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# Social Workers' Management of Error: Ethical and Risk Management Issues

*Frederic G. Reamer*

## ABSTRACT

Social workers, like all professionals, sometimes make mistakes. For example, they may disclose clients' confidential information inappropriately, fail to respond to clients' reasonable requests in a timely manner, or engage in improper dual relationships with clients. Ideally, social workers who err would follow a protocol that honors the profession's commitment to responsible and honest communication and minimizes the practical risks faced by social workers who might be named in lawsuits, licensing board complaints, and ethics complaints. This article explores the nature and forms of social work error and possible constructive responses to it that (a) protect clients, (b) minimize risk to social workers, (c) prevent future error, and (d) adhere to prevailing ethical standards in the profession.

Professionals sometimes err. The annals of professional literature, journalistic reports, and court transcripts attest to instances when surgeons have severed a patient's artery or amputated the wrong limb, pharmacists have misread prescriptions and given patients lethal doses of medication, engineers have overlooked critically important flaws in building design, and police have shot innocent bystanders (Banja, 2001; Finkelstein, Wu, Holtzman, & Smith, 1997; Kohn, Corrigan, & Donaldson, 2000).

Social workers, too, sometimes commit errors. In their efforts to assist individuals, families, couples, and groups of clients, social workers inadvertently may overlook critically important assessment information, provide services in a flawed manner, or mishandle ethical dilemmas. Errors occur in all social work settings, such as community mental health centers, family service and counseling agencies, schools, health care settings, substance abuse treatment programs, independent practice, prisons, and public welfare agencies.

Ideally, social workers—and all other professionals—would acknowledge their errors forthrightly, convey their regrets to injured parties, and engage in constructive steps to prevent any recurrence. Honest and sincere communication with injured parties, during which social workers accept responsibility for any mistakes they may have made, is certainly consistent with enduring social work values. As the *Code of Ethics of the National Association of Social Workers* (1999) states, social workers “treat each person in a caring and respectful fashion” (p. 5) and “act honestly and responsibly” (p. 6).

Practically speaking, however, social workers face significant disincentives to acknowledge their errors openly and candidly. They may feel a personal sense of shame about their mistakes and, for this reason, may find it difficult to disclose their errors (Kraman, 2001). In addition, social workers may fear that any admission of wrongdoing would be used against them in the context of lawsuits, licensing board complaints, or ethics complaints filed by

disgruntled clients or colleagues (for example, ethics complaints filed with the National Association of Social Workers).

Preferably, social workers who err would follow a protocol that simultaneously honors the profession's deep-seated commitment to open, responsible, and honest communication and minimizes the practical risks faced by social workers who might be named in lawsuits, licensing board complaints, and ethics complaints. The purpose of this discussion is to explore the nature and forms of social work error and possible constructive responses to it that (a) protect clients, (b) minimize risk to social workers, (c) prevent future error, and (d) adhere to prevailing ethical standards in the profession.

### The Nature of Professional Error

Professional error occurs when practitioners depart from widely accepted standards and best practices in the profession. Prevailing standards in a profession—typically known as *standards of care*—are based on what an ordinary, reasonable, and prudent practitioner with the same or similar training would have done under the same or similar circumstances (Madden, 2003; Reamer, 2003; Stein, 2004). Professional error can be defined as “failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim” (Gallagher, Waterman, Ebers, Fraser, & Levinson, 2003, p. 1002). Some professional errors occur unintentionally—for example, when a clinical social worker inadvertently discloses confidential information, without proper authorization, to a client's spouse or neglects to complete a client's insurance claim form in a timely manner. However, other errors occur with intent—for example, when a social worker fraudulently documents services that were never provided or when an impaired clinician becomes sexually involved with a client. In general, errors may occur because of social workers' incompetence (for example, unskilled use of widely accepted interventions, failure to use best practices, or inadequate training), unethical behavior, or impairment.

Some professional errors cause harm and some do not. For example, a social worker who releases confidential information about a client's substance abuse, without consent, to an estranged spouse might cause harm if the estranged spouse uses that information against the client during a child custody dispute. In this instance, the social worker's error or departure from the profession's standard of care related to informed consent causes harm. In contrast, a social worker who errs clinically by disclosing too much personal information to a client—in a manner that is inconsistent with current standards of care and confuses boundaries in the professional-client relationship—would not necessarily (although could possibly) harm the client. Thus, some errors do not cause significant injury.

