ADVANCING COMMUNICATION OF MEDICAL ERROR:
BRIDGING THE GAP BETWEEN TRANSGRESSION AND TRANSPARENCY

BY

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Over the past two decades medicine has witnessed an about-face in publicly endorsed
attitudes toward medical errors – from concealment, cover-up, and turning a blind eye to
transparency, acknowledgment, and prevention. Medical error is a pervasive problem;
the Institute of Medicine estimates that between 44,000-98,000 people die annually due
to preventable errors in treatment. There is robust moral justification for communication
of errors to patients who have been harmed and to their loved ones. Physician-patient
relationships depend upon truthfulness to maintain the trust that is essential to the
delivery of effective medical care. In addition to this ethical rationale, several federal
initiatives require the reporting of medical errors. Professional organizations, including
the American Medical Association, advocate that patients who are harmed should be
informed of what went wrong and why, accompanied by sincere expressions of empathy
and regret.

Still, many physicians have been slow to adopt this change in practice. I survey
the many reasons offered to explain the hesitancy of well-intentioned practitioners to
disclose and apologize for errors, exploring the mixed messages they receive from within
the culture of medicine, from society at large, and from the healthcare institutions in
which they practice. In conclusion, I argue that only a moral justification for disclosure,
as contrasted with patient safety rationale, will summon the courage practitioners need to accept their own fallibility and subordinate fears of malpractice litigation. Integrated, ethically-guided institutional change initiatives will support these providers in overcoming the potent barriers to disclosure posed by the culture of medicine.
CHAPTER ONE

INTRODUCTION

On the one hand, mistakes are inevitable. On the other hand, they are to be avoided; nothing counts as a mistake unless in some sense we could have done otherwise. This fundamental paradox creates the moral challenge of accepting our fallibility and at the same time struggling against it. - Judith Andre

Over the past two decades the world of medicine has witnessed an about-face in espoused attitudes toward medical errors – from concealment, cover-up, and turning a blind eye to transparency, acknowledgment, and prevention. Initiated in 1991 with release of the Harvard Medical Practice Study analyzing hospital adverse event rates within New York State,² this shift gained significant momentum with the widely publicized 2000 Institute of Medicine report To Err is Human: Building a Safer Health System³ (IOM Report). The IOM Report and its lesser known companion, Crossing the Quality Chasm: A New Health System for the 21st Century⁴ (IOM Report II), sought to draw attention to the frequency of error occurring within the routine practice of medicine and to propose strategies for error prevention. Both reports are grounded in principles of quality improvement and systems theory that have served to reduce error rates dramatically in industries such as aviation and nuclear power generation – industries in which, as in medicine, mistakes can be fatal. Organizations that subscribe to these principles of prevention, often dubbed “high reliability organizations” or HROs, are characterized by cultures in which reporting of mistakes is an essential precursor to learning, which is, in turn, an essential precursor to improved outcomes.
Notably absent from the IOM reports, both of which recommend the establishment of error reporting systems and allude to the importance of patient-centered care, is compelling endorsement of disclosing errors to patients.\(^5\) Errors arising in the aforementioned HRO contexts pose threats of a communal nature to persons acting within their normal course of affairs. By contrast, mistakes in the delivery of healthcare most often befall one patient at a time in the context of a therapeutic relationship, the express purpose of which is to benefit, not harm. The IOM reports fail to engage ethical issues that are of paramount importance to providers and patients – issues surrounding the nature and extent of duty owed by the physician to the patient when harmful error occurs. These ethical issues comprise the heart of this inquiry.

The desirability of reducing medical errors in order to save lives and improve health outcomes would appear inarguable. The IOM reports proposed solutions that included initiatives in policy, education, mandatory incident reporting, quality improvement, and evidence-based practices. The federal government quickly responded by financing a myriad of such programs, including a $50 million appropriation for patient safety research to the Agency for Healthcare Research and Quality (AHRQ) in 2001.\(^6\) In response to the IOM Report, professional societies amended their ethics guidelines to recognize the need for error disclosure to patients.\(^7\) Likewise, bioethicists representing a wide spectrum of moral theories reiterated their long-standing support for truthfulness and disclosure between physicians and patients.\(^8\),\(^9\),\(^10\) However, this seeming alignment of public and administrative policy and ethics – which I will discuss in more depth in chapters to follow – has met with lukewarm acceptance among practicing physicians who bear primary responsibility for disclosing errors.
Physician Attitudes Toward Medical Error and Disclosure

Error Prevalence. The IOM report garnered significant media attention by asserting that an estimated 44,000 to 98,000 people die each year due to medical error.\textsuperscript{11} This wide range can be explained by the fact that the estimates were extrapolated from two separate retrospective studies, the Harvard Medical Practice Study involving record review in fifty-one randomly selected New York State hospitals\textsuperscript{12} and another study that employed a similar methodology in twenty-eight non-teaching hospitals in Utah and Colorado.\textsuperscript{13} Those studies report that adverse events occurred in 2.9 to 3.7 per cent of hospital admissions, of which 6.6\% to 13.6\% resulted in death.

Many physicians responded to the IOM Report with disbelief; others feared that such reports would undermine public trust.\textsuperscript{14} Some contended that the estimates were exaggerated, questioning the implication of a causal relationship between adverse events and patient deaths and suggesting that a number of the patients would have died absent medical error.\textsuperscript{15} However, Lucian Leape persuasively defended the studies’ methodology by explaining that rigorous exclusion criteria eliminated from consideration patients with high levels of acuity.\textsuperscript{16} If anything, the IOM Report likely underestimated the prevalence of iatrogenic mortality. For instance, the IOM estimates did not include deaths from nosocomial infections, which were estimated to be 88,000 per year by the CDC’s National Nosocomial Infections Surveillance System during the same time period.\textsuperscript{17} Nearly ten years after the IOM Report, despite significant federal expenditures for improvements in patient safety, AHRQ estimated that our performance is actually declining. “Distressingly, measures of patient safety in the NHQR [National Healthcare Quality Report] indicate not only a lack of improvement but also, in fact, a decline of...
almost 1 percent in this area.” This is admittedly an estimate. The NHQR continues to reiterate statistics from the IOM Report inasmuch as the original studies have not been updated and data capture is fragmented. Health Grades, an independent organization that grades health care providers based on Medicare data provided by the Centers for Medicare and Medicaid Services (CMS), projects that the inpatient risk-adjusted mortality rate improved by 14.17% from 2005 to 2007; however mortality rates varied widely by procedure, by volume, by region, and by institution. Recently, however, HealthGrades reported that there remain one million Medicare patients per year who experience patient safety incidents, nearly one-tenth of which are fatal.

The IOM Report estimates captured headlines in the mainstream media from the Los Angeles Times to the Washington Post to Reader’s Digest. Yet in a survey of physicians and patients just two years later, the majority substantially underestimated the frequency of preventable fatal errors. 63% of physicians and 50% of patients projected the death rate at 5,000 per year or less. At this low rate, a physician might be inclined to think, “This could never happen to me.”

While the IOM Report emphasizes the most serious errors – those that resulted in death, other errors can be similarly problematic. In 1994 Leape reports that medical ICU errors occur at a rate of 1.7 per patient per day, reflecting a 99% accuracy rate given that ICU patients averaged 178 medical activities daily. By comparison, a 99.9% accuracy rate would mean two unsafe airplane landings per day at O’Hare Airport. According to Leape, many errors go undetected, not because of concealment, but due to lack of awareness. He reports that retrospective studies of autopsy results revealed fatal misdiagnoses in 20-40% of cases. In the bestseller How Doctors Think, Jerome
Groopman offers insight into the origins of these misdiagnoses, ranging from cognitive bias to inherent imprecision in interpreting diagnostic tools such as radiology reports. Graber contends that diagnostic errors are largely neglected even within the patient safety community, perhaps because they are so difficult to identify. Also of note are errors that arise in the prescribing and administration of medications. The IOM Report estimates that 7,000 deaths annually are attributable to such errors.

No point of care is immune to errors, the consequences of which may extend beyond health outcomes. Consider the example of a routine blood test offered in a primary care physician’s office. A few years ago during a well-visit exam, my physician revealed test results that placed my cholesterol 100 points higher than it had routinely been and my blood sugar over 40 points higher. After a momentary shock, I concluded that the test must have been erroneous and asked that it be redone. Fortunately the second test indicated values consistent with prior results. One might conclude that this mistake was rectified promptly and therefore immaterial to my health beyond an unsettling initial response. However, the incorrect values remain a part of my medical record where they may be viewed by health, life and long-term care insurers, all arguably motivated to find a reason to exclude me from their most advantageous rating categories. More importantly, it is plausible that my results were switched with those of someone else, leading that individual to conclude that she was healthy when in fact she had uncontrolled diabetes and hypercholesterolemia. The frequency of such events in daily practice is impossible to estimate. If the NHRQ cannot provide contemporary estimates of error prevalence in hospital systems; they cannot begin to capture what goes on in a physician’s office. Neither are there studies reporting physician beliefs about the
prevalence of these quotidian mistakes. Would they be underestimated to the same degree as fatal errors? Are they so ubiquitous as to become invisible? Perhaps, as will be discussed in Chapter 2, my atypical test values might not be classified as “error;” my physician did not characterize them as such.

**Error Disclosure.** Several studies have identified a gap between espoused attitudes toward error disclosure and disclosure behaviors. In a random survey of 245 non-VA hospitals nationwide by Lamb et al., 54% of respondents indicate that it is routine practice at their institutions to disclose harm-producing errors to patients or their families, and 44% respond that such disclosures happen some of the time. However the respondents’ mean frequency of actual disclosures is 24.6 per annum, which would correspond to 7.4 disclosures per 10,000 admissions. This disclosure rate is considerably lower than the error rates reflected in the IOM Report, which would translate to 290-370 potentially disclosable events per 10,000 admissions, of which 44-66 would be serious harms. A likely explanation for the disparity lies in the fact that the respondents in the Lamb survey are predominantly hospital risk managers and CEOs, whereas identification of errors to be disclosed depends on practitioners. Though 70% of these institutional leaders report an increase in disclosures during the prior two years, indicating a trend consistent with intentions in the IOM Report, there remains a substantial gap between professed and actual institutional practices.

Kaldjian et al. also find a discrepancy between espoused and actual behaviors in their study involving faculty and residents at four medical centers in the Midwest, Mid-Atlantic and Northeast. In response to hypothetical case vignettes, 97% of respondents reply that they would be either likely or very likely to disclose error in a case
exemplifying minor harm, with 93% endorsing disclosure in a case of major harm. Yet only 65% respond in the affirmative to the question: “Have you ever made a mistake that prolonged treatment or caused discomfort and not told the patient (or the patient’s family) that a mistake was made?” 15% respond that they had failed to tell a patient or family member about a mistake that resulted in disability or death. The same phenomenon is observed in research conducted by Cook et al. with participants at 29 rural hospitals in the Western U.S. With regard to institutional climate, 97% reply that they feel comfortable or somewhat comfortable in discussing medical errors. Yet when analyzing case vignettes, participants’ reluctance to disclose errors to patients becomes apparent. In one case 97% of respondents believe an error occurred, but only 64% would tell the patient about the error; in another case 75% would have reported the error to the institution but only 57% would disclose to the patient. Gallagher et al. report that 98% of the general physicians and surgeons in their study either agreed or strongly agreed that “serious errors should be disclosed to patients.” Yet only 58% overall had ever made such a disclosure, though the rates were 65-66% for surgeons. While it is possible that these physicians had fortuitously avoided errors in their own practice, this is unlikely, especially for surgeons where the potential for immediate and noticeable harm is greater. When viewing communication of error from the patient perspective, Blendon et al. also find that rates of error communication fall below rates of error incidence. In their nationwide survey of patients and practicing physicians, 42% of the public and 35% of physicians report that they or a family member had experienced an error in their medical care, of which 25% and 18% respectively resulted in serious health consequences. Of those reporting that they had experienced errors, only about one-third of both physician
and patient respondents had been notified of those errors by the health care providers involved. These studies reveal that aspirations regarding error disclosure exceed actions.

Exploring the Gap.

This thesis will examine the gap evidenced in public policy, ethics, and medical practice regarding the disclosure of medical error. Simply put, the question I will explore is this: if disclosure it is the right thing to do, the prudent thing to do, and is mandated by regulatory policy, why has the medical profession failed to implement this practice consistently? My search will draw upon extensive review of the literature regarding medical error, supplemented by confidential interviews I conducted with 8 practitioners from 4 institutions. In addition, I will draw upon my own observations from ethics consultations at a large academic hospital system as well as on my experiences as a patient and as a consultant in leadership and organizational change.

The most frequently suggested impediment to disclosure is fear of medical malpractice litigation. No doubt such risk aversion plays a role. However, as will be discussed in Chapter Five, physician reluctance to disclose is also evidenced in countries with less litigious climates than that of the U.S.

