Abstract

Introduction: There is a growing consensus that disclosure of medical mistakes is ethically and legally appropriate, but such disclosures are made difficult by medical traditions of concern about medical malpractice suits and by physicians’ own emotional reactions. Because the physician may have compelling reasons both to keep the information private and to disclose it to the patient or family, these situations can be conceptualized as privacy dilemmas. These dilemmas may create barriers to effectively addressing the mistake and its consequences. Although a number of interventions exist to address privacy dilemmas that physicians face, current evidence suggests that physicians tend to be slow to adopt the practice of disclosing medical mistakes.

Methods: This discussion proposes a theoretically based, streamlined, two-step plan that physicians can use as an initial guide for conversations with patients about medical mistakes. The mistake disclosure management plan uses the communication privacy management theory.

Results: The steps are 1) physician preparation, such as talking about the physician’s emotions and seeking information about the mistake, and 2) use of mistake disclosure strategies that protect the physician-patient relationship. These include the optimal timing, context of disclosure delivery, content of mistake messages, sequencing, and apology. A case study highlighted the disclosure process.

Conclusion: This Mistake Disclosure Management Plan may help physicians in the early stages after mistake discovery to prepare for the initial disclosure of a medical mistakes. The next step is testing implementation of the procedures suggested.

Introduction

Mrs G, a woman age 54 years, was admitted to the hospital for management of a clotted femoral bypass graft. Her primary care physician, Dr A, received a telephone call to inform him of the admission. He glanced through the electronic medical record care physician, Dr A, received a telephone call to inform him of the admission. He glanced through the electronic medical record doing so, Dr A noticed a laboratory value from 1 week earlier the admission. He glanced through the electronic medical record for management of a clotted femoral bypass graft. Mrs G’s international normalized ratio (INR) was subtherapeutic at 1.3. Nothing had been charted regarding any warfarin dose adjustment in response to this value. Dr A believed that promptly addressing this subtherapeutic value might have prevented Mrs G’s complication and current hospitalization.

Much attention has focused on the management of medical mistakes in recent years. Currently, there is a consensus that disclosing medical mistakes is advantageous for patients, clinicians, and medical organizations in reducing the number of medical malpractice suits and increasing patient satisfaction. Although a large number of interventions have been developed to facilitate mistake disclosures, evidence remains that clinicians have been slow to adopt the practice. As such, one of the problems may be a need for an alternative, theoretically based model that provides a tool to guide initial conversations with patients after a mistake, which can be followed up with additional details. Thus, a more directed set of strategies may provide impetus for physicians to make a disclosure closer to the mistake event and to do so effectively. The objective of this article is to provide a streamlined two-step template for physicians to follow when disclosing medical mistakes to patients and their families using the communication privacy management (CPM) theoretical frame.

Revealing medical mistakes is challenging because of a long history of feeling reticent about disclosing such information and because of physicians’ strong emotional reaction to mistakes, both of which lie in tension with the inviolable ethical obligation to be truthful with patients. On one hand, there often is a culture among physicians that may lead to suppression of disclosure; on the other hand, they are ethically expected to reveal mistakes to patients and their families. These conflicting expectations can lead to a privacy dilemma for physicians who must decide whether, when, and how to disclose. Anxiety about disclosure of mistakes may be compounded by fears that the information surrounding mistakes will be made public, that the patient may respond by requesting cost reimbursement, or that disclosure will result in legal consequences. The complexities surrounding ethical disclosure of medical mistakes highlight the need for physicians to learn productive and ethically sound ways of disclosing these mistakes. Currently, evidence suggests that physicians are not adequately equipped to handle such discl-
Disclosing Medical Mistakes: A Communication Management Plan for Physicians

Two-Step Mistake Disclosure Management Plan

The mistake disclosure management plan (MDMP) is proposed to address the initial needs of physicians disclosing mistakes. The MDMP is a two-step process (Table 2): 1) physician preparation and 2) mistake disclosure strategies. The first step involves focusing on issues that physicians personally need to address before revealing the mistake to patients so that the needs of both physician and patient are met. This step helps physicians intellectualize and emotionally cope with the fact that a mistake has occurred “under their watch.”9,10 The second step involves

Table 1. Principles of communication privacy management theoretical perspective1—mistake disclosures

