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When Things Go Wrong: A Guide for Learners and Facilitators AN ANNOTATED BIBLIOGRAPHY

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Developed for *When Things Go Wrong: Voices of Patients and Families* [DVD], Cambridge, MA: CRICO/RMF; 2006. This bibliography focuses on the issues around medical errors and adverse events. The selected articles and books are valuable tools in understanding the importance of disclosure, apology, communication, and trust, as well as the patient's feelings of isolation, anger, and frustration after a medical error occurs.

Amori G. Disclosure skills training. *Forum* [serial online]. May 2003;23:16–17. Available at http://www.rmfm.harvard.edu/files/documents/Forum_v23N2.pdf. Accessed August 2, 2006.

The author presents the argument that more generalized communications training does not properly prepare a physician to inform patients that a medical error has occurred, and provides specific training techniques to prepare physicians for the disclosure of medical error to patients.

Augello T. Patients teach about error. In: Augello T, ed. *Resource: Current Issues in Patient Safety* [CD audio recording]. Cambridge, MA: CRICO/RMF; May 2006. Available at <http://www.rmfm.harvard.edu/patients-teach-about-error/index.aspx>. Accessed August 2, 2006.

This recording highlights recent qualitative studies on medical errors and learning from patients' experiences to improve the quality of care; includes interviews with original researchers and discussion of patients' psychological responses to medical errors.

Baker, SK. Adverse patient outcomes. In: Baker SK. *Managing Patient Expectations: The Art of Finding and Keeping Loyal Patients*. San Francisco: Jossey-Bass; 1998: 213–22.

This book addresses the importance of clear communication in the physician-patient relationship, and offers advice on addressing patient preferences and needs.

Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor-patient relationship and malpractice: lessons from plaintiff depositions. *Arch Intern Med*. 1994;154:1365–70.

In this study, plaintiff depositions are analyzed to identify the issues that prompted patients to sue hospitals and physicians. Emerging themes are deserting the patient, devaluing patient and/or family views, delivering information poorly, and failing to understand the patient and/or family perspective, as described by the authors.

Berlinger N, Wu AW. Subtracting insult from injury: addressing cultural expectations in the disclosure of medical error. *J Med Ethics*. 2005 Feb;31(2):106–8.

This article proposes that knowledge of the Judeo-Christian concepts of confession, repentance, and forgiveness will better prepare physicians and medical students to deal with their own and patients' emotional responses after a medical error.

Bonacum D, Houk C, Moidel BI, Haas D. Communicating harm to patients. In: Leonard M, Frankel A, Simmonds T. *Achieving Safe and Reliable Healthcare: Strategies and Solutions*. Chicago: Health Administration Press; 2004:93–112.

This book provides a plan for establishing a culture of patient safety within the healthcare organization, and Chapter Six presents strategies and tools for open communication with patients and family when a medical error occurs.

Buckman R. *How to Break Bad News: A Guide for Health Care Professionals*. Baltimore: Johns Hopkins University Press; 1992.

Well-organized and highly readable, this book features examples and suggestions to help any physician confronted with the task of breaking bad news to a patient.

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Christensen JF, Levinson W, Dunn PM. The heart of darkness: the impact of perceived mistakes on physicians. *J Gen Intern Med.* 1992;7:424-31.

An analysis of physician interviews on the impact of a previous mistake reveals that the physician seldom discloses a mistake, feels support from colleagues is lacking, and suffers significant emotional distress.

Duclos CW, Eichler M, Taylor L, et al. Patient perspectives of patient-provider communication after adverse events. *Int J Qual Health Care.* 2005;17:479-86.

This study focuses on patients' perceptions of physician communication after an adverse medical event. It concludes that timeliness and quality of physician communication has an important influence on the patients' responses, and can minimize their commonly reported feelings of frustration and anger.

Gallagher TH, Garbutt JM, Waterman AD, et al. Choosing your words carefully: how physicians would disclose harmful medical errors to patients. *Arch Intern Med.* 2006;166:1585-93.

In a survey of U.S. and Canadian medical and surgical physicians, a majority responded that they would disclose an adverse event to the patient, but not the error. The authors note the uncertainty among physicians about what information to reveal and how to talk to patients about errors; disclosure standards and training are recommended.

Gallagher TH, Waterman AD, Ebers AG, Fraser VJ, Levinson W. Patients' and physicians' attitudes regarding the disclosure of medical errors. *JAMA.* 2003;289:1001-7.

Thirteen focus group sessions, including groups of patients, groups of physicians, and groups of both physicians and patients, were convened to determine how medical errors should be disclosed. Analysis includes the patient's need for full disclosure, apology, and emotional support.

Hilfiker D. Facing our mistakes. *NEJM.* 1984;310:118-22.

The author examines his mishandling of a case, reflects on the resulting physical discomfort and emotional trauma to the patient, and shares his deep feelings of uncertainty, guilt, and anger.

Hobgood C, Peck CR, Gilbert B, Chappell K, Zou B. Medical errors –what and when: what do patients want to know? *Acad Emerg Med.* 2002;9:1156-61.

Patients and their families were surveyed during evaluation in an academic emergency department. A majority would want immediate full disclosure of a medical error; a reporting to regulatory organizations and committees; and teaching medical students honesty, compassion and disclosure techniques.

Hobgood C, Tamayo-Sarver JH, Elms A, Weiner B. Parental preferences for error disclosure, reporting, and legal action after medical error in the care of their children. *Pediatrics.* 2005;116:1276-86.

This study surveyed parents of children in an emergency department to determine preferences for and responses to medical error disclosure. An overwhelming majority of respondents favor disclosure regardless of error severity. Over a third of respondents want the error reported, but is less likely to sue if the disclosure comes from the physician.

