Ethics in Cardi thoracic Surgery

Another Surgeon’s Error: Must You Tell the Patient?

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Introduction

Robert M. Sade, MD

The question of whether physicians should report medical errors to patients and their families has been the subject of much commentary ever since the 1999 report of the Institute of Medicine, To Err is Human: Building a Safer Health System, which brought the problem of hospital deaths due to medical errors to public attention [1]. A general consensus has been reached among bioethicists and within the medical profession: physicians have an ethical obligation to patients to disclose errors made during their health care. Much less clear is a closely related but quite different problem: is a physician obligated to disclose errors made by others when those others will not personally disclose them?

A debate addressing that question was held at The Society of Thoracic Surgeons Annual Meeting in 2014, based on the following case.

The Case of the Missing Biopsy

A 72-year-old man is referred to Dr Paul Jones with the new diagnosis of bronchopleural fistula. He underwent right pneumonectomy 10 days previously, performed by Dr John Lapps, a cardiothoracic surgeon in another part of the state, after having undergone induction chemoradiation therapy for stage IIIA non-small cell lung cancer, clinically staged. This procedure was complicated by hemorrhage. The final pathology report disclosed multistation mediastinal lymph node disease.

A review of the operative note reveals that no frozen sections were sent. Dr Jones is surprised that Dr Lapps did not obtain a biopsy specimen of the mediastinal lymph nodes by a less invasive procedure than thoracotomy, or at least after thoracotomy but before pneumonectomy. If the patient had been his originally, he, like most thoracic surgeons, would have biopsied the nodes, and the patient would not have undergone pneumonectomy.

Dr Jones intends to describe to the patient and his family what he believes needs to be done now. Before he talks with the patient and his family, however, he contacts Dr Lapps, describes the error Dr Lapps made in not obtaining a lymph node biopsy specimen, and encourages him to report this to the patient. Worried about a possible lawsuit, Dr Lapps refuses to do so. Dr Jones will answer honestly any questions the patient and his family might ask, but wonders if he should tell them about Dr Lapps’ omission.

Pro

Susan D. Moffatt-Bruce, MD, PhD

Dr Jones must tell the patient and his family about Dr Lapps’ omission. Several ethical principles support this stance. Before taking a pro or con stance, however, a preface must be made. This is a very challenging and perhaps not unfamiliar scenario. With patient care becoming more complex and care teams being more diverse, this is likely to become a sadly familiar situation. Having said that, I will outline ethical principles, as well as expand on, what the benefits are in dispelling myths about care that may not be true and unveiling the reality of the clinical scenario presented here: Dr Lapps’ omission likely did not meet the standard of care. Lastly, I will review what tactics and teaching must be part of the surgeon’s armamentarium to properly care for the patient and render this a very professional disclosure.

The ethical principles that support Dr Jones telling the patient and his family that Dr Lapps should have biopsied the mediastinal lymph nodes, thereby obviating the need for a pneumonectomy, include (1) the surgeon’s professional obligation; (2) the surgeon’s integrity; (3) the patient’s right to informed care and to be fully engaged in his care; and (4) the patient’s right to informed consent regarding further care he will require.
The American Medical Association Code of Medical Ethics helps render clarity to the surgeon’s professional obligation to tell the family that Dr Lapps has made an error in judgment in completing the pneumonectomy. The Code states, “Situation occasionally occur in which a patient experiences 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” [2].

Furthermore, the American College of Physicians Ethics Manual states “Physicians should disclose to patients information about procedural or judgment errors made during care, as long as such information is material to the patient’s well-being. Errors do not necessarily imply negligent or unethical behavior, but failure to disclose them may” [3]. This statement leaves no ambiguity that surgeons, and in particular, Dr. Jones, are obligated and it is their professional duty to disclose an error of another surgeon once it has been discovered. Professional self-regulation requires sharing and acting on information collectively and should become our professional norm.

