MEDICAL ERRORS ARE THE FIFTH LEADING CAUSE OF DEATH IN THE United States and result in annual costs of up to $29 billion, according to estimates from the Institute of Medicine (IOM).1 These figures suggest that medical mistakes occur commonly in medical practice. Indeed, 95% of physicians surveyed reported witnessing a medical error, and 61% of health care professionals believe errors are a routine part of medical practice.2 Because medical errors have a large impact on patient care, it is important to consider the ethical issues regarding disclosure that arise when health care providers make or witness errors.

According to the IOM report, many medical errors are due to systemic flaws rather than mistakes by particular health care providers.1 Examples of such systemic culprits include poor communication between multiple health care providers and inadequate labeling of drug interactions. Therefore, strategies that focus less on individuals’ actions and concentrate on systemic problems are more likely to detect and prevent medical errors. Such strategies include instituting electronic medical records3 and improving the coordination of patient care. A major challenge for hospitals in reducing errors is to institute systems that can better pinpoint, investigate, and prevent medical errors without exposing staff to excessive blame and litigation.

When medical error is not disclosed, those who witness the error must determine whether they should remain silent or reveal the error. This decision can be particularly difficult for medical students, who must violate the traditional medical hierarchy to disclose the error. The doctrine of respondeat superior holds the attending physician ultimately responsible for all decisions concerning a patient. Does this doctrine relieve the medical student of any ethical responsibility to the patient? Entrants in the 2001 Conley Ethics Contest were asked to apply this question to the following scenario: “During your surgical clerkship, you observe a medical mistake during a procedure in the operating room. The error does not result in the patient’s death, but requires the patient to extend his stay in the hospital several days. In addition, the postoperative pain experienced by the patient is more significant than it would have been otherwise. The attending physician informs the patient that there was a complication during the procedure, but does not specify that it was secondary to his error. How do you respond?”

In this issue of MSJAMA, the winning essays ultimately urge disclosure of the error by the physician and not by the medical student. Courtney Wusthoff discusses how the student should facilitate disclosure when the attending physician refuses to reveal the error. Scott Cowie and Susan Lee emphasize the importance of categorizing error by type and severity. Norman Fost adds a new perspective to this debate by examining ethical issues involved when a physician considers disclosing the error of another physician. Understanding these ethical issues will ultimately help reduce the occurrence of medical errors.

REFERENCES
WHISTLEBLOWING IS NOT AN APPEALING ACTIVITY. THE target of the accusation may suffer, but so can the accuser, even if the accusations are substantiated. At the least, “snitches” may become unpopular. At the worst, they may be ostracized and even driven from their institutions. Consequently, physicians often discuss their colleagues’ mistakes among themselves, but less so than with patients. There is an emerging literature on the virtues of disclosing one’s own mistakes, but remarkably little on the empirical or ethical aspects of discussing the mistakes of others. The following justifications (and some responses) for not disclosing others’ mistakes are often used:

“Do unto others as you would have them do unto you; treat your colleagues the way you would want to be treated.” One problem with the Golden Rule is that it doesn’t specify who to fill in for the word “others.” Colleagues may prefer that we don’t discuss their possible errors, but if “others” refers to patients the conclusion is different. And the claim that loyalty to a colleague, particularly a stranger, exceeds a fiduciary duty to a patient is difficult to defend.

“I don’t really know what happened.” This may be true, but the purpose of bringing the possibility of an error to a patient’s attention is not because a conclusion has been reached, but because there is a reasonable suspicion that an error has been committed. The majority of errors are unknown to the patients. Uncertainty can’t be a justification for silence. An analogy is the duty to report child abuse: the state does not expect physicians to report completed investigations. That is the responsibility of state agencies. The duty is to report “reasonable suspicion.”

“A lawsuit won’t bring back a dead person or heal an injury.” True enough, and that is one reason the patient may decide not to sue. But lawsuits have other purposes besides restoration of the status quo ante. They may compensate the patient for out-of-pocket expenses; they may deter future errors; they may uncover a pattern of errors. And while they may lead to “defensive medicine,” sometimes they lead to better medicine, if the physician was truly negligent and learns from his or her mistakes.

