shall not be admissible to prove negligence or culpable conduct by the health care provider . . ."[60] Legal commentators caution, however, that most state apology statutes protect only "partial apologies," that is, expressions of sympathy for a patient's injury but not admissions of fault.[47,49]

Several studies suggest that the legal consequences of disclosure of errors may depend in part on the severity of the patient's injury.[22,51,61] In a survey study of parents of pediatric ED patients, for example, respondents reported that they would be less likely to pursue legal action after disclosure of a moderate error than after disclosure of a severe error.[51]

Although the effect of disclosing errors on liability risk remains unclear, proponents of disclosure cite other moral and psychological benefits of this practice. Cohen[49] argues that apologizing for errors shows respect for the patient and a desire to maintain a positive relationship. Apologizing may assuage the patient's feelings of anger by "subtracting the insult from the injury," and it may also ease the physician's feelings of guilt for causing harm. Finally, disclosure and apology may completely mitigate the patient's desire to sue or open the door to an early settlement, thereby avoiding the burdens on both the patient and physician of a lengthy legal battle.[54]

## CREATING A CULTURE THAT PROMOTES PATIENT SAFETY AND DISCLOSURE OF ERRORS

Disclosure of errors is an important practice, but it is only one part of a comprehensive approach to error in medicine. The task of disclosing errors will be less onerous if health care institutions and physicians are able to reduce the overall number of errors. Thus, in addition to disclosing errors when they occur, institutions and individual professionals should seek out ways to prevent errors though improved training, staffing, support, design, and equipment. Department chairs, directors, administrators, risk managers, insurers, and others should also implement policies and procedures that encourage physicians to report errors to appropriate patient safety personnel and to disclose errors to patients. For example, institutions might establish a "safety hotline" to encourage reporting of errors. After receiving such reports, managers should seek out the root cause of the problem and communicate the lessons learned to staff in an effort to prevent reoccurrences.

Joint Commission on Accreditation of Healthcare Organizations standards require that patients and families be informed about unanticipated outcomes of care, including those caused by medical errors.[62] Most physicians and clinical staff practicing today were trained during an era when error disclosure was not encouraged; instead, the medical culture routinely punished those who committed errors. Morbidity and mortality and other conferences, as well as the quality assurance process, were primarily concerned with finding "the bad apples" and assigning blame. Not surprisingly, physicians responded with denial, discounting, and distancing.[26] New educational offerings and other conferences should be aimed at reorienting caregivers to a more constructive approach to error in medicine. One recent report, for example, describes a restructuring of the traditional mortality and morbidity conference to include consideration of systems problems, communication problems, and ethical issues in a nonintimidating and nonjudgmental manner.[63]

Health care institutions and continuing education providers should offer formal training in the skills of divulging errors to patients and reporting them within the system. Institutions should also assure physicians that this is the right thing to do

and should support them when they make reports. Emergency physicians should take an active part in designing and implementing procedures for error identification, disclosure, and investigation in the ED.

Recent discussions of medical error have emphasized the central role of system errors in medicine,[1,32] and so this section has focused on system initiatives to identify, disclose, and prevent errors. We acknowledge, however, that some errors are the result of an individual physician's misjudgment or lack of technical skill and that everyone makes errors from time to time. When such errors occur, physicians should disclose the error and accept responsibility for it. Disclosing errors may not be easy or comfortable, but not all moral responsibilities are easy to discharge.

The current malpractice liability system does a poor job of holding physicians accountable for their performance because it does not identify most negligent errors and it awards damages in many cases in which care was not negligent.[44] It is important, however, that some mechanism be in place to protect patients from injury at the hands of physicians who are incompetent, impaired, or malevolent. When institutional investigations of errors or injuries uncover evidence of physician incompetence, impairment, or malice, patient safety systems should make reports to professional licensure boards for their investigation.

## PRACTICAL GUIDELINES FOR ERROR DISCLOSURE IN EMERGENCY MEDICINE

In fulfilling the obligation to disclose medical errors, a good place to start is to develop the habit of error disclosure at every appropriate opportunity. Smith and Forster[26] have stated this eloquently: "The virtue of truthfulness is the habit of telling the truth even when it is inconvenient or involves some personal risk. When professionals develop a habit of telling the truth, every truth told strengthens their inner selves . . . the virtue of truthfulness is ultimately essential for an effective professional-patient relationship because relationships cannot endure failures of truthfulness for long."