So, the professional codes of conduct under which we should ethically support the disclosure of Dr Lapps’ error by Dr Jones. Where does the patient’s care and expectations come into this debate? Every patient is entitled to what is truly informed care. That is to say, patients are entitled to honest information. When asked, Dr Jones must be truthful and answer to the best of his ability about what transpired to render such to the patient under his care. He may choose to not use words like “error” and “mistake” but rather choose more productive and less judgemental words such as “clinical opinion” and “divergence from.” If he is not asked, Dr Jones is still obliged to render an appropriate disclosure as it pertains to the patient’s clinical care. Patients and families should not have the burden of trying to discover “what happened” or how it should happen that, in this instance now, the patient is facing additional care by another surgeon.

Financial burden to the patient should be relieved. Often patients and families will need help after such a serious error that is now going to prolong their care, and they will have difficulty accessing compensation without information about what really happened. Family must be kept informed along with the patient about the long-term care plan. The patient had initially consented to 5 to 7 days of hospitalization time, and now his care has likely turned into a prolonged stay. In addition, the patient may have been moved from his local environment and is now in an unfamiliar city with the family incurring additional costs. The patient’s needs are very real, and as professionals, we are expected to put the needs of the patient and the family above our own. Honest and expeditious disclosure will serve to move beyond blame to advocacy for the patient.

The patient is entitled to informed consent. This will be a particularly important component of this patient’s care because Dr Lapps’ omission has now required further intervention and care by Dr Jones. For the patient and his family to give informed consent for additional therapy or surgical intervention, they must understand the clinical course thus far. This has the potential to be important for the patient as well as the surgeon and their own relationship, particularly if an additional operation is fraught with the potential for further complications or prolonged care. To be truly informed, a patient has to understand what care rendered to them resulted in the current state of their disease.

Although surgeons may be ethically obligated to disclose errors, pressures from society and the medical profession itself make it very difficult for physicians and surgeons to rush to disclose in a timely and professional manner. In one recent study, only approximately one-third of patients who had some experience with a medical error said that a health professional involved in the incident disclosed the error or apologized [4]. Most physicians have trained in a culture that supports “shame-and-blame” approaches to medical errors. Shame, fears about blame, and worries about legal liability also play a role in the underreporting of medical errors. Most physicians have trained—and some continue to train—in poor working conditions that include heavy workloads, inadequate supervision, and poor communication. All those factors contribute to medical mistakes, which are often very difficult to take responsibly for [5]. A balance must be found between “nonblame” and appropriate accountability.

In theory, there are many benefits to a timely and appropriate disclosure. There are data, particularly in the labor and delivery literature, supporting that good, open, and honest communication improved patient satisfaction and, ultimately, outcomes [6]. Improved surgeon-patient relationships and, ultimately, improved patient and family satisfaction results from open communication and honesty [7, 8]. Although the research suggests that good communication about adverse events may reduce litigation and malpractice payouts, I must concede that data are lacking from studies to indicate how to disclose other’s errors while minimizing the risk that a patient will initiate a claim [9, 10].

There is also the well-being of the surgeon to consider after an error has been made. One study, for example, demonstrated that when house staff could no longer deny or discount a mistake, they were plagued by profound doubts and guilt. For many, “the case was never closed,” even when they finished their training [11, 12]. A surgeon’s emotional and reputational-related consciousness require sensitivity. Providers may feel accountable yet unprepared to disclose or help find a solution without support. “Just Culture” and accountability has become a buzz word but one that does facilitate better care. This really engenders an atmosphere of trust in which people are encouraged, even rewarded, for providing essential safety-related information but also allows for the expectation that appropriate and acceptable medical care be provided as the standard.

Gallagher and colleagues [9] recently published a very timely article in the New England Journal of Medicine
whereby the tactics and teaching required to meet the patient’s needs were explored in depth. The authors speak to the concept of “explore, do not ignore” when a colleague’s possible error has occurred. The clinician’s first obligation is to obtain the facts; inaccurate or speculative information is damaging.

Only Dr Lapps will know exactly what happened during the care or operation. To engage with the surgeon to give him the opportunity to correct assumptions and join the disclosure process is the first step. This should ideally be a very professional surgeon-to-surgeon discussion so that it is productive rather than disruptive. Approaching Dr Lapps with curiosity rather than accusation will be much better received. The goal is to engage the practitioner to help determine how to disclose an error, if together you decide there has indeed been one, as well as determine if there are others to which the disclosure must be made (ie, institution, The Joint Commission). In fact, Gallagher and colleagues give us guidance on how best to proceed with the disclosure, in that sometimes additional people should be present, including medical directors or department chairs. If Dr Lapps were to decline the invitation, then disclosure must proceed, and when asked, Dr Jones is obliged to always tell the truth.

