

Persisting Problems in Disclosing Medical Error

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Although the anecdotal literature suggests that for much of the 20th century, harmed parties, contemporary moral sensibilities categorically repudiate error concealment.¹⁻⁵ Routinely concealing harm-causing errors is tantamount to deceiving and, in many cases, defrauding harmed patients. It explicitly violates section 8.12 of the AMA’s *Code of Medical Ethics: Current Opinions with Annotations*, which requires physicians “to inform the patient of all the facts necessary to ensure understanding of what has occurred.”⁶

Recent research offers both encouraging and disheartening findings regarding the professional community’s contemporary management of error disclosure. Fortunately, health professionals appear increasingly conscientious about error disclosure and are disclosing errors more comprehensively and truthfully than they have in the past.⁷ The downside is that many medical errors remain undisclosed. Even when disclosure occurs, professionals admit to shaping their communications

with words and phrases that do not draw explicit attention to the error or to themselves as wrongdoers.⁸ Not surprisingly, doctors cite the fear of malpractice litigation as the principal reason why their error disclosure communications often fall short of being truthful and comprehensive.⁷

Although disclosing medical error often requires enormous courage, health professionals have yet to adopt a uniform set of ethical and practical guidelines for disclosing error. In what follows, I will describe four rather vexing problems that professionals commonly encounter in error scenarios. These problems not only obscure the moral goals of disclosure, but their mishandling could increase, rather than contain, a professional’s malpractice exposure.

Four Problems in Disclosing Error

The first problem in disclosing error involves whether to explicitly use the words



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“error” or “mistake” in the disclosure conversation. While standard RI.1.2.2 of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) requires that the health professional “clearly explain” instances of unanticipated outcomes to the patient or family, the standard does not require an admission of “error” or “mistake” when that outcome is the result of a harm-causing error. Furthermore, malpractice carriers commonly recommend that when an unanticipated outcome occurs, the health professional should “not use words which might imply negligence,” such as error or mistake.⁹ The JCAHO’s reluctance to require health professionals to admit “error” by its name along with malpractice carriers discouraging such terms cannot fail to affect error disclosure conversations, especially among those health professionals who are perhaps traumatized by having committed a harm-causing error.

It should come as no surprise, then, that one of the studies mentioned above discovered that “many physicians spoke of ‘choosing their words carefully’ when talking with a patient about errors.” Most often, this careful choice of words involved mentioning the adverse event but not explicitly stating that an error took place.”⁸ That finding, however, is hardly indicative of a truthful, patient-centered communication and arguably violates section 8.12 of the AMA’s current opinions on the code of ethics. If, following an initial communication that does not acknowledge error, the professional later explains that an error occurred, he or she risks losing the patient’s trust and good will.

The second problem in disclosing error lies in whether the disclosure violates the “assistance and cooperation of the in-

sured” clause of the professional’s or hospital’s malpractice insurance policy. Such clauses typically require that “the insured shall not, except at his own cost, make any payment, admit any liability, settle any claims, assume any obligation or incur any expense without the written consent of the company.”¹⁰

I recently posted an article on Emory University’s Center For Ethics weblog that not only urged the disclosure of error but also recommended that the professionals involved in the error request forgiveness from the harmed party. A colleague referred my article to a medical administrator who responded almost immediately with the following:

An admission of fault exposes the doctor and/or institution to damages per se. And the medical malpractice[...]insurance policies usually provide that an admission of the insured of error voids coverage for the related claims for damages. In today’s world, that situation is simply not one that a doctor or hospital, etc., can accept. In fact, a physician will not be admitted to the staff of most hospitals without evidence of effective coverage under an adequate med mal policy.¹¹

Now, one might argue that the physician’s ethical obligation to disclose error would make the non-cooperation clause unenforceable or that describing the error ambiguously could be interpreted as a fraud, which could also invalidate coverage. Nevertheless, the clause has the strong potential to discourage covered physicians from making an explicit error disclosure because doing so might cause their carrier

to refuse renewing their coverage.

A third problem arises when it is difficult to determine if an error on the part of the provider actually resulted in a patient's adverse outcome. Because error disclosure is often psychologically painful, concealing errors that do not appear to have caused the harm which the patient experienced might provide the professional with a comforting justification for not being entirely forthcoming about what happened. The health provider can easily convince him or herself that if the patient's welfare is not affected by the error, concealing it does not explicitly violate any ethical code or regulatory standard.

