

Editorial

Medical error disclosure: a pressing agenda for Public Health researchers

Medical errors are not a prevalent discussion topic in the current public health literature. However, their impact on patient lives across the world is alarming. In the United States alone, more than 1.3 million patients are harmed every year by medical treatments that are intended to help them. About three quarters of these adverse events are caused by preventable human error.¹ These statistics suggest that a US person is more likely to be harmed by a medical error than by a traffic accident, airplane crash, suicide, fall, poisoning, or drowning.² Such medical injuries cost the nation an estimated \$17-29 billion every year.³ Parallel investigations in Australia,⁴ the United Kingdom,⁵ Denmark,⁶ Italy⁷ and Switzerland⁸ indicate that human errors in medicine are a serious international public health problem.

In recent years, research on this predicament has proliferated with the aim to generate clear paths of action that could decrease the number of error-induced patient injuries and fatalities. One preventative strategy is the disclosure of medical errors. In 2001, the United States Joint Commission on Accreditation of Healthcare Organizations required hospitals to disclose all unanticipated outcomes to patients.⁹ Five years later, the National Quality Forum passed *safe practice* guidelines for health care professionals that recommend providers to disclose factual information about critical incidents, express regret, offer an apology, and encourage an organizational disclosure support system.¹⁰ Research has proliferated since then in various related disciplines, particularly emphasizing the ethical and legal dimensions of apologizing to a patient. The impact of this research line became visible in recent legislation – at least 34 United States, for example, now mandate the disclosure of adverse events or rely on *apology laws* that encourage health providers to apologize to their patients without having to face litigation.¹¹ Preliminary evaluations of such public efforts suggest that error disclosure – if conducted competently – has the potential to intervene further preventable injury and reduce the likelihood of malpractice litigation,¹¹ whereas insufficient disclosures imply a loss of opportunities to improve quality of patient care and strengthen the provider-patient relationship.¹²

Given these initial findings in face of the severity of the problem, the pressure for disclosure interventions is becoming increasingly intense. However, the existing data are still too weak to support empirically grounded disclosure training programs. Most notably, investigations to this date lack predictive validity because of their limiting reliance on focus groups, correlational data, independent data points and non-theoretical framing. Furthermore, existing research findings lack intercultural validation and thus cannot be ethically considered for disclosure training efforts outside of the United States, where most of the research to this date has been conducted.

Despite these significant limitations, various disclosure training programs are currently being implemented inside and outside of the United States. Several situational variables might explain this phenomenon. For instance, numerous studies have shown that patients want to be informed about errors in their care. Similarly, physicians feel responsible toward their patients, themselves, their profession and their community to disclose any errors in their care.¹³ These findings imply an urgent need to exercise some degree of formal control over error disclosures, striving for a clear interdisciplinary vision.

This vision requires a coherent research agenda that prioritizes several key issues: first, there are significant gaps in the conceptual-

ization and operationalization of competent error disclosures between the fields of law, ethics, and communication that need to be merged. Second, insurance carriers play an invisible influential role in disclosure practices. For example, insurers typically prohibit providers from voluntarily assuming liability and thus typically allow mere explanations of the facts without any wording that could imply negligence (*e.g.*, an apology).¹⁴ Thus, an apology might void physicians malpractice insurance coverage and could place a physician at risk of being fired at will. The law to protect providers from these incidents is still not well settled, and efforts to overcome this interdisciplinary hurdle are sparse. Third, future research needs to examine disclosure after close calls, which involve errors that caused no or trivial harm. These particular incidents create opportunities for patients to become part of quality-improvement efforts and thus can lead to positive patient outcomes.¹¹ A fourth area for future investigation includes the disclosure of latent errors and errors that affect multiple patients. Fifth, the methodological limitations of the existing investigations warrant more appropriate study designs that integrate theoretical frameworks and assess longitudinal, dyadic, and experimental data with the goal of prediction. Finally, international collaborations need to be established to validate the existing research findings across cultures.

In sum, the real issue is not whether the truth should be told, but whether there is a way of telling it responsibly.¹⁵ Up to this point in time, error disclosure research has only investigated the tip of the iceberg. There is a pressing need for a coherent interdisciplinary and international research agenda that addresses this severe public health concern strategically by i) merging the current conceptual gaps in the literature and ii) identifying the overarching competencies that can reduce the harmful impact of preventable incidents on patients, providers, and medical institutions alike.

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