Surgeon-to-surgeon conversations about errors are difficult and certainly require institutional transparency and support. The support has to come in the form of well-trained investigators of events so that we capture events that make a difference at the system level rather than always demanding personal accountability. This needs surgeon input and engagement and to actually be part of the root cause analysis process. Robust team training, event reporting, and peer review are key.

Lastly, coaching and support for the surgeon who has to disclose an error of his own or another needs to be provided. This is never an easy or pleasant process but one that will turn the focus to patient-centered care as opposed to surgeon-centered protection. The earlier we start this training and setting expectations around appropriate accountability, apology, and disclosure the better; medical school is the ideal initial forum.

In conclusion, Dr Jones is obligated to discuss the potential error with Dr Lapps, thereby verifying the facts and determining whether an error was made or not. Dr Jones then must provide the surgeon the opportunity to disclose the error to the patient and family and to truly be part of the accountability process. Ultimately, the patient and family must be informed because it is a shared professional responsibility, of all surgeons, to provide transparent disclosure of errors that impact patient outcomes.

Con

Chadrick E. Denlinger, MD

Several recent statements provide guidance related to the disclosure of medical errors by physicians to the patients for whom they have been providing care [13–15]. It is fair to conclude that a consensus has been reached regarding our ethical duty to inform patients of our own medical errors. In addition to being the ethically acceptable practice, disclosing one’s own errors is critical for preserving trust between patients and physicians. Arguments supporting nondisclosure because of concerns for provoking anxiety or confusion have largely been discredited. Therefore, most agree that medical errors should be disclosed to the patient by the physicians involved as soon as reasonably possible given their overall medical situation.

The situation of Dr Jones disclosing an error involving Dr Lapps, who practices at a different institution, is significantly different. Encountering medical errors involving other physicians is extremely common. In fact, a recent survey of practicing clinicians found that more than two-thirds of physicians had encountered a peer’s medical error within the prior 6 months, although 90% of them had received little or no prior training on how to manage this situation [16]. Given the frequency in which analogous situations occur, it is instructive to think of our own situations and ask ourselves “how did I respond?” rather than to ask hypothetically “how would I respond?” As we reflect on prior situations, we should realize that our prior actions were guided by our own ethical code and sense of justice.

Several years ago, I accepted a patient from another hospital and I quickly realized that the patient had, in my opinion, been mismanaged at the previous institution. As I treated the patient, I focused on the current situation and what treatments were necessary. We did not discuss the prior care at another hospital. Eventually the patient recovered and returned to a normal lifestyle, but this only came after an initial prolonged hospitalization and numerous subsequent admissions for minor procedures and a few significant operations. Over the course of the following year, the patient and family began asking questions related to my opinion of what had occurred at the prior hospital and I answered openly and honestly.

In preparation for the discussion involving Drs Jones and Lapps, I conducted my own survey of 20 different colleagues scattered throughout the United States as well as several individuals at my own institution. Those surveyed were provided a succinct review of the case and were asked, “should I have discussed with the patient regarding the previous care?” Those surveyed were
asked that in addition to treating the patients, should I have:

A. told the family that I agreed with the prior management;
B. offered no opinion regarding the prior management, but answer honestly if asked; or,
C. proactively told the family that I thought the prior management was inappropriate.

Everyone surveyed responded that I should have answered questions honestly when asked, but that I should not have proactively informed the patient or family that the prior management was inappropriate.

The topic of disclosing medical errors involving a different physician has recently been addressed in other publications. The authors acknowledge that existing guidelines emphasize the importance of disclosing errors pertaining to our own practice, but they offer little guidance on disclosing mistakes involving others. This lack of guidance heightens the clinician’s uncertainty about what to do [9]. There are three primary challenges with disclosing another’s mistakes. Most importantly, it is often difficult to determine exactly what happened when a physician was not directly involved in the event in question.