Although physicians may not be strictly morally obliged to disclose mistakes of marginal or no impact, it can be argued that there is little to lose and much to gain by doing so.[39] In fact, minor mistakes, which are much more common than more serious errors, may provide a fertile training ground for acquiring the communication skills and comfort level necessary to admit error. For example, a not-infrequent error in the ED is a computerized order for a radiograph on the wrong patient or body part. In such cases, when the study has been completed before the error is discovered, the best practice is to inform the patients of the error and tell them that they will not be charged for the unnecessary study. This practice has uniformly been met with positive feelings. An example of a more invasive error is administration of a medication to the wrong patient. In this circumstance, the error may produce morbidity, discomfort, or inconvenience. Although this information is sometimes less well received by the patient, physicians who have developed the habit of truthfulness will be better prepared to fulfill their

responsibility to disclose both major and minor errors to their patients.

Mistakes should be disclosed at the earliest appropriate moment, taking into account the patient's physical and emotional condition at the time, as well as the magnitude and consequences of the error. For instance, a patient experiencing an acute myocardial infarction and anxiously waiting to be taken to the catheterization laboratory need not be told immediately about a minor error. In contrast, if a massive overdose of heparin in the ED caused a hemorrhage that results in the patient's having to be transfused before leaving the catheterization laboratory, the physician should inform the patient of this while obtaining consent for the transfusion.

In some cases, it may be rapidly apparent that an adverse event has occurred but not clear whether the event was the result of a medical error. When such a situation arises, the patient and, if appropriate, family members should be informed that a problem has occurred and told what is known about the problem. The patient and family should also be informed that the problem is being investigated and that further information will be given to them when it is uncovered.

When an error is identified, the physician should begin by simply and clearly stating that a "mistake" or an "error" has occurred, rather than using euphemisms that may be intended or be perceived as efforts to conceal the error. When systems issues result in error (sometimes called latent errors), this also should be communicated, perhaps involving a nursing or administrative member of the team. An example of this might be the mislabeling or loss of a specimen. It is good practice to document this discussion in the written record. An apology should be offered, as well as an assurance that any related medical charges will be cancelled or expenses reimbursed. When a subordinate working under the care of a supervising physician (eg, a house officer or allied health professional) makes an error, the attending physician has a duty to inform the patient along with the supervisee. The attending physician should use this opportunity to educate his or her charge about the ethics and practical application of error disclosure.

## DISCLOSURE OF ERRORS MADE BY ANOTHER

Physicians bear primary responsibility for the medical care they provide or direct and for medical errors that occur in the course of that care. We have argued that this responsibility extends to informing patients about significant medical errors made by the physician or under the physician's direction. Does it also extend to informing patients about medical errors that the physician believes were made by a previous physician?

Emergency physicians often discover errors that occurred in care provided to a patient by another physician during a previous (usually recent) ED visit. Radiologists also commonly encounter this situation, as discussed by Berlin.[64] Should the emergency physician mention such a previous error in his or her dictation? Should the physician disclose the error to the patient and to the physician who will assume care of the patient? Or should he or she remain silent, let the previous records speak for

themselves, and restrict any comments to the current findings and situation?

We have proposed above that the professional duty of truthfulness be understood as requiring that physicians share with their patients all medical information that a reasonable person in the patient's position would want to know. On this interpretation, truthfulness may require that physicians disclose information about previous errors because that information may play an important role in patient decisions about whether to seek care from another physician or hospital and whether to seek redress if harmed.

Professional codes of ethics also commonly ascribe to physicians a duty to protect patients from impaired or incompetent physicians. Principle 6 of the American College of Emergency Physicians' "Principles of Ethics for Emergency Physicians," for example, states that "Emergency Physicians shall deal fairly and honestly with colleagues and take appropriate action to protect patients from health care providers who are impaired, incompetent, or who engage in fraud or deception."[19] Carrying out this duty to protect patients may require disclosing to them that an error has been made in care provided to them by another physician so that they can make informed decisions about their future medical care.