Some of the most prominent advocates for error disclosure posit that the key to more transparency lies in changing the culture of medicine. Truog et al in their new book, *Talking with Patients and Families about Medical Error*, state that:

Fundamental to the patient safety movement has been the insight that the current culture of medicine not only fails to promote quality improvement and safety but effectively impedes its development and progress. The strong historical emphasis
on personal responsibility has fostered the view that patient safety depends on ferreting out and eliminating the ‘bad apples,’ those who lack either the personal character or the knowledge to provide good medical care. This bad apple mentality has helped to create a culture of silence in health care regarding error.\textsuperscript{35}

The authors contend that this “blame and shame” culture has a chilling effect on disclosure. In this regard they are echoing sentiments expressed in the IOM Reports. While I would heartily concur that culture change is required to support error disclosure, I will argue that the cultural barriers are far more subtle and nuanced, going beyond blame.

Culture reflects deeply embedded shared meanings and norms, most of which exist outside the consciousness of the members of that culture.\textsuperscript{36} One core dimension around which meaning is framed is orientation toward the collective and the individual. The framers of the two IOM Reports cited herein are proponents of the quality movement, including process improvement and systems thinking. As such, they adopt the perspective that individuals are actors within a collective environment. While Leape and others acknowledge that medicine is unlike more mechanistically based industries such as aviation due to uncertainty in disease states and the “unpredictability of the human organism,”\textsuperscript{37} they nonetheless seek to alter the interactions within complex systems to gain mastery over that which is replicable, measurable, and thus controllable. The IOM Report II offers this description of the interaction between individuals and the system:

Health care systems are adaptive because unlike mechanical systems, they are composed of individuals – patients and clinicians who have the capacity to learn and change as a result of experience. Their actions in delivering health care are not always predictable, and tend to change both their local and larger environments. The unpredictability of behavior in complex adaptive systems can
be seen as contributing to huge variation in the delivery of healthcare. If such a system is to improve its performance – that is, improve the quality of care it provides – some of these actions need to be specified to the extent possible so they are predictable with a high level of reliability. Other actions are not specifiable because their relationship to outcomes is not well understood.  

Herein lies a paradox that is pertinent for the inquiry at hand. Complex adaptive systems (CAS) are comprised of individuals operating out of free will. Yet in order to intentionally improve the outputs of those systems, it is necessary to harness individual actions, redirecting them toward more predictability. This necessitates that individuals be willing to accept some level of personal restraint in service of collective aims. From a cultural frame, Americans are more inclined toward individualism than collectivism. Interestingly, W. Edwards Deming, considered by many to be the father of the quality movement, could not find an audience for his theories in the U.S. and thus introduced his pioneering techniques first in Japan, a much more collectively oriented culture. As a result American automobile manufacturers fell considerably behind their Asian competitors in quality and market share. I submit that physicians are among the most individualistic segment of our culture owing to how they are selected and trained, a topic I will examine in more depth in Chapter Four. Further, their practice orientation is primarily dyadic – between patient and provider – rather than directed toward wider populations, as is the orientation of evidence-based medicine and patient safety. Thus proponents of error prevention are speaking what is akin to a foreign language to the practitioners who are charged with implementing preventive measures. Atul Gawande describes this dissonance:

This may explain why many doctors take exception to talk of ‘systems problems,’ ‘continuous quality improvement,’ and ‘process re-engineering.’ It is the dry
language of structures, not people. I’m no exception: something in me, too, demands an acknowledgment of my autonomy, which is also to say my ultimate culpability.  

While collectivists speak of transparent systems, individualists think in terms of dealing with personal transgressions. The collective orientation is toward prevention of future mistakes, brought about through reconstruction of past acts viewed retrospectively with benefit of hindsight. By contrast, the clinician addressing error, whether focusing on his own feelings or on the dyadic relationship between him and his patient, is examining past acts – seeking strategies for coping with and managing the consequences of what has already happened. Moreover, these past acts are judged prospectively, meaning through the lens of what made sense at the time they were performed in light of circumstances and resources present at that time. The significant cognitive disparities between these collectivist and dyadic orientations impede acceptance of a transparent patient safety/quality culture by those who are immersed in the day-to-day practice of medicine.

Transforming culture, while attainable and potentially gratifying, is a challenge that few leaders have the courage to undertake. Essential to success is achieving alignment between the changes in beliefs and norms espoused by leadership and the core systems that influence and reinforce those beliefs, such as systems for communication; measuring and rewarding performance; engendering accountability; and selecting, rewarding, and training those who will carry out the institution’s mission. When there is misalignment – or dissonance – among these systems or between these systems and the larger environment in which an institution resides, culture change is undermined. I propose that the key to understanding the gap between policy, ethics and practice in the disclosure of medical error lies in understanding the dissonance – the myriad mixed
messages – received by the medical community. The practitioners with whom I spoke were struggling with the most basic of questions, such as how to define error and how to determine what to disclose when. These are not individuals seeking to conceal their mistakes; rather, they are well-intentioned physicians and nurses who want to “do the right thing” as much as they want to do things right. Yet they are swimming in a sea of mixed messages – from their institutions, from their profession, from society at large, and from within themselves. What follows is an exploration of these sources of dissonance.

Before embarking on this inquiry, I want to exemplify the process of ferreting out and correcting mixed message by eliminating from this thesis one small source of dissonance in the culture surrounding medical error. Language both serves and reflects culture in that it carries meaning. The vernacular term for communicating error to patients and their families is “disclosure.” Inherent in the meaning of this word is the concept of unveiling or revealing, a subtle reinforcement of the thought that there is something to be kept secret – which is incongruent with the desired state of transparency. Thus, going forward I will speak of “communicating” or “conveying” error, except when citing the work of others who employ the term “disclose.” This is consistent with the recommendations of the American Society for Healthcare Risk Management (ASHRM) and with the convention observed by Truog et al.41
CHAPTER TWO

CONCEPTUALIZING MEDICAL ERROR

Defining Medical Error

Nowhere is the cultural dichotomy between the dyadic and the collective more evident than in the various conceptualizations of medical error. The patient safety movement seeks a definition of error that is concise, objective, and distinctly bounded to facilitate comparative studies and measurement of outcomes across many sites. In addition, errors that do not result in harm are of equal importance to those that do in the context of prevention, since today’s near miss could be tomorrow’s mishap. Systematic reporting of errors for the purpose of performance improvement requires a commitment to transparency.

By contrast, the practitioner’s focus is on “this patient,” and his central question is, “did I cause harm to this patient?” One physician in a study conducted by Gallagher et al. described this persistent self-doubt:

If something goes wrong with a patient…the things that come to the doctor’s mind are ‘Was it something I prescribed? Was it an instruction I failed to give? Did I do something wrong?’ You get that sinking feeling probably on a daily basis almost.42

Notions of causation are considerably more ambiguous in the physician’s experience than they are in the quality/patient safety arena. An obstetrician with whom I spoke provided the example of shoulder dystocia, a complication present in an estimated 0.15 to 1.7% of vaginal births.43 On its face, this would appear to be an adverse event caused by the
unique physiology of mother and baby – one for which the physician feels compassion, but not guilt. Yet, this physician is left with questions about the degree to which such an event may be predicted and how to determine when and if a Caesarean section is advisable. These factors may be within the practitioner’s control, thus leaving room for lingering doubt about agency. Another of my interviewees pointed to the example of nosocomial infections, noting that it was impossible to determine whether a particular infection arose from a “hand washing defect” or some other cause. If from a failure to practice appropriate hygiene, the offender would never know that his actions, in particular, led to the undesired outcome. Other physicians with whom I spoke echoed this expansive concept of adverse events with accompanying uncertainty about causation.

Underlying the physician’s concept of medical error, particularly his view of himself in relation to error, is the question of preventability – a matter that is frequently not clear or even determinable. This uncertainty, which contributes to the physician’s anxiety about transgression, lies in stark contrast to the definable, measurable, rectifiable, collectivist, detached concept of error in the quality/patient safety community. Of course, also inherent in ambiguity is room for rationalization, which I will address in chapters to follow.

The conceptualization mismatch described above is captured in the IOM Report definitions of error and adverse events, as follows:

An **error** is defined as the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning).

An **adverse event** is an injury caused by medical management rather than the underlying condition of the patient. An adverse event attributable to error is a ‘preventable adverse event.’ Negligent adverse events represent a subset of
preventable adverse events that satisfy legal criteria used in determining negligence (i.e., whether the care provided failed to meet the standard of care reasonably expected of an average physician qualified to take care of the patient in question).45

By narrowing the definition of an adverse event to those caused only by medical management, the IOM has created a communication gap with physicians for whom the adverse event universe is more encompassing, extending to all unexpected undesirable outcomes. The IOM’s mission would have been better served by embracing a definition of adverse events more in alignment with the physicians’ perspective. Also, use of the term “medical management,” which includes both medical intervention and surrounding system performance, further reinforces the impersonal “corporatization of medicine,” which many members of the medical community find alienating.

Banja proposes that the concept of intentionality be removed from the definition of medical error; he would substitute a “standard of care” (SOC) test, meaning that error would be found only in cases where the SOC is breached. He offers a definition that he posits is more consistent with the practitioner point of view: “An error is an unwarranted failure of action or judgment to accommodate the standard of care”.46 Gallagher et al. confirmed that physicians typically define error as deviation from accepted standards of care.47 This conceptualization also comports more closely with legal constructs of negligence. Within the medical malpractice liability arena, a claim of negligence must be supported by evidence that the physician provided care that fell below the SOC provided by other physicians practicing in the same specialty.48 There are, however, drawbacks to employing the SOC in defining medical error. First, standards of care are often no less ambiguous than determinations of causation, as exemplified by offsetting expert witness
testimony in litigation. Secondly, standards of care are often sluggish in responding to advances in medical practice. Lastly, using a definition of error that coincides with the definition used in litigation can erroneously convey that error and negligence are synonymous, reinforcing already problematic and unpleasant associations for physicians. I will examine this relationship between medical error and litigation more extensively in Chapter Four.

Myriad other definitions of error exist, exhibiting variations on the themes noted above. Kaldjian et al. state: “We use ‘medical error’ and ‘medical mistake’ interchangeably to describe a preventable adverse event that affects a patient by prolonging treatment or causing discomfort, disability, or death.”49 This injury-dependent definition would not be favored by the quality/patient safety community for its failure to recognize “near misses,” defined by the Quality Interagency Coordination Task Force (QuIC) as, “an event or situation that could have resulted in an accident, injury, or illness, but did not, either by chance or through timely intervention.”50 Wu et al. suggest another definition: “We define a medical mistake as a commission or an omission with potentially negative consequences for the patient that would have been judged wrong by skilled and knowledgeable peers at the time it occurred.”51 This definition, while not injury dependent, raises the SOC limitations noted earlier. The University of Michigan employs this definition: “A medical error occurs when a patient is injured as a result of medical care that was unreasonable under the circumstances.”52 Boothman et al. add: “Caregiver decisions, in hindsight, may turn out to be wrong, and an error indeed may have been ‘preventable’ or ‘avoidable;’ however, acting prospectively, one could still say that the caregiver behaved reasonably.”53 I find this to be a common sense definition that
may hold appeal for clinicians in that it removes the hindsight bias present in public
determinations of error based on causation and preventability, if not from personal doubt.
Further, it has been employed with documented success at Michigan, as will be described
in Chapter Four. Still, like the Wu et al. definition, it is injury dependent.

Patients express yet another, decidedly more expansive, view of error. Gallagher
et al. find that patients, even when presented with a standardized definition, conceptualize
“error” as including poor service (e.g., long wait times for a routine procedure), non-
preventable adverse events such as a previously unknown drug allergy, and deficient
interpersonal skills, in addition to deviations from the standard of care. Furthermore,
patients express a desire to be apprised of all errors that caused harm, even if the harm is
trivial.

The above review of definitions reveals that no single construct will satisfy all of
the aims of clinicians, quality and patient safety professionals, the legal community, and
patients alike. The dissonance that clinicians experience surrounding communication of
error begins at this very fundamental question: what do we mean by error? If the aim is
improving the safety of the healthcare system, including prevention of potential future
adverse events; errors will encompass any act of planning or execution that does not
achieve its intended result, regardless of consequences to the patient. If the aim is
ascribing legal liability, errors will include only those where injury has arisen from
actions that are judged unfavorably by comparison to other able practitioners. If the aim
is satisfying patients, errors will include service criteria in addition to health outcomes.
With so many definitions in use, there is little guidance for practitioners in what constitutes error for the purpose of communication to patients and families.

Truog et al. use the model in Figure 1 below to depict the relationship between adverse events and errors. Using the IOM definition for adverse events, meaning events caused by medical management; this diagram conveys that most adverse events are not caused by error. Likewise most errors do not cause adverse events. In fact, most errors go undetected. These include, for instance, errors in diagnosis, failures of preventative measures, or systems errors that are unnoticed because their consequences are distanced in time or masked by other conditions. Errors that are noticed but that do not cause harm, either by fortuity or by timely intercession, are called “near misses.” While a useful depiction, this model incurs the limitations of the IOM definition of adverse events, which does not coincide with the more expansive way in which clinicians conceptualize adverse events. Nor does the Truog et al. model convey the ambiguity which they acknowledge to be present after an adverse event occurs. The authors observe: “In the immediate aftermath of an adverse event, clinicians commonly cannot know whether the event was the result of an error. [Exceptions to this include a relatively

Figure 1: "The relationship among adverse events, medical error, and near misses" – Truog et al. at 13
small set of obvious errors, such as wrong site surgery)…Initial impressions are almost always incomplete and sometimes completely wrong.” Consequently, they acknowledge conflation of the terms adverse event and error throughout their book, saying: “[W]e tend to lump these concepts together because, for purposes of disclosure, they are typically handled in the same way.”