Second, it is difficult to understand what conversations occurred between the physician(s) involved and the patient regarding the risks and benefits of various treatment options. Furthermore, there is likely some uncertainty regarding the degree of patient involvement in selecting a given treatment pathway.

Finally, opinions differ about what constitutes a medical error. Potential errors exist on a spectrum ranging from “not what I would have done” but within the standard of care to blatant errors suggesting medical incompetence. These three issues contribute the lack of clarity of the appropriate response when we encounter a peer’s medical error.

Several examples in the literature illustrate the difficulty with determining what defines a medical error. In 1991, the Harvard Medical Practice Study investigated the number of adverse outcomes and deaths that occurred as the result of negligent medical errors [17]. For the purposes of that study, more than 30,000 medical records from New York state were randomly selected and screened by nurses to identify patients with adverse outcomes. The screeners identified nearly 8,000 patient records as showing evidence of adverse outcomes.

Two physicians then independently reviewed each of these records. The vast majority of the reviewers were board-certified surgeons or board-certified internists. Each reviewer received specific training for the purpose of the study to educate him or her about what constituted an adverse outcome and what constituted medical negligence. The interobserver reliability of identifying adverse outcomes was good, with a \( \kappa \) value of 0.61. Conversely, the physicians’ opinions regarding negligence were far less reliable, with a \( \kappa \) value of only 0.24.

The authors acknowledge that judgments regarding the causes of adverse outcomes or negligent care are difficult and sometimes inaccurate. The fact that physicians had difficulty determining whether or not a standard of care had been met was really not surprising given the complexity of medical care.

A second similar study involved pairs of anesthesiologists independently reviewing the appropriateness of care in more than 100 actual malpractice claims [18]. The 2 reviewers agreed on the appropriateness of care in 62% of the cases. Each reviewer thought the care was appropriate in 27%, and they both thought the care was inappropriate in 32%. Interestingly, the 2 reviewers disagreed on whether or not the care was appropriate in 38% of cases (\( \kappa = 0.37 \)).

These two studies highlight the fact that physician medical record reviewers who receive specific training that prepares them to properly identify negligent or inappropriate care have a substantial degree of agreement. If this is true, it is unacceptable for each of us to assume that we are capable of correctly judging the appropriateness of care provided by other previously treating physicians and to inform patients of our opinion.

Given the degree of disagreement between expert reviewers, consideration should be given to when the disclosures should end. In the current case, if Dr Jones informs the patient that Dr Lapps has provided negligent care, what are the ethical responsibilities of subsequent physicians taking care of the patient? Almost certainly, the patient will be transferred to an intensive care unit where care will be provided, in part, by intensivists. If one adopts the policy that we are all responsible to disclose medical errors involving other physicians, then we should also be responsible to share our opinion regarding reviews of care rendered other physicians. Therefore, the intensivist would be responsible to inform the patient of his or her opinion of Dr Lapps’ care and would also be responsible for providing an opinion about the appropriateness of comments made to the family by Dr Jones regarding Dr Lapps’ care. This scenario would continue when the patient leaves the hospital and the primary physician involved in his care is the primary care physician.

Physicians have strong opinions about how they would like their colleagues to disclose information when their own care is thought to be negligent. A recent survey presented physicians with clinical vignettes where adverse outcomes occurred [16]. The outcomes were characterized as being a near miss, an event leading to harm, or an event leading to the patient’s death. Those surveyed were then asked how they would respond to the situation. More importantly, they were also asked how they would prefer their peers to react when they had made the error. Regardless of the severity of the outcome, approximately two-thirds of all respondents indicated that they would report their opinion to the original physician rather than report their opinion to the patient when they were the one observing the error. However, when the respondent was the physician responsible for the error, 93% of the respondents expected their peers to report the error to them.
When encountering medical errors involving other physicians, the most appropriate response is to speak directly with those involved. This may clarify the rationale behind decisions that were made and will expound the discussion that occurred with the patient before rendering treatment. After this discussion, the 2 physicians may agree that no harmful error had occurred and therefore nothing needs to be disclosed. Alternatively, the physicians may agree that there was an error and they agree upon who should disclose the error to the patient and when this should occur. A third scenario is that the 2 physicians disagree either on whether an error occurred or they disagree on how the information should be disclosed to the patient. Under these circumstances, institutional guidance should be sought given the frequent disagreements even among expert reviewers related to the appropriateness of previous care.