Several factors speak against explicitly mentioning the error in the medical record or disclosing it to the patient. It may be difficult for the physician who discovers an apparent error in the past to gather and evaluate all the relevant information about the patient's condition and the treatment provided during a previous visit. Mention or disclosure of the past error may also serve as a stimulus for initiating legal action and may complicate future efforts at defending a lawsuit.[41] Not all errors or omissions constitute negligence in the eyes of the law, however, and unless the patient has experienced real harm, a lawsuit should not be successful. Whether or not a lawsuit ensues, reporting or disclosing another physician's error could lead to strained professional relations.

The factors described above may make the decision to disclose someone else's mistakes more difficult than that of disclosing one's own. Perhaps for this reason, the American College of Emergency Physicians policy is silent on the issue of disclosing to patients other providers' errors.[13] Emergency physicians should not, however, simply ignore evidence of an error made in the patient's previous treatment. Rather, they should discuss the situation with the previous physician and, if an error is identified, urge that physician to discuss the error with the patient. Finally, if the patient asks specific questions about the reason for a complication, the emergency physician should not withhold relevant information or provide false information.

## CONCLUSION

After a long period of neglect, the issue of medical error has in recent years captured significant public and professional attention. The ED is the locus of a variety of errors, and emergency physicians must therefore be prepared to identify errors and respond to them appropriately. Physicians have a professional responsibility to communicate truthfully with their patients; that responsibility includes disclosure to patients of errors that occur in their care. Barriers imposed by health care systems, patients, physicians, and the law complicate the practice of disclosing errors to patients. To overcome these barriers, health care institutions and individuals should develop policies and procedures that encourage and support the identification, reporting, and disclosure of errors. To fulfill their responsibility to be truthful with their patients, physicians should consider making the disclosure of error a matter of routine or habit. Physicians should also reflect carefully on the scope of their responsibilities when they discover an error made by a previous physician.

Address for correspondence: John C. Moskop, PhD, Department of Medical Humanities, Brody School of Medicine at East Carolina University, 600 Moye Boulevard, Greenville, NC 27834; 252-744-2361, fax 252-744-2319; E-mail moskopj@mail.ecu.edu.

## REFERENCES

1. Kohn LT, Corrigan J, Donaldson MS, et al. *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press; 2000.
2. Altman DE, Clancy C, Blendon RJ. Improving patient safety: five years after the IOM report. *N Engl J Med*. 2004;351:2041-2043.
3. Amalberti R, Auroy Y, Berwick D, et al. Five system barriers to achieving ultrasafe health care. *Ann Intern Med*. 2005;142:756-765.
4. Bayley C. Turning the Titanic: changing the way we handle medical mistakes. *HEC Forum*. 2001;13:148-159.
5. Classen DC, Kilbridge PM. The roles and responsibility of physicians to improve patient safety within health care delivery systems. *Acad Med*. 2002;77:963-972.
6. Fernandez CV, Gillis-Ring J. Strategies for the prevention of medical error in pediatrics. *J Pediatr*. 2003;143:155-162.
7. Goode LD, Clancy CM, Kimball HR, et al. When is "good" enough? the role and responsibility of physicians to improve patient safety. *Acad Med*. 2002;77:947-952.
8. Goldberg RM, Kuhn G, Andrew LB, et al. Coping with medical mistakes and errors in judgment. *Ann Emerg Med*. 2002;39:287-292.
9. Leape LL, Berwick DM, Bates DW. What practices will most improve safety? evidence-based medicine meets patient safety. *JAMA*. 2002;288:501-507.
10. Studdert DM, Brennan TA. No-fault compensation for medical injuries: the prospect for error prevention. *JAMA*. 2001;286:217-223.

11. Volpp KGM, Grande D. Residents' suggestions for reducing errors in teaching hospitals. *N Engl J Med.* 2003;348:851-855.

12. Fordyce J, Blank FS, Pekow P, et al. Errors in a busy emergency department. *Ann Emerg Med.* 2003;42:324-333.

13. American College of Emergency Physicians. Disclosure of medical errors: policy statement, approved September 2003. Available at: http://www.acep.org/webportal/PracticeResources/PolicyStatements/ethics/DisclosureMedicalErrors.htm. Accessed May 19, 2006.

14. Shapiro MJ, Croskerry P, Fisher S. Profiles in patient safety: sidedness error. *Acad Emerg Med.* 2002;9:326-329.

15. Croskerry P, Shapiro M, Campbell S, et al. Profiles in patient safety: medication errors in the emergency department. *Acad Emerg Med.* 2004;11:289-299.