Kraman SS, Hamm G. Risk management: extreme honesty may be the best policy. *Ann Intern Med.* 1999;131:963-67.

The financial consequences of a humanistic risk management policy, which includes full disclosure of a medical error to the patient, early injury review, a continuing relationship between the hospital and the patient, and fair compensation, are not known. But the Department of Veteran Affairs has implemented this policy across its facilities as a result of one VA medical center's experience since 1987 that showed moderate liability payments.

Kuzel AJ, Woolf SH, Gilchrist VJ, et al. Patient reports of preventable problems and harms in primary health care. *Ann Fam Med.* 2004;2:333-40.

Patient interviews were conducted to identify preventable errors that led to physical or psychological harm. Seventy percent resulted in psychological harm, including anger, frustration, belittlement, and loss of relationship and trust in the physician, according to the analysis. This study suggests that physician-patient relationships and physician availability may be overlooked in the current patient safety movement, which focuses on surgery and medication errors.

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Lamb R. Open disclosure: the only approach to medical error. *Qual Saf Health Care*. 2004;13:3-5.

Drawing from interviews with patients who suffered an adverse event, this editorial suggests most patients were angry about how they were treated afterward. Patients want open, honest, timely disclosure and an apology, according to the author.

Lazare, A. *On Apology*. New York: Oxford University Press, 2004.

A leading authority on the psychology of shame and humiliation, Lazare examines the process of apology and its power to restore the dignity and self-respect of the offended party.

Leape LL. Full disclosure and apology—an idea whose time has come. *Physician Executive*. March-April 2006;32:16-18.

Lucian Leape, MD, health policy analyst at the Harvard School of Public Health, and a leading voice for patient safety and prevention of medical errors, presents ethical and therapeutic arguments for full disclosure and apology when an adverse event occurs.

Liebman CB, Hyman CS. A mediation skills model to manage disclosure of errors and adverse events to patients. *Health Aff*. 2004;23:22-32.

This article describes a disclosure model that calls for physicians to communicate more effectively with patients, learn from mistakes, and respond to patient and family concerns; hospitals should resolve valid claims by a fair and cost-effective settlement.

Massachusetts Coalition for the Prevention of Medical Errors. *When Things go Wrong: Responding to Adverse Events; A Consensus Statement of the Harvard Hospitals*. Burlington, MA: Massachusetts Coalition for the Prevention of Medical Errors; 2006.

Led by Lucian Leape, MD, the Coalition Working Group crafted this evidence-based consensus statement on how hospitals should communicate with patients about errors and adverse events. The paper's concepts and principles are used by all Harvard teaching hospitals to implement practices and policies on disclosure.

Mazor KM, Simon SR, Gurwitz JH. Communicating with patients about medical errors: a review of the literature. *Arch Intern Med*. 2004;164:1690-97.

The authors sought to identify empirical research on the medical error disclosure decision, the process of disclosing to patient and family, and the ramifications of disclosure or nondisclosure. Findings from more than 800 articles reviewed indicate little empirical research has been published on disclosing medical error to patients and families; disclosure is supported by patients, families, and physicians, although physicians often do not disclose; and conclusions about the consequences of disclosure cannot be supported by the available empirical research.

Mazor KM, Simon SR, Yood RA, et al. Health plan members' views about disclosure of medical errors. *Ann Intern Med*. 2004;140:409-18.

A random sample of managed care adult members in one geographic area was surveyed on patient responses to the type, severity, and disclosure of medical errors. Given the context of the study, the authors suggest a more favorable response to full disclosure where the physician accepts responsibility and offers an apology.

Morath J, Hart T. Partnering with families: disclosure and trust. In: *Spotlight on Solutions: Compendium of Successful Practices, Volume One; Patient Safety Initiative 2000*. Chicago: National Patient Safety Foundation; 2001: 247-51.

The authors, recipients of the Patient Safety Award for Patient Provider Communication Solutions, discuss the patient/family-centered organizational response to medical errors at the Minnesota Children's Hospitals and Clinics, a recognized model for advancing a culture of safety.

Porto GG. Disclosure of medical error: facts and fallacies. *J Healthcare Risk Mgt*. Fall 2001;21:67-76.

The author identifies and dispels the fallacies of medical error disclosure, and emphasizes its importance in follow-up care for the injured patient and for re-building the physician-patient relationship. An organizational culture where physicians can admit mistakes, talk with patients about them without fear, and access support services to cope with the emotional aftermath is viewed as fundamental.

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Rosner F, Berger JT, Kark P, Potash J, Bennett AJ. Disclosure and prevention of medical errors. *Arch Intern Med*. 2000;160:2089-92.

Two aspects of the professional ethics of medical error disclosure are examined in this article: the physician's obligation to disclose an error to the patient, and the physician's obligation to disclose errors made by others.

Sorry Works! Coalition. Sorry Works! Interview with Dr. Aaron Lazare. Sorry Works! Website. Available at <http://www.sorryworks.net/article20.phtml>. Accessed August 17, 2006.

Aaron Lazare, Chancellor and Dean of the Massachusetts Medical School, discusses his book, *On Apology*, and notes that physicians and health care providers can learn that "apologizing to patients and their families for medical errors is both an ethical and a psychological remedy for damage to the professional/patient relationship."

Vincent C. Understanding and responding to adverse events. *NEJM*. 2003;348:1051-56.

This article addresses two broad themes on responding to an adverse event: how to investigate clinical incidents and learn from them; and how to support patients, families, and staff who are involved, according to the author.

Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. *Lancet*. 1994;343:1609-13.

This study reveals that patients take legal action for four main reasons: to prevent similar medical errors recurring; to understand how the error happened and why; to be compensated for the actual injury or to provide future care for the injured patient; and to ensure the staff or facility is held accountable.