

**Interview:**

Dr. Thomas H Gallagher, M.D., Associate Professor of Medicine, University of Washington School of Medicine.

This is an interview with Dr. Gallagher about the disclosure of medical errors to patients. It was conducted by Dr. Mike Astion and first appeared in *Laboratory Errors and Patient Safety* (LEPS) in 2005. Dr. Gallagher is an international expert on the topic of error disclosure and has written about it extensively<sup>1,2</sup>. He is an internist who cares for both inpatients and outpatients.

**LEPS:** What is the current belief among healthcare practitioners and patient safety experts regarding the disclosure of medical errors to patients?

**Dr. Gallagher:** Most healthcare groups are aligned regarding their beliefs about disclosure of errors that harm patients. These groups believe that disclosure should occur for all errors that involve significant harm to the patient. However, there is a significant gap between these beliefs and actual practice since currently, disclosure occurs in only about one-third of these cases.

**LEPS:** Why is there a gap between our values, which are strongly in support of disclosure, and our actions?

**Dr. Gallagher:** Research has clearly indicated that there are three barriers to disclosure of harmful errors.

1. Fear of malpractice,
2. Fear that disclosure will do more harm to the patient than good because disclosure might damage the therapeutic relationship between physician and patient., and
3. Physicians' discomfort in disclosing harmful errors.

**LEPS:** Why do physicians perceive that talking about an error might harm the patient?

**Dr. Gallagher:** This perception usually arises in two settings. The first is the case where there has been an error but the patient only experienced minor, reversible harm that was easily corrected. In this setting, physicians fear that mentioning the error would damage the relationship with the patient, and this relationship is important to the patient's well-being.

The other setting where this perception arises is when there is a medical error, and there is a poor patient outcome, but the relationship between the error and the outcome is unclear. Here, physicians will often not disclose the error since it might very well be unrelated to the patient's condition, and they do not want to harm the doctor-patient relationship.

**LEPS:** You mention that many physicians are uncomfortable disclosing errors. What are some characteristic features of the way physicians talk about errors?

**Dr. Gallagher:** This is an interesting area of research. What has been revealed is that physicians tend to discuss the outcome of the error but not the error itself. For example, take a case where a laboratory error in identifying an organism led to delays in correctly treating a post-surgical infection. Physicians will often tell the patient the outcome,

which is that they have a severe post-surgical infection, but will not discuss the laboratory error that contributed to that outcome. In general, physicians have a tendency to choose their words too carefully, and in so doing, they fail to reveal the facts that most patients want to know.

**LEPS:** What is it that patients want to know about medical errors?

**Dr. Gallagher:** Patients want the following:

- They want harmful errors disclosed to them, even if the harm is minor.
- They want a health care provider to admit there was an error.
- They want information regarding why the error occurred.
- They want to know the effect of the error on their health.
- They want to know that a recurrence of this error is going to be prevented.
- They want an apology.

In addition, patients want the physician and other healthcare providers to come off their pedestal and discuss all of the above aspects of the error in a person to person manner. Patients do not like when physicians take the attitude that this is no big deal. It is a big deal to the patient.

**LEPS:** Are hospitals and individual healthcare providers more likely to be sued if errors are disclosed?

**Dr. Gallagher:** There are some well known cases where hospitals have adopted an environment where disclosure is strongly encouraged<sup>3</sup>. For example, the Veteran's Affairs (VA) hospital in Lexington, Kentucky started an open disclosure policy in the late 1980s after two high profile lawsuits. The VA showed no dramatic change in claims after adapting this high disclosure approach, but it is not clear if this finding would generalize to all hospitals.

**LEPS:** Are there data suggesting that juries would award less money in cases where an error was disclosed rather than hidden?

**Dr. Gallagher:** Yes. Mock jury data suggest that juries would award less money in cases when the error was fully disclosed to the patient. Similarly, surveys of plaintiffs' lawyers show they believe juries award more money to their clients if the jury feels a harmful error has been hidden.

**LEPS:** So what, on average, is the likely overall effect of disclosure on malpractice claims?

**Dr. Gallagher:** Overall, existing data suggest that error disclosure is likely to have beneficial effect on decreasing the number and amount of malpractice claims. But for any one physician, the outcome of a particular error disclosure may not be so favorable.

**LEPS:** What is your advice to hospitals regarding the disclosure of harmful errors?

**Dr. Gallagher:** First, I would say to healthcare providers that if you feel a harmful error has been made, get help. Do not try to figure out the entire event, and the proper response to it, on your own. In a hospital practice, there are colleagues that can support you, especially the medical and nursing directors, risk managers, and other experienced

managers. The group can determine what actually happened, and decide what information should be given to the patient. In addition, the group can plan and practice the disclosure to ensure that the right amount of information is delivered in a considerate and caring manner. This team approach prevents the common management blunder of rushing to a flawed conclusion about the event and then revealing inaccurate information to the patient.

**LEPS:** Who discloses the harmful error to the patient?

**Dr. Gallagher:** Currently, the physician who is primarily responsible for the patient usually discloses the error. However, there is a healthy trend toward disclosing the most serious errors as a team, where the team consists of various health care providers who are involved in the care of the patient.

**LEPS:** Why does team-based disclosure make sense?

**Dr. Gallagher:** It makes sense because patients are cared for by groups of healthcare workers, and most serious errors are due to complex, inter-dependent, error-prone systems rather than the fault of individuals. The disclosure team consists of staff that can provide insight into these systems-based problems. Thus, if the error involved nursing and the laboratory, experienced representatives from nursing and the lab should be on the team. In contrast to an individual, a team can provide a richer explanation of the error and how a recurrence of the error is going to be prevented. In addition, a team is more likely than an individual to be able to answer the questions of the patient and their friends and family.

Team disclosure also makes sense because it is good for the people on the team. Errors are very upsetting to healthcare providers. Participating in a discussion about the event makes most providers feel a little better, and gives them hope that a future recurrence can be prevented.

**LEPS:** Are there any pitfalls to team-based disclosure?

**Dr. Gallagher:** You must avoid using the team as an excuse to present, for blaming and shaming, the particular party that was involved in the error. The team as a whole must take responsibility for the error. For example, in the case of an error committed in the laboratory, an experienced laboratory representative should be on the team, but it does not have to be the person who committed the active error. In most cases, the error occurred as part of an error-prone system, and it could have happened to anybody, so it is inappropriate to blame an individual, especially in front of the patient.

**LEPS:** Taking a bigger picture view, how far have healthcare organizations come in their approach to disclosing harmful errors to patients? For example, if the goal is for healthcare to get to New Jersey, and we started in Seattle, where are we? Have we left Seattle? Keep in mind that whenever we phrase a question in this way, the experts always answer "Montana".

**Dr. Gallagher:** Sorry to disappoint you, but I would say the answer is Montana. We are improving regarding disclosing serious harm events, but there is still a long way to go.

In addition, there are significant problems regarding how we are communicating. In general, we are not giving the patient all the information they desire. Progress will take time, because it involves significant cultural changes in many individual healthcare organizations.

**References**

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2. Burroughs TE, Waterman AD, Gallagher TH et al. Patient concerns about medical errors in emergency departments. *Acad Emerg Med*. 2005 Jan;12(1):57-64.
3. Associated Press. Doctors Urged To Say 'I'm Sorry'. *CBS News*. November 11, 2004. <http://www.cbsnews.com/stories/2004/11/11/health/main655219.shtml>