

# Virtual Mentor

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## CLINICAL CASE

### Medical Culture and Error Disclosure

Commentary by Amy G. Lehman, MD, MBA

Dr. Jackson and his resident, Kim, were performing surgery on Mr. Frank, a patient with recurrence of a metastatic germ cell tumor. The standard of care for this surgery includes retroperitoneal lymph node dissection. Before the surgery, Dr. Jackson told Mr. Frank about the procedure and its risks, benefits, and alternatives. Mr. Frank was made aware that the surgery carried significant risk of bleeding and the need for blood transfusions; his informed consent to the surgery was documented and placed in the medical record.

During the lymph node dissection, several small blood vessels were inadvertently severed, and Mr. Frank lost enough blood to require a transfusion of one unit of red blood cells. Although Mr. Frank's blood pressure was borderline low for several minutes during surgery, the procedure was completed without other complications, the remaining tumor and lymph nodes were removed, and Mr. Frank emerged from anesthesia in good condition.

Before Kim left the operating room, she told Dr. Jackson she would speak with the patient's family and let them know that the surgery went well and that Mr. Frank had received a blood transfusion because several vessels had been cut.

Dr. Jackson responded, "There's no need to inform them of the nicked vessels. Patients know that bleeding and blood transfusions are a risk of the surgery, and Mr. Frank was no exception. He signed the consent saying he was aware of these risks. If we told patients every time something unplanned happened in medicine, we would spend all our time defending lawsuits. Patients simply aren't capable of understanding the idiosyncrasies of medicine. I've talked to my malpractice insurance company and a malpractice attorney about these types of situations. They both advised me that when something happens like this that's not a black-and-white error there's no need to tell the whole story unless there's some lasting effect, or I think it's in the best interest of patient care. All that we need to do is tell Mr. Frank and his family that he lost a lot of blood and needed a transfusion."

Kim spoke with the family immediately after the procedure and informed them that the surgery went well, with only a minor complication that involved some blood loss and the need for a transfusion. Several hours later, Dr. Jackson gave Mr. Frank the same explanation.

Having recently attended a training session with the hospital risk management department, Kim knew that the hospital had a policy of full disclosure when there were clear medical errors. She had even heard that lawsuits might occur less frequently if physicians disclosed their errors and apologized. But she was not sure that this situation qualified as a clear error, whether she was obligated to contact risk management, what the consequences might be for her and Dr. Jackson if she didn't report this, or whether she might face a lawsuit if the patient found out about the nicked vessels.

When Kim saw Mr. Frank the next day, she reiterated what Dr. Jackson had said about the surgery. Mr. Frank asked her if he would recover from the blood loss okay, and Kim stated that he might feel a little more tired than usual for a few days and that the blood loss might delay his recovery by a day or two, but that the blood loss would not affect his ability to make a full recovery.

### **Commentary**

Kim, the surgery resident in this vignette, is put in a difficult moral and professional position, one that many medical students and residents have experienced [1]. On one hand, physicians and physicians-in-training are expected to tell the truth. On the other hand, the institution of medicine has created an entirely separate and mostly unspoken culture built around secrecy and nondisclosure [2, 3]. Often, students and residents choose to ignore their ethical concerns in order to fit in with this culture, believing their grades and professional success depend upon it.

Many of the strategies employed by malpractice litigators and risk managers reinforce secrecy, creating containment-like mindsets in physicians and adversarial relationships between patients and patients' families and physicians. Physicians' and hospitals' fear of lawsuits is widespread, and much has been written about "defensive medicine" [4-7], i.e., physicians' attempts to ward off lawsuits by ordering excessive diagnostic testing and performing invasive procedures. This approach can subject patients to unnecessary risk and inflate costs. Attending physicians are likely to experience more direct pressure from medical malpractice and institutional risk-management systems than are residents, and clinical experience among attending physicians changes their perception of risk [8]. Thus, an institution-wide disconnect is created between the physicians' concerns and goals at different points along the training spectrum. Generational differences in opinions about how to handle conflict resolution may also pose a barrier to a more transparent risk management system. All of these systemic factors become more complex when medical errors occur.