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<tr>
<th>Principles</th>
<th>Description</th>
<th>Application to medical mistake disclosure</th>
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<tr>
<td>Privacy ownership</td>
<td>People believe they own their private information</td>
<td>Patients believe that any information about their health care is private to them</td>
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<td></td>
<td>Giving access to that private information creates co-owners</td>
<td>Physicians are given access to the patient’s private health information as their caregiver and are therefore authorized co-owners, but because they make decisions, they may feel a greater sense of ownership than patients want</td>
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<td>Privacy control</td>
<td>People believe ownership means right to control access</td>
<td>Patients always believe they should have continued control over their information even when physicians are co-owners</td>
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<td>People use privacy rules developed to control their private information</td>
<td>Patients have a set of privacy rules they use to control access to their medical information</td>
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<td>Giving access rights to authorized co-owners assumes that co-owners will use the original owner’s privacy rules for dissemination</td>
<td>Patients assume that physicians know how they want them to treat their information</td>
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<td>Privacy breakdowns</td>
<td>People assume their privacy rules will be properly used by co-owners; in reality, mistakes can be made by co-owners in management of this information</td>
<td>Physicians often receive their patients’ private health information (eg, test results) before the patient and can confuse this information as theirs to control and regulate; when involving medical mistakes, the need to control information flow becomes more challenging for physicians, whose sense of self may be perceived to be on the line</td>
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formulating and adhering to a method of disclosing mistake messages that is geared toward preserving the integrity of the physician-patient relationship.

**Rationale for Using Both Steps**

Since ownership of the mistake information is perceived as “shared” by both the patient and physician, not preparing adequately in step 1 may ultimately complicate the goal of step 2. An unprepared or inappropriate disclosure prematurely delivered to patients before these processes are enacted may do more harm than good. For example, disclosure without the physician preparation step is more likely to result in the physician asking for forgiveness from the patient (tending to be more about the physician than the patient) instead of helping the patient come to terms with the mistake event. Moreover, in an effort to rid themselves of the burden of the information, physicians troubled by the knowledge of a mistake may be more apt to engage in a communicative “hit-and-run” in which the physician quickly discloses and departs before the patient can ask questions.

When physicians sufficiently prepare for these disclosures in advance, they are more likely to consider the needs of the patient over their own needs and to provide more successful and compassionate messages about mistakes.

**Step 1: Physician Preparation for Mistake Disclosures**

In step 1, there are two tasks that help accomplish a more productive disclosure: 1) recognizing and talking about the physician’s own emotions and 2) information seeking.

**Recognizing and Talking about Emotions**

For this task, there are two issues to consider. First, it is useful to recognize that there are potential emotional barriers that physicians need to take into account to prepare for making a mistake disclosure. Second, to overcome these emotional barriers, a “talking process” is needed.

One primary issue physicians face in preparing for mistake disclosures concerns taking stock of and addressing personal needs. Often a tension exists with physicians’ inviolable obligation of truth telling and their own need to control revelations about the mistake. Emotions frequently surround medical mistakes, and they can become barriers to effective mistake disclosures.

**Potential emotional barriers**

Christensen et al. found that physicians’ fears surrounding mistakes are “related to concerns for the patient’s welfare, possible litigation, and colleagues’ discovery of their ‘incompetence.’” In general, physicians may experience four main emotional or cognitive barriers to effective disclosure of medical mistakes: 1) shame, 2) uncertainty, 3) anxiety, and 4) threat of legal liability. Each of these barriers may be anticipated, perceived, and/or real; nevertheless, having a grip on them can help alleviate the potential negative impact on both the physician’s emotional response and the disclosure process.

One major reason physicians report not talking about mistakes is because the experience negatively affects their self-esteem and they fear embarrassment. Feeling shame has the capacity to interfere with being able to formulate disclosure messages that help patients understand the circumstances surrounding the mistake. The uncertainty a physician feels about the reason for mistakes and the anxiety about the outcome also contribute to the difficulty in revealing a mistake. Because medicine takes place in complex systems, the potential for many contributors to any given mistake is high. Ambiguity surrounding the definition of a mistake and uncertainty about when these mistakes should be revealed to patients and families add another layer of complexity to an already problematic situation.

When a mistake occurs, the threat of legal liability looms over decisions to disclose the information to a patient. Fear of malpractice claims often pressure physicians to keep a mistake incident a secret. However, nearly all the evidence suggests that effective disclosure to patients provides the most robust legal

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<th>Table 2. Components of the Mistake Disclosure Management Plan</th>
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<td><strong>Step</strong></td>
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<tr>
<td>1. Physician preparation for mistake disclosure</td>
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<td>2. Formulating and delivering mistake disclosure messages</td>
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<td>1 and 2: Used jointly</td>
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Talking process to overcome emotional barriers

Pennebaker" argues that "translating experiences into words forces some kind of structure to the experiences themselves." Talking about emotions has a therapeutic effect and may provide relief when a person is experiencing guilt, shame, or inner turmoil. For example, a physician notes, "one must be resigned to live with a lot of guilt. It was comforting to hear that other physicians felt the same way and that I was not alone." Consequently, physicians' personal disclosure about their own feelings surrounding the medical mistake is important to surmount because this stressful situation can produce the emotional barriers already identified. Talking to colleagues or others the physician trusts can help physicians work through feelings and make sense of the incident before disclosing to the patient. This type of "talking process" overcomes hurdles resulting from anxiety fostered by uncertainties of how and why a medical mistake was made. A talking process also overcomes any initial tendency for secret keeping and the desire for control when events occurred on a physician's "watch." Although complex to achieve, fostering an environment of openness among all health care professionals makes it easier for everyone to take co-ownership of the problems that lead to medical mistakes, thereby stemming a tendency to retreat from the problem. An environment of openness also gives a forum for the "talking process" to more easily take place.

