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Clinical Cases

Disagreement over Error Disclosure

Physicians have an ethical obligation to admit mistakes to their patients, even if no harm came of the mistakes.

Commentary by Brintha Krishnamoorthy and Kevin O'Rourke, OP

Andy Miller has acute myelocytic leukemia and is receiving chemotherapy. When he was at home after his most recent round of chemotherapy, he developed a fever. He came to the emergency room and was found to be neutropenic, common after the chemotherapy regimen Mr. Miller received.

Joe admitted Mr. Miller after midnight on a busy call night. He wrote the admission orders, including cefipime for the neutropenic fever. A new clerk entered the orders and was unable to read Joe's writing. She was not familiar with the medication and selected cefoxitin from the medication list. Joe was busy on call and post call and did not review the orders.

Mr. Miller continued to have a fever and over the next 24 hours developed low blood pressure and evidence of sepsis, including positive blood cultures. He was transferred to the intensive care unit for management of septic shock. On admission to the ICU, the medication error was noted, and the medication was corrected to cefipime. Mr. Miller required ICU care for 2 days and was on pressors for several hours to maintain his blood pressure. Ultimately he responded to the antibiotics, and he remained in the hospital on antibiotics until his neutropenia resolved.

On rounds Joe and his team discuss Mr. Miller's care and the effect of the mistake. Joe reasons, "If Mr. Miller had received the correct antibiotic he would have remained in the hospital for the same duration, until his white count improved. The effect of the mistake was that Mr. Miller was in the ICU for a few days, which may not have happened if the right medication had been started immediately. Sepsis can be fatal, but in this case it was treated effectively, and Mr. Miller will not have any long-term consequences from the error. I feel terrible, but it was the clerk's error."

Dr. Anderson, the attending physician, asks Joe, "Should Mr. Miller be told about the error, and if so, what should he be told?"

Joe says, "I feel terrible about the mistake, but we're not responsible for the clerical error. No one on the medical team was at fault, and there is no benefit to Mr. Miller from telling him of the error. If it was our mistake I would feel different, but all we will do is upset Mr. Miller and destroy his trust in us when he has a long course of treatment ahead of him. Besides, maybe it wasn't the mistake that caused the problem. He might have become septic anyway."

Sarah, Joe's coresident on the service, thinks Mr. Miller should be told of the error. "An error occurred, and Mr. Miller should be told. We can't decide which errors to disclose and which not to, because then the whole question of disclosure becomes discretionary. We are his doctors—we are responsible for whatever happens to him, whether it is our mistake or not. We erode his trust more by not telling him. He might have become septic anyway, but it seems likely that having him on the wrong antibiotic allowed him to get worse. Since the error could have contributed to the ICU admission, and probably did, Mr. Miller should be told."

Commentary 1

by Brintha Krishnamoorthy

> *Virtually every practitioner knows the sickening realization of making a bad mistake. You feel singled out and exposed—seized by the instinct to see if anyone has noticed. You agonize about what to do, whether to tell anyone, what to say. Later, the event replays itself over and over in your mind. You question your competence but fear being discovered. You know you should confess, but dread the prospect of potential punishment and of the patient's anger. You become overly attentive to the patient or family, lamenting the failure to do so earlier and, if you haven't told them, wondering if they know.*

A.W. Wu [1]

Because physicians adhere to the principle "primum non nocere" (first, do no harm), a medical error threatens the very foundation upon which a physician practices medicine. When a mistake does occur, it is not uncommon for a physician to harbor powerful emotions for days or years after the critical incident. Therefore, timely and honest responses to errors become vitally important to reducing the lasting emotional and medical consequences of error and facilitates productive changes in medical practice [2].

Since we cannot deny the existence of error, the central question becomes, "How do we take measures to prevent errors that do occur from having devastating effects on both patients and the medical staff involved?" [3]. Integral to the answer and to the case at hand is the issue of disclosure of the medical error to the patient and family.

The medical literature broadly supports the legal and ethical principles that disclosure of medical errors respects trust, beneficence, and patient autonomy, all of which are essential to the patient-physician relationship. One study showed that 88 percent of patients in an emergency department would want to know everything about a mistake, while 12 percent responded that they only wanted to know about a mistake if it could or did affect their health. Additionally, 76 percent of these patients wished to learn of the mistake as soon as it was detected [4]. Similarly, another study found that 98 percent of outpatient internal medicine patients desired disclosure for even minor errors [5].

Despite these patient desires, a surprisingly low number of errors are disclosed. An anonymous survey of 114 resident physicians looked at each resident's most significant medical mistake and subsequent response [6]. This multi-center study revealed that 90 percent of housestaff physicians were involved in a medical error in which patients suffered serious adverse outcomes, including death in 31 percent of the cases; however, only 24 percent of house officers had discussed the error with the patient or the patient's family [6]. House officers who accepted responsibility and discussed the case were more likely to make constructive changes in their practice [6]. A more recent European study demonstrated that while 70 percent of ICU physicians felt that they should provide full details of an iatrogenic incident, only 32 percent actually disclosed the error to the patient or patient's family [7].

