
Moral Courage in Medicine — Disclosing Medical Error

by John Banja

Medical error is an inevitable occurrence that stresses the relationship between healthcare professionals and their patients. The number of errors is shocking; so, too, is the revelation that few medical errors are routinely disclosed. When healthcare providers fail to inform patients of harm-causing medical error, then trust in the patient/provider relationship is broken and many ethical challenges surface. To successfully restore trust and perhaps lower liability costs, healthcare providers must avoid pointing fingers and adopt a policy of honesty and full disclosure.

Although healthcare providers have openly acknowledged and studied the occurrence of medical error over the last two decades, the Institute of Medicine's release of *To Err Is Human* (2000) captured the public's attention and concern in an unprecedented way. The report stated that medical error causes 44,000 to 98,000 deaths each year and compared the gravity and number of healthcare errors to those reported in other industries, especially the airlines (Kohn, Corrigan, and Donaldson 2000). The comparison was unfavorable and disconcerting; so, too, was the revelation that few medical errors are routinely disclosed to the patients and families involved. Thus, it is tempting to suppose that in addition to fatal errors, countless other nonfatal but serious errors go unreported.

What is fundamentally, ethically, important in instances of harm-causing error and what makes concealment so shocking is that in the majority of cases concealment is without moral justification. There are at least four fundamental reasons to argue against concealment.

First, the physician-patient relationship is a contractual one grounded in trust. Consumers of professional services assume that they will not be unreasonably harmed by the relationship; or they assume that if some harm is foreseeable, they will be forewarned of that possibility during the risk disclosure component of the informed consent process (Rosoff 1981). Harm caused by error is not one of the risks patients routinely assume in giving informed consent. Permitting licensed health providers to behave as though harm-causing error is a "reasonable" risk that patients must assume in consenting to treatment would contradict the essence of licensure, which is to protect the public from incompetence (King 1986).

Consequently, when error occurs, the patient's legitimate expectation that his or her healthcare provider will act reasonably and prudently has been disappointed and disclosure is required to restore trust. Thus, the Current Opinions of the American Medical Association's Code of Medical Ethics: Current Affairs plainly states,

Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Concern regarding legal liability which might result following truthful disclosure should not affect a physician's honesty with a patient (AMA 1998).

Second, harm-causing error should be disclosed because it respects the other-regarding nature of ethical behavior. Studies show that patients want to be informed in cases of medical error, and granting moral permission to healthcare providers to conceal information about error violates the patient's right to be fully informed (Joint Commission on Accreditation of Healthcare

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Organizations, 2000; Sweet 1997; Witman, Park and Hardin 1996; Smith and Forster 2000). Denying an individual's rights denies that person the right to seek compensation for error.

The third reason for error disclosure derives from the patient's status as an end-in-himself. Error concealment is closely related to fraud and misrepresentation. Patients have an inherent right to know about their care and anything that might diminish their well being. The stakes are higher if the patient requires further treatment because of a harm-causing error. The patient who needs another abdominal surgery because a sponge was left in his or her belly and is not told the reason for the surgery in a truthful fashion must base

his or her consent to the second surgery on a misrepresentation.

And finally, a fourth and potentially powerful, reason for disclosure: As harm-causing medical errors result in higher healthcare costs and higher liability claims, third party payers will insist on disclosure. Health insurance companies have reason to feel defrauded if they pay for treatments caused by medical error. Insurance companies understand medical necessity that is related to treatment associated with the patient's "disease." From an ethical perspective, the healthcare provider becomes a classic "free rider" when his or her patient requires additional treatment because of an unreported error that quietly passes costs on to others (Lowes 1997).

Professional ethics is unequivocal in insisting that the interests of clients must override the self-serving interest of professionals. For example, most state licensing laws begin with a statement that the purpose of the licensing law is to foster the welfare of the public, the consumers of professional health services. Healthcare providers are placing their self-interest above that of the patients when they fail to disclose error. Because this motivation is ethically unacceptable, the media sensationalizes each example of error cover-up as an intentional act of concealment.

Error as systemic and multifactorial

Despite the unassailable nature of the ethical arguments encouraging disclosure, it would be unfair to dismiss or gloss over the need for moral courage in disclosing serious medical errors. The threat of professional censure, institutional penalty, malpractice litigation, bad publicity, humiliation, and the need to perpetuate the myth of perfectionism in healthcare militate against error disclosure (Wu, Folkman, and McPhee 1993). But if the sine qua non of professional ethics is to be other regarding, then the primary question is not whether to disclose error but how to disclose error in a productive and ethical fashion.

Interestingly, there are two dimensions of error occurrence that deserve attention because they are counterintuitive and also because they suggest a model of culpability different from the usual approach of looking for a scapegoat. These dimensions are the systemic and multifactorial nature of error occurrence. An excellent example is the case of Richie Williams.

Richie's Case

In April 1997, a twelve-year-old boy with lymphatic cancer was scheduled to receive his last dose of chemotherapy at Great Ormond Street Hospital, a famed children's hospital in London, England (Anti-Cancer Job, 2001). Richie Williams hated the sight of needles so he was routinely sedated with anesthesia before receiving intravenous administrations of his chemotherapeutic drug Vincristine. However, on his last treatment day, a physician named John Lee who had never treated Richie injected Vincristine directly into Richie's spine. Richie died in agony five days later. The label on the vial of Vincristine was clearly marked "for intravenous use only." Dr. Lee was subsequently prosecuted for manslaughter.