I propose an alternate model below in Figure 2 to help practitioners understand the relationship between adverse events and medical error, with the aim of guiding discussion about what should be communicated to patients and families when an adverse event occurs. By explicitly situating adverse events caused by the conduct of medical treatment within a larger universe of adverse events, I have attempted to mirror the conceptualization of adverse events commonly used by practitioners. Thus I would define an adverse event as “any unexpected undesired health outcome, whether arising from the underlying condition of the patient or from the conduct of medical treatment.” I use “conduct of medical treatment” as synonymous with the IOM’s term “medical
management,” encompassing both the practitioners’ treatment actions and circumstances in the larger system that surround and influence the conduct of that treatment. This diagram is intended to depict the murkiness described by physicians in the often undeterminable boundary between those events that are caused by medical treatment and those that are naturally occurring. It also conveys the blurriness found in determining whether the adverse event is attributable to error.

Physicians routinely convey to patients adverse events (AEs) caused by the patient’s medical condition or the patient’s unique physiology. They are less inclined, as discussed in the Introduction above, to communicate errors. Sometimes this reluctance extends to implying that the error was an expected outcome or to portraying an AE caused by error as if it were caused by the natural progression of illness. Such is the case when a physician, after failing to monitor potassium levels following initiation of a new drug regimen, explains the patient’s resulting tachycardia by saying: “Your potassium level got too high, which led to a dangerous heart rhythm.” By depicting AEs caused by the conduct of medical treatment within wider universe of AEs, Figure 2 conveys a bias toward treating iatrogenic AEs – including those caused error – in an equally transparent manner. Like Truog et al., I agree that initial conversations surrounding AEs and errors are approached similarly, as the cause of the AE may not yet be known. In the event that an error is unambiguously determined to have occurred, communication with patients and families takes on additional elements, the essentials of which will be detailed in Chapter Three.
Types of Medical Error

Errors occur throughout the continuum of care and throughout the healthcare system. The IOM Report categorizes errors as follows.\(^{58}\)

Diagnostic
- Error or delay in diagnosis
- Failure to employ indicated tests
- Use of outmoded tests or therapy
- Failure to act on results of monitoring or testing

Treatment
- Error in the performance of an operation, procedure, or test
- Error in administering the treatment
- Error in the dose or method of using a drug
- Avoidable delay in treatment or in responding to an abnormal test
- Inappropriate (not indicated) care

Preventive
- Failure to provide prophylactic treatment
- Inadequate monitoring or follow-up of treatment

Leape et al. add to the above several system errors, including factors such as defective or unavailable equipment or supplies, inadequate monitoring systems, inadequate reporting or communications, inadequate training or supervision of physicians or other staff, inadequate staffing, and inadequate functioning or scheduling of a hospital service.\(^{59}\) As will be discussed below, it is not uncommon to find several of these factors present within a single case. Often practitioners, however, do not recognize many of these as errors. Cook et al. found that most respondents in their study; when presented with case studies illustrating errors caused by treatment delays, use of outmoded treatments, failure to conduct needed diagnostic tests, failure to act on test results and failures to communicate; did not classify these events as “errors.” Instead, they used terms such as
“practice variances” or “unfavorable outcomes.” This may affect willingness to report errors internally more than willingness to communicate adverse events to patients. Yet, as will be discussed in Chapter Three, patients expect a full and transparent explanation of causes leading to adverse outcomes.

Origins of Medical Error

Thus far I have portrayed the IOM reports as reflecting a tone that does not resonate well with physicians. This is particularly unfortunate because the systems approach offers invaluable insights about the origins of error. Incidents once thought to be solely caused by clinician error can now be understood to have been caused or compounded by inadequately designed systems. Smetzer et al. report on the case of Julie Thao, the Wisconsin nurse who erred by infusing into her 16-year-old patient’s peripheral IV line a solution that was intended only for epidural administration, resulting in the patient’s death. This case gained widespread public attention when Ms. Thao faced criminal charges for her actions. According to Smetzer and colleagues, the root cause analysis that was performed in this case by an external consultant team found four proximate causes for the unfortunate event, resulting in nineteen recommendations for the hospital system. These included things such as relabeling to make confusion of the solutions less likely, requiring that epidural medications be ordered only by the anesthesia staff, and recommendations to improve holiday staffing to reduce fatigue (as Ms. Thao had worked a double shift followed by only six hours rest). In another highly publicized case, 17-year-old Jesica Santillan received a heart-lung transplant with mismatched organs at Duke University Medical Center. Though the transplant surgeon absorbed much of the negative publicity for this error, there were numerous opportunities
for others to have caught and prevented the error in the course of delivering these organs. The hospital has instituted a dozen checks and double-checks and implemented new technology to prevent such a tragedy in the future. In both of these cases, the systems in which these clinicians worked failed to help them avoid error. In HRO thinking, the more serious the potential consequences of an error, the more checks and balances need to be designed into the system to preclude the occurrence of such errors.

The IOM Report, referencing the work of James Reason, describes both individually-based and system-based errors. Errors of execution and errors of planning contained in the IOM definitions provided earlier in this chapter, can be further explained as “slips,” “lapses,” and “mistakes.”

- A slip is an observable error of execution, as in infusing the wrong IV solution. Leape adds that slips are unintended acts, often caused when attention is diverted and monitoring fails. Other examples of slips include failure to notice a change in a familiar pattern (capture error) or performing the correct action on the wrong object (description error).

- A lapse is an unobservable error of execution, as in forgetting the correct dosage of a medication. This includes “loss of activation” errors such as entering a room and forgetting the purpose for entering. These, too, can be caused by interruptions.

Both slips and lapses are vulnerable to diversions of attention. Leape notes that diversions can be caused by a variety of psychological factors including fatigue, alcohol or drugs, illness, “busyness” with other activities, and emotional states such as boredom, frustration, fear, anxiety or anger.
• A mistake is an error of planning due to incorrect assessment of the situation or inadequate knowledge, as in selecting the wrong drug because of an incorrect diagnosis. Several cognitive processes can contribute to commission of knowledge-based mistakes. These include “biased memory,” which can involve either overgeneralization from what is common or overemphasis on what is unusual; “availability heuristic” in which there is a tendency to rely on information that first comes to mind; “confirmation bias” in which one seeks confirmatory evidence, ignoring contradictory data; and “overconfidence” in a selected course of action.

One such case of ignoring contradictory data was offered by a physician fellow I interviewed whose diagnostic error led to the death of a premature infant. The physician was called to the NICU at 2 a.m. because of leakage in the baby’s nasogastric tube. While leakage is not uncommon, this incident was concerning in that the leakage appeared to contain fecal matter. He ordered a scan, and it indicated that there might be a bowel perforation; but the child had no other accompanying signs or symptoms. Thus a perforation did not make sense clinically and the fellow had been told repeatedly to treat his patient, not the tests. He opted for watchful waiting, not wanting to put this infant through more painful procedures, and asked to be called if conditions changed. A few hours later, the clinical indicators of infection had appeared, but too late to be addressed. The fact that the child, born at thirty-four weeks, had multiple comorbidities and a questionable prognosis for survival did not assuage this physician’s sense of guilt. He said, “I didn’t miss the signs; I dismissed the signs – which is so much worse.” He added, “I will never, ever forget this.”
Another useful concept in understanding the origin of errors is the distinction between active errors and latent errors.\footnote{69}

- **Active errors** occur at the level of the person performing the action and are typically felt immediately, as in administering an incorrect medication.

- **Latent errors** are removed from the person performing the action, as in poor design, faulty maintenance, inadequate staffing, etc. Leape describes these as “accidents waiting to happen”\footnote{70} and their solutions are systems solutions.

Most errors will entail some combination of the above. Such was true in both the Julie Thao and Jesica Santillan cases. Leape passionately observes:

The transforming insight for medicine from human factors research is that errors are rarely due to personal failings, inadequacies, and carelessness. Rather, they result from defects in the design and conditions of medical work that led careful, competent, caring physicians and nurses to make mistakes that are often no different from the simplest mistakes people make every day, but which can have devastating consequences for patients. Errors result from faulty systems not from faulty people, so it is the systems that must be fixed. Errors are excusable; ignoring them is not. \footnote{71}

Regrettably, this message of absolution from personal failing is lost on many physicians. Because it comes from the other side of the individuality/collectivist divide, it is not recognized or reinforced by the culture of medicine, as I will discuss in Chapter Four. Still, the ability to recognize the systems components of error becomes essential in constructing an ideal error communication process, as most patients want assurances that errors have been fully investigated and preventive measures installed. However, before turning to the content and process of error communication in Chapter Three, I will first
explore in Chapter Two the moral considerations underlying why medical error *should* be communicated to patients and their loved ones.
CHAPTER THREE

MORAL FOUNDATIONS OF MEDICAL ERROR
COMMUNICATION

Introduction

In my Introduction, I discussed the reluctance of physicians to embrace the trend toward openness in the communication of medical error. A variety of reasons has been advanced for this ambivalence, many of which will be explored in depth in subsequent chapters. Common to these communication barriers are perceived threats to the communicator’s self-interest – from sources such as litigation, loss of future patients, reduced earnings, institutional sanctions, and personal psychological distress. Other practitioners, however, choose to communicate errors even in the face of such threats. What propels some toward openness where others remain silent? And, from a moral standpoint, what should be the posture of practitioners toward communication of medical error? I will begin with a brief overview of moral philosophy relating to truthfulness more generally and then consider how truthfulness has evolved in medical professional ethics. Finally, I will examine communication of medical error as viewed through various schools of thought in contemporary bioethics.

Defining Truthfulness

I begin by distinguishing between “truth” and truthfulness. Truth, as is commonly observed, lies in the eye of the beholder. The complex derivations of truth are not the subject of this inquiry. Of far more interest from a moral standpoint is how
one employs one’s own “truth.” One can assert something in the sincere belief that it is true when it is not. On the contrary, one can offer a true statement in a manner intended to deceive. For instance, one seasoned physician whom I interviewed shared the story of an error “disclosure” he observed during his surgical residency. His chief resident advised a family member about the need for additional surgery following a retained sponge incident by saying: “That sponge has done its job and now it’s time to remove it.” Technically speaking, this was not a false statement; but it was clearly intended to deceive.

Still, one need take care when evaluating truthfulness. It can be tempting to assume that the person who sincerely believes his statements to be true is morally superior to the deceiver. Yet would we draw that conclusion if the former were a research scientist who could faithfully defend his conclusions only because he had purposefully avoided other points of view that might challenge his cherished theory, and the deceiver was protecting another from an assailant? Not surprisingly, moral theorists do not agree as to how these actors should be judged.

The definitions offered here will not provide an answer to the question posed above. Rather, they establish a common language that will be useful in observing the landscape of moral theory. “Truth” can be an elusive quality, and “telling the truth” does not necessarily ensure laudable aims without intention to deceive; therefore, truthfulness is often defined in its breach. Untruthfulness, characterized by lying and deception, brings moral issues into sharper focus. In order to facilitate comparison of moral theories in the sections to follow, I will adopt the definitions offered by Sissela Bok in her book *Lying*. She narrowly defines a *lie* as “any intentionally deceptive message which is
stated.”72 This is a clear act of commission. **Deception** is a broader category that includes any attempt to mislead, including gestures, facial expression, omissions, failure to correct erroneous impressions, and the use of truth to create a false impression. Lying, too, is included in the more expansive category of deception.

There appears to be agreement among moral philosophers that I not need share every thought that crosses my mind in order to be considered an honest person. And, there is agreement that at some point my withholding information could migrate into deception. By defining deception broadly as any attempt to mislead, the boundary of honesty becomes clearer, though not entirely distinct. As will become evident below, while untruthfulness may be more easily characterized than truthfulness, it is far from morally unambiguous.

**Philosophical Accounts of Truthfulness**

While an in-depth review of the moral philosophy pertaining to truthfulness is beyond the scope of this thesis, I will endeavor to describe the polar ends of the spectrum of philosophical thought. To set the stage for this inquiry, I ask the reader to imagine a society utterly devoid of truthfulness. With deception as the norm, nothing is as it appears. No assertions can be relied upon. No promises or contracts are honored; nor are they enforceable. One need not extend this thought experiment very far before realizing that a society whose members cannot count on each other to be truthful is not sustainable — not socially, economically or politically. Beyond truthfulness itself, what sustains the social fabric is the *expectancy* of truthfulness which, when relied upon, engenders trust.
This suggests the question: would a society devoid of deception be equally unsupportable?

Broadly speaking, moral philosophers fall within two camps with regard to deception – those who unequivocally reject lying in all circumstances and those who recognize justifiable exceptions. Catholic theologian St. Augustine espoused the belief that all lies were to be considered sins against God, a philosophy that ultimately proved untenable for the church. In order to comply with the spirit of this dictum, though arguably not the letter, subsequent theologians created a number of conventions to circumvent Augustine’s hard line approach. Aquinas developed a schema for pardoning some lies – those being officious lies, which were considered to be helpful lies, and jocose lies, which were employed in jest. Only lies told for malicious purposes were deemed unpardonable. Grotius devised a circumvention by which not all lies were to be treated as lies. Using a rights-based rationale, he argued that morally bereft individuals, such as robbers, give up their right to receive truthful information.