A problem with concealing apparently non-harmful errors, however, is illustrated by some recent research using mock juries. In the study, one group of mock jurors was told that a probably non-harmful medication error occurred and was disclosed to a patient who went on to have a poor health outcome.¹² Another group of mock jurors was given the same clinical scenario but was told that the medication error was concealed from the patient because the professionals providing treatment did not believe that the error contributed to the patient's poor outcome. During its subsequent deliberations, the latter group of jurors never even considered whether the error did or did not cause harm. They directly interpreted error concealment as evidence of a conspiracy and cover-up, and, therefore, in contrast to the other group, awarded huge damages to the patient to punish the hospital and staff. This research illustrates how an arguably non-harmful error may present vastly different meanings to the principal parties. While health professionals might resist disclosing these errors because they view them as

irrelevant to the patient's health outcome, their patients might regard any concealment of error as a sign of the professional's lack of trustworthiness and integrity.

A fourth problem lies in the debate over the definition of the word "error." How an institution understands and defines error will play a decisive role in how it regards its adverse outcomes, describes and explains adverse outcomes to harmed parties, chooses to exonerate or discipline involved staff and decides how to proceed in the event of suit.

A number of prominent error definitions understand error as a characteristic of an actor's intention (or lack thereof), either with regard to the actor's behavior or the action's outcome. Lucien Leape's 1994 definition of error is virtually identical to the one adopted by JCAHO. JCAHO defines error "as an unintended act (either of omission or commission) or one that does not achieve its intended outcome."¹³ According to the Joint Commission, error is defined as "an unintended act, either of omission or commission, or an act that does not achieve its intended outcome."¹⁴ Consider, too, how the following are variations on the "intentionality" theme: "Error is an event or act of commission or omission with unintended, potentially negative consequences for the patient" (Dana Farber Cancer Institute), "error is defined as the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e. error of planning)" (Institute of Medicine and The Agency For Healthcare Research and Quality) and "error means that something has been done which was: not intended by the actor; not desired by a set of rules or an external observer; or that led the task or system outside its accept-

able limits” (Senders and Moray).¹⁵⁻¹⁷

A central problem with these definitions is that they disregard the occurrence of variables *that are beyond the actor’s reasonable control* but that can render his or her action unintentional or that negatively affect the action’s consequence(s).¹⁸ To take a simple example, would we call Dr. Smith’s sneezing upon entering a patient’s room an error? Suppose the patient is pathologically paranoid and reacts hysterically. Such a “consequence” would certainly count as an unintended outcome of Dr. Smith’s unintended sneeze, but would our first inclination be to call this incident one of error?

A less fanciful example is this one: Dr. Jones, who is considered his hospital’s surgeon at Ajax Hospital, is about to repair Mr. Green’s abdominal aortic aneurysm. Because Mr. Green has undergone numerous abdominal operations, Dr. Jones realizes that this surgery might be extremely complex because of scarring and anatomical reconfiguration at the surgical site. Although Dr. Jones exercises enormous patience, care and skill during the operation, he nevertheless lacerates Mr. Green’s bowel, which necessitates additional surgery.

Did Jones commit an error? He certainly didn’t intend to lacerate Green’s bowel nor did he intend for Green to require additional surgery. Although both happened and would neatly accommodate the error definitions listed above, I suggest that most health professionals would not ascribe error to Dr. Jones. Instead, they would rather call the bowel laceration a surgical complication that should have been discussed in Dr. Jones’s informed consent conversation with Mr. Green. If analysis shows that it was impossible for Dr. Jones, or any competent surgeon, to

execute his intention or, in the alternative, if Dr. Jones does what he did not intend to do (i.e. lacerate Mr. Green’s bowel) because of factors outside his control, what sense does it make to say he erred? The only way he could have avoided “error” according to the above definitions would be to have not done the surgery at all. But to blame Dr. Jones for that is tantamount to blaming him for not being clairvoyant.

Recommendations

The first three of these problems over disclosing error primarily stem from the professional’s and his or her insurance carrier’s anxieties over how disclosure might culminate in a costly malpractice action. As such, they admit a testable, largely economic, hypothesis: that the financial costs associated with a prompt, comprehensive and truthful disclosure of error are unreasonably high. But when this hypothesis is simply taken as fact, which seems often to be the case, it can overwhelm the professional’s moral obligation to disclose harm-causing error in a patient-centered fashion. A body of research is urgently needed, therefore, that can confidently address the economic aspects of this hypothesis, if not its ethical implications.