What are the arguments in favor of disclosing to patients possible mistakes made by other medical professionals? There are several ethical obligations involved. First, there is the duty to be truthful to patients. Normal care typically includes a discussion of how the present illness occurred. Failure to discuss another’s error as the cause of a patient’s condition is to pretend that one has no idea how the patient came to be ill. Silence falsely implies that the physician believes the patient’s problem occurred by natural means. This may be a deception. Uncertainty about etiology doesn’t preclude a discussion of the possible and likely causes. It is routine to discuss the most likely etiologies, regardless of whether the patient asks for the information.

Second, there is the principle of reparations. When a person causes harm to another, particularly when it results from a negligent action, reparations are owed. Regrettably, in the United States the only effective system for providing such payments is the imperfect tort liability system. It reflects a shared belief in the moral importance of reparations. This is not to say the patient should be encouraged to sue. That is his or her decision. But most patients will have no way of knowing that they may be entitled to reparations if they are not told the likely cause of their condition.

Third, there may be a duty to protect others; namely, the future possible patients who may also be harmed by the wayward physician. This is a matter for hospital boards and state licensing boards. The duty to report possible errors to these agencies is less clear, and the threshold for reporting will usually be more than a single case.

Whistleblowing, of course, should not be equated with disagreements about the best way to manage a problem. The practice of medicine is unavoidably imprecise, and there is hardly a situation in which all informed physicians agree on the best way to proceed. There is a continuum including, at one end, disagreements about different approaches, and at the other end, gross negligence. Reasonable people will disagree about the threshold for beginning such discussions with patients, and there will be disagreement about the precise words to be used. Whether an apparent mistake is due to negligence, and whether a patient is entitled to compensation, is for others to decide. But these questions will usually not be asked if a physician does not alert the patient to the possibility that his or her injury may have been caused by others.

REFERENCES
1. Howe EG. How should ethics consultants respond when care providers have made or may have made a mistake? Beware of ethical flypaper. In Rubin SB, Zoloth L, eds. Margin of Error: The Ethics of Mistakes in the Practice of Medicine. Hagerstown, Md: University Publishing Group; 2000:165-181.
"TO ERR IS HUMAN," DECLARES THE TITLE OF THE RECENT, well-publicized report by the Institute of Medicine. According to this study, errors cause between 44000 and 98000 deaths annually in hospitals in the United States. While these figures have gained much attention, this is not the first examination by the medical community of its mistakes. Since 1990, several studies have also scrutinized medical error. These publications mark a break from the traditional secrecy surrounding mistakes by physicians. A new approach in medicine encourages physicians to acknowledge mistakes, both to themselves and to others.

Physician error commonly affects patients, physicians, and other health care providers. A 1998 study of registered nurses, for example, showed 33% were aware of at least 1 incident of patient harm caused by physician error in the previous month. Those surveyed reported a troubling dilemma in deciding when to report other health care providers' mistakes. Similarly, some medical students will witness physicians' medical mistakes. The student must then reconcile conflicting desires to ensure patient welfare through truth-telling with those to protect and remain loyal to the teaching physician. Facing this dilemma, the medical student will find many reasons to facilitate disclosure of the error.

A physician has a multifold ethical duty to admit mistakes to the patient. As the American Medical Association Principles of Medical Ethics states, "A physician shall...be honest in all professional interactions." Moreover, in cases in which "a patient suffers significant medical complications that may have resulted from the physician's mistake...the physician is ethically required to inform the patient of the facts necessary to ensure understanding of what has occurred." This ethical requirement to inform the patient of the mistake can be concluded from both deontological and consequentialist perspectives, that is, both by considering the ethical value of the action alone and by considering the possible consequences of the action.

