Do health care providers have a moral and ethical obligation to disclose medical errors honestly and promptly to involved patients and their families? The mother of a child who is blind, mute, and suffering from cerebral palsy provided testimony on this topic at a hearing held by Senator James Jeffords (Ind.-Vermont). The child’s condition was caused by a brain hemorrhage secondary to puncturing the lung during a fluid aspiration attempt, but the error was not revealed to the child’s parents. Three years later, an obstetrician discovered the error while investigating information provided by the mother in preparation for the birth of her second child.

The mother testified, “I was able to accept the fact that a human being made a serious mistake, but I felt betrayed, hurt, and angry toward the hospital who had lied to us and continued to lie to us when we asked questions and when we were told that probably would not have resulted in claims if the hospital had not honestly disclosed the errors. Unexpectedly, however, this policy has not caused a flood of lawsuits, and payments for claims have been moderate.

Compared with other VA medical centers, the Lexington facility is in the top quartile for the number of claims filed but at the bottom quartile for payments made. Although most organizations encourage and embrace honest and full disclosure of errors, many may be struggling to standardize that process.

Guidelines similar those at Lexington can be established and approved by the hospital’s ethics committee. The policy would be as follows:

- Unless disclosure is needed to obtain consent for immediate treatment, a multidisciplinary risk management committee should be assigned to investigate the facts promptly.
- If the event was caused by error and if the error resulted in loss of the patient’s functions or life, the chief of staff should ask the patient and family to meet with him or her; the facility attorney (as well as a risk-management representative); and a quality manager.
- All details should be stated as sensitively as possible.
- Emphasis should be placed on the regret of the institution and the personnel involved. Any actions that have been taken to prevent similar events should also be mentioned.
- All questions should be answered.
- If appropriate, an offer of restitution should be made, based on a reasonable calculation of loss.

Disclosure is likely to upset patients and their families. Caution is advised against acting defensively or ignoring the patient and family. Role-playing can be helpful before the parties and practitioners involved meet.

Full disclosure of errors with fair compensation for injuries seems to be a solution that is both ethical and cost-effective. Disclosure restores organizations and practitioners to the role of patient advocates. This step puts the patient’s interests first and has the potential to minimize the financial impact on the organization. This policy encourages open communication about errors and helps to restore the public’s trust in health care. Most important, it’s the right thing to do.

REFERENCES

The reports described in this column were received through the USP-ISMP Medication Errors Reporting Program (MERP). Errors, close calls, or hazardous conditions may be reported on the ISMP (www.ismp.org) or the USP (www.usp.org) Web site or communicated directly to ISMP by calling 800-FAIL SAFE or via e-mail at ismpinfo@ismp.org.