Perhaps the most controversial device developed by the Church to circumvent the absolute proscription against lying was known as “mental reservation.” Under this construct, misleading statements were permissible so long as the deceiver mentally “covered his tracks” with a qualifying statement uttered only in one’s mind. Thus in response to a patient’s concerned question, “Is my condition serious?” a physician might reply, “You’re doing fine,” with the mental reservation, “for one as gravely ill as you.” The underlying intent of the mental reservation was to serve beneficent purposes, such as protecting a patient from worry or deceiving a thief. However this device also provided a convenient source of rationalization for those seeking to justify duplicitous behavior.
Also falling in the absolutist camp is Kant, who described truthfulness as “an unconditional duty which holds in all circumstances.” He held that lying undermined not only the dignity of the person being lied to but the dignity of the liar as well. Yet even Kant was not above deception. Jackson reports an incident wherein Kant was chastised by King Wilhelm II for having threatened Christianity with his lectures. In reply he promised to desist, “as your Majesty’s loyal subject;” knowing that censors would take this to mean a permanent forbearance. Kant later explained that he used the phrase “as your Majesty’s subject” as a calculated qualifier, knowing that the king did not have long to live. He had never intended to renounce his freedom of speech indefinitely. This act seems analogous to the mental reservation exception escape clause supported by the Church. Kant, too, held that truthfulness is not owed where it is not expected, as when a thief asks a victim where his money is kept. Thus even for Kant, the strict prohibition against lying proved impracticable in daily life. Those theorists who espoused such an absolutist stance required a narrow view of what constitutes a lie to hold true to their prohibitions, thereby leaving open the broader construct of deception as permissible under some circumstances, subject to interpretation either by the Church or by the individual himself.

Not all moral theorists adopted such an absolutist stance toward lying. Aristotle clearly advocated for truthfulness, describing lies as “base and reprehensible.” Yet he distinguished between those that were particularly shameful and those that were tolerable or merely foolish. Among those in shameful category were false promises, perjury, slander and falsely accusing others, the distinguishing characteristic of these untruths being the desire to gain unjust advantage over others. He also held as blameworthy
exaggerations used solely to gain an argumentative advantage. By contrast, falsehood in
the form of boastfulness might be considered shameful if employed to enhance
reputation, but only when used to secure commercial benefit. Zebaty offers persuasive
evidence that Aristotle deemed justifiable lies that were offered to protect either the
public welfare or the well-being of a friend.\textsuperscript{81} Both Aristotle and Plato, not unlike Kant,
found a consequence of lying to fall upon the liar himself; Plato observed:
"Untrustworthy is the man who loves the voluntary falsehood and senseless is the man
who loves the involuntary falsehood. Neither of these is enviable; for everyone who is
untrustworthy or ignorant is friendless."\textsuperscript{82}

In a more contemporary vein, Dietrich Bonhoeffer, having participated in the
German Resistance movement against Nazism, was more acquainted than most with the
use of lying to protect others. Accordingly, his beliefs about truthfulness lie in the
nuanced camp, with reliance upon context and the nature of relationships. He observes,
"The more complex the actual situations of a man’s life, the more responsible and the
more difficult will be his task of ‘telling the truth’… But the simple fact is that the ethical
cannot be detached from reality, and consequently continual progress in learning to
appreciate reality is a necessary ingredient in ethical action.”\textsuperscript{83} He offers the example of a
child whose teacher asks him in front of the class whether it is true that his father comes
home drunk. Wishing to protect the family, the child lies by answering in the negative.
Bonhoeffer chastises the teacher for having placed the child in such a position, and
asserts that the child’s lie conveyed the truth that the family institution was to be
protected. He has harsh words for those who take an absolutist approach against lying,
asserting, “It is only the cynic who claims ‘to speak the truth’ at all times and in all places
to all men in the same way, but who, in fact, displays nothing but a lifeless image of the truth. He dons the halo of the fanatical devotee of the truth who can make not allowance for human weaknesses; but, in fact, he is destroying the living truth between men.”

Despite having argued for this more nuanced view of truthfulness, he is not unaware of its moral hazards, recognizing that it can lead to rationalizations which eventually undermine the essence of truthfulness. He declines, however, to abandon his position; instead he advocates that critical discernment will serve to mitigate this concern.

The difference between those who espouse an inviolate proscription against lying and those who do not is the latter’s willingness to acknowledge exceptions without relying on contrivances, such as the mental reservation, that can prove to be as deceitful as a lie itself. Bok summarizes the more expansive position this way: “Lying requires a reason; while truth-telling does not.” Still, knowing these two postures offers little guidance about how to construct the reasons needed to justify lying. A utilitarian perspective suggests that the answer lies in weighing the detrimental and beneficial consequences produced by the untruth. Is this not what Aristotle did in justifying lies to protect another? Or what Kant did in deciding that deception was preferable to incurring the church’s wrath? Such reasoning is likely to figure into the calculus that most individuals employ when deciding whether or not to be truthful.

Yet this consequentialist approach is deficient in several respects. First, few moral dilemmas are so uncomplicated that all of the relevant consequences will be readily apparent, and often it is the unintended consequences that are most detrimental. Such would be the case when a physician fails to give timely disclosure of an error that is later exposed, leading family members to avoid future treatment for potentially life-
threatening conditions. Such thinking is evident in the video *When Things Go Wrong*, produced by CRICO/RMF, the patient safety and medical malpractice insurer owned by and serving the Harvard medical community, to capture the voices of actual patients who have been harmed by medical error and their family members. One family member said, “After this whole experience, I really lost faith in our overall medical system.” Another family member was reluctant to speak up during care: “I was frightened to complain anymore. Scared that, you know, you hear stories about being mistreated in the hospital.” Yet another said, “For me to go back to the hospital again, I would have to be unconscious.”

I personally witnessed this experience-based avoidance behavior in a patient I observed being interviewed by a first-year medical student. No one had been able to understand why the patient, a woman in her 80’s, had for years ignored her primary care physician’s request that she undergo diagnostic heart monitoring to help determine the source of her light headedness and occasional blackouts. Not until the student did an extensive medical history, revealing that the patient had years ago experienced a bowel perforation during a hysterectomy with subsequent serious infection for which she never received an explanation from the surgeon, did it become apparent why this patient had avoided subsequent hospital care.

Another weakness of the consequentialist approach is that it leaves evaluation of consequences to the potential deceiver, subject to his beliefs and biases. Hence the potential for self-serving rationalization looms large, as it would, for instance, with the physician seeking to protect himself from litigation. If, in his analysis, he were to assign substantial weight to this consequence, the patient’s needs for financial recompense would carry comparatively little import. Lastly, often excluded from the potential
consequences considered are those that reside within the deception itself, such as those that befall the liar or a relationship in which trust is breached. Given these flaws inherent in the subjective weighing of consequences, one can see why some theorists thought it tempting to eschew all lies.

If the absolute proscription against lying is impracticable and the consequentialist approach toward lying is vulnerable to bias and rationalization, what is left? Bok suggests that the answer lies in subjecting the consequentialist calculus to a publicity standard. The publication test proposed by Bok requires the one who is weighing the consequences of an untruth to consider whether the preferred course of action would be “capable of public statement and defense” in the eyes of “reasonable persons.” Included in her proposal is something akin to the “golden rule” in that she would expect these reasonable persons to consider whether they would tolerate the deceit upon themselves. I find Bok’s proposal persuasive as a means for overcoming the bias problems within the consequentialist approach. Typically, a liar does not want to be the victim of a lie. However, the publicity test would not address the problems related to unforeseeability because consequences that are not imagined cannot be considered in light of public opinion. Nor would a publication test address harms to the potential liar himself, such as guilt or loss of self-respect, as these are not a public matter. I can imagine no source to address these two concerns other than reliance on the virtue of honesty as a foundation that guides truthful actions. In contrast to the utilitarian view in which truthfulness serves an instrumental role and is thus vulnerable to expedient self-interest; the virtue of honesty is intrinsically derived, demanding constancy even when inconvenient or uncomfortable.
Such constancy need not, however, demand absolute adherence when deception may benefit others.

When I asked physicians how they learned about the importance of disclosing errors to patients, their answers revealed intrinsic foundations. I heard things such as: “It came from a person-to-person culture of humility transmitted through my father.” This physician, a surgeon, then recited a poem for some ninety seconds that celebrated the virtuous doctor – a poem given to him by his father upon graduation from medical school. Another physician relied on his deep religious faith as his moral compass. Others said they were not consciously aware of the source; for them it was a defining quality of character. One said, “It’s in your DNA.” From their responses, it was clear that honesty was a duty these practitioners owed to themselves as much as to others. To be a person worthy of trust was as important to them as the trust their actions engendered.

As noted above, I would not hold the demands of virtue to be unconditional. Such absolutes are impracticable. Medicine, for instance, recognizes a narrow therapeutic exception, permitting the withholding of medical information from a small category of emotionally fragile patients or from those with particular cultural beliefs – patients who would be more harmed than helped by such information. Thus I advocate that truthfulness be considered a presumptive duty, relying on the Bok’s publication standard to offer guidance about justifiable exceptions. Additional light can be shed on the moral foundations of truthfulness by exploring professional ethics and contemporary bioethics.
Truthfulness in Medical Practice

Truthfulness in medical practice did not gain favor until the last century. The ancient medical texts attributed to Hippocrates, while not condoning lying, encouraged concealment, saying that one was to reveal “nothing of the patient’s future or current condition” while attending to him. Plato was more explicit, condoning deceit when needed to gain a patient’s cooperation. Eighteenth century medical philosophers likewise promoted the use of deceit when they deemed it to be in the patient’s interest. John Gregory strongly discouraged telling a patient of his imminent death for fear of hastening it, though allowing that in some cases the poor soul might need time to get his affairs in order. He was unequivocal, however, about not revealing mistakes to patients, saying: “A prudential regard indeed for the patient’s safety may make it necessary to conceal any embarrassment or mistakes from him, lest it alarm him and lose his confidence.” Both Thomas Percival and Francis Hutcheson agreed that deceptively encouraging hopefulness was permissible to prevent a patient from becoming too discouraged. Ironically, Hutcheson reasoned that trust permitted deception rather than being eroded by it. He stated: “Wise men allow this liberty to the physician in whose skill and fidelity they trust. Or if they do not, there must be a just plea of necessity.” In the following century, Washington Hooker introduced an opposing view, recognizing that the loss of trust from deception may be worse than the effect of being told the truth. However even he allows that concealment may at times be necessary. The first AMA Code of Ethics, written in 1847, borrowed liberally from the works of Percival. Thus, not surprisingly, it stated: “Secrecy and delicacy, when required by peculiar circumstances, should be strictly observed.” It went on to suggest that the physician should not offer
“gloomy prognostications” in the belief that the words and manner of a physician might
themselves shorten the life of a sick person.\textsuperscript{92}

Richard Cabot stands out as one of the most forthright early proponents of
truthfulness in medicine. His 1903 article entitled “The Use of Truth and Falsehood in
Medicine: An Experimental Study” remains in use at many medical schools today. In it
he argues persuasively against the standard practice of the day in which bad news was to
be disguised or couched in euphemisms; and truth, if offered at all, was given only to
family members and then only if they were deemed able to handle it without ill effects of
nervousness or excessive worry. Though not absolutist in his views, Cabot asserted he
had learned through experience that patients and families had far more capacity than was
generally believed to assimilate unpleasant information, provided it was offered so as to
convey a “true impression.” By this he means that the physician should seek to
communicate his own understanding of the situation, with attention to the capacity of his
patients to assimilate the information provided. He adds: “[B]etter than either a
misleading half truth or a pleasing lie, is an attempt so to answer the patient’s question
that he shall see not only what he can’t do and can’t hope for, but what he can do and
what there is to work for hopefully.”\textsuperscript{93} Cabot also notes that the consequences of
deception can extend beyond the patient. He holds that a family member who is given
truth with the understanding that she is to conceal it from the patient will lose trust in
subsequent information given to her about her own health. Beyond this, Cabot reasons
that the widespread use of falsehood in medicine had the potential to undermine the
moral fabric of a community, likening it to the unleashing of a poisonous gas. He
observes: “If we cannot trust one another, we cannot take a step in any direction.
Business, social relations, science, everything worth doing depends on mutual confidence. It is the very air we breathe. To poison it is to do a far worse thing for society than could result from the loss of a single life. So that though I believe that it is extraordinarily rare to be able to save a life by a lie, it seems to me that the remedy, the lie, is worse than the death.”

Cabot’s concept of giving a “true impression” adds a valuable dimension to the presumptive duty I proposed above. Moreover, his recognition of the broader societal impacts arising from deception suggests that there are systems consequences to be considered. While he does not specifically address the benefits of truthfulness in preventing harm to other future patients, one can imagine that he would have been a proponent of modern-day quality and patient safety efforts. This is evidenced by articles he published in JAMA in 1910 and 1912 reporting results of his review of over 3000 autopsies which revealed significant levels of diagnostic errors. Like Leape, Cabot does not blame individual physicians for these mistakes, saying the errors were representative of the state of medicine of his day. In return for his transparent public revelations about diagnostic inadequacy, he was threatened with expulsion from the Massachusetts Medical Society. Cabot was far ahead of his time by advocating for truthfulness in both dyadic physician-patient interactions and in improving the practice of medicine collectively.

