PSNet
PATIENT SAFETY NETWORK

Disclosing errors and adverse events in the intensive care unit.

July 21, 2010
Boyle DJ, O'Connell D, Platt FW, et al. Disclosing errors and adverse events in the intensive care unit. Crit Care Med. 2006;34(5):1532-7.
https://psnet.ahrq.gov/issue/disclosing-errors-and-adverse-events-intensive-care-unit

This study used a systematic framework for disclosing errors and adverse events to guide providers and facilitate appropriate discussions. The authors provide context to their recommended approach by discussing the scope of the problem in intensive care units, when and how to talk about errors, and the benefits of and problems with doing so. They provide a case example with a detailed dialogue between an attending physician, an intern, and a patient in disclosing news about an error that occurred during her hospitalization. The case illustrates and advocates for the approach recommended both predisclosure and during disclosure. A past study discussed patient and physician attitudes about the disclosure of medical errors.