Social work errors that cause harm or injury constitute *adverse events*. An adverse event entails injury caused by the provision of care rather than by the client's clinical condition (Cantor, 2002; Kohn et al., 2000; Wu, 1993).

### Case Studies: Theo and Martha

In social work, errors occur in three forms. First, some errors result from genuine mistakes or inadvertent oversight on the part of social workers—for example, related to proper management and protection of confidential information.

Theo L., a school social worker, was preparing a clinical summary of his work with a 15-year-old client to be submitted to the local juvenile court. The juvenile court judge planned to use the report when she conducted a hearing concerning the student's arrest on robbery charges.

Theo L. was unable to finish his report by the end of the day. He left the report on his desk and planned to complete it the following morning. However, during the evening a custodian was in Theo L.'s office and noticed the report sitting on the desk. The custodian recognized the client's unusual surname on the exposed file label and read the report. The custodian shared confidential information about Theo L.'s sensitive family circumstances with several acquaintances.

Martha B. was a social worker in a family service agency. One afternoon, she stepped onto the elevator in the agency's building and encountered one of her colleagues. Martha B. had been trying to reach this colleague to give her an update on a client they shared who is prominent in the local community. During the elevator ride, Martha B. told her colleague about the client's psychiatric hospitalization. Martha B. did not realize that one of the other elevator passengers knew the client, overheard the conversation, and shared the news about the hospitalization with several friends and relatives. The inadvertent disclosure embarrassed Martha B. and harmed her reputation.

### Case Studies: Benita and Sondra

The second form of error occurs when social workers make deliberate decisions about how best to work and intervene with a client. These errors are the result of social workers' thoughtful, intentional, but mistaken, attempts to do what they believe is in clients' best interests—for example, their use of high-risk clinical interventions and casework services.

Benita D. was a social worker in independent (private) practice. One of her clients—a nine-year-old child diagnosed with “reactive attachment disorder”—struggled in her relationships with family members, primarily her parents. In an effort to help this child, Benita D. decided to use a controversial clinical intervention known as “rebirthing therapy.” Rebirthing therapy involves

wrapping the child in a blanket to recreate the womb and simulating the child's birth in an attempt to rewind the clock and enhance the child's emotional attachment to others. During the intense procedure, the child asphyxiated on her own vomit, suffocated, and died.

Sondra T. was a clinical social worker in a community mental health center. One of Sondra T.'s clients was diagnosed with severe depression and anxiety. The client was evicted from her home and began living on the streets. As an act of compassion, Sondra T. offered to let the client live in a spare room in Sondra T.'s home until the client could find alternative housing. After three weeks, the client refused to leave Sondra T.'s home.

### **Case Studies: Daniel and Alma**

The third form of error occurs when social workers intentionally depart from standards of care in a way that clearly constitutes ethical misconduct—for example, in the form of boundary violations and other forms of client mistreatment.

Daniel V. was a clinical social worker at an outpatient mental health clinic affiliated with a large hospital. Daniel V.'s client was a woman who sought therapy to address a number of troubling issues in her marriage. Daniel V. found that he was attracted to his client. Eventually Daniel V. disclosed to the client this his own marriage was fragile and that he was attracted to his client. Daniel V. and the client became sexually involved during the course of their clinical work together.

Alma F. was a social worker with a state child welfare agency. Her responsibilities included recruiting, screening, training, and approving foster parents for her agency's therapeutic foster program. Alma F. became very friendly with a foster couple with whom she placed a 15-year-old client who struggled with serious mental health issues. Alma F. began socializing with the foster parents, became actively involved in the foster parents' church, and, during one weekend, left her own two teenage children in the care of the foster parents while she visited out-of-town relatives. Alma F. knew that she was involved in an unusual dual relationship with the foster couple but believed she could handle the relationship. The 15-year-old foster child became pregnant; the biological father was Alma F.'s own teenage son.

### **Professionals' Response to Error**

Relatively few empirical studies document the extent of professional error. The most prominent studies of error have been conducted in the health care field. For example, Brennan et al. (1990) reviewed over 30,000 randomly selected medical charts and estimated that negligent adverse events occurred in 1% of hospitalizations; one quarter of those errors led to death. Wu (1991) surveyed 254 internal medicine house officers, 45% of whom com-

pleted an anonymous questionnaire regarding their mistakes, and found that 90% reported that they had made errors causing serious adverse outcomes, including death in 31% of the cases.