### **Deciding to Disclose**

Mr. Frank's case creates a particular conflict for Kim. The medical culture tells her that it is her duty to obey Dr. Jackson's decision not to discuss the reasons behind Mr. Frank's need for a blood transfusion. This same culture teaches physicians that they should not question the actions of their colleagues [9]. Her own moral sense and the enlightened policies of her hospital's risk management department guide her

towards telling Mr. Frank that Dr. Jackson's nicking of the blood vessel led to his needing a blood transfusion. Kim's initial response, validated by risk management, reflects a change that is slowly transforming how doctors and hospitals deal with disclosure of errors. This case also depicts the difficult position residents find themselves in when their more recent education conflicts with long-standing policies and attitudes among more senior physicians.

Another change is taking place. Patients, on the whole, used to be obedient and passive participants in their medical care; if doctors prescribed a treatment plan, they would follow it. Patients rarely complained to their practitioners about the "service" they were getting and rarely questioned medical decisions. Patients today are far more likely to express dissatisfaction with their physician, challenge clinical recommendations, and share their experiences with others [10, 11]. This new patient behavior makes nondisclosure by physicians a risky strategy: if patients or families are suspicious or undergo unexpected treatments, they are more likely to press for information. Cagery or incomplete responses from physicians only inflame suspicion and distrust.

Kim, a product of more recent medical education, has a heightened appreciation of these new patient-doctor dynamics. She wants to preserve the trusting relationship she and Dr. Jackson have with Mr. Frank by discussing the outcome of the operation fully, including the nicking of several blood vessels. She also wants to apologize because an error in technique has occurred. A number of recent studies have lent support to the effectiveness of this strategy, and several institutions have adopted programs that require disclosure of error [12-15].

Current evidence suggests that disclosure does not necessarily result in a higher rate of malpractice suits [13, 14, 16, 17]. While "the jury is still out" [18], this conclusion continues to be analyzed from several perspectives [19-21]. Nevertheless, what seems clear is that disclosure creates a better relationship between doctors and their patients, whatever the legal consequences [22]. Moreover, patient safety advocates believe that telling patients about medical errors is an integral part of root-cause analysis, which can help identify system-level problems and individual responsibility in the commission of the error [16, 23].

In certain cases, it is difficult to determine whether an error has actually occurred. When physicians and surgeons treat severe or complex diseases, the complication rate is often higher. Experts in their respective fields must determine what the acceptable rates and types of complications are for various operations and procedures. If, in this case, the cutting of small vessels is a known and likely complication of retroperitoneal lymph node dissection, then Dr. Jackson's error was not the cutting of the vessels but neglecting to tell Mr. Frank during the consent process that cutting of small vessels was a known and likely complication of his surgery. Bleeding and infection are a risk of any operation; surgeons have the professional and ethical responsibility to disclose those specific, known risks. In

cases of complex illness, clear communication and trust between health care professionals and patients is even more crucial.

How will these new policies and attitudes be communicated to the medical profession at large, and how can we determine if physicians are actually fully disclosing errors to their patients [24]? Ultimately, regulatory bodies like JCAHO (the Joint Commission on the Accreditation of Healthcare Organizations) or governmental oversight via the Medicare program may have to enforce the change in practice. The Center for Medicare and Medicaid Services has already initiated a nonpayment policy for avoidable hospital complications [25], but this may not be enough to change the culture of medicine. The best way to transform the medical profession into one that embraces disclosure and open communication is for the change to come from within. Many medical school curricula are beginning to address this topic by spending more time on ethics, patient safety, and medical error disclosure. If medical students and residents are educated to identify normative errors and are empowered to ask questions about specific errors that require advanced knowledge, than perhaps the frequency of situations such as the one Kim is faced with in this scenario will decrease.

### **Conclusion**

Trust between a physician and his or her patient is at the very core of the patient-doctor relationship. Hiding from, obscuring, or omitting facts and details in conversations with patients, particularly in the face of a medical error, erodes that trust. Full disclosure, whether it increases malpractice liability or not, is the appropriate ethical path. While hospitals wait for more conclusive data on the effect that truth-telling and apologizing have on medical malpractice claims, patients and their families who have been harmed by medical errors continue to suffer with no explanation about how they ended up in their current predicaments. The trust between patient and doctor, however, demands disclosure even in cases where obvious or lasting harm has not occurred. Patients should not feel that their doctors are their adversaries. If they do, medical practice as we know it will be in serious jeopardy, and the only winners will be malpractice litigators.

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Amy G. Lehman, MD, MBA, is a resident in general surgery at the University of Chicago Medical Center and is a fellow in the MacLean Center for Clinical Medical Ethics at the University of Chicago. Dr. Lehman is a 2005 graduate of the University of Chicago Pritzker School of Medicine and is interested in clinical decision making from both physician and patient perspectives.

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