Significant barriers to disclosure obviously exist: the difficulty of admitting a mistake, the emotional pain associated with being responsible for a patient's illness, the fear of exposure to a malpractice suit, the potential for dismissal from training, loss of licensure, privileges, or referrals, and damaged personal and professional reputation. One of most important barriers to disclosure is fear of litigation and the myth that disclosure will increase the likelihood that patients will take legal action against the physician. In reality, patients appear to be less likely to seek legal action when the physician discloses a mistake than when they learn of the event through other means [5]. A study of 149 outpatients indicated that patients' responses to hypothetical situations depended on the severity of the mistake [5]. More severe mistakes were met with greater inclination to sue or report the physician. However, for each level of severity, the proportion of patients who would keep seeing their physician if they were *not* told of a mistake was significantly lower than the percentage who would continue if they were told. While the link between disclosure and litigation is not directly demonstrated in this study, it implies that the risk of litigation increases when mistakes are not acknowledged [5].

Although it is extremely difficult, disclosure helps to preserve fidelity in the patient-physician relationship, an integral part of the bond between a physician and patient [5]. It can also be beneficial to the physician, providing him or her with emotional relief from admission and the possibility of absolution for the mistake. Disclosure may decrease the likelihood of legal liability as discussed above, and helps physicians accept responsibility, learn, and make constructive changes to their practices. While some patients may prefer not to be informed of medical errors, and

others may become disillusioned with the medical profession (leading to future noncompliance, reducing the benefits of treatment), the benefits of disclosure far outweigh these potential harms. With timely disclosure, patients can provide informed consent for corrective action as a result of the errors. Probably the most important benefit of disclosure for the patient is that it promotes trust in the physician, demonstrates respect for patient autonomy, and respects the privilege of the relationship [8].

The case of Joe and Mr. Miller is an example of a systemic or latent error in which the physician shares the responsibility with other components of the health care delivery system. I believe that the attending has appropriately created an open environment for discussion of medical errors, demonstrating that mistakes can be used as a teaching tool. Thousands of students and residents train each year and none is immune to medical errors. This makes medical school and residency the most logical environments for formulating positive error management strategies [2]. Whether or not Joe feels ultimately responsible for what has transpired, he is likely to be experiencing many emotions associated with guilt and self-doubt that result in defensiveness. While patients are the most obvious victims of medical errors, the physician involved is also wounded and needs emotional support to maintain his or her confidence and develop professionally [1]. Thus, colleagues and attendings provide important support and guidance.

In this case, Sarah is correct in saying that a mistake should be recognized independent of whether or not there are negative consequences. Similarly, the response to the mistake must be independent of its consequences. Joe may not have made the clerical error himself, but as a member of a health care team, he is intimately tied to the mistake and is probably the closest contact person to the patient. Taking the lead in an honest discussion with the patient could be a very valuable learning experience for Joe. However, disclosure should not lie entirely on his shoulders, and, because this occurred during Joe's medical training, it would be most appropriate for the attending to be present with Joe during the discussion with Mr. Miller. Additional consideration should be given to whether an appropriate institutional representative (risk manager, quality assurance representative, etc) should be present.

Arguably, if Mr. Miller remains ignorant of the mistake it will not affect his ability to make future informed decisions. However, patients have a right to know the truth of their own past, present, or future medical condition. Mr. Miller is fortunate that the mistake had marginal impact on his final medical condition. Nonetheless, the outcome of the mistake should not influence a medical professional's decision to disclose what occurred. The team could view this incident as an opportunity to make this powerful formative experience a beneficial one by engaging in an open and honest discussion about mistakes. This may reduce future fear of these types of discussions; moreover, it may strengthen the trust Mr. Miller has in those that will be providing his care in the future.

Given the responsibility that physicians assume in their profession, all will experience the angst of being involved with a medical mistake. A physician's obligation to respect patient autonomy indicates that a doctor has an ethical responsibility to disclose mistakes to a patient. Joe has an opportunity to demonstrate to himself, his colleagues, and Mr. Miller the notion of responsibility and respect for others. He should seize it and reap the benefits of his patient's great confidence in the abilities of his physicians.

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Commentary 2

by Kevin O'Rourke, OP

Medical error and patient safety are 2 prominent ethical issues in the profession of health care. As a result of contemporary studies, articles, and books, a paradigm shift has occurred in the reaction to medical error. Prior to widespread attention to studies discussed in the Institute of Medicine report on medical error and patient safety [1], health care professionals faced with error would often ask the type of question mentioned in the case under discussion. "Was there any real harm?" or "whose fault was it?" as though blame for the event could be assigned in each case to 1 person. Moreover, in the past, the system was seldom investigated as a cause of error. In this case, the prescription was hand-written; a source of many errors. The questions that are posed in this case are as outdated as a suit coat with a belt in the back. Rather, the whole method of writing prescriptions should have been computerized and a fail safe system installed to check whether or not the proper prescription had been filled. To describe the error that occurred in this case as a "clerk's error" is incomprehensible. Computer-based innovations such as physician order entry are systems-based solutions. As cause of frequent error, difficulty with written prescriptions was identified long ago and a mechanism was created to diminish these types of errors. Physicians enter their own orders, thus decreasing communication errors and putting the input responsibility on the person with the knowledge and responsibility.

Moreover, the dialogue of the medical team indicates that they are living in never-never land. "Should the patient be told of the mistake?" Of course he should be told. Even if the mistake is judged to be "not serious," preventing this type of mistake in the future requires a system revision as well as a forthright admission that disposes the team to greater honesty and candor in the future. What medicine has learned from the nuclear energy industry and from the airline industry, is that the only way to limit or eliminate errors is to face up to them. The systems which support patient care should be studied and revised so that dependence upon written instructions and oral commitments is eliminated.

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Other Resources

- MedicalErrorReduction.com web site. Available at: http://medicalerrorreduction.com/ for other books and articles.

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