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Very few social work studies summarize errors in the profession. Reamer (1995, 2003) examined the pattern of malpractice claims against social workers covering a 22-year period and found that the most common allegations involved so-called "incorrect treatment" (i.e., flawed interventions and service delivery) and sexual impropriety. Less common allegations involved breach of confidentiality/privacy, improper client referral, defamation of character, breach of contract, failure to protect third parties, and client abandonment. Strom-Gottfried (2000) analyzed *NASW Code of Ethics* violations covering an 11-year period and documented significant clusters related to boundary violations, poor practice and incompetence, documentation, honesty, confidentiality, informed consent, collegial actions, reimbursement, and conflicts of interest.

Social workers have a vested interest in responding to errors constructively. Social workers' primary reason for handling error responsibly should be to protect clients and third parties. As the *NASW Code of Ethics* states, "social workers' primary responsibility is to promote the well-being of clients" (p. 7). Social workers thus have a duty to respond to errors in a way that protects and minimizes harm to clients.

Yet social workers must also recognize that they have self-interested reasons to respond to error constructively. Empirical evidence suggests that professionals who respond to unintentional error in a forthright, conscientious manner may minimize the likelihood that they will be sued by disgruntled clients or be named in licensing board and ethics complaints (Kraman, 2001; Mazor, Simon, & Gurwitz, 2004; Zimmerman, 2004). Although forthright, constructive response to serious intentional error—such as sexual misconduct—is desirable, it should not be viewed as a way to minimize or mitigate the extent to which misbehaving social workers are held accountable for their actions by licensing boards, NASW, or courts of law.

Unfortunately, research evidence suggests that professionals often do not respond to error forthrightly or constructively. Based on their comprehensive review of literature and empirical research on health care professionals' management of error, Mazor, Simon, and Gurwitz (2004) conclude that practitioners and trainees rarely disclose their mistakes. In studies using retrospective self-reports of error, health care trainees mentioned addressing the patient or family in only 6% of the cases. When asked about their most significant mistake in the past year, only 24% of trainees had discussed the error with the patient or family.

Surveys of clients and their relatives suggest low rates of error disclosure by health care professionals (Mazor, Simon, & Gurwitz, 2004).<sup>1</sup> A recent national survey found that of those who believed that they had experienced an error in their care or in the care of a family member, approximately 30% had been told by the professional involved that an error had been made. Of clients who believed that they had been injured as a result of their treatment, 21% reported that staff accepted responsibility for what had happened, and 27% reported that they had been offered an apology. Mazor, Simon, and Gurwitz (2004) further reported that practitioners' explanations about error did not necessarily lead to client satisfaction. Among clients who believed that they had been injured and were seeking advice from professionals about possible recourse, 82% were dissatisfied with the amount of information they received, 67% were dissatisfied with the clarity, and 63% were dissatisfied with the accuracy. In addition, 63% believed that the explanation was given unsympathetically, and 44% indicated that they had no opportunity to ask questions.

Evidence suggests that professionals who err commonly respond to clients unsatisfactorily in several ways (Finkelstein et al., 1997).

**Providing incomplete information.** The practitioner withholds key information when explaining to the client what went wrong (an act of omission). In social work, this would occur when, for example, a practitioner acknowledges to the client that he or she misplaced portions of the client's case record but does not tell the client that some of the missing documents were left on an airplane on which the social worker traveled. Incomplete disclosure would also occur when a social worker fails to tell a client the full details about the way the social worker confused the client with another client in discussions with the client's psychiatrist—confusion that led to the psychiatrist's decision to prescribe inappropriate psychotropic medication that caused serious side effects.

**Lying.** The practitioner deliberately gives the client

incorrect information about the error (an act of commission). An example would be a social worker who lies to the client about putting the incorrect code on the client's insurance form, which led to the insurance company's refusal to pay for the clinical services. Another example is a social worker who lies about using an outdated release of information form to disclose confidential information to a lawyer who used the information against the client during a child custody dispute.

**Avoiding.** The practitioner avoids discussion of the error. An example would be a social worker who dodges or evades a client's question about whether the social worker prepared and mailed to another treatment provider a long overdue clinical summary. Another example would be a social worker who avoids talking to a client about the fact that, without the client's knowledge, the social worker added information about intervention risks to a consent-to-treat form after the client signed the form.

