

**University of Michigan Hospitals and Health Centers  
Applying Steps 1, 2 & 3 to Determine Levels of Disclosure  
(Case Example 3: Error / Death)**

Case Example 3	Step 1	Step 2	Step 3
<p><b>Death of a patient related to a programming error at the bedside resulting in the overdelivery of a narcotic through a PCA pump. The incident was immediately reported by phone to Risk Management for further analysis.</b></p>	<p><b>(Severity Scale Rating) NCC MERP Category I Incident: Error / Death</b></p>	<p><b>(Potential harm of disclosure to the family)</b>  <ul style="list-style-type: none"> <li>◆ Knowing the error may have been avoidable could cause insurmountable suffering.</li> </ul> <p><b>(Potential benefits of disclosure to the family)</b>  <ul style="list-style-type: none"> <li>◆ The patient's family may obtain just compensation for the injury.</li> </ul> <p><b>(Potential harm to the practitioner)</b>  <ul style="list-style-type: none"> <li>◆ There might be a perceived or real loss of reputation and respect among peers and patients/families.</li> </ul> <p><b>(Potential benefits to the practitioner)</b>  <ul style="list-style-type: none"> <li>◆ Emotional distress may be alleviated after admitting error, especially if forgiveness is received from the patient's family.</li> <li>◆ Accepting responsibility for the error may facilitate constructive changes in clinical practice.</li> </ul> <p><b>(Potential harm to the organization)</b>  <ul style="list-style-type: none"> <li>◆ There might be a loss of public trust and confidence.</li> <li>◆ There is a risk of liability.</li> </ul> <p><b>(Potential benefit to the organization)</b>  <ul style="list-style-type: none"> <li>◆ The sharing of such experiences can broaden collective learning and encourage implementation of proactive changes in clinical practice.</li> </ul> </p></p></p></p></p></p>	<p><b>(Guiding principle to consider)</b>  <ul style="list-style-type: none"> <li>◆ It is the obligation of the institution to its internal customers and to the community as a whole to hold true to the intent of its statements of mission, vision, values, and goals, which place a premium on putting patients and families first.</li> </ul> <p><b>(Making the decision to disclose)</b>  <ul style="list-style-type: none"> <li>◆ In this case, the worst possible outcome occurred, which was the death of a patient.</li> <li>◆ The obligation to disclose is self-evident and is driven not only by external legal and ethical mandates, but also by the desire to preserve the integrity of the institution itself within its own walls and within the community at large.</li> </ul> </p></p>

**COPYRIGHT © 2002 THE REGENTS OF THE UNIVERSITY OF MICHIGAN  
ALL RIGHTS RESERVED**

PERMISSION IS GRANTED TO USE, COPY AND REDISTRIBUTE THIS DOCUMENT FOR NONCOMMERCIAL EDUCATION AND RESEARCH PURPOSES, SO LONG AS NO FEE IS CHARGED, AND SO LONG AS THE COPYRIGHT NOTICE ABOVE AND THIS GRANT OF PERMISSION APPEAR IN ALL COPIES MADE; AND SO LONG AS THE NAME OF THE UNIVERSITY OF MICHIGAN IS NOT USED IN ANY ADVERTISING OR PUBLICITY PERTAINING TO THE USE OR DISTRIBUTION OF THIS DOCUMENT WITHOUT SPECIFIC, WRITTEN PRIOR AUTHORIZATION. PERMISSION TO MODIFY OR OTHERWISE CREATE DERIVATIVE WORKS OF THIS DOCUMENT IS NOT GRANTED.