In conclusion, Dr Jones should not tell the patient that he believes Dr Lapps made a medical error for several reasons: Medical errors involving other physicians must be first discussed with the physicians involved to fully understand the decisions that were made. Second, there is frequent lack of agreement regarding the appropriateness of care previously provided. Entangling a patient and their family in the midst of differing medical opinions would likely increase their anxiety beyond the stress already felt because of the illness itself. Therefore, only a collaborative approach to accountability can fully meet the needs of patients after harmful medical errors have occurred and the physician involved is no longer taking care of the patient.

**Concluding Remarks**

Robert M. Sade, MD

Both essayists make persuasive arguments to support their positions. A few of their arguments are less than convincing, however. Moffatt-Bruce, for example, claims that her citations of sections of the American Medical Association Code of Medical Ethics and the American College of Physicians Ethics Manual support the disclosure of Dr Lapps’ error by Dr Jones. The American Medical Association Code does not support disclosure of another physician’s error; it refers to a physician disclosing his own mistake [2]. The American College of Physicians Manual is more ambiguous than she asserts; it does not mention reporting errors of others [3]. Elsewhere, however, in support of her position, the American College of Physicians is much clearer about the obligation of a physician to report another physician’s error: “The patient has both an ethical and a legal right to the information [about another clinician’s mistake]” [19].

Denlinger wants us to believe that a great deal of uncertainty surrounds the question of whether or not an error occurred, which is assumed by Moffatt-Bruce to be a fact. In the Jones-Lapps scenario, however, Dr Jones talks with Dr. Lapps, and it is clear that Dr Lapps’ refusal to disclose the omission of a lymph node biopsy is not based on denial that an error occurred but is based on fear of a lawsuit.

Moffatt-Bruce and Denlinger share many points of agreement. They both agree that Dr Jones must discuss the omission of the biopsy with Dr Lapps and that the 2 surgeons should jointly determine whether or not an error was made. They agree that Dr Lapps should be offered an opportunity to disclose the omission to the patient and that a collaborative approach to resolution of the issue is needed.

Their major disagreement is on the final step of the process, after Dr Lapps refuses to participate in disclosure of the omission. Moffatt-Bruce speaks of a “shared professional responsibility” to ensure disclosure of what happened to the patient, which is ethically necessary. Denlinger similarly speaks of a “collaborative approach to accountability,” but stops at that point, leaving open the question of whether disclosure of the omission is obligatory.

Discussion of physicians’ responsibility to report their own mistakes to patients is extensive in the medical and the bioethics literature, but little commentary can be found about disclosure of errors made by other clinicians. The best exploration of this subject is the recent report of Gallagher and coworkers [9], which was cited by both essayists. The article provides a closely reasoned analysis of how to deal with errors made by other clinicians. The general conclusion is that patients and their families should be informed of errors or deviations from standard practice, as a matter of openness, honesty, and trust. The authors consider several different relationships between a clinician who makes an error and another clinician who discovers the error. One of those relationships involves a physician who discovers an error made by a physician at another institution, mirroring our scenario. In the situation of Drs Jones and Lapps, the strategy they describe suggests that when Dr Lapps refuses to participate in disclosing the misadventure to his former patient, Dr Jones should seek assistance from the senior leadership at his own institution in deciding how to proceed, and in the best of circumstances, should be advised by a “disclosure coach” to ensure a well considered, carefully planned discussion with the patient and his
family—what Gallagher and colleagues describe as “skillfully executed disclosure conversations.”

Our essayists disagree about whether reporting the error to the patient and his family is ethically obligatory. They agree on one critical issue, however: when a possible error is reported to the patient, it must be done with careful attention to the words and manner of communication to minimize adverse emotional responses by the patient and the family and to avoid burdening them unnecessarily.

References