There is compelling evidence that clients want practitioners to be honest with them about errors that occur in the delivery of service and want to be compensated when errors cause injury (Gallagher et al., 2003). In their survey of a sample of health plan members, Mazor, Simon, Yood, et al. (2004) found that given a hypothetical situation in which harm occurred as a result of practitioner error, respondents overwhelmingly reported that they would want to be told of the error. The authors conclude that full disclosure increases client satisfaction, trust, and positive emotional responses. Similarly, Gallagher et al. (2003) conclude that, based on data drawn from 13 focus groups of patients and practitioners, recipients of service "were unanimous in their desire to be told about any error that caused them harm" (p. 1003). More specifically, focus group participants "wanted to know what happened, the implications of the error for their health, why it happened, how the problem will be corrected, and how future errors will be prevented" (p. 1004).

Although forthright disclosure about error may make clients feel better, it may not always eliminate their wish for financial compensation. In one major study of health plan members, most respondents (83%) reported that they would want financial compensation for harm that occurs because of an error, and 13% expressed a desire for compensation even if harm did not occur (Mazor, Simon, Yood, et al., 2004).

Research on the subject of professional error suggests a number of key reasons why many practitioners respond to error with incomplete disclosure, false information, and avoidance (Finkelstein et al., 1997). These include concern that disclosure will do the following:

- Damage the practitioner's reputation, self-esteem, and authority.
- Diminish the practitioner's effectiveness.

<sup>1</sup> Nearly all of the empirical research on professional error and error management has been conducted in the health care field. The author's comprehensive literature review produced very little social work research on the subject.

- Discourage referrals and threaten the practitioner's income.
- Lead to lawsuits.
- Increase malpractice insurance premiums.

## Protecting Clients, Practitioners, and Agencies

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It is not realistic to think that social workers should disclose each and every error they commit. After all, some errors are relatively minor and cause no significant harm. In some instances, disclosure would seem excessive and counterproductive.

However, some errors indeed are serious, harm others, and warrant disclosure. Social workers should disclose these errors to clients for two principal reasons. First, and primarily, social workers have an ethical obligation to be forthright and truthful with clients (Congress, 1999; Loewenberg, Dolgoff, & Harrington, 2000; Reamer, 2006a, 2006b). Acknowledging error is a way for social workers to treat clients with dignity. As the *NASW Code of Ethics* (1999) states: "Social workers treat each person in a caring and respectful fashion" (p. 5) and "should not participate in, condone, or be associated with dishonesty, fraud, or deception" (p. 23).

Second, research evidence suggests that human service agencies can minimize risk when they disclose error responsibly. Specifically, candid disclosure can reduce the financial costs associated with error. In the most prominent study on the subject to date, conducted at the Veterans Administration (VA) Medical Center in Lexington, Kentucky, researchers found that the hospital administration's earnest, deliberate attempt to learn about possible patient injuries, investigate them, and honestly acknowledge errors with patients and next of kin led to very reasonable financial settlements and avoided significant litigation costs (attorneys fees, expert witness fees, and so on). The hospital administrators also found that handling malpractice and errors in the open immunized the facility from negative media publicity:

This is because vulnerability to media criticism and lawsuits comes not so much from the fact that errors are committed but from the perception that they are covered up. We operate our risk management program in the open and have even invited the press to film our committee proceedings and interview patients and families of patients who had suffered from medical errors. So far, the coverage has been uniformly positive, both locally and nationally. Unexpectedly, we have also experienced progressively increased self-reporting of errors from doctors and nurses. (Kraman, 2001, p. 255)

VA hospital administrators' perceptions are supported by evidence reported in the *Annals of Internal Medicine* indicating that the Lexington VA's willingness to acknowledge error actually limited the hospital's costs; the hospital's average cost of error-related payouts—including settlements and jury verdicts—was in the bottom quarter of 35 comparable VA hospitals (Zimmerman, 2004).

Research suggests that some individuals decide to sue their care provider because they did not receive an apology or explanation of an error. Mazor, Simon, and Gurwitz (2004) and Mazor, Simon, Yood, et al. (2004) report that in a major study of malpractice claims, 91% of respondents indicated that their desire for an explanation was a reason for their decision to pursue legal action. Nearly two fifths (39%) of this group suggested that an explanation and apology would have prevented legal action. Further, individuals in the sample who decided to pursue legal action against care providers were more dissatisfied with the explanations they had received than those who had chosen not to proceed. Respondents indicated that error disclosure by the care provider would make them more likely to continue to see this practitioner for treatment, less likely to report the practitioner, and less likely to file a lawsuit.

