Whether harmed or not, patients have a right to know when errors are made

Medical errors do happen and, despite considerable efforts to develop systems to minimise the risk of such errors, they are unlikely to be entirely eliminated. Medical errors are commonly defined as "preventable adverse medical events". Patients are harmed as a consequence either of what is done to them or what is not done that should have been done to prevent an adverse outcome. In many complaints to HDC the complainants indicate that they have made a complaint because they want to know what really happened, want the responsible persons to be accountable for their decisions and actions, and want to be assured that steps have been taken to minimise the chance of the events happening to someone else. An important aspect of this process is the disclosure of errors and an appropriate apology. Patients also have a right to know about critical incidents even if they are not physically harmed by them. Open disclosure is important because a failure to disclose errors or incidents to patients undermines public trust in medicine and suggests that the preservation of professional interests overrides the wellbeing of patients. If errors are not reported appropriately the non disclosure may undermine efforts to improve the safety of medical practice.

The Medical Council of New Zealand guideline "Disclosure of Harmful and Adverse Events" (the Guideline) (December 2010) states that when a patient is harmed while receiving medical treatment, MCNZ expects that the patient's doctor will advise the patient of the facts of the harm in the interests of an open, honest and accountable professional relationship. The Guideline requires that the disclosure be made in a timely manner and states that it is appropriate to make the initial disclosure as soon as practical, with a more detailed discussion with the patient to follow once the team has had an opportunity to meet and discuss the circumstances that led to the patient being harmed. This will give time for the patient to think about the situation and provide an opportunity to ask for more information. The Guideline requires that the doctor document in the patient's clinical notes details about the nature of the harm, and any subsequent actions, including disclosure to the patient.

It is not uncommon in HDC complaints for disclosure to be insufficient or not timely. For example, in 13HDC01345 (16 June 2015) an ophthalmology trainee inadvertently touched a scraper on a woman's retina. The woman was conscious during the procedure and aware that the consultant had taken over the procedure. She said she asked to speak to the doctor before she left the theatre but the trainee told her that there was nothing to worry about. The trainee did not document the adverse event in the clinical notes or in two letters to the woman's GP. The trainee again did not disclose the event at a follow up appointment 10 days after the surgery and it was not until a month later when the woman saw the consultant that it was confirmed that her eye had been damaged permanently during the procedure.

Similarly, in 15HDC00677 (13 May 2015) a GP became aware on, or soon after, 28 July 2014 that he had missed an adverse PSA result in 2012. However, he did not inform the patient of his error until 23 September 2014. The GP said he did not notify the patient of his error immediately because he wanted to avoid causing the patient further upset (in addition to the cancer diagnosis) before the patient went on an overseas holiday. The Commissioner stated that a consumer should be informed about any adverse event in a timely manner and he was critical of the time it took the GP to notify the patient that he had missed the 2012 PSA result.

One way in which doctors can respond to a medical error is to apologise. An apology is a statement that acknowledges an error and its consequences, takes responsibility and

communicates regret for having caused harm. An apology may also include information about steps being taken to prevent similar events in the future. An appropriate apology can decrease blame, decrease anger, increase trust and improve relationships.

It is undoubtedly true that it can be difficult to apologise. Gallagher and colleagues suggest that "the norms, values, and practices that constitute the culture of medicine" may play a greater role in encouraging or inhibiting disclosure and apologies than does the risk of liability.[i] Furthermore, a personal expectation of perfection may make it difficult to apologise for errors given that one of the central features of an apology is the acceptance of responsibility for having caused harm.

In many cases, HDC recommends that an apology be made. Sincere apologies offered in the wake of a medical error may assist both patients and doctors to cope with the error and its consequences, and contribute to improved relationships so that the patient/doctor relationship is able to continue. Disclosure of an adverse event together with an appropriate apology may lead to acceptance, forgiveness and restoration of the trust in the relationship. It is the right thing to do.

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NZ Doctor, 25 October 2017

[i] Gallagher TH, Waterman AD, Garbutt JM et al "US and Canadian Physicians' Attitudes and Experiences regarding Disclosing Errors to Patients". Arch Intern Med. 2006; 166: 1605-1611.