The patient-physician relationship is fiduciary in nature; as such, it relies on principles of autonomy, beneficence, nonmaleficence, justice, and fidelity in all actions. The physician must act in the patient's best interest at all times. Most often, disclosure of mistakes would benefit patients. For instance, to gain patient cooperation, it is often necessary to explain exactly how a condition arose. In some cases, knowledge of a mistake could affect the patient's current and future decisions regarding care. Thus, to maintain autonomy and to give true informed consent, the patient must know of relevant errors. Also, understanding that a mistake occurred may relieve patients' anxieties about slow recovery or complications. Even knowledge of an iatrogenic cause could allay fears that a worse problem exists. Providing such relief is an important example of beneficence. To knowingly allow continued anxiety would constitute maleficence, as the physician would consciously impair the patient's well-being. Furthermore, if the physician's error resulted in increased costs to the patient, justice would dictate disclosure to ensure patient compensation. Indeed, some cases may require monetary reimbursement to the injured patient. Finally, fidelity demands truth-telling at all times. A recent survey of patients found that 98% desired acknowledgment of even minor mistakes. This refutes the assertion that nondisclosure "protects" patients by maintaining an image of physician infallibility; patients want physicians to disclose their errors. For all these reasons, and because a physician must always act in accordance with the principles of the patient-physician relationship, disclosure is clearly the ethical action after a medical mistake.

In addition to reasons arising from these principles, consideration of future consequences also compels the physician to disclose errors. Accurate information could improve the patient's subsequent treatment. Other caregivers can then work with better facts, while the cooperation of the informed patient greatly facilitates recovery. Additionally, disclosure could aid in relief of the physician's own emotional stress while fostering a stronger patient-physician bond. These practical results alone suggest disclosure is the best course of action.

While it is relatively clear that a physician has the ethical obligation to admit medical errors, what should the medical student do when the physician refuses to disclose a mistake? In determining a course of action, the medical student must consider duties to the patient, physician, and himself or herself. It is inappropriate for the student to unilaterally disclose the error, yet the student must not allow the patient to be deceived.

Although the student's responsibility to the patient does require acting to facilitate disclosure, the same responsibility precludes responding to patient queries by accusing the physician of error. In clinical situations, the medical student has a unique relationship with the patient. The student often accepts the description "student doctor" and thus is obligated to maintain ethical conduct appropriate for a physician. As such, all of the reasons for physician disclosure considered above also apply to the medical student. However, there are also reasons a medical student should not independently tell a patient of a physician's mistake. The student's limited medical knowledge may make it difficult to explain the nature of the error adequately. Also, a small number of patients specify before treatment that they do not...
wish to know if anything goes wrong. Moreover, the attending physician may see reason to wait before disclosing his or her error. For example, it might be prudent to wait until the patient has achieved a certain degree of recovery before mistakes by the physician are discussed. In any of these cases, for the medical student to preempt the physician would do a gross disservice to the patient by undermining the relationship and trust between the patient and attending physician. Instead, the student could tell the patient that he or she would like to invite the physician to help explain the circumstances. The student must ensure that disclosure of the physician’s error does occur, but only after discussing the situation with the attending physician.

Not only do duties to the patient necessitate disclosure, but the student can help the physician avoid negative consequences by doing so. Telling the physician the patient would like a clear explanation of the current circumstances gives the physician an opportunity to discuss the mistake with the patient. It alerts the physician that the patient is concerned about the cause of the complications. Communicating this concern may also allow the physician to resolve anxiety before hostility develops. This can save the physician from future emotional strain and legal repercussions. Indeed, there is some indication patients may be less likely to pursue litigation if the physician promptly admits a medical mistake. Risk management organizations note patients often file lawsuits out of anger at not having been told the truth about their conditions. Likewise, surveyed patients responded they would be significantly less likely to file a lawsuit if the attending physician informed them of a mistake than if they found out by some other means. Attempting to conceal a mistake could extend legal repercussions: many states hold the statute of limitations in abeyance when a physician has concealed negligence, and a physician caught concealing error is more likely to be perceived negatively by a jury if a lawsuit does proceed to court.

However, in cases where a mistake is admitted, reimbursement for subsequent treatment is rarely paid by the physician personally.

In reality, physicians may use fears of litigation primarily as conscious or subconscious pretexts to avoid the unpleasantness of admitting mistakes or even acknowledging an error. These admissions can be very difficult and painful. Yet when the physician takes responsibility for the mistake, both physician and patient benefit. Admittedly, this reasoning may provide little comfort to the student when facing the attending physician. Nonetheless, the student can minimize awkwardness by discussing the matter with the physician appropriately. The student may privately approach the physician and nonconfrontationally state that the patient has asked about the situation, and the student would appreciate the physician’s help in informing the patient of the mistake. While approaching the physician may remain difficult, it remains the duty of the student to both the patient and the attending physician to encourage disclosure.