More than one hundred years after Cabot, Pellegrino similarly espouses that trust and truthfulness are distinguishing hallmarks of medical professionalism. Inherent in this virtue-based rationale is a belief that the physician-patient relationship is characterized by vulnerability on the part of patients stemming from their lack of specific medical knowledge, necessitating dependence on the physician’s knowledge and skill. Pellegrino
maintains that physicians are thus behooved to treat this dependence respectfully, subordinating self-interest to the welfare of their patients. He asserts that a relationship characterized by such power disparities cannot be sustained without the trust of the dependent party. As Hall notes, many today find these notions of dependency to be paternalistic and thus inconsistent with modern perspectives on patient autonomy and other rights-based constructs. He posits, however, that trust is essential to the physician-patient relationship for intrinsic as well as instrumental reasons. Hall et al. observe: “Intrinsically, it is the core, defining characteristic that gives the doctor-patient relationship meaning, importance, and substance – the way love or friendship defines the quality of an intimate relationship.” From an instrumental perspective, trust is considered important to information gathering and to patient willingness to engage in treatment.

Moreover, Hall notes that patients experience trust not only in the context of a particular physician relationship, but also with respect to provider relationships in general, to specific healthcare institutions, and to the institution of medicine. He suggests: “Thus one can visualize a three-tier model in which trust in an individual physician interacts with trust in a specific institution, and both types of trust relate to trust in larger social systems of science, medicine, commerce or law.” Hence a breach of trust by one’s own physician, as by being untruthful, can engender distrust in other physicians and in the hospital system in which the practice occurred and in the healthcare system at large, including insurers and manufacturers. Likewise, breaches by others within a system also have the potential to reflect negatively on an individual physician. This phenomenon is evidenced in the patient perspectives cited in the previous chapter. Of
course positive experiences of trust can positively influence expectations across this care continuum by creating a halo effect. The only way to safeguard the flow of trust across these three tiers is through an expanded view of one’s commitment to the truthfulness that engenders trustworthiness. It is not enough to consider one’s duty to one’s immediate patient; a physician must also consider how his actions may affect others in the system, including not only his own patients but other current and prospective patients within the system who could be beneficially or detrimentally impacted as a result of his actions. As an example, should a physician elect to conceal a medical error, he must consider not only the impact on his patient and the patient’s family but also whether his concealment forecloses the development of preventive measures that would benefit other patients – his and those of fellow practitioners. Further, he must consider how asking others to collude with his concealment will influence not only their commitment to truthfulness, but how his actions influence the system’s culture for truthfulness, which in turn will influence his colleagues’ future actions.

The connection between truthfulness and trust espoused from Plato through Pellegrino supports a normative foundation for openly communicating medical error to patients, at least presumptively. Bonhoeffer and Cabot offer that more important than absolute truthfulness, is conveyance of a truthful impression. Hall’s conceptualization of trust, like Cabot’s, supports a duty for truthful communication of error owing to individual patients, to institutions, and health care system – thus bridging the dyadic/collectivist divide.

In contrast to the 1847 iteration of the AMA Principles of Medical Ethics cited above, the current version reads: “A physician shall uphold the standards of
professionalism, be honest in all professional interactions, and strive to report physicians
deficient in character or competence, or engaging in fraud or deception, to appropriate
entities.” The duty for communication is stated more forcefully in a 2003 report by the
AMA Council on Ethical and Judicial Affairs (CEJA). The report states:

The medical profession’s stewardship of patient well-being is thus the ethical
foundation of the profession’s commitment to the prevention of patient harm
through error reduction. Additionally, the physician’s duty to deal honestly with
patients extends the ethical responsibility beyond error reduction to a duty to
relate the openness to patients who may have experienced harm.

Patients have a right to know their past and present medical status and to be free
of any mistaken beliefs concerning their conditions. Situations occasionally occur
in which a patient suffers 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.

Thus the CEJA endorses both a duty for communication of error to patients in the dyadic
context and to institutions in the collectivist, error prevention context.

**Contemporary Bioethics and Communication of Error**

Support for communication of error to patients can be found in virtually every
school of bioethical theory. From the principlist approach espoused by Beauchamp and
Childress, with which most practitioners are familiar, communication is grounded
primarily in respect for patient autonomy – respecting not only their personhood, but their
need for information to inform future decision-making. These authors affirm:

“[I]ndividual clinicians and institutions have an ethical responsibility to disclose
unanticipated negative outcomes. Respect for personal autonomy entails disclosure of
what occurred – even if no further medical decisions are involved – and of options to take
nonmedical actions, including legal actions, if appropriate.” Notably, Beauchamp and Childress emphasize that this ethical responsibility should be exercised even when it threatens self-interest. Arguably their principle of justice is also served when information is offered that enables patients to seek compensable damages. Additionally, beneficence is advanced to the extent that communication avoids exacerbation of harm through silence. As stressed in the CRICO/RMF video: “Incomplete communication created more stress and more concern.”

The casuist approach advocated by Jonsen et al. is also popular with many physicians. Using the case of a retained sponge as his exemplar case, these authors contend: “A fundamental duty of respect for persons dictates that apology be offered the patient for harms of this sort. The surgeon should inform and apologize to the patient and report the error to the institutions, which also should apologize. Appropriate compensation measures should be taken… A climate of disclosure and honesty is necessary to maintain patient confidence and trust in the relationship with their physicians and with the health care institutions.” Thus advocates of casuistry, too, support both the dyadic and collectivist aims of disclosure, extending as well to admissions that will have known financial consequences. However, it should be noted that one of the drawbacks of casuistry lies in the subjectivity that influences the selection of exemplar cases.

From a rights-based perspective, communication of error is grounded in the patient’s right to respectful treatment and self-determination. This appears to be supported by Moskop et al. in their suggestion that expectations for error disclosure are similar to those underlying the doctrine of informed consent, adding errors to the list of
information that a reasonable person would want to know about their care. Likewise, from a duty-based perspective, error communication evidences the respect for patients that forms the fiduciary relationship between physician and patient. And, from a virtue-based perspective, truthfulness strengthens the communicator’s view of himself as a moral person. One physician I interviewed espoused a belief that informed consent is often interpreted as shifting responsibility to the patient, thus absolving the physician of responsibility. He posits that the duty to protect the patient should be paramount.

From the perspective of feminist bioethics, one would assert that the power differential inherent in the physician-patient relationship, together with more characteristically feminine traits such as empathy and concern for a patient’s emotional well-being in the aftermath of error, would demand that a truthful, open, sensitive explanation be extended to a patient who has been harmed. Bioethical scholars in the Judeo-Christian tradition support communication of error, but with the focus on repentance and seeking forgiveness of self, if not from the patient. Personally, I appreciate the eloquently simple statement from a medical student in the Kaldjian et al. study. Commenting on whether errors should be conveyed to patients, he says: “It boils down to just how you view other people. Do you view them as worthy of knowing?”

As might be expected, from a consequentialist school of thought, both harms and benefits may be anticipated from communication of error. Smith and Forster suggest several in both categories. Potential harms to patients include exacerbation of stress and loss of trust in providers and medical institutions. For clinicians, communication may heighten emotional stress and, as mentioned earlier, potentially threaten livelihood, reputation, referrals, practice privileges, and employment – whether or not litigation
ensues. However, on the benefit side, patients will be better informed and therefore better equipped for future decision-making. Communication promotes closure and provides information that enables patients to seek compensation for their harms. Benefits to physicians include a potential lessening of stress and preservation of self-respect. Berlinger and Wu note that while physicians should not expect forgiveness in exchange for disclosure; without acknowledgment and apology, forgiveness from patients is hardly possible. They caution: “To expect forgiveness without first disclosing, apologizing for, and making amends for one’s mistakes is to expect what Christian theologian Dietrich Bonhoeffer disparagingly calls ‘cheap grace.’”¹¹¹

Narrative ethics may provide the most persuasive support for communication of error. The patient stories told in the CRICO/RMF video offer poignant portraits of the harms caused not only by error, but by how error is managed. More than one family member experiences substantial lingering guilt, believing that she should have done more to oversee her injured family member’s care. One reports: “I feel like I didn’t ask the right questions… I didn’t do enough to help him.” Another says, “When he suffers, I suffer; the kids suffer; the grandkids suffer… Six people suffer.”¹¹² Physician narratives are equally compelling. Perhaps the most well-known of these is Daniel Hilfiker’s essay, “Facing Our Mistakes,” first published in the New England Journal of Medicine in 1984. He speaks of the devastating psychological pain associated with his termination of a live thirteen-week pregnancy that he mistakenly believed was necessary to clear an incomplete miscarriage. This diagnostic error arose because he was reluctant to make his rural patient seek ultrasound in a larger city some distance away when repeated pregnancy tests came back negative, despite the patient’s having missed several periods.

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Hilfiker, an advocate for open communication to patients and family members, recognizes that while this may preserve one’s self respect, it does not necessarily alleviate psychological pain. He reports:

Although I was as honest with the Dailys as I could be in those next months, although I told them everything they wanted to know and described to them as completely as I could what had happened, I never shared with them the agony that I underwent trying to deal with the reality of the events. I never did ask for their forgiveness. I felt somehow that they had enough sorrow without having to bear my burden as well. Somehow, I felt, it was my responsibility to deal with guilt alone. 113

One of the physicians with whom I spoke, also a gynecologist, told of having lost a baby to shoulder dystocia while a resident – the day after he failed to read up on the syndrome as directed by his attending. He spoke of the healing power of Hilfiker’s story, which helped him feel less alone in reliving his indelible memory. While other sources of ethical grounding offer guidance – almost unanimously – about what a practitioner should do in communicating error; they do not prepare him for the onslaught of feelings and recollections that both patients and practitioners experience and re-experience in the aftermath of an error. Stories are the currency of a culture, embodying the beliefs and norms that, often unconsciously, steer behaviors. Thus they can serve as a potent force for embedding and, when necessary, changing practice – touching the practitioner at the deeply personal level desired by Hilfiker, my interviewee, and others – while advancing the collective aim of promoting transparency.

Communication of error to patients and their families is widely endorsed in the fields of bioethics and medical ethics. Yet translation of theory to practice requires guidance to inform practitioners’ actions in individual cases. I propose that provider
uncertainty be resolved by recognizing a rebuttable presumption in favor of truthful communication to families and their loved ones, with exceptions justifiable only if they can pass the publication standard suggested by Bok. In other words, exceptions would be supportable only when withholding of communication would be considered acceptable by reasonable persons in the community at large who would be willing to have such information withheld if they were in the same situation as the patient or the patient’s loved ones. I will explore the application of this standard in the following chapter.
CHAPTER FOUR

ERROR COMMUNICATION

Patient v. Physician Perspectives

The practitioners’ dyadic orientation toward error moves to the foreground in the communication that takes place between the practitioner and the patient who has been harmed, or between the practitioner and the patient’s loved ones. Patients and physicians express differing views about what should be conveyed to patients and families when an error occurs. Gallagher et al. report that patients want a comprehensive explanation including: what happened, the implications for their health, why the error occurred, how the problem will be corrected, how future errors will be prevented, and what measures will be taken to ensure that they do not incur financial consequences. In addition, patients want an expression of apology that is sincere and empathic. Moreover, they want to be advised of all errors that produce harm, not only those that produce serious harm. In summary, patients want to be treated with openness, respect, and compassion.

Physicians, however, are less inclined to provide such full communication. In a subsequent study involving physician reactions to case scenarios, Gallagher et al. find that 3% of physicians would not disclose at all; 56% would offer a partial disclosure, meaning they would communicate the adverse outcome but not reveal that it was caused by an error; and only 42% would offer a full disclosure. The percentage of respondents offering full disclosure drops to 17-21% among surgeons, depending on how apparent the harm was to the patient. Interestingly, the full disclosure was more likely among this
group in cases of less readily apparent harm.\textsuperscript{117} In this same study, when asked how they would address giving an apology, 61\% of respondents said they would extend merely an expression of regret; only 33\% would offer a full apology.\textsuperscript{118} Thus physicians were considerably more guarded in their communication than patients would desire. Potential reasons for this cautiousness are many and will be discussed in the following chapter which explores mixed messages received by practitioners from their profession, their institutions, and from society at large.

