From the President's Desk: The move to disclose medical error, 10/02

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October 2002—It is an axiom that painful transition is a prerequisite for meaningful change. This is true of organizational change as well as of life passages. It is also true of social and economic movements. Changes occurring now in the culture of our health care system suggest that the issue of medical liability is in this type of transition.

We have heard much about patient *safety*, *sentinel events*, and *systems error*, which are the themes of two monographs published by the Institute of Medicine's Committee on Quality of Health Care in America. Both documents, titled *To Err Is Human: Building a Safer Health System and Crossing the Quality Chasm: A New Health System for the 21st Century*, propose sweeping, systemic changes and have sent ripples across the profession.

To Err Is Human, the major goal of which was to end what it termed a "cycle of inaction" about patient safety and medical error, generated far more publicity than the second, though the latter covers more ground. *Crossing the Quality Chasm* calls for broad-based health systems improvement in six areas: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.

To Err Is Human put patient safety and medical error on the Sunday morning talk shows, but it is the new Joint Commission on Accreditation of Healthcare Organizations standard requiring that patients and families be "informed about outcomes of care, including unanticipated outcomes," that brings the story home. We in the practice of pathology serve patients, and when failures occur in the provision of our services, we are all affected by this standard. This, of course, applies to problems of transcription, misidentification, or misinterpretation in the clinical laboratory as well as matters of misinterpretation when dealing with tissues or cells.

Many of us have been raised in the tradition of paternalism, where the patient is told only what she or he needs to know. We tend to look in horror at this new standard, which seems to be, at best, an invitation to higher levels of liability risk. Yet there is a positive side. For many of us, this new policy is in concert with our personal ethic of being truthful with those who entrust us with their care. This standard, too, without question, is consistent with the patient empowerment movement that is sweeping the country. Appropriate disclosure also is important to preserving patient relationships that could otherwise disintegrate, improving outcomes for others by prompting systems improvements, and helping patients form more realistic expectations of a system that, as we all know, is not infallible.

Preliminary evidence suggests that voluntary disclosure does not lead to an increase in liability lawsuits. When settlement does take place, the monetary payments are often lower. This is so in part because prompt and considerate disclosure defuses anger, and in part because lawyer fees and hyperbole are minimized.

Better settlement outcomes can also be attributed to the development and teaching of the art of appropriate disclosure methods, which are based on the science of effective negotiation and conflict resolution. The method calls for sensitivity to the setting and the participants, and, most important, to the oral communications employed. Physicians need to listen closely to patients and families during the post-incident encounter, should not hesitate to show sympathy, and should understand the difference between an apology and an admission of liability. Saying "sorry" can go a long way. Careful speech and thoughtful listening are key to achieving satisfactory resolution of untoward events.

The best medicine, of course, is to prevent error. The College sponsored a Virtual Management College series on medical error earlier this year, which addressed systems-based approaches to counter human fallibility. Speakers explained the rationale for a culture centered on collective responsibility for patient safety, and they challenged

conventional “blame and shame” thinking. Human fallibility is a given, they explained, but other enterprises have demonstrated that good systems can minimize mistakes and prevent oversights. *Errors are consequences*, *not causes*, said Lee H. Hilborne, MD, MPH, in his presentation for the first workshop on Feb. 12. *We can engineer safety into the system*, Ronald L. Sirota, MD, declared at the second VMC a month later. We can create *protective systems as well as productive systems*.

The College will sponsor a third program on errors in surgical pathology at the U.S. and Canadian Academy of Pathology meeting on March 3, 2003.

Fears about disclosing errors in care are rooted in fear of legal action, a concern that is being addressed by a bipartisan bill now before Congress. The Patient Safety and Quality Improvement Act, introduced in June, would create a medical errors reporting system made up of independent patient safety organizations that would analyze reports of untoward events and give feedback on how to fix problems. Information reported voluntarily for quality improvement and patient safety purposes would be held privileged and confidential.

The House version of the bill, sponsored by Rep. Nancy Johnson (R-Conn.), includes an excellent section on informatics. This version would create a medical information technology advisory board to advise the secretary of Health and Human Services on the best practices in medical information technology and methods to implement them. This legislation recognizes, as does the IOM, that greater attention to information technology can eliminate much of the medical error that is inherent in the system. *Crossing the Quality Chasm* calls for eliminating most handwritten clinical data by the end of the decade. This clear commitment to modern medical informatics is the way to go.

As pathologists, we work with a cross-section of specialists. Being dedicated to the clinical laboratory, we are comfortable with systems approaches, at home with quality assurance and quality improvement mechanisms, and appreciate the value of sound data analysis. As respected leaders in medical quality management, we are ideally prepared to take the lead in shaping a new culture of collective responsibility for quality in our hospitals. Continuous quality improvement in patient care and the application of top-quality laboratory informatics have been the hallmarks of our specialty and drivers for many of the CAP’s activities, including such premier services as Q-Probes, Surveys, and SNOMED, the universal vocabulary for medicine. Suddenly, our longtime ideals have become a necessity for all of medicine.

The need to develop efficient communication systems, methods for error analysis, and systems adjustments are all proper places in which our long-honed skills can be used effectively. Let us put our knowledge to work for the common good.