Unfortunately, an attending physician may not be eager to admit a mistake. In such a case, the student has an additional responsibility to him or herself and fellow students to pursue disclosure. A second opinion regarding the incident should be sought, preferably through an official, impartial group, such as the hospital’s ethics board. The student should notify the attending physician of such intentions and contact the board personally. This will ensure that the proper steps are taken to promote the patient’s best interests, which remains the student’s primary duty. By pursuing the matter through official channels, the student takes the best means possible to guard against any negative repercussions from the attending physician.

Ethical actions are often unpleasant and difficult to perform. Yet in doing so, the student develops professionally in reaffirming personal ethical standards and learning firsthand how to manage conflicting priorities. To ignore the opportunity would be to abandon a chance to learn how to handle medical errors, an ability that will most likely be needed in the future. By pursuing disclosure, the student further ensures that peers will not be required to maintain silence when other medical mistakes occur; the act serves to defy the stigma of admitting a mistake. Beyond duties to the patient and physician, the student has a responsibility to him or herself to practice responsible medicine. This responsibility begins as a student; there is no easier way to learn to be an ethical physician than to engage in ethical practice from the start.

REFERENCES

The landscape of medicine is strewn with lapses of judgment and slips of the knife and pen that mar the orderly lines of scientific practice. The Harvard Medical Practice study found that errors resulting in adverse events occurred in approximately 10% of patients. Occasionally medical errors are identified and discussed at morbidity and mortality meetings. However, many are never publicized and are known only to those directly involved. A medical student who observes a mistake during a surgical procedure is placed in the difficult position of deciding what to do with this information. If the patient inquires about the possibility of a mistake, how should the medical student respond?

Like all medical professionals, the medical student has a duty not to misrepresent or omit unpleasant facts. It can be argued that incomplete disclosure, avoidance of particular questions, or outright falsehood demonstrates a lack of respect to patients as persons. Does this imply that the medical student should disclose all errors to all patients, regardless of the circumstance or consequence? The medical student should appreciate the complexity of the situation and carefully balance the interests of the patients, including respect for patient autonomy and well-being, with the interests of the profession that he or she is aspiring to enter. The latter consideration includes the medical student's role within the medical system and an appreciation of the patient-physician relationship. Ultimately the role of medical student is not to disclose error but to facilitate the therapeutic relationship by conveying patients' concerns to the appropriate persons.

Are All Medical Errors Equal?

An error can be defined generally as “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.” Before the student initiates any response or action, he or she must determine whether they know all the relevant facts surrounding the perceived medical error. Students might feel a genuine uncertainty as to whether an error has actually occurred given their relative lack of experience and expertise. Medical students should also realize that “error” is not synonymous with negligence. For example, for centuries physicians reasonably prescribed bloodletting as means of expelling “bad humours.” These physicians were acting appropriately by the standards of their time and were therefore not negligent, although we now know that the logic of their treatment was flawed. Recognizing this distinction between negligence and error should decrease the tendency of the student reflexively to assign blame or to confront the physician with an attitude of veiled criticism.

Furthermore, not all medical mistakes are similar in type. For example, the medical student may have witnessed a surgical error that resulted from defective equipment. Or perhaps the error reflects a systematic defect in medical organization that allowed an operation to continue with inappropriately low levels of nursing staff, resulting in a crucial delay. Alternatively, the mistake may have been in the surgical technique, such as an inadvertent nick in the bowel causing peritonitis. Finally, and perhaps most commonly, the error may have been the result of several separate factors. Thus, it is evident that not all errors are qualitatively equal. By categorizing errors, physicians and administrators are able to better decide what is the most appropriate response. This might entail reorganization of a medical system that fosters repeated errors or instituting changes on an individual level.

Moreover, not all errors are similar in severity, as measured by the degree of harm that results. An appreciation of the magnitude of error might affect the decision to disclose. For example, informing a patient that their dosage of aspirin had been accidentally halved would serve little purpose unless the half dose of aspirin would have made a clinical difference. Admittedly, assigning some form of objective measurement to subjective expressions of suffering is difficult. Nonetheless, such considerations might play an important part in the decision-making of physicians as they struggle with the issue of disclosing error.

