



American College of  
Emergency Physicians®

ADVANCING EMERGENCY CARE 

# POLICY STATEMENT

Approved March 2023

## *Disclosure of Medical Errors*

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September 2003

The American College of Emergency Physicians (ACEP) believes that emergency physicians should provide prompt and truthful information to patients or their representatives about their medical conditions and treatments. Decades of patient safety research have shown that medical error resulting from both system and human factors can and does occur in all healthcare settings, including the emergency department (ED). Medical error is defined as the preventable failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.

If, after careful review of all available relevant information, an emergency physician determines that a medical error has occurred during their care of a patient in the ED, the physician or an appropriate designee should inform the patient in a timely manner that an error has occurred. They should also provide information about the error and its consequences, following institutional and practice group policies and applicable state statutes. If the patient is incapacitated and therefore unable to receive this information, an emergency physician or an appropriate designee should provide the information to the patient's representative.

To show respect for the patient and commitment to patient welfare, disclosure of a medical error in the patient's care should include 1) an explicit statement that an error has occurred, 2) a factual description of the error and its clinical implications, 3) an apology, and 4) description of any system review to prevent similar future errors. Content may vary if specifically limited by legal constraints. Depending on specific circumstances and institutional or practice group policies and considering applicable state statutes, this disclosure may be offered by the emergency physician, another member of the patient's health care team, or an officer of the institution.

In some cases, it may be apparent that an ED patient had a poor outcome but may not be obvious whether this was the result of a medical error or was an unavoidable complication of an appropriate treatment. When such an adverse event occurs, an emergency physician or an appropriate designee should inform the patient or the patient's representative that a problem has occurred in the patient's care, that the problem is being examined, and that additional information will be provided when it is available.

This policy addresses errors that occur as a result of care received in the ED by emergency physicians but does not address errors made as a result of care received after the patient leaves the ED or after the care has been transferred to an admitting service.

ACEP recognizes that substantial obstacles, including unrealistic expectations of physician infallibility, lack of training about disclosure of errors, and fear of increased malpractice exposure, may obstruct the free disclosure to patients of medical errors. To overcome these obstacles, ACEP recommends the following initiatives:

- Health care institutions should develop and implement policies and procedures for identifying and responding to medical errors, including continuous quality improvement (CQI) systems and procedures for disclosing significant errors to patients.
- Medical educators should develop and provide specific instruction to trainees at all levels on identifying and preventing medical errors and on communicating truthfully and sensitively about errors with patients or their representatives.
- States should enact legislation that makes apology statements by physicians related to disclosure of medical errors inadmissible in malpractice actions.