This case looks like a stereotypic example of medical negligence: a doctor injecting a chemotherapeutic drug that is clearly labeled for intravenous use directly into a patient's spinal canal, causing the patient's death. But after considerable analysis of this case, it was apparent that this error was similar to many other seemingly egregious mistakes made at hospitals. The error does not result from a single individual, making a discrete, inexplicable mistake; it is facilitated by a host of mistakes and mishaps that enable the error to occur.

Richie's tragedy began when he ate a cookie the morning of his treatment. When he mentioned this snack at the hospital a short time later, his treatment team chose to delay giving him anesthesia for fear of complications. Consequently, rather than be anesthetized and then sent to the chemotherapy unit where a nurse would start the Vincristine injection, Richie went instead to

a general ward, where nurses unfamiliar with his care mistakenly ordered the Vincristine sent to anesthesia.

When Richie arrived at anesthesia later than usual, he was met by Dr. Lee and a team unfamiliar with Richie's standard regimen and no experience in providing chemotherapy. Dr. Lee called Richie's usual physician, Dr. Dermott Murphy, and asked if he would like to treat Richie. Having no idea that Dr. Lee was referring to the Vincristine, which Murphy had no reason to believe was in Dr. Lee's presence, Dr. Murphy told him to proceed. Dr. Lee persuaded Richie to have a local anesthetic and then injected the Vincristine into his spine.

A Complex Chain of Events

Dr. Lee appeared to be the culprit in this story, but analysis showed a much more complex picture of

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mistakes and misunderstandings that the hospital subsequently confessed. On several previous occasions, mistakes and events similar to the ones in Richie's case had occurred at the hospital though not at the same magnitude. Although the hospital confessed to a number of "near misses," it had done nothing to correct the problematic sequence of events. A fairer ascription of blame would have implicated the entire hospital for allowing a system to exist in which life-endangering errors are possible.

When medical errors are analyzed, we find that our first reaction — to blame and penalize the "error perpetrator" — is usually unwarranted.

Indeed, the individual seems conspicuous only because he or she was the last agent in a complex chain of events, each of which contributed to the error. Rather than sacrifice the scapegoat to the media and the harmed parties, a more ethical approach to error disclosure is for an institution to take collective blame for the mistake (Joint Commission on Accreditation of Healthcare Organizations 2000).

Can Disclosure Lower Malpractice Costs?

The primary reason hospitals do not disclose error is their fear of malpractice litigation. Recent research suggests, however, that hospitals might lower their overall malpractice experience and

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its associated costs by instituting a policy of "extreme honesty."

In a recent issue of the *Annals of Internal Medicine*, a doctor and an attorney described the disclosure policy at the Veterans Affairs Medical Center in Lexington, Kentucky (Kraman and Hamm 1999). The article outlined the facility's practice of error disclosure and how the facility helps people gain compensation. During the seven years the authors studied, five settlements occurred that would probably never have been pursued had there not been "voluntary disclosure to patients or families." Yet, the authors found that the facility's liability payments over that period "have been moderate and are comparable to those of similar facilities." Despite the fact that this hospital has maintained a policy that seems deliberately designed to increase malpractice claims, its malpractice experience has not become excessive. How can this be?

It appears that in instances in which a hospital comes forward and admits culpability, the incident

is much less likely to go to court. Out-of-court settlements, where damage awards are more amicably and reasonably reached, are the norm. On the other hand, when harm-causing error is intentionally concealed from the patient who ultimately finds out, he or she will likely request punitive damages in addition to the usual request for compensation for pain and suffering (Vincent, Young, and Phillips 1994; Hickson et al. 1994).

A policy of disclosure inspired by honesty has a spillover effect that enhances overall patient-professional communications. Such a policy may encourage more open communications in which the professional feels more at ease in discussing information about mistakes. It also allows professionals to become more skillful and confident in conducting emotionally painful or awkward conversations.

Most patients appear to appreciate open and honest responses to their queries and concerns and report feeling more positive about their care. It is interesting to speculate, therefore, that such conversations might diminish a facility's yearly liability costs since happier, more satisfied patients may be less likely to sue.

Conclusion

While some hospitals in the United States appear to be taking serious steps to deal ethically with harm-causing error, many others are reluctant to adopt a policy of extreme honesty. In order to realize such a policy, a significant change in the core beliefs of hospital supervisors and institutional representatives must occur. People must understand error as systemic and realize that liability costs will not always increase — but may even be reduced — by disclosure.

They must also acknowledge that serious error will occur in medicine and that blaming the involved parties is not a constructive response. And finally, they must strive to make medical training less punitive and more humane (Joint Commission on Accreditation of Healthcare

Organizations 2000). Because it requires moral courage, the disclosure of harm-causing error is an enormously caring and loving act. If the harm-causing parties themselves feel protected, it will be easier for them to act caringly for others and to find the courage they need when heart-wrenching conversations are morally warranted.

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