Information Seeking

Given that medical mistakes tend not to be isolated incidents, but rather represent the culmination of a "chain of events and a wide variety of contributory factors leading up to the event" in the early stages after a mistake, physicians are not able to do an in-depth, root cause analysis. Nevertheless, it is necessary to make sense of the events that contributed to the mistake early enough so that information can be communicated to patients. Information gathering reduces uncertainty and determines the direction that physicians should take.

Dr A closely reviewed the patient's chart, talking with the nursing staff about how the laboratory results were scanned and flagged for review. Dr A discovered that Mrs G's results had been faxed from the patient's local laboratory and inadvertently scanned into Mrs G's chart without being properly flagged for review. Dr A and his partners worked with their EMR clinician to ensure that all scanned laboratory results require physician review and signing. They also established a new mechanism for keeping track of anticoagulation levels in their clinic, whereby one physician keeps a log of all patients receiving warfarin. Additionally, the patients receiving warfarin are instructed to use the EMR patient portal to follow up on INR results and are given a card with their goal INR. Having worked out a process to correct future mistakes of this nature, Dr A felt more prepared to discuss the mistake with Mrs G and demonstrate that he took responsibility to address the problem causing her injury.

Step 2: Mistake Disclosure Strategies

Mistake disclosure strategies are proposed to help physicians manage the relationship with patients and families and to focus on disclosure messages that are relevant to the patient. Two tasks help develop mistake disclosure strategies: 1) the context of disclosure delivery and 2) the content of mistake messages, sequencing, and apology.

Context of Disclosure Delivery

For this task, two dimensions are proposed in designing an effective message: 1) the timing of the mistake disclosure and 2) the presence or absence of other people.

Timing of the mistake disclosure

Recommendations suggest that the disclosure be made soon after the mistake occurs. Typically, patients do not expect a medical mistake to occur. Hence, the disclosure timing is important to consider, as are general precautions and best practices surrounding disclosure of all bad news. Given the unexpected nature of these revelations, the physician should take into account that this information is not only a surprise but also likely represents emotionally volatile information that could include life-threatening or life-altering information. Research shows that disclosure timing affects how revealed information is understood, particularly in unexpected situations. Consequently, carefully selecting a time when patients are not engaged in distracting activities and can give full attention to the disclosure is optimal.

Presence of other people

Because mistake disclosures are unexpected and personal to patients, they may or may not wish others to be present for discussions about the mistake. It is best if physicians state that they have important information to share about the patient's case and ask whether the patient is comfortable with family members or friends present. Asking communicates both a willingness to be open and respect for the patient, family members, and others involved. In cases where the patient is not able to process the information or is incapacitated for any reason, the same considerations should be accorded to family members or guardians.

Content of Mistake Disclosure Messages and Disclosure Sequencing

For this task, two concerns are identified when developing a mistake disclosure message. They are as follows: 1) disclosure strategies affecting trust and the physician-patient relationship and 2) a logical message sequence to ensure effective mistake disclosure messages.
Fostering or hampering trust

Constructing messages to disclose mistakes should take into account the importance of both the content and the physician-patient relationship. The way that patients feel about their physicians likely has an impact on how patients interpret the mistake message. Consequently, there are message strategies to avoid in constructing mistake disclosures (Table 3). Avoiding the use of these strategies can help overcome roadblocks and will more likely preserve the physician-patient relationship.

Mistake disclosure message sequence

A logical message sequence is necessary to effectively communicate a mistake disclosure. Doing so is consistent with best evidence-based practice. Likewise, the ability to reach a satisfactory fit between making the disclosure and doing so in a way that patients are able to process is important. The suggested message sequence is 1) forecasting, 2) incremental disclosure, and 3) full apology.

Forecasting that something has gone awry as the initial statement in the message about a mistake is essential to allow the physician to mentally and emotionally prepare the patient to hear the mistake disclosure. For example, while setting up the meeting by phone, Dr A could say, “Mrs G, there is something important about your illness I need to talk to you about.”

