Ethics case study

Must you disclose mistakes made by other physicians?

This is the 30th in a series of case studies with commentaries by ACP's Ethics and Human Rights Committee and the Center for Ethics and Professionalism. The series uses hypothetical examples to elaborate on controversial or subtle aspects of issues not addressed in detail in the College's "Ethics Manual" or other position statements.

Case history

Dr. Gray was definitely feeling the effects of his partner's vacation. A general internist, Dr. Gray practices with three other physicians, all of whom are close friends. One of the partners, Dr. Leavitt, had recently taken a three-month sabbatical to take care of some business in his home state, and Dr. Gray was caring for most of his patients. He felt fortunate, at least, that Dr. Leavitt generally kept good records.

The first patient Dr. Gray saw this particular morning was Mr. Karnofsky, a uitt eTc -0s3kgks pabronchitis he hadn't bee
sputum and had begun to lose weight, but he thought it was probably beca
him a little nauseous. Dr. Gray was concerned, and he sent the patient do

Later in the morning, the radiologist called Dr. Gray and reported that the X-ray looked like cancer. The radiologist then asked if the patient had refused the follow-up X-rays that had been recommended the previous year.

Puzzled, Dr. Gray replied that the patient was new to him, but that there were no notes in the chart of any abnormalities. The radiologist explained that his colleagues had spotted a lung nodule in the same lung where the cancer was now located about 18 months ago. The clinical information given at that time had stated, "Pt. with fever/cough, r/o infiltrate."

Dr. Gray thanked the radiologist and picked up Mr. Karnofsky's chart. Sure enough, he found a note from 18 months before about the fever and cough and a follow-up note indicating that a course of antibiotics had taken care of the complaints. No mention was made of the abnormal chest X-ray.

In the chart's radiology section, however, Dr. Gray found the report of the faint nodule with the recommendation for repeat films in a few months. Apparently, his partner had overlooked this report.

A biopsy confirmed lung cancer, and a CT scan revealed that the disease had spread to the mediastinum. Dr. Gray had to conclude that early detection may have made a difference.

Now he had to tell this gentleman who he'd seen only once that he had a terminal condition. Mr. Karnofsky said he was surprised that the cancer had grown so fast. After all, he explained, he had just had an X-ray about a year and a half ago that didn't show anything.

Dr. Gray didn't know what to tell the patient about that X-ray. In fact, he debated whether to say anything about it at all.

Dr. Leavitt was his friend and an excellent physician, and anyone could make a mistake. On the other hand, this patient now had a terminal condition that might have been curable if followed up sooner.

"Am I obligated to reveal someone else's mistake if no one asks directly?" Dr. Gray wondered.

Commentary

Disclosing errors to patients presents physicians with a situation where the principle is clear but the practice is difficult.

The AMA's "Code of Medical Ethics" is fairly clear about physicians' obligation: "Situations 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." (1)

ACP's "Ethics Manual" states that 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. It goes on to say that errors do not necessarily imply negligent or unethical behavior, but failure to disclose them may. (2) Therefore, there is no ambiguity that physicians are obligated to disclose the information that Dr. Gray has discovered.

While physicians may be ethically obligated to disclose errors, pressures from society and the medical profession make it very difficult for physicians to rush to disclose. In one recent study, only about 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. (3)

In part because physicians receive little to no training in discussing errors, admitting errors is difficult. (4) Most physicians have trained in a culture that supports "shame-and-blame" approaches to medical errors.

One study, for example, demonstrated that when housestaff 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. (5)

Shame, fears about blame and worries about legal liability also play a role in the under-reporting 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.

Dr. Gray asks, "Am I obligated to reveal someone else's mistake if no one asks directly? And am I liable if I don't?" Because this mistake falls in the category of a major error, Dr. Gray needs to inform the patient of the abnormal chest X-ray done 18 months ago.

Here are some issues Dr. Gray needs to consider as he works through a difficult situation:

- **Disclosure.** Given the nature of the patient's illness, Dr. Gray needs to disclose his partner's mistake expeditiously. As a courtesy, Dr. Gray should first tell Dr. Leavitt about the error and give his partner the option of informing the patient. If he cannot reach his partner (who is on an extended sabbatical), or if his partner does not wish to inform the patient, then it is Dr. Gray's responsibility to do so. The patient has both an ethical and a legal right to the information.

  It is possible that if his physician had noted the lesion earlier, the patient could have received treatment that may have cured the cancer or extended the patient's life. That will never be known.

  The patient should be given a follow-up appointment in one or two days and asked to have a family member accompany him. The patient now has many decisions to make about his future treatment and life plans, and he needs to be well-informed to make those decisions.

  Communicating quickly and honestly with the patient in this case may help to maintain trust in the relationship, dispel any uncertainty or fear, and promote patient satisfaction. Timeliness, honesty and a sincere apology may also help prevent the possibility of a malpractice lawsuit.

- **Office procedures.** Dr. Gray's practice should also take this opportunity to review tracking and notification systems that clearly need to be improved. The radiology report was filed in the patient's chart without having been read by a physician—and without the patient being told of the results.

  Office procedures must be changed to prevent such errors in the future. The practice should monitor its tracking and notification systems to pinpoint areas where changes are needed. All radiology and laboratory reports should be signed and dated by the physician, and patients should receive a note informing them of all test results.

  The 1999 Institute of Medicine report, "To Err is Human," focused on medical errors and patient safety. The report concluded that up to 98,000 individuals die each year in hospitals as the result of preventable medical errors.

  The report also concluded, however, that most medical errors are systems-related and cannot be attributed to individual negligence or misconduct. (6) We therefore need to move away from a culture that blames individuals to one where systems of health care delivery are improved.

- **Patient trust and legal risk.** Physicians may hesitate to tell the truth because of conc(patient 0 1 Tf6(ere 7(ciai0 Tc w 1.5ni)6(sty tf)malractic))]TJ0.00061 Tc -0.00217Tw 19.7623 0 Td[lawsu

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Additional readings

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