Espin et al. find similar disparities between patient and practitioner reactions to case studies in a smaller Canadian study, though patients in their study are slightly less demanding than those in the Gallagher et al. research. Again, 3\% of physicians would not disclose error at all. Only 24\% would offer a full description of what happened together with attribution to error. 57\% of patients would want a full communication of error plus causation. Interestingly, 10\% of patients would agree that no disclosure should be given. One explains this by saying: “It could be upsetting, they will not understand this could happen to anyone with this case.”\textsuperscript{119} Lamb et al., in their national survey of practices at non-Veterans Administration hospitals, report that while 66\% of hospitals claim that they acknowledge harm and 68\% apologize, only 41\% promise to share the results of their investigation into the incident.\textsuperscript{120} Fein et al. also identify less than full disclosures in their study involving focus groups of clinicians and administrators at five academic medical centers who were asked to describe how they would communicate a hypothetical error. Only 27\% of the offered disclosures are described as complete in that they include an admission of error, explain all the causative factors, and link the causes to the harm produced. 21\% of the communications are described as “nondisclosures” in that
they make no reference to an error having taken place. The remainder are labeled “partial disclosures,” of which the authors found three types: (1) “connect-the-dots” disclosures in which there is failure to explicitly link cause and effect, leaving the patient to figure this out; (2) “misleading” disclosures in which the harm is portrayed as stemming not from error, but from the underlying medical condition: and (3) “deferred” disclosures wherein the known causes of the error might be suggested along with other possibilities needing further investigation.¹²¹

These studies confirm that clinicians continue to observe the admonition to keep a “cautious tongue” that was first issued in 1934.¹²² In so doing, they fail to fulfill what the majority of patients say they expect when error occurs. Moreover, patients do not want to pry this information out of their physicians; nor is it in the physician’s best interest to reveal pieces of the story only in response to patient or family interrogation. One patient in the CRICO/RMF video put it this way:

If I’ve gotta play games with some doctor who’s avoiding this subject or trying to pretend like something didn’t happen when I know darn well it did … that’s just bad all around. I mean, they lose credibility with me. I’m not gonna believe anything else this doctor tells me. I’m gonna grill him left, right, upside down and go get five other opinions, ‘cause if he or she isn’t telling me the truth about this, what else aren’t they telling me the truth about?”¹²³

Clearly trust erodes when a patient or family member is left to discover on his own what the physician has artfully omitted. These attempts at self-protection are perceived through the patient’s lens as deception.
Trust is also eroded in the face of silence. Berlinger offers this patient’s account of the aftermath of her brother’s death in the emergency department from unexplained causes:

Those that could give some answers hide behind the hospital doors. The hospital administrator, who attends church with my parents, offers no condolences. Is this the kind of person who is in charge of caring for their community’s health? We are able to forgive mistakes but not indifference, not denial and hiding.  

Imagine the frustration and confusion of families who have experienced an event that is so all-consuming to them, but which appears to go unnoticed by those with the power to explain it. This is more than abandonment. The silence conveys to families that their loved one was inconsequential, thus invalidating their suffering. Or as one patient in the CRICO/RMF video said: “It was like it never happened.”

Thus far I have focused on the content of error communications; however, vocal tone and body language are equally, if not more, important to conveying error effectively. While non-verbal actions are an essential element of all communication, they take on added importance when health care conversations are emotionally charged. An error communication that is received as mechanistic, routinized, or perfunctory will exacerbate an already painful situation. Empathy is often most called for when it is least likely to arise spontaneously, as when a patient is expressing anger toward a physician – a not improbable response in the case of harmful error. In a study comparing the tone of voice of surgeons who had been sued to that of those who had not been sued, Ambady et al. find that those judged to have a dominant tone of voice are more likely to have been involved in litigation as compared to those who were judged to be more empathic. Levinson et al., though not able to corroborate these findings for surgeons, similarly find
distinguishing characteristics between primary care physicians who have been sued and those who have not. The physicians without a claims history are judged to be friendlier and more likely to use conversation facilitators that encourage patients to speak more.  

In both the Ambady and Levinson studies, content was virtually irrelevant; what mattered was how the content was conveyed.

Anatole Broyard eloquently expresses his desire for connection with his physician in his book, Intoxicated by My Illness, musing:

I wouldn’t demand a lot of my doctor’s time; I just wish he would brood on my situation for perhaps five minutes, that he would give me his whole mind just once, be bonded with me for a brief space.

Patients who have been harmed through error could reasonably assume that, at some point in their care, they were so unseen or unacknowledged that a lapse was allowed to occur. In the aftermath of that harm, this feeling of invisibility will be exacerbated if the practitioner does not take extra care to ensure that the patient and/or his loved ones feel that they have the access to the practitioner’s “whole mind” for the time needed to communicate a thorough explanation of what transpired and why. Moreover, when a “wall of silence” is erected around error as so often happens, the patient and loved ones are shielded from the pain on the other side of the wall, the raw feelings that might convey humanity and build connection. One mother in the CRICO/RMF video observed: “Inevitably care givers protect their hearts, and sometimes opening up their hearts helps a patient a lot.”  

Jodi Halpern, author of the pivotal book From Detached Concern to Empathy, describes what she calls “clinical empathy” that supports a “heart connection” between practitioners and patients. This clinical empathy includes an
affective element of “emotional resonance” or “attunement” to others combined with a
cognitive ability to appreciate the patient’s experience from the patient’s point of view.\textsuperscript{132}
I assert that empathy, as defined by Halpern, is essential to error communication that
resonates with patients as sincere, compassionate, and respectful. Absent such empathy,
the words of apology are but words.

**Apology**

As noted above, most patients find the communication of error to be incomplete if
not accompanied by an apology. In fact, to exclude an expression of compassion and
remorse at such a poignant moment seems robotic – neither human nor humane, more
likely to engender than to assuage anger. Aaron Lazare, M.D., a former professor of
psychiatry at Harvard and Dean of the University of Massachusetts Medical School, has
written extensively on the subject of apology as a healing force for the both the aggrieved
(“offended party”) and those responsible for the offense (offender). He describes
apologies as being at once simple, yet complex.\textsuperscript{133} Their simplicity lies in the essence of
truthfulness, conveyed straightforwardly and purely without rationalizing excuses and
justifications. Their complexity arises from the multi-layered sociological factors that
influence decisions to apologize.

Attitudes toward apology are culturally embedded through language. The English
word for “apology” is notable in that it does not contain any element of guilt or blame, its
root being in the Greek *apologia*, meaning to justify or defend.\textsuperscript{134} By contrast, in other
cultures the linguistic concept of apology includes elements of contrition. Lazare
observes that the German phrase for “I apologize” contains the root word “*schuldig*”
which means guilt. Thus the literal translation of *entschuldige bitte* is “please take away my guilt.” Similarly, the Spanish *disculpar* includes the concept of seeking excuse from culpability. Lazare also points to Japanese culture wherein the purpose of apology is to restore the relationship. Consequently Japanese apologies often incorporate self-denigration and humility.136

Lazare holds that humility is an essential element of apology. Yet in American culture, “humility” is often interpreted as synonymous with meekness and self-effacement – merely the antithesis of arrogance. To the extent that humility is equated with weakness or lack of confidence, it will not be readily embraced by the medical profession, which is open only to those who graduate at the top of their class. Judith Andre explores the more nuanced moral underpinnings of humility, concluding that it reflects one’s ability to hold oneself in perspective relative to one’s circumstances.137 This conception of humility is not incompatible with confidence. One can, for instance, be “humbled” in recognition of one’s own aptitudes as well as one’s weaknesses. Thus in the context of medical error, Andre defines humility as, “the ability to recognize and be at ease with one’s flaws.”138 From this balance, in which humility and confidence can coexist, the practitioner can accept his human fallibility and make peace with himself without being distracted by his own anxieties when communicating with patients about errors. Halpern finds this balanced humility to be inherent in the ability to practice clinical empathy as she defines it.139

An apology holds the potential to meet one or more of the following patient and family needs identified by Lazare: “[T]he restoration of respect and dignity, assurances that they and the offender have shared values, assurances that they were not at fault,
assurances that they are safe from further harm by the offender, knowledge that the offender has suffered as a result of their offense, a promise of adequate reparations, and the opportunity to communicate their suffering and other feelings about the offense.”

On the other side of the wall, Lazare observes that those who apologize typically do so for one or more of these reasons, some of which are instrumental: “The first reason is their response to shame, guilt, and empathic regard for those they have offended. The second reason is their attempt to restore the relationship and to avoid further damage to the relationship, abandonment, retaliation, or other punishments.”

In order to facilitate fulfillment of these often divergent needs from both patients and practitioners, Lazare suggests that the ideal apology contain the following elements:

- **An acknowledgement of the offense, including details and validation that the behavior was unacceptable.** Lazare emphasizes that vague or conditional acknowledgements (as in “if mistakes have been made…”) or statements in passive voice do not constitute fulfillment of this element, which he deems to be the most important. Regrettably, such statements are all too common in the conveyance of error. Gawande describes the prevalence of passive voice to divert accountability in his surgical training: “No one screws up a cricothyroidotomy. Instead, ‘a cricothyroidotomy was attempted without success.”

- **An expression of remorse, shame, forbearance (meaning a promise to refrain from similar actions in the future), and/or humility that conveys acceptance of responsibility.** Lazare cautions that expressions of regret such as “I’m sorry
that you suffered…” do not fulfill this element as they deflect responsibility.¹⁴⁴

- **Some form of reparation.** Lazare claims that an apology is not complete if reparations are not offered when available and appropriate.¹⁴⁵

The danger in having a list such as Lazare offers is that those seeking quick absolution will employ it as an obligatory check-list. Without sincere empathy as described by Broyard, Halpern, and others; an apology will be perceived by those receiving it as a perfunctory act, motivated more by the self interests Lazare identifies – relief of guilt or curtailment of further damage – than by a desire to fulfill the aggrieved parties’ needs for reassurance and restoration of dignity.

**Error Communication Guidelines**

The Joint Commission’s posture on error is that patients should be informed of all outcomes of care, including unanticipated ones.¹⁴⁶ However no guidance is given on specific communication practices. This void is filled by the National Quality Foundation (NQF), a non-profit organization whose mission is to promote harmonization of national priorities and standards for quality improvement, including standards for measurement and reporting. NQF first issued explicit guidelines for communication of error to patients, families and caregivers in 2006, reissuing them in 2010.¹⁴⁷ Institutions are encouraged to apply these voluntary guidelines following the occurrence of a “sentinel event” as defined The Joint Commission,¹⁴⁸ a “serious reportable event” (SRE) as defined
by NQF, or any other unanticipated outcome that necessitates additional care. In such instances the response should include the following:

- The “facts” – an explicit statement about what happened that includes an explanation of the implications of the unanticipated outcome for the patient’s future health, an explanation of why the event occurred, and information about measures taken for its preventability;
- Empathic communication of the “facts,” a skill that should be developed and practiced in healthcare organizations;
- An explicit and empathic expression of regret that the outcome was not as expected (e.g., “I am sorry that this has happened.”);
- A commitment to investigate and as possible prevent future occurrences by collecting the facts about the event and providing them to the organization’s patient safety leaders, including those in governance positions;
- Feedback of results of the investigation, including whether or not it resulted from an error or systems failures, provided in sufficient detail to support informed decision-making by the patient;
- “Timeliness” – the initial conversation with the patient and/or family should occur within 24 hours, whenever possible. Early and subsequent follow-up conversations should occur, both to maintain the relationship and to provide information as it becomes available;
- An apology from the patient’s licensed independent practitioner (LIP) and/or an administrative leader should be offered if the investigation reveals that the adverse outcome clearly was caused by unambiguous errors or systems failures;
- Emotional support for patients and their families by trained caregivers should be provided;
- A disclosure and improvement support system should be established and maintained to provide the following to caregivers and staff that includes:
  - Emotional support for caregivers and administrators involved in such events by trained caregivers in the immediate post-event period that may extend for weeks afterward,
  - Education and skill building about the concepts, tools, and resources that produce optimal results from this practice, centered on systems improvement rather than blame, and with a special emphasis on creating a just culture,
  - 24-hour availability of advisory support to caregivers and staff to facilitate rapid responses to serious unanticipated outcomes, including “just-in-time” coaching and emotional support, and
  - Education of caregivers on the importance and technique of disclosure to care teams of errors or adverse events when they happen.
These guidelines share considerable commonality with Lazare’s guidelines for apology, including detailed explanation of facts, apology, and a commitment to take preventative measures, which could be considered a form of forbearance. While the guidelines explicitly endorse the use of generic expressions of regret, which Lazare finds to be ineffective for conveying a true sense of apology, the expression is envisioned to take place in the immediate aftermath of an event, before accountability can be determined. A full apology is to ensue should subsequent investigation determine, unambiguously, that errors or systems failures were responsibility for the harms. Such unambiguous conclusions are not always available, which may leave patients longing for an apology that never comes. In those cases, expressions of regret – offered in a heartfelt manner – may well suffice. Importantly, the guidelines suggest that communication surrounding adverse events is a process, not an event, by noting that additional information should be conveyed as it becomes available. Of particular note, recognition is given to the advisability of providing emotional support for patients and loved ones and for practitioners. NQF has provided a comprehensive approach, building on the best of expert opinions. I assert, however, that these recommendations should not be limited to the serious situations captured by sentinel events or SREs; rather they should apply in all cases where an unexpected undesirable outcome has occurred, including those of less harmful nature. Truog et al. agree, stating: “Since the cultural change that we’re trying to promote demands that transparency apply to all types of adverse events and medical error, disclosure should become standard practice for small as well as devastating errors.”\textsuperscript{151} This is consistent with patients’ expressed preferences, as noted in the previously cited study by Gallagher et al. Moreover, respect for patients, advancement of
trust, and other moral foundations for communication of error are not obviated by lesser severity.

