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Perspectives on Error Disclosure in Radiology

Interviewees

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“we need to establish for radiologists a convincing ethical rationale for why error disclosure is in patients' interests”

Disclosure of errors in healthcare is not as straightforward as simply admitting that mistakes have occurred. The effect on patients, families and physicians, and the perceived risk of litigation, are just some of the barriers to disclosure. Radiologists have additional barriers to overcome, as they do not generally come into direct contact with patients.

To find out more about current research on error disclosure, HealthManagement editor, Claire Pillar, spoke to two experts.

Professor Stephen Brown practises paediatric and obstetrical imaging at Boston Children's Hospital. His research interests focus on the qualitative and quantitative assessment of professionalism in radiology and medicine.

Professor Thomas Gallagher is a general internist with research interests in the conflict of interest in the doctor-patient relationship. He practises as a physician in the General Medicine Clinic at the UW Medical Center-Roosevelt and as an inpatient attending physician.

Issues in Error Disclosure

What Motivated You to Research in the Area of Error Disclosure?

TG: Recognising how stressful medical errors can be on the patient-provider relationship, and realising how difficult it was to know what to say to patients when something had gone wrong. This motivated me to learn more about the problem, and develop tools and strategies to help physicians and other clinicians respond to patients better in this difficult situation.

Why Do You Think There Is Such a Gap Between Error Incidence and Disclosure, As Observed in Several Countries?

TG: I think for a long time everyone thought that the gap was mostly due to healthcare providers' fear that disclosure would lead to litigation. It's not that doctors and others don't worry about being sued, but I think that other barriers like physicians' shame and embarrassment, their lack of comfort with the communication skills associated with disclosure, and the mixed messages they get from their institutions and malpractice insurers about disclosure are much more important barriers.

What are Particular Issues for Radiologists in Error Disclosure?

SB: Radiologists don't have primary relationships with patients, so they don't get to form any kind of bonds with patients that might help them in more difficult circumstances. They are strangers, essentially, to the patients. Without any face time in advance of any adverse event, it's an important obstacle.

The nature of radiology itself is significant. Firstly, the abnormalities or potential errors are right there on a picture for everyone to see. There can be a lot of retrospective bias. There's a lot of overlap between what might reasonably be called normal, and what in retrospect might be discovered to be an error or an incorrect judgement. One might make a very reasonable judgement about a particular finding that turns out to be wrong, but only in retrospect. The great majority of breast and lung cancers, for example, are in retrospect present on earlier studies. It's a major challenge. Because we don't have frontline relationships with patients, we as radiologists are vulnerable to how the primary level physicians might characterise the misdiagnoses or misjudgements that we make to the patient. If it was a reasonable call, but it turned out to be wrong, it can be characterised in any number of different ways by the primary physician, without the radiologist having any input into having that patient understand the process of radiology and what actually happened.

Are There Notable Differences in Willingness to Disclose Errors Between Countries or Between Medical Specialities?

TG: There doesn't appear to be a major difference between countries, interestingly, because the litigation environment between countries varies a lot. There are differences between specialities. When we looked at, for example, medicine versus surgery, surgeons are much more enthusiastic about disclosure. However, when you ask them what they would say, they would disclose less information about what happened than internists. Mammographers have very conservative attitudes on disclosing errors, and there are also special challenges for radiologists. We see much bigger differences across specialities than we do between countries.

Prof. Gallagher – In Your Study of US And Canadian Physicians' Attitudes on Error Disclosure (Gallagher et al. 2006), 55% Reported Involvement In a Serious Error. Did That Seem High or is it Borne Out by Other Studies?

TG: It's a little hard to know, because studies that have looked at this have either used different definitions of error or the disclosure was self-reported. However, I wasn't surprised by that number. If anything, it is probably a bit low. I think most physicians, at some point in their career, will have been involved in an error that causes serious harm to a patient. Healthcare is an inherently complex and dangerous activity.

In the Same Survey only 23% Did Not Report that Any of the Barriers Mentioned Would Make Them Less Likely to Disclose a Serious Error to a Patient. 75% Reported Relief After Disclosure. Did These Findings Surprise You?

TG: No, our experience has definitely been that physicians find disclosure very difficult. They frequently experience a variety of barriers, which is why support of physicians is so important, to help them overcome some of those concerns.

Overcoming Barriers

How can Barriers to Disclosure be Overcome?

SB: It's in radiologists' control to be more visible to patients. There are a lot of obstacles to that in the way radiology workflow is managed, but radiologists have the opportunity to interact with patients more directly. In becoming more visible, over time that may potentially be to their benefit when errors occur. Some of the historical reticence to talking to patients overall could be overcome, which would facilitate culture change toward being more upfront with patients about errors when they do happen.