Disclosure and the Patient-Physician Relationship

In contemplating the appropriate response to the patient’s request for information, the medical student should consider the possibility that some disclosures of medical error may be harmful rather than beneficial to patients. It has been argued that there are particular situations in which disclosure of a medical error might cause serious and irreversible harm to the patient. In such situations, physicians can exercise “therapeutic privilege” and choose not to disclose. An example would be a medically unstable patient whose recovery would be jeopardized by an ill-timed disclosure of a medical error. Patients may feel anxious and alarmed upon learning of the mistake: they may lose confidence and faith in the physician’s ability to help them, thereby prolonging their recovery. This doubt and disillusionment may even extend to the medical profession as a whole, and so hamper any subsequent attempts to provide appropriate medical care. However, recent literature suggests that therapeutic privilege should be used rarely and in emergent situations, followed by a commitment to reassess disclosure when the patient is more stable. Physicians should also be prepared to explain their decision not to disclose.

On the other hand, truthful disclosure can promote patient well-being. Patients have a right to receive information about their medical condition. Disclosure of such information, including medical errors, can strengthen the bonds of trust between physician and patient. Patients might better understand...
Medical students must understand that extreme caution is fundamental to a medical professional's interactions with patients. The consideration of medical error raises the issue of legal liability. It is incumbent upon the attending physician and not the medical student who might result from the physician's care. Therefore, it is the attending physician and not the medical student who must recognize and respect the attending physician's ultimate responsibility for the care of his or her patients. This responsibility includes explaining any errors or complications that might result from the physician's care. Therefore, it is the attending physician and not the medical student who must determine whether a particular patient is, or is not, to be informed of a medical error.

Medical Error and Legal Vulnerability

The consideration of medical error raises the issue of legal liability. An understanding of established legal precedents is fundamental to a medical professional's interactions with patients. Medical students must understand that extreme caution is required in discussions with patients about any detailed aspects of a therapeutic intervention. Students must realize that they are not qualified to enter into any technical discussions that can later be held legally against the health professionals involved. This does not mean that the student should ignore the patient's concerns. In fact, several studies have demonstrated that it is the poor quality of communication surrounding an adverse event rather than the adverse event itself that motivates patients to take legal action. By acknowledging the patient's desire for additional information and by taking steps to pass along this request and any related concerns to the responsible physician, the student will avoid incurring legal liability by either omission or commission.

The Patient Asks: The Medical Student's Response

A recent Canadian court case concluded that nursing staff did not have a legal obligation to tell a patient of a surgeon's error. Disclosure of an error that resulted in substantial adverse effects to the patient was viewed by the court as a specific duty of care owed by the surgeon to the patient. This finding can be extended to the role of the medical student. By understanding his or her role—as a facilitator between patients and their physicians—the student succeeds in upholding her responsibilities to both patients and the medical profession.

REFERENCES


2002 John Conley Ethics Essay Contest for Medical Students

Often the cultural and moral sensibilities of a patient come into conflict with those of the physician. Participants in the 2002 John Conley Medical Ethics Essay Contest are asked to consider the following case.

"You are a surgeon trained in urogenital reconstruction. An 18-year-old female patient comes to you because she is returning to her home village in an African nation. She reports, and you believe, that upon return to her home, she will be obligated to undergo female circumcision. In her homeland, the procedure involves removal of the clitoris and part of the labia majora, and sutting of the vaginal opening, which leaves a small opening for menstruation. These procedures are typically performed in an unsterile field without anesthesia. Because she is concerned about pain and the risk of infection, she requests that you perform the procedure under sterile conditions before she returns home. Regardless of where it is performed, this form of female circumcision results in a permanent decrease in genital sensation, and causes bleeding during intercourse, with accompanying risk of infection. What are some ethical issues to consider as you decide whether to perform the surgery?"

Entries must be postmarked by February 1, 2002, and sent to Conley Essay Contest, c/o MSJAMA, 515 N State St, Chicago, IL 60610. The author(s) of the best essay(s) will be awarded $5000 or a portion thereof. More information about the contest is available online at www.msjama.org.

The judges for the 2001 John Conley Ethics Contest were Linda Emanuel, MD, Northwestern University School of Medicine; Thomas Duffy, MD, Yale University School of Medicine; and Norman Fost, MD, MPH, University of Wisconsin School of Medicine.