16. Croskerry P. The importance of cognitive errors in diagnosis and strategies to minimize them. *Acad Med.* 2003;78:775-780.

17. Kuhn GJ. Diagnostic errors. *Acad Emerg Med.* 2002;9:740-750.

18. American Medical Association. Principles of medical ethics. Adopted June 17, 2001. Available at: http://ama-assn.org/ama/pub/category/2512.html. Accessed June 1, 2005.

19. American College of Emergency Physicians. Principles of ethics for emergency physicians. In: *Code of Ethics for Emergency Physicians.* Available at http://www.acep.org/webportal/PracticeResources/PolicyStatements/ethics/codeethics.htm. Accessed May 19, 2006.

20. Gabbard GO, Nadelson C. Professional boundaries in the physician-patient relationship. *JAMA.* 1995;273:1445-1449.

21. Brock DW. Informed consent. In: VanDeVeer D, Regan T, eds. *Health Care Ethics*. Philadelphia, PA: Temple University Press; 1987:98-116.

22. Mazor KM, Simon SR, Yood RA, et al. Health plan members' views about disclosure of medical errors. *Ann Intern Med.* 2004;140:409-418.

23. Hobgood C, Peck CR, Gilbert B, et al. Medical errors: what and when: what do patients want to know? *Acad Emerg Med.* 2002;9:1156-1161.

24. Witman AB, Park DM, Hardin SB. How do patients want physicians to handle mistakes? a survey of internal medicine patients in an academic setting. *Arch Intern Med.* 1996;156:2565-2569.

25. Gallagher TH, Waterman AD, Ebers AG, et al. Patients' and physicians' attitudes regarding the disclosure of medical errors. *JAMA.* 2003;289:1001-1007.

26. Smith ML, Forster HP. Morally managing medical mistakes. *Camb Q Healthc Ethics.* 2000;9:38-53.

27. Hilfiker D. Facing our mistakes. *N Engl J Med.* 1984;310:118-122.

28. Hobgood CD, Ma OJ, Swart GL. Emergency medicine resident errors: identification and educational utilization. *Acad Emerg Med.* 2000;7:1317-1320.

29. Pierluissi E, Fischer MA, Campbell AR, et al. Discussion of medical errors in morbidity and mortality conferences. *JAMA.* 2003;290:2838-2842.

30. Croskerry P, Sinclair D. Emergency medicine: a practice prone to error. *Can J Emerg Med.* 2001;3:271-276.

31. Beach C, Croskerry P, Shapiro M. Profiles in patient safety: emergency care transitions. *Acad Emerg Med.* 2003;10:364-367.

32. Institute of Medicine, Committee on Quality Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.

33. Hobgood C, Xie J, Weiner B, et al. Error identification, disclosure, and reporting: practice patterns of three emergency medicine provider types. *Acad Emerg Med.* 2004;11:196-199.

34. Wu AW, Folkman S, McPhee SJ, et al. Do house officers learn from their mistakes? *JAMA.* 1991;265:2089-2094.

35. Wu AW. Medical error: the second victim: the doctor who makes the mistake needs help too. *BMJ.* 2000;320:726-727.

36. Rosner F, Berger JT, Kark P, et al. Disclosure and prevention of medical errors: Committee on Bioethical Issues of the Medical Society of the State of New York. *Arch Intern Med.* 2000;160:2089-2092.

37. Hobgood C, Hevia A, Tamayo-Sarver JH, et al. The influence of the causes and contexts of medical errors on emergency medicine residents' responses to their errors: an exploration. *Acad Med.* 2005;80:758-764.

38. ACGME Outcomes Project. General competencies: minimum program requirements language. Available at: http://www.acgme.org/outcome/comp/compMin.asp. Accessed July 24, 2005.

39. Banja J. *Medical Errors and Medical Narcissism*. Sudbury, MA: Jones & Bartlett; 2005.

40. Sweet MP, Bernat JL. A study of the ethical duty of physicians to disclose errors. *J Clin Ethics.* 1997;8:341-348.

41. Wu AW, Cavanaugh TA, McPhee SJ, et al. To tell the truth: ethical and practical issues in disclosing medical mistakes to patients. *J Gen Intern Med.* 1997;12:770-775.