Truog et al. offer thirty-four guidelines for error disclosure. In large measure, these are based on extrapolation from the NQF guidelines, with the addition of practical advice regarding implementation. Essential to their recommendations is reliance on the role of a disclosure “coach” who is trained in helping practitioners prepare for communication with patients and loved ones. They describe the scope of this role as follows: “While some health care organizations may choose to give coaches decisional authority in these situations, most seem to prefer a model that sees the coach in much the same role as a medical consultant. In other words, the role of the coach is to provide support, practical advice, and the informed perspective of someone who is not directly involved in the event… [S]ince almost all medical errors involve more than just one clinician, coaches should represent a cross-section of professional disciplines.” However the authors advise that, unlike other consult services, the coaching consult not be documented in the patient record. I agree that documentation could have a chilling effect on open exploration of all relevant issues, including potentially irrelevant ones that may not appear as such at first glance. In this respect, the coaching meeting mirrors event reporting that takes place in the aftermath of an error, and should likewise be excluded from future discovery in litigation.

These authors advocate that communication of adverse events requires prior planning, including the facts to be included, who should be involved in the meeting, who should lead the meeting, how support will be offered to the family, and who will be responsible for conveyance of facts that continue to emerge in the days and weeks to
follow, as will inevitably happen when the initial communication takes place in a timely manner. While communication by the involved providers is preferable, judgment needs to be exercised as to the size of the practitioner contingent, recognizing the potential to overwhelm patients or family members. Truog et al. counsel that on rare occasions, an involved clinician may be excused from the error communication because his presence would be more disruptive than helpful due to distracting dynamics within the treatment team or because he is “too emotionally distraught.” Gallagher estimates that such exclusions would be appropriate in less than five percent of cases.\textsuperscript{154} He also emphasizes the importance of having medical trainees involved in these conversations with patients and families, both as a learning experience and so that they can experience the healing to be derived for both patients and themselves.\textsuperscript{155}

Determination of error is often not possible at the initial meeting with patients or families. Truog et al. caution: “Risk managers warn that the first explanations of adverse events are frequently incomplete and sometimes completely wrong.”\textsuperscript{156} The authors also emphasize the importance of conveying all presently known facts in meetings with patients and families, asserting that no additional exposure to legal risk will be derived from conveying the facts as known and understood at the time. Risk can accrue, however, if known facts are later found to have been withheld.

Emphasizing the need for compassion and empathy, Truog et al. state that risk managers should be excluded from initial patient/family meeting to avoid conveying a loss-prevention intent when focus on the patient and the family are to be in the forefront for all involved. The authors recommend that matters of compensation be deferred until later conversations. This deferral will not satisfy patients for whom financial concerns
are a salient element of their vulnerability and anxiety. However, it would seem a practical approach for which there is little alternative given the ambiguity typically present in the early phases of error investigation. In the final chapter I will point to several successful models of error communication in which early compensation is a key component. Patients’ and families’ need for what and why in the aftermath of an adverse outcome require assurances that a thorough investigation will be conducted. This includes evaluation of compensation for care arising from events for which practitioners and/or the institution are responsible. Transparency, though necessary for sustaining trust, may not be sufficient to deter litigation by those who are inclined to be suspicious of the institution’s inherent financial conflicts of interest when investigating adverse outcomes. There will always be some individuals for whom no amount of information or compensation offered by the institution *sua sponte* is likely to satisfy. However, absence of transparency may serve to alienate those whose predisposition is toward trust.

Regarding apology, Truog et al. emphasize that compassionate empathy, including expressed sadness that an event has occurred, is always warranted. However, apology is appropriate only when investigation reveals that the event in question was “an avoidable consequence of a medical error.” They point out that it is just as ethically unjustifiable to accept responsibility when results remain inconclusive as it is to fail to accept responsibility for actions known to have caused harm – especially where acceptance of premature responsibility involves other actors. When the cause is unambiguously attributable to error, Gallagher et al. advocate that the words “error” or “mistake” be used when describing the incident to patients and families. Avoiding
these admittedly provocative words is likely to prompt the question, “What else aren’t they telling me?”

**Complexities**

Practitioner uncertainty surrounding error communication with patients and their families can arise in several situations. Here I will discuss five such circumstances: (a) whether to communicate the error in cases where error is determined to be the cause of an adverse event; (b) whether an adverse event is attributable to error; (c) whether to communicate that an error has occurred when its causative relationship to an adverse outcome is not readily apparent; (d) whether to communicate that an error has occurred when its connection to an adverse event is speculative; and (e) whether to communicate near misses. Truog et al. offer practitioners the following suggestions for resolving uncertainties about communication:

Two useful “rules of thumb” are that an event should be disclosed if, first, it may result in a change in medical treatment for the patient, now or in the future, or second, you would want to know about the event if it happened to you or a member of your family. At a more practical level, it is also prudent to disclose any adverse events that are documented in the chart, since patients and families have full legal access to the medical record and failure to discuss events described in the chart could be seen as an attempt to minimize or even conceal them.159

The first of these would be a form of materiality test, the second a version of the Golden Rule, and the third a preemptive measure. I suggest that these rules of thumb suffer from susceptibility to bias on the part of the decision-maker. With regard to the proposed materiality test, providers may, for instance, fail to recognize a patient’s interest in making decisions about future provider relationships or about seeking compensation – both of which could adversely impact the practitioner or the institution. In addition,
providers may not be aware of the extent to which patients, in the absence of facts, create speculative generalizations about their own health or the about the susceptibility of family members to conditions imagined to have caused an event. Gallagher, a co-author with Truog, suggests a broader definition of the materiality standard in a 2009 article: “[S]pecific disclosure content should be considered material if that information were essential for a reasonable patient or family to be free of fundamental misconceptions about what transpired.” This would address the latter issue I raised with regard to the materiality standard, but the concerns about bias would remain. With regard to the “Golden Rule” test, providers’ needs for information may be decidedly different than those of the patient and families, owing to fundamental knowledge disparities. Factors taken for granted by practitioners based on their training may be outside the understanding of others. Additionally, practitioners may not hold the same values as patients, who may, for instance, desire to learn what measures are being taken to prevent future errors for themselves and others. As an alternate approach for resolving ambiguities of error communication to families and their loved ones, I turn to the discussion in Chapter Two. There I suggested presumption of a rebuttable duty to convey a truthful impression, with exceptions justifiable only if they can pass a publication standard. Thus any deviation from truthfulness would need to meet the approval of reasonable persons willing to have such actions applied to themselves. My proposed approach reverses the posture regarding error communication from one of seeking a rationale in support of disclosure to one of seeking justification for non-disclosure. This is consistent with the bias favoring communication that I intended to convey in Figure 2 in Chapter One. My proposal will resonate with practitioners whose
actions are informed by commitment to the virtue of truthfulness or with those who recognize a duty to preserve trust in the practitioner/patient relationship. To these individuals for whom truthfulness is “in their DNA,” the rules of thumb offered by Truog et al. may feel narrowly construed or instrumental. Yet even these normatively guided individuals may encounter situations in which truthfulness might prove to be more harmful than beneficial; in those instances, the publication standard provides a basis for justifying exceptions. Further, the publication standard will appeal to those providers seeking a more extrinsically focused standard. Yet it provides more objectivity than the materiality test, Golden Rule standard, or preemptive measures suggested by Truog et al. Lastly, the publication standard affords consideration of all to whom the error is already public, namely other members of the care team. Often ignored when a practitioner, typically a physician, elects not to communicate an error, is the collusion he expects from his colleagues. Concealment can evoke significant emotional distress for others whose ethical grounding obliges truthful disclosure.

Using several illustrative cases in the five categories of ambiguous circumstances listed above, I will next compare application of the Truog et al. rules of thumb to my approach.

**When error is determined to be the cause of an adverse event.** Practitioners may have many reasons, inside or outside of awareness, for withholding communication of a medical error. These will be explored in more depth subsequent chapters, but may include fear of ensuing malpractice litigation, apprehension about patient reactions such as anger or loss of trust, embarrassment and potential loss of esteem from patients or colleagues, concern about adding to family or patient distress, lack of confidence in skills
for communicating bad news, or personality traits that impede acceptance of responsibility. In the face of these barriers, the temptation to withhold information can be great in cases where the error is not as obvious as, for instance, a wrong-site surgery or a retained foreign object. Presumption of a rebuttable duty to communicate a truthful impression, overcome only by surviving a publication test, poses a high threshold for withholding information.

I offer for discussion a case described by Gallagher in Surgery. The patient in this case was to undergo a simultaneous kidney-pancreas transplant. The kidney graft was successfully implanted; however as the pancreatic procedure was to commence, the surgical team discovered that the graft had been discarded by an O.R. technician together with debris removed from the surgical site. The surgeon reported to the family that the kidney transplant had proceeded as planned but that the pancreas graft was “not transplantable.” The family appeared satisfied with this explanation, even stating that they were most concerned about alleviating the patient’s need for dialysis. A new pancreatic graft was obtained and transplanted at the same hospital.161 In this case an error of execution was obscured by the proffered communication. Under the standards proposed by Truog et al., the practitioner might reason that there was nothing to be gained by disclosing the error in that further surgery would be required even absent the disclosure; thus the fact of the error would be immaterial to future treatment. Similarly, a surgeon might rationalize, under the Golden Rule test, that he would have no need for information about an inadvertent act by a non-physician. In a similar dropped specimen case, practitioners were reluctant to describe the incident as error, instead calling it an “act of God” or “an accident.”162 Using the publication standard I propose,
rationalizations for overcoming the obligation of truthfulness would be less supportable. A reasonable person would want to be apprised of the dropped graft, if for no other reason than to be given an opportunity to assess the competence of the staff to perform the subsequent operation and to receive assurances about how such errors would be prevented in the future. Moreover, the patient should not have to bear the financial cost of the subsequent surgery, the risks and burdens of which may be uncompensable. Under both the Truog et al. preemptive measure and the publication standard, there is a risk that the truth would be divulged by a subsequent provider reading the patient’s medical record, assuming that the error is so documented. Lastly, this error would be known to several others who were present in the O.R.; thus publication would be consistent with their experience, whereas concealment would require inauthentic action (or inaction) on their part.

Another example is offered by Gallagher et al. In this case an internist fails to check blood potassium levels in a test ordered to determine whether the patient is experiencing a known side effect of a newly prescribed medication. The patient subsequently presents at the emergency department complaining of heart palpitations and experiences ventricular tachycardia requiring cardioversion. Potassium blood levels were dangerously elevated upon admission to the E.D. 163 56% of the physicians surveyed would not mention error in communicating this event to patients, responding that they would use an explanation such as: “The new medicine we started caused your potassium level to become too high, which led to a dangerous heart rhythm.” 164 The Truog et al. materiality test is not applicable in this case as it speaks only of relevance to future decision-making; it does not address costs for treatment already incurred. While it is
likely that their Golden Rule test would yield a decision in favor of communication of error in that a practitioner would arguably find potassium blood levels of import, such thinking is not natural to practitioners as evidenced by the high percentage reporting that they would not share this information. However, truthful communication of the error would not be excused under a publication test. Under such a standard, failure on the part of the primary care physician to be vigilant about potentially dangerous side effects would be relevant, calling into question the effectiveness of follow-up systems within that provider’s practice. Further, the patient should not be left with worry that any subsequent medications may prompt a similar cardiac event. And again, a reasonable person would hold that the patient should not bear the costs of the emergency care.

Another perhaps more provocative example of ambiguity in the communication of error arises in the context of academic medicine or continuing education, particularly in skill-based specialties such as surgery or radiology. Gallagher et al. use such a scenario in one of their empirical studies. The case posed involves a surgeon who is utilizing a new coagulation/dissection instrument while performing a laparoscopic cholecystectomy (lap chole). Not knowing that the tip of the instrument remained hot once the instrument was turned off, he momentarily diverts attention to answer a resident’s question, damaging the common bile duct. The surgery is then converted to an open procedure to allow repair of the duct. While the long-term outcome would likely be unchanged from that of the laparoscopic procedure, open surgery requires more recovery time and greater risk of infection.