An emerging trend among a number of health care organizations is to establish formal error disclosure policies. For example, prominent institutions such as the Dana-Farber Cancer Institute in Boston and Johns Hopkins Hospital in Baltimore have made it a policy to urge their staffers to own up to mistakes and apologize. The National Patient Safety Foundation's statement of principle on disclosure of health care injuries urges health care professionals to be forthcoming about health care injuries and errors and to provide truthful and compassionate explanations to patients and families when errors occur (Mazor, Simon, & Gurwitz, 2004). Some agencies are retaining consultants to help staffers learn how best to convey their apologies.

## A Protocol for the Ethical Management and Prevention of Error

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Virtually all of the research and scholarly inquiry related to professionals' management of error has been conducted in the health care field. This literature contains important implications for social work, although one must extrapolate cautiously when transferring findings from one profession to another. Given the paucity of social work research on the subject, at this point social workers should look to guideposts in allied professions for relevant findings and for guidance to help social work cultivate its own research agenda.

In recent years, the medical profession has begun to cultivate protocols that encourage doctors to disclose serious, harmful errors and, simultaneously, reduce the

likelihood that such disclosures will be used against them in legal or quasijudicial proceedings. Research on the impact of these protocols suggests that ethical and responsible management of error should include a number of key elements (Banja, 2001; Finkelstein et al., 1997; Gallagher et al., 2003; Liang, 2002; Mazor, Simon, & Gurwitz, 2004; Thurman, 2001).

### **Care Partnership Agreement**

As a preventive measure, Liang (2002) encourages professionals and agencies to enter into a *care partnership agreement* with clients. For example, in a mental health program the agreement might state the following:

Mental health care is complex and sometimes complicated. We believe that clients are an equal partner in the delivery of care and essential in improving the system. We will do everything we can to provide safe and effective care to you. As our partner, please ask any questions you have about your care, and in particular please let us know if you observe any mistakes in your care so we may use this important information as an opportunity to improve how we treat you and all clients. We want to work with you to make the best health delivery system for everyone. Thank you for your help and participation. (adapted from Liang, 2002, p. 65)

### **Error Investigation Team**

In agency settings (as opposed to independent practice), an error investigation team can explore the extent to which serious errors occurred and practitioners adhered to policies and appropriate procedures. The team's members—typically senior staffers (administrators, program directors, managers, and supervisors)—should have appropriate expertise to investigate errors that might have led to adverse events. Liang (2002) suggests that the investigation team include “on call” members who can be summoned to begin assessment as soon as a potential or actual error is identified.

### **Error Disclosure Team**

Serious errors—for example, the inappropriate disclosure of confidential information, inadequate provision of services, mishandling of a client's crisis, or conflict of interest—should be disclosed to appropriate parties (e.g., clients and, with proper authorization, family members) by senior staffers, a client care liaison, and a clinically trained individual with expertise related to the error and adverse event. Clients and family members often ask questions that have clinical implications, so it is important for the staffers involved to have the requisite knowledge and skill. Liang (2002) argues that when serious errors occur, the provider who “last touched” the client—or who was most closely connected to the error—should not be part

of this disclosure, at least initially, since he or she may be too close to the circumstance, may be experiencing intense emotional turmoil as a result of the error, and may be ineffective in addressing it. Also, when very serious errors occur, the provider's presence “may incite high levels of conflict and devolve the disclosure effort into a finger pointing and blame reaction. The provider should be part of the investigation of the event, however, including important face to face encounters with patients during mediation, and hopefully this activity will allow him/her to sublimate the difficult emotional issues experienced into positive corrective action efforts” (Liang, p. 66).

The client care liaison should communicate regularly with the client/family regarding the progress of the error investigation. The client care liaison offers a point of contact for clients and family members for all information regarding the error and its investigation. The client care liaison also can help the client and family obtain additional assistance and remedial help, to the extent necessary, whether or not the adverse outcome was a result of error (Liang, 2002).

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***Social workers must also recognize that they have self-interested reasons to respond to error constructively.***

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Gallagher et al. (2003) argue that, at the very least, providers who err should offer the following information, whether or not the client asks: (a) an explicit statement that an error occurred; (b) a basic description of what the error was, why the error happened, and how recurrences will be prevented; and (c) an apology.

Ideally, practitioners should encourage and respond forthrightly to clients' questions and attempt to empathize with them. Organizations should be sensitive to clients' preferences to be fully informed about errors and encourage staffers to disclose such information (Baylis, 1997; Gallagher et al., 2003; Vincent, 2003). According to Finkelstein et al. (1997), if it is clear that the care provided was substandard, that the practitioner was clearly at fault, and that the client was harmed by the substandard care, the practitioner should express regret, apologize to the client or family, and offer to explore the issue of compensation for the harm, if appropriate, in collaboration with management.

