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

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Introduction

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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

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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.

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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, "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 " [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 work 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*