42. Baylis F. Errors in medicine: nurturing truthfulness. *J Clin Ethics.* 1997;8:336-340.

43. Blendon RJ, DesRoches CM, Brodie M, et al. Views of practicing physicians and the public on medical errors. *N Engl J Med.* 2002;347:1933-1940.

44. Brennan TA, Mello MM. Patient safety and medical malpractice: a case study. *Ann Intern Med.* 2003;139:267-273.

45. Gallagher TH, Levinson W. Disclosing harmful medical errors to patients: a time for professional action. *Arch Intern Med.* 2005;165:1819-1823.

46. Liang BA. A system of medical error disclosure. *Qual Saf Health Care.* 2002;11:64-68.

47. Robbennolt JK. Apologies and legal settlement: an empirical examination. *Mich Law Rev.* 2003;102:460-516.

48. Kilcullen JK. Groping for the reins: ERISA, HMO malpractice, and enterprise liability. *Am J Law Med.* 1996;22:7-50.

49. Cohen JR. Advising clients to apologize. *S Cal Law Rev.* 1999;72:1009-1069.

50. Dauer EA. A therapeutic jurisprudence perspective on legal responses to medical error. *J Legal Med.* 2003;24:37-50.

51. Hobgood C, Tamayo-Sarver JH, Elms A, et al. Parental preferences for error disclosure, reporting, and legal action after medical error in the care of their children. *Pediatrics.* 2005;116:1276-1286.

52. Kellett AJ. Healing angry wounds: the roles of apology and mediation in disputes between physicians and patients. *Spec Law Dig Health Care (Mon).* 1989;10:7-27.

53. Kraman SS, Hamm G. Risk management: extreme honesty may be the best policy. *Ann Intern Med.* 1999;131:963-967.

54. Liebman CB, Hyman CS. A mediation skills model to manage disclosure of errors and adverse events to patients. *Health Aff (Millwood).* 2004;23:22-32.

55. Wu AW. Handling hospital errors: is disclosure the best defense [editorial]? *Ann Intern Med.* 1999;131:970-972.

56. Beckman HB, Markakis KM, Suchman AL, et al. The doctor-patient relationship and malpractice: lessons from plaintiff depositions. *Arch Intern Med.* 1994;154:1365-1370.

57. Hickson GB, Clayton EW, Githens PB, et al. Factors that prompted families to file medical malpractice claims following perinatal injuries. *JAMA.* 1992;267:1359-1363.

58. Mazor KM, Simon SR, Gurwitz JH. Communicating with patients about medical errors: a review of the literature. *Arch Intern Med.* 2004;164:1690-1697.

59. The Sorry Works! Coalition. States with apology laws. Available at: http://www.sorryworks.net/media25.phtml. Accessed February 13, 2006.

60. North Carolina General Statutes. Ch. 8C, Art. 4, Rule 413.

61. Schwappach DLB, Koeck CM. What makes an error unacceptable? a factorial survey on the disclosure of medical errors. *Int J Qual Health Care.* 2004;16:317-326.

62. Joint Commission on Accreditation of Healthcare Organizations. *Comprehensive Accreditation Manual for Hospitals: The Official Handbook.*Oakbrook Terrace, IL: JCAHO; 2005:RI-13.

63. Rosenberg JC. Using the morbidity and mortality conference to teach and assess the ACGME general competencies. *Curr Surg.* 2005;62:664-669.

64. Berlin L. Reporting the "missed" radiologic diagnosis: medicolegal and ethical considerations. *Radiology.* 1994;192:183-187.

---

IMAGES IN EMERGENCY MEDICINE

*(continued from p. 522)*

**DIAGNOSIS:**

*Activated charcoal aspiration.* At autopsy, gross examination of his pulmonary tree revealed activated charcoal in his oropharynx, trachea, and pulmonary parenchyma, described as diffuse and focal black geographic discoloration of both lung fields, with airways containing black particulate matter (Figure 1, white arrow). Histologic slides revealed activated charcoal within bronchiole and in peribronchiolar alveolar spaces, with extensive polymorphonuclear leukocytic infiltration (Figures 2 and 3). Although much is written on indications for activated charcoal, timing of administration, and complications, death is rarely reported. This case illustrates the importance of patient selection for activated charcoal administration and the potentially fatal complications associated with its use.

---