Ethical Issues Involved in Disclosing Medical Errors

Pam R. Rajendran

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). 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. 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. 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 records 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