In fact, the relatively few empirically based papers that address the correlation of error disclosure and malpractice litigation suggest that error concealment may invite a greater, rather than lesser, probability of suit. A fairly consistent finding over the last decade is that patients feel betrayed when they learn that errors which were present in their care were not disclosed to them. Evidence further shows that these feelings of betrayal may prompt

a decision by the patient to sue if an adverse outcome occurs.¹⁹⁻²² Also, a modest body of research has indicated that a policy of extreme honesty in disclosing errors does not increase and might even lessen the costs associated with litigation that might result from error disclosure.^{12,23}

If worries about the financial expense of error disclosure constitute the primary barrier to doing what is morally right, let us hope that future research on error disclosure shows that moral propriety results in cost savings. If, on the other hand, the expense connected with truthful error disclosure turns out to be cost prohibitive, then the fiduciary nature of the professional-patient relationship will have been subverted by a cost-benefit determination, which would be intolerable.

The fourth problem on error definition permits, I suggest, the following resolution. In her essay, "Taking Responsibility for Medical Mistakes," Virginia Sharpe notes that:

When we consider medical mistakes and particularly those that cause harm, the blameworthiness of the error depends on how it squares with the obligation of due care. Due care is a legal doctrine that allows that certain individuals may inflict injury while engaged in lawful professional behavior and are liable for damages only if their conduct fails to meet a certain standard of care. In moral terms, if harm results from one's legitimately risky professional conduct, one's blameworthiness depends upon a number of factors related to the reasonable standard of care due or owed[...]. Harms associated with recklessness, incompetence, or neg-

ligent incapacitation (such as when the practitioner is inebriated) are not genuine "mistakes," since they do not result from error per se, but from a disregard for due care itself. When a mistake in reasoning, judgment, or action does involve erring from standards of due care, however, it is a genuine error and, as such, is presumed to have occurred within a context of good faith.²⁴

The strength of defining error according to the standard of care is its emphasis on the reasonable. Attributing error only makes sense if 1) a standard exists which differentiates erring from non-erring conduct or judgment and 2) actors can reasonably be expected to be knowledgeable about that standard and can reasonably conform their behavior to such a standard or depart from it. If no such standard exists, or if the particular situation is such that no one acting in a reasonable fashion could avoid an untoward action or outcome, we ought not to say that the person erred.²⁵ Thus, Dr. Jones did not err despite his lacerating Mr. Green's bowel because he did all that a competent surgeon acting in a reasonable manner was required to do. Despite the best intentions carried out in the most competent fashion, negative or unexpected health outcomes are not completely avoidable.


This definition of error, however, is hardly perfect. The weaknesses of a definition of error that rests on the standard of care are that 1) it may be entirely speculative or argumentative as to what the standard of care requires in a given case – indeed, there might not even be such a standard and 2) even if such a standard exists, there might be no consensus in a

given instance as to whether the standard was reasonably followed or violated. Put another way, while JCAHO prefers the language of “process variation” as a proxy for error, experts can argue among themselves over how much a procedure can vary from the ideal before it is labeled a process variation.

As long as medicine remains an art, these conceptual problems will persist. On the other hand, it seems grossly unfair to hold health professionals to a definition of error that can, in certain instances, require them to perform in a manner that far exceeds reasonable competence. Because imputing error can carry onerous implications, health professionals and especially risk managers must insist on a coherent understanding of error and resist imprecise definitions of error that could confuse or compromise hospital policy on patient safety and managing adverse outcomes. Consequently, the definition of error that I believe ought to prevail is simply, “an error is an unwarranted failure of action or judgment to accommodate the standard of care.”

Conclusion

Although it is morally unproblematic to insist that health providers should disclose harm-causing errors honestly and comprehensively, various clinical scenarios may cause immense disagreement over whether an error actually occurred or the extent to which it played a causal role in a poor outcome. Furthermore, one must appreciate how health professionals receive contrasting recommendations on how to disclose error from various influential and powerful healthcare stakeholders. A

convergence of opinion on error disclosure, however, seems to be taking shape. For both ethical and economic reasons, that opinion strongly urges the open and relatively comprehensive disclosure of error when error is known to have occurred and caused harm. While such disclosure will never be easy, ethically progressive and patient-centered healthcare organizations will insist on such a policy regardless of its economic consequences. One hopes, too, that they will also support and comfort not only those persons who have been harmed by error but also those professionals who are involved in the admission of error and its disclosure. 

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