A prominent theme in the literature on error management is the importance of the practitioner's communication style. Clients consistently report that the way in which practitioners acknowledge their error and

apologize is often as important as the words themselves (Levinson, 1994). Communications by professionals to clients and others must be characterized by sensitivity, transparency, honesty, and trust (Cantor, 2002). As Kraman (2001) notes with respect to staffers' management of error at the Lexington, Kentucky, VA Medical Center, "it has been our experience through this program that people judge hospital management and staff more by how responsible they act when they err rather than by the fact that an error was made" (p. 255). This sentiment is echoed by Gallagher et al. (2003), who found that many health care plan focus group participants said they would be less upset if practitioners disclosed their errors honestly and compassionately and apologized. These focus group participants thought that explanations of errors that were incomplete or evasive would increase their emotional distress.

### **Sound Documentation**

Social service agencies and practitioners should maintain a "disclosure record" of all actions related to the management of error (Liang, 2002). Disclosure records should document when key events occurred, where they occurred, who was involved, and any known consequences. A summary of contacts between practitioners and clients and family members should be included. The disclosure record should include descriptive information rather than conclusions, accusations, and/or assessments of fault (Liang).

### **Error Prevention Protocol**

To minimize the likelihood of future error, social work agencies and continuing education sponsors should conduct comprehensive risk management audits to ensure that their policies and procedures are consistent with prevailing standards of care (Houston-Vega, Nuehring, & Dagvio, 1997; Kurzman, 1995; Reamer, 2001). The primary purpose of a risk management audit is to provide social workers with a mechanism to do the following:

#### **Identify pertinent risks in their practice settings.**

What specific risks and sources of error do social workers face? Are there risks that arise in social workers' settings that are unique to the client population, treatment approach, setting, program design, or staffing pattern?

**Review and assess the adequacy of their current practices.** Has the practice setting addressed compelling risks? How adequate are the current practices, policies, and procedures in light of current standards of care, ethical guidelines, and laws? What issues need to be addressed?

**Design a practical strategy to modify current practices as needed.** What steps does the agency or practice need to take to protect clients, prevent disgruntled parties from filing ethics complaints with state licensing boards and professional organizations, and prevent lawsuits (for example,

enhancing staff education and training, creating or revising key agency policies)? Who in the practice or agency should work to address these risks? What resources will they need? What timetable should they follow?

**Monitor the implementation of this quality assurance strategy.** How can practitioners ensure that the implementation plan has been implemented effectively? What indicators can staff members use to assess the extent to which the audit goals have been met?

### **Legal Implications**

Social workers should recognize that fulfilling their ethical duty to acknowledge errors forthrightly may be accompanied by legal risks. Understandably, social workers may worry that admissions of error or negligence will be used against them in litigation and the adjudication of ethics or licensing board complaints (Barker & Branson, 2000; Houston-Vega et al., 1997; Reamer, 2003). Practitioners should thoroughly review relevant laws in their communities (Liang, 2002). In the United States, there are some jurisdictions where expressions of empathy or offers of assistance will not generally be taken as an admission of liability. For example, Colorado and Oregon have passed laws stipulating that a physician's apology cannot be used against her or him in court (Zimmerman, 2004).

Also, as noted previously, administrators of the VA Medical Center, Lexington, Kentucky, found that the hospital administration's willingness to acknowledge errors with the patient and next of kin led to reasonable financial settlements and avoided significant litigation costs. As Liang (2002) notes, "it has also been suggested that patients and their families are much less likely to engage in lawsuits if they have a positive open and honest relationship with their healthcare providers" (p. 67).

Error is a fact of life in professional practice. Even the most skilled practitioners make mistakes. Evidence suggests that clients are more likely to forgive errors when social workers handle them sensitively, honestly, responsibly, and forthrightly.

Unfortunately, social workers have conducted relatively little research on the nature of practitioners' errors and responses to them. It is essential for the profession to embark on ambitious research designed to assess the prevalence and correlates of professional error; the diverse ways in which practitioners respond to error; factors that influence practitioners' responses to and disclosures of error (for example, fear of litigation, concern about possible impact on professional reputation or malpractice insurance premiums); and practitioners' attitudes toward various protocols designed to protect clients and prevent error, ethics complaints, and litigation.

To protect clients and adhere to the profession's ethical standards, social workers who err should strive for transparency, candor, and supportive, nondefensive



communication with clients and others who are affected. Ethically speaking, honest acknowledgement of error is not only the right course of action, it is also the most prudent.

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