PSNet
PATIENT SAFETY NETWORK

Disclosure of Errors

June 15, 2024
Disclosure of Errors. PSNet [internet]. 2019.
https://psnet.ahrq.gov/primer/disclosure-errors

PSNet primers are regularly reviewed and updated by the UC Davis PSNet Editorial Team to ensure that they reflect current research and practice in the patient safety field. Last reviewed in 2024.

Background

Many patients harmed by a medical error never learn of the error. Physicians have traditionally shied away from discussing errors with patients, in part due to fear of precipitating a malpractice lawsuit, but also due to embarrassment and discomfort with the disclosure process. However, attitudes have changed in recent years–most physicians in a 2006 survey had disclosed a serious error to a patient and agreed that such disclosure was warranted.

Surveys have helped to define the components of disclosure that matter most to patients. These include:

- Disclosure of all harmful errors
- An explanation as to why the error occurred
- How the error's effects will be minimized
- Steps the physician (and organization) will take to prevent recurrences

"Full disclosure" of an error incorporates these components as well as acknowledgement of responsibility and an apology by the physician. However, there may be a disconnect between physicians' views of ideal practice and what actually happens. For example, most physicians agree that errors should be fully disclosed to patients, but in practice many "choose their words carefully" by failing to clearly explain the error and its effects on the patient's health.

Increasing the amount and quality of error disclosure will require addressing physician discomfort with disclosure and fear of lawsuits. This may also require changes in how organizations approach error disclosure. Clinicians' fear regarding legal repercussions of error disclosure is not entirely unfounded, as a clinician's disclosure of an error may be admissible in a malpractice lawsuit. According to a 2008 survey, only eight states in the US explicitly prohibited "admissions of fault" from being used as evidence at trial (although the majority of states exclude "expressions of sympathy" from being admissible evidence).

However, data does indicate that patients are less likely to consider filing suit if physicians apologize and fully disclose errors. Low disclosure rates also persist because few physicians have received formal training in how to discuss errors with patients, and given that the circumstances surrounding an error are invariably complex, physicians may be unclear about the amount of information that should be disclosed and how to explain the error to the patient. There is some evidence that formal training in error disclosure can improve physicians' comfort with the process.

When a patient is a victim of an error, hospitals have traditionally followed a "deny-and-defend" strategy, providing limited information to the patient and family and avoiding admissions of fault. This response has been criticized for its lack of patient-centeredness, and in response, a growing number of institutions have implemented "communication-and-response" strategies that emphasize early disclosure of adverse events and a more proactive approach to achieving an amicable resolution. This model includes full disclosure of adverse events, appropriate investigations, implementation of systems to avoid recurrences, and rapid apology and financial compensation when care is deemed unreasonable. An early adopter of this model—the University of Michigan—demonstrated that this approach resulted in fewer malpractice lawsuits and lower litigation costs since implementation, and other institutions have found similar results. Although communication-and-resolution programs are being more widely adopted, implementing such a process is quite complex. Several studies indicate that the error disclosure process must be handled thoughtfully and sensitively to avoid alienating patients and families. A growing body of literature describes the regulatory, legal, and practical considerations with implementing these programs, and the Agency for Healthcare Research and Quality has developed the Communication and Optimal Resolution (CANDOR) toolkit to help organizations implement communication-and-response programs.

Current Context

Disclosure of errors and adverse events is now endorsed by a broad array of organizations and mandated in some states. Since 2001, the Joint Commission has required disclosure of unanticipated outcomes of care. In 2010, the National Quality Forum endorsed disclosure of "serious unanticipated outcomes" as one of its 34 "safe practices" for health care. Safe Practice 7: Disclosure includes standards for practitioners regarding the key components of disclosure. It also calls for health care organizations to create an environment conducive to disclosure by integrating risk management and patient safety activities and providing training and support for physicians. Many states and the District of Columbia passed apology laws making apology statements inadmissible in court but the effect on malpractice lawsuits has been mixed. In a 2022 study, 38 state medical boards viewed patient disclosure favorably and those actions would not make the clinician a target of disciplinary action.