TG: Physicians' shame and embarrassment is probably the most important barrier. Firstly, we need to learn how to provide much better support for the upset emotions of physicians following errors. Physicians experience a lot of distress, and that largely goes unsupported. We also have a way to go to normalise disclosure as part of the culture of medicine. It's helpful when physicians see leaders they respect disclosing errors and doing it well.

Professor Brown, You've Recently Published a Paper On Professional Norms Regarding How Radiologists Handle Incidental Findings (Brown 2013). How Do You Think Radiologists Should Handle These?

SB: It's a big question, but I think radiologists should adhere as much as possible to evidence-based guidelines. They should try as much as possible to explain rationales for various recommendations that one might make on the basis of a finding, being as firm as possible about things that are benign, and trying to be (and it's not easy) as unequivocal as possible. Overall radiology needs to come up with more evidence-based guidelines for the management of incidental findings. More research is needed, particularly in paediatrics.

Do Radiologists Need Professional Guidance On Error Disclosure?

SB: All practical obstacles aside, we need to establish for radiologists a convincing ethical rationale for why error disclosure is in patients' interests. We also need to help define for radiology some of the terms that we're dealing with – what is an error, what is a reasonable misjudgment, what is harm from the patient's point of view, what are the thresholds for disclosure. Does a harm need to have been incurred, or are there times when there's not a harm, perhaps even merely an inconvenience, when open and direct communication with the patient may still be appropriate?

In the absence of guidelines, then practice around the U.S. and around the world is likely to be highly variable. At the least you can set out for the profession some uniformity that can try to mitigate if possible the heterogeneity of practice resulting from the diversity of state laws and institutional practices. And we can offer some guidance to radiologists on effective disclosure practice in states where it may be mandated. We're advocating that a rationale exists that speaks to the interests of patients as well as radiologists. We would like to see radiologists given the chance to explain how radiology works, and how the error has occurred, in the context of how they practise. And we hope that radiologists will be given the opportunity to say they're sorry, when it seems appropriate. An apology shows significant benefits to patients, indicates respect for their autonomy, and promotes optimal patient centered care.

Are Guidelines On Error Disclosure Being Developed?

SB: Few professional organisations for physicians have solid, granular guidelines and policies on error disclosure. The American Medical Association has strongly promoted the principle that errors ought to be disclosed, but the AMA has not offered specific recommendations on the mechanics of the disclosure process. Certain institutions have very robust mechanisms around error disclosure, for example the University of Michigan. That is one system that is enterprise-wide and very coordinated and thoughtful, and it's been of significant benefit to that institution and to the patients. The University of Michigan is a single payer system so it's probably easier to get one risk manager and one insurer than if you have five, and Michigan is a state that may allow latitude in a way that other states might not.

Do You Think That Errors Discovered During Quality Review Should Be Disclosed? What is The Best Way To Do This?

SB: Probably there are times when these processes will uncover errors that patients should know about, and times where the simple question is: is this something that you would want to know about if it were you, your family or friend? How would you want it to be handled in that situation, and if the answer is I'd want to know, that's a reasonable standard to use to determine whether or not these types of errors ought to be, in some way, revealed to patients. This may not be best managed by the radiologists directly calling the patient, but rather by incorporating it into a process in which there's full communication between all the stakeholders in the hospital, providers, risk managers, department and hospital leadership (if it's a big enough error), and figuring out a coordinated way to disclose to the patient and offer an apology.

In Investigations Into Medical Errors, Do You Think The Patient's Or Family's Voice Is Sufficiently Heard?

TG: I think that disclosure of medical errors is in many respects the ultimate test case in providing patient-centric care. When something goes wrong, our natural inclination is to think about what the impact is on healthcare providers, on clinicians, and the patient's perspective is in the background. Trying to keep the process focused on patients is important, but difficult to do.

How Can Doctors Do That In Practice?

TG: Better understanding patients' preferences is an important start. Physicians oftentimes think, "Well, the patient wouldn't want to know about this error, it would upset them, or reduce their trust in us". They come up with all sorts of reasons why the patients wouldn't want to be informed. However, the research is really very clear. Patients do want to know about any error in care that is harmful, even when the harm is minor. Physicians and institutions can better understand what patients want in these circumstances. Secondly, we are seeing more and more organisations using patient advisers, who can really help ensure that the patient perspective is represented and how to respond.