Incremental mistake disclosure messages come next in the sequence. Building on the forecasted message, CPM research on disclosing stressful events suggests communicating subsequent mistake disclosure message in increments. In other words, the physician should develop a message that provides some details about the events using simple language. In an incremental way, the physician should add additional details when it appears that the patient comprehends the previous information. To be sure that the patient grasps the information about the mistake, the physician should use similar statements about the mistake while also adding other aspects over the course of making a complete disclosure. Doing so gives patients time to catch additional details that may be overlooked in previous statements. Because the stress of hearing about a mistake requires “absorption time,” offering the information in this incremental way is more likely to overcome a possible misunderstanding. Research suggests that people judge communication on the basis of whether messages are positive or negative, meet levels of expectedness, and their degrees of message relevance. Disclosure of medical mistakes is typically negative, unexpected, and relevant to the person, thereby requiring patients to engage in substantial levels of cognitive processing. Therefore, patients should be permitted an opportunity to process the information without feeling that the physician is pressed to move on to other things.

When considering the content of the mistake disclosure, research identifies that patients want physicians to tell them about a mistake, and they tend to have a good idea of what they want to know. Consistent with CPM, any mistake disclosure should fully acknowledge the patient’s perceived rights to know all of the circumstances surrounding the mistake incident. A detailed revelation of the harm associated with the mistake needs to be conveyed to achieve truth telling about the mistake.

Full apology comes last in the message sequence. Two major goals of apologizing to patients include: a) conveying that physicians have a desire to provide emotional support and b) acknowledging that the physician and/or the hospital/clinic have learned from the mistake. The first goal illustrates the relational aspects of the disclosure message, and the second goal is outcome oriented. Consequently, full apologies include statements recognizing any inappropriate conduct or unsuitable behavior and a promise to act more appropriately or to correct the circumstance that led to the inappropriate behavior or outcome. Genuine apologies of this nature are not excuses for mistakes, in which physicians state that the mistake was not their fault. Nor do apologies include statements of justification, in which physicians deny anything inappropriate happened. Instead, they convey accountability and culpability, a promise of corrective actions, and an explanation of circumstances leading to the mistake. One of the more important aspects of constructing the apology is resisting any temptation to embed a request for forgiveness within an apology; otherwise, the integrity of an apology may be compromised. Asking for forgiveness places the primary focus on the physician’s needs. A proper and effective apology must focus only on the needs of the patient.

Dr A called Mrs G in her hospital room and set up a time to visit her. He let her know on the phone that he had something important to discuss regarding her current illness, and suggested that if she wanted any family present at the time of their meeting that they should be alerted.
With trepidation, Dr A entered Mrs G’s room knowing that the conversation might be difficult for him. Mrs G, and her family. He took a seat and revealed he had information to give her that may have contributed to her failed bypass graft. He explained to her about the laboratory value from the week earlier and how it had been filed without his being able to review it. He told her that an increase in her warfarin dose might have avoided her current situation. He also was clear in stating that the mistake occurred in his office, and he was ultimately at fault for the mistake. Mrs G asked several questions regarding the steps that led up to the mistake and asked how such a mistake could happen. Dr A did his best to answer her questions honestly. Mrs G’s husband was upset with the situation and asked how such situations would be addressed in the future. Dr A outlined his office’s new workflow management for patients on warfarin and noted that their practice was working on an automated INR monitoring system through the EMR that would help alert physicians of subtherapeutic levels. He also informed Mr G about the newly established patient portal, allowing them immediate access to their laboratory values so that they could follow-up on the test results as well.

Mrs G had a successful revascularization of her femoral bypass graft the next day.

Conclusion
Disclosures of medical mistakes require preliminary considerations to effectively and compassionately disclose these events to patients. The ethical requirement to disclose mistakes and physicians’ personal desires to conceal mistakes create a privacy dilemma surrounding disclosure. Use of a CPM perspective offers a potential way of coping with privacy dilemmas of this nature through developing and following management strategies to overcome maladaptive ways of telling patients about mistakes. As this discussion underscores, before physicians are able to tell patients about problematic medical situations, it seems best to reduce the emotional tension that physicians are able to tell patients about problematic medical disclosures in the future.

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Disclosure Statement
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References
Draw From Your Errors

Start out with the conviction that absolute truth is hard to reach in matters relating to our fellow creatures, healthy or diseased, that slips in observation are inevitable even with the best trained faculties, that errors in judgement must occur in the practice of an art which consists largely in balancing probabilities—start, I say, with this attitude of mind. ... You will draw from your errors the very lessons which may enable you to avoid their repetition.

— Sir William Osler, 1849-1919, physician, clinician, pathologist, teacher, diagnostician, bibliophile, historian, classicist, essayist, conversationalist, organizer, manager, and author