SURGEONS VARY WIDELY IN THEIR APPROACHES TO DISCLOSING MEDICAL ERRORS TO THEIR PATIENTS

Surgeons are encouraged to fully disclose medical errors they make during the care of patients, yet few receive training on the best way to talk to patients about errors. Surgeons are also often reluctant to do so because of possible malpractice suits, discomfort in facing angry patients, and concern about potential damage to their reputation. A study, supported in part by the Agency for Healthcare Research and Quality (HS11898 and HS14012), analyzed how surgeons talk with patients about medical errors and found that the surgeons' approaches to these discussions varied widely.

Researchers randomly assigned 30 surgeons to meet with standardized patients, who portrayed patients in 3 different hypothetical error scenarios. The scenarios included a wrong-side lumpectomy related to a surgeon's error in labeling breast biopsy specimens, a retained surgical sponge after a splenectomy, and life-threatening hyperkalemia-induced cardiac arrhythmia related to the surgeon forgetting to check laboratory test results. The patients, who had experience in assessing physicians' communications skills, rated each encounter based on five communication elements of effective error disclosure.

The surgeon were rated highest on their ability to explain the medical facts about the errors (average scores for the three scenarios ranged from 3.93 to 4.20 out of a maximum score of 5). However, surgeons used the word "error" or "mistake" in only 57 percent of disclosure conversations. In 27 percent of cases, surgeons used the words "complication" or "problem" to describe the error.

Academic physicians are fortunate to have available a 24 hour "hot line" staffed with professionals that can guide physicians in having these conversations without increasing their risk of legal action. **Academic subscribers may call 800-572-0179 to reach the law firm of Feldman, Kieffer & Herman, LLP, to gain advice in handling risk management questions.**

The report cited above, "How surgeons disclose medical errors to patients: A study using standardized patients," by David K Chan, M.D., Thomas H. Gallagher, M.D., and Wendy Levinson, M.D., is in the November 2005 Surgery 138, pp. 851-858.