How Can Hospital Managers Create or Promote An Environment In Which It is Encouraged to Disclose Errors?

TG: Firstly, they need to perform what I describe as a 'search and destroy' mission for any mixed messages they are sending to physicians around disclosure. Often there is a formal policy promoting disclosure, but, in practice, the response that physicians hear is much more guarded. They will be told, "Well, of course we want you to tell the patient what happened, but don't say that, don't admit fault." Those sorts of mixed messages make it very hard for doctors to know what to say. It helps if there is a comprehensive disclosure policy, but also if the institutions provide 'just-in-time' disclosure coaching, so physicians can call, and in the moment immediately before having to talk with a patient, get advice from an expert.

Providing emotional support for clinicians is also important. In addition, institutions ought to start applying all the quality improvement tools to the disclosure process – how well do patients and providers think that disclosures are going? Institutions should start to track if disclosures are happening when they should, and if so, how well they are going, and what patients and providers think.

Disclosure makes lawsuits less likely: most of your survey (Gallagher et al. 2006) thought so, and the University of Michigan experience bears this out. Why don't more healthcare facilities have programs like the University of Michigan one?

TG: There is widespread awareness of the experience of the University of Michigan. Their programme is emulated by a number of other organisations, including Stanford University, the University of Illinois at Chicago and many others. The federal government has been funding several large-scale demonstration projects on disclosure and resolution. I think we are on the verge of seeing these spread nationally.

Communication Skills

There's Some Evidence That Patients Do Not Understand Risk Very Well. Does a Focus On Safety and Medical Errors Perhaps Need To Be Balanced By Looking At Patients' Attitudes Towards and Understanding of Risk?

TG: Improving the way we talk with patients before they seek medical care, such as through better informed consent and shared decision making, can play an important role in helping patients understand what happens when something doesn't go well with their care. Improvement in communication on the front end can really make a big difference on the back end, when there's been a problem. Part of that is through helping patients understand and interpret risk. Part of it is just through a straight provider-patient relationship: that seems to be a big help in conversations with patients when care has not gone as expected.

You Have Suggested That Physicians Should Provide Feedback to Colleagues About Their Communication. Often It's Support Staff Who Observe Poor Communication By Physicians. Is There a Role For 360° Feedback On Communication?

TG: 360° feedback is really important. Support staff may not feel comfortable mentioning their concerns directly. One of the common denominators we see in physicians having trouble with their interpersonal skills, whether it's communication with patients, colleagues or staff, is a lack of self-awareness. They are not aware of how their behaviour is perceived by those around them, so coming up with much better ways of providing that feedback will be important.

Do You Think Medical Schools Pay Enough Attention to Students' Communication skills?

TG: All medical schools teach communication skills to their students, and increasingly they are using simulation as a way of assessing those skills. However, we don't do a good job of continuing that focus on communication skills after medical school, into residency and beyond into practice. Physicians often don't have the opportunity to practise their communication skills or get feedback once out of the training setting. I think physicians sometimes wrongly assume that communication skills are something that you are either good or bad at and cannot improve. That's really not the case. Communication skills are like any other: if you don't consciously seek feedback and practice, your skills are likely to atrophy.

Next Steps

What Research Are You Working On Currently?

TG: We are working on how to improve the response to medical incidents that goes beyond disclosure. Patients value disclosure, but the response to injury needs much more than just words. Patients want to see action in the form of healthcare institutions and providers learning from what happened, and making sure it does not happen to someone else. This may take the form of providing patients with financial and non-financial compensation, sometimes actions by regulators to make sure that a physician is safe to continue practice. So a lot of our work is focused on those broader areas of accountability – making sure that those actions follow the disclosure conversation in the way that they should.

SB: I have developed a workshop to teach communication skills to radiologists, which focuses on communicating new or unexpected bad news, communicating about errors and about radiation risk. We've done two years' worth of workshops and we're beginning to analyse the data on whether the workshops have an effect on radiologists' levels of confidence with communication and certain attitudes about error disclosure. These have been geared towards radiology trainees, who are quite receptive to the communication training. There is still reticence within many circles in the world of radiology towards communicating more directly with patients overall. Many radiologists feel that it is not their place. That is magnified considerably when it comes to talking about medical errors. In order to train radiologists to communicate with patients you not only have to teach the skills, but also provide rationales for the communication to help overcome some of the historical barriers and historical reticence and try and begin some degree of culture change. There are important practical barriers, which I fully acknowledge. A lot of practices are not set up to communicate more directly with patients, and a lot of radiologists are not comfortable with it, and don't see it as their role.

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