The informed consent process for a lap chole includes disclosure of the potential for conversion to an open procedure. However, rarely do surgeons explain in advance
their intent to employ new instruments or new techniques. In teaching institutions, it is likewise rare to disclose that trainees will be performing surgeries or conducting other skill-based procedures such as interpreting radiographs. Even when patients ask if a resident will be performing their procedure, it is common to imply that the attending physician will be guiding throughout when, in truth, he will often not be present for the entire procedure, depending on the resident’s experience and skill level. In specialties that require hands-on practice, trainees have no way to learn but by doing. Yet if patients were to have a choice, most would prefer to have their procedure performed by a highly skilled practitioner. Thus the ethics of error communication collide with the interests of developing new practitioners and the continuous learning of experienced practitioners. When the instant case was posed by Gallagher et al., only 21% of respondents reported that they would give a full disclosure including attribution to error and 4% would make no mention of the adverse event; the remainder would disclose the AE, but make no mention of error.166

In the face of such attitudes, informed by the culture of medicine, the rules of thumb offered by Truog et al. would appear susceptible to rationalization in this case. Under the Golden Rule test, in particular, surgeons’ views would be colored by awareness of the trial and error nature of their specialty – knowledge which is decidedly different from that possessed by most patients. And, the preemptive measure test could be overcome if the patient’s medical record were to reflect only an injury to the common bile duct without accompanying documentation of the use of the new instrument. Of course all present in the O.R., including the device sale representative, would know otherwise. With the presumptive duty I propose, a practitioner contemplating non-
disclosure is left with the question of whether the incident can be justifiably excluded by the publication test. I assert that reasonable persons would expect to be informed that error had occurred because their experienced surgeon had elected to experiment with a new technique for a common procedure; in fact, most would want to be told prospectively of his plan. Few lay people understand the implications of seeking care at an academic medical center; even fewer are aware of the experimentation that goes on in the daily practice of medicine. Some of this occurs on an ad hoc basis when practitioners are confronted with a heretofore unencountered situation, necessitating improvisation. Such is the case, for instance, when a surgeon performing a lap chole encounters an unusual anatomical configuration. However, in the case at hand, the patient would have had a reasonable expectation that his procedure would be unremarkable, which it would have been had the surgeon employed his tried and true method. Moreover, there are options available for training in the use of new laparoscopic instruments, using animals or animal tissue rather than patients. Of note, my rationale frames this as an error of planning more than an error of execution.

When there is uncertainty in attributing the adverse event to error. This situation is exemplified by the shoulder dystocia case raised in Chapter One. As noted by Truog et al., it would be inappropriate to convey such an event as error where causation remains ambiguous. In light of this ambiguity, neither the rules of thumb suggested by Truog et al. nor my proposed approach would call for communication of an error. However, the guidelines for error disclosure can still be instructive. Clearly the family is entitled to a full explanation of what happened, including the rationale the physician used for not electing to perform a caesarean section. And, an empathic expression of regret is always
appropriate. Also, the parents may be comforted by the provider’s commitment to use this case to as an opportunity to learn more about predictors for shoulder dystocia, so that other infants can be spared this complication. If subsequent review reveals that the provider missed a predictor in this case that he reasonably should have known about, then communication of error should ensue.

When the relationship between error and the adverse event is not readily apparent. This situation is exemplified in a case reported to me by one of the physicians I interviewed. The case involved his own seventeen-year-old son, who has autism combined with mental retardation and cerebral palsy. The boy was running inside at the group home where he lives and collided with a light fixture, causing a head wound with severe bleeding. The physician accompanied his son, who was highly agitated, to the hospital by ambulance. By the time they arrived, the father was drenched in sweat from restraining his son to prevent him from removing dressings or pulling out his IV. Closure of the head wound required surgery under general anesthesia because the young man was so distressed that local anesthesia was not an option. Four days later the emergency physician who had treated the boy called the physician father with a tearful apology in which she admitted having neglected to administer pain medication to the son. The father was grateful and touched by the emergency physician’s courage in making this difficult call to communicate a fact that would not otherwise have come to light, the boy’s agitation having been viewed as an unavoidable consequence of his injury. Moreover, the father, himself a physician, was chagrined by his own failure to recognize the omission of pain medication. Both physicians were operating with the cognitive error of confirmation bias. Due to the boy’s mental compromise, both had expected him to
exhibit out-of-control behaviors, assuming he would not have the capacity to comprehend what was happening to him. Thus it had not occurred to either of them that his extreme agitation might be caused, or at least exacerbated, by pain. The ED physician might have rationalized that her communication of error was not material to the boy’s future treatment, though it would have met Gallagher’s additional materiality test of preventing fundamental misconceptions about what transpired. However, she was motivated by a strong sense of duty for truthfulness. Given this, reliance upon the publication standard was not necessary; but had it been relied upon, there is little question that reasonable persons would find communication to be required in this case to inform future care for the young man.

Gallagher offers another case of causation not obviously connected to the adverse outcome. In this case an 82-year-old woman presented at a medical center, with which she had a long-standing relationship, complaining of heart palpitations. An ECG revealed atrial fibrillation. Because this was presumed to be a new condition, she received electrical cardioversion without anticoagulation and was discharged to her husband, a man with mild dementia. The couple had no children or local relatives. Two days later she suffered a massive embolic stroke from which she died. The woman’s primary care physician (PCP), upon receiving a letter of thanks from the husband for treatment provided over the years, reviewed the woman’s file in which the PCP noted a prior episode of atrial fibrillation ten years previously. Anticoagulation had not been prescribed at that time because the woman was a fall risk; thus her history did not adequately reflect the prior heart anomaly. The physician’s failure to document the history of a-fib left the medical center uninformed of a crucial element of the patient’s
history, which thereby led to an error of planning in that the standard of care would have dictated the use of anticoagulation prior to cardioversion. The medical center determined that communicating these errors to the husband would be more distressing than helpful,\textsuperscript{167} thus invoking a kind of “therapeutic privilege” to excuse nondisclosure. Applying the materiality standard, the medical center could reason that the information about this breach of the standard of care was not relevant to future decision-making for the deceased patient. Clinicians might also be able to rationalize that they would not want to be informed were they in the shoes of the husband in light of his dementia. Further, the likelihood of his learning of this error by other means was remote. However, by the presumption of truthful communication that I propose, there would be a duty to communicate the error to the husband. His dementia was not so severe that it prevented him from writing a note of appreciation to the PCP. Moreover, a reasonable person would conclude that the man’s own future care was in the hands of the same PCP and therefore the husband was owed an explanation that might cause him to be more vigilant or to change physicians. Given the long-standing favorable relationship and the man’s age, it is conceivable, if not probable, that he would not wish to seek a change. Still, this option should be his to make.

When the relationship between the error and an adverse event is speculative. This situation is exemplified by so-called large scale events such as occurred at the University of Washington Medical Center. Dudzinski et al. report that one step in a six-step sterilization process for endoscopes failed due to an equipment malfunction that persisted for a two-month period, potentially affecting over 600 patients.\textsuperscript{168} There was no way to determine whether the step was essential to preventing contamination, nor whether any of
the affected patients had suffered any harm. Communication of the error posed the threat of potential needless worry for patients and substantial costs to the institution, in terms of money and reputation. In the end, the Medical Center elected to communicate the error, which garnered coverage in the local media. In this case no patients were injured and no litigation ensued. A similar Canadian case resulted in an out-of-court settlement to over 700 patients who alleged emotional distress while awaiting test results to determine whether harm had resulted. At Duke University Hospitals in 2005, construction workers discarded hydraulic fluid into an empty drum labeled as fluid used in the sterilization of surgical instruments. The drum was returned to the fluid manufacturer, which returned it to Duke as cleaning fluid without having verified the drum’s contents. Practitioner complaints of unusually slippery instruments resulted in extra wash cycles by technicians. Hospital officials, maintaining that the error was attributable to the construction crew and chemical vendor, eventually notified patients of the errors, stating that the risks were no greater than the general risks of surgery. Patient harm and liability are yet to be fully reported in this case.

Communication of error in these instances is advisable under either the rules of thumb proposed by Truong et al. or the approach I propose, because the information was potentially relevant to the patients’ future care. Moreover, had the event come to public light via other means, such as whistle blowing, trust in these institutions would have been even more eroded than it was by the disclosures they undertook. In fact, some might argue that immediate transparent self-report of such errors could serve to highlight the success of an institution’s patient safety efforts, thereby enhancing public trust.
Whether to disclose near misses. Patients are ambivalent about communication of near
misses, while physicians are generally opposed to such disclosures. One physician in
the Gallagher et al. study, explaining his opposition, comments: “I think that [near miss]
happens so often we wouldn’t have the opportunity to practice medicine.” Inasmuch as
near misses do not result in harm, the Truog et al. rules of thumb do not come into play,
as there would be no required change in future treatment. These authors suggest that a
near miss need only be disclosed if the patient was aware of it or if the patient might
otherwise come to learn of it. However, I would suggest reliance on the publication
standard to determine whether communication can be excused. Some near misses may be
of so little consequence as to be of no value to patients. Others may serve the purpose of
alerting patients and families so that they can become vigilant partners in their care. In
other circumstances patients may be reassured that their practitioner is looking out for
them or that preventive measures are indeed working.

Near misses serve to illustrate the difference between error reporting and error
communication. Error reporting has patient safety as its aim; thus reporting near misses
fulfills an important role in prevention, irrespective of outcomes experienced by patients.
By contrast, communication of error to patients serves the physician/patient relationship.
Truog et al. advocate that error reporting should be considered a patient safety function,
rather than a risk management function, as has traditionally been the case. This
perspective is reinforced by the fact that guidelines for error reporting are promulgated by
a safety organization, the NQF. Because patient safety has assumed a high profile since
the publication of the IOM Report, situating error disclosure within this context affords it
institutional clout. In fact, protection of patient safety may be one of the few interests
that hospitals recognize as superseding protection of financial interests. Still, reporting of error is objective and detached; communication of error is often intensely emotional for practitioners as well as for the patients and families involved. Thus it is understandable that some practitioners facing communication of error might seek justification for avoiding the difficult disclosure conversation. The following chapter will examine some of the mixed messages providers receive to further cloud their decision-making. Yet the difficulty of communicating medical error does not excuse it. Moral action often demands difficult choices. Thus, while medical error touches on elements of patient safety and risk management, the decision to communicate medical error is, above all, an ethical choice.
CHAPTER FIVE

MIXED MESSAGES THAT CLOUD PRACTITIONERS’ REASONING ABOUT TRANSPARENCY

Even practitioners who aspire to be morally responsible may be prompted to question the advisability of communicating medical error when confronted with mixed messages from their profession, from their institutions, and from society at large. Those with less moral resolve will have no difficulty finding ample rationale to justify non-disclosure. In this chapter I identify some of the more salient sources of doubt. In my final chapter I will offer suggestions for resolving these mixed messages.

Mixed Messages in the Culture of Medicine

Culture is a potent, often invisible, influence on behavior. Darrel Kirch, President and CEO of the Association of American Medical Colleges (AAMC), offered this observation in a 2007 address: “Most definitions of culture focus on the shared values, assumptions, norms, behaviors, and rituals developed by a group, as well as all the structures used to preserve these essentials. While culture is an extraordinarily powerful force for a group or organization, it is so pervasive and interwoven with every activity that we may not give it much conscious attention.”174 Below I explore, and bring “conscious attention” to, some of the ways in which the culture of medicine collides with the communication of error to patients and their loved ones.
The Role of Error in Training. Medical education, beyond the first two years of medical school, consists primarily of experienced physicians – often only minimally more experienced – sharing their expertise with lesser experienced trainees and aspiring physicians in the “see one, do one, teach one” approach. Oral traditions, passed down from generation to generation, serve to convey the culture of medicine as much as the skills and knowledge of medicine. In the book *Forgive and Remember*, Charles Bosk provides a rich illumination of this educational process in his ethnography of surgical trainees’ experiences with error at a prestigious academic medical center. Originally published in 1979, the book remains relevant today. Bosk continues to receive testimonials as to its accuracy; likewise, those interviewees with whom I shared his framework for medical error related to it immediately. He identifies four categories of errors. The first two – technical errors and errors of judgment – are not dissimilar to errors of execution and errors of planning as defined by the IOM. Bosk notes that these categories of errors, provided they are not repeated, are readily forgiven by superiors.

One trainee observes:

> Of course I worry about making a mistake and it really being disastrous for a patient. But really the crime is not making a mistake; everybody is going to make mistakes. The crime is not learning from your errors. What is really inexcusable is making the same mistake twice.

What stands out in Bosk’s account is the sheer ubiquity of error in the day-to-day practice of surgery in an academic setting. Also of note, trainee errors – particularly errors of judgment – are detected primarily from clinical outcomes, not through the reasoned oversight of superiors. In other words, given the inexperience of trainees, errors of judgment may abound but go unnoticed until brought to light by an adverse event. In the
Preface to the second edition of his book, written after release of the IOM Report, Bosk makes a point of expressing his skepticism about reporting of near misses. He argues that these errors are so prevalent that they often go unrecognized as errors, stating: “There is much to suggest that physicians have trouble seeing these ‘near misses’… Moreover, those ‘near misses’ that are seen are so obvious as to be trivial. Dangerous ‘near misses’ are, as a rule, only appreciated as harbingers of disaster after disaster has materialized.”

The other two types of error defined by Bosk can be potentially detrimental to a surgical trainee’s career. The first of these is what he calls “normative errors,” meaning violations of professional norms as evidenced by behaviors such as dishonesty, lack of diligence, negligence, or failure to get along with nursing staff or patients and families. Bosk observes that a patient’s dying is not in and of itself a problem for the trainee; however a patient’s dying because a trainee did not answer his page is evidence of failure to act in the patient’s best interests. Chief among these normative dictates is the “no surprises” rule. As noted above, errors are to be expected. However, failing to report an error to a superior, immediately upon detection, is viewed as a character flaw. Interestingly, this same fidelity to disclosure does not extend to patients in the world described by Bosk.

Three of the practitioners I interviewed expressed exasperation with normative errors by trainees. Two gave examples of residents who claimed to have completed patient exams, only to have it later come to light that they had not done so. In a study by Green et al., a significant minority, 14%, of residents respond that they would probably fabricate a lab value in verbal report to an attending; another 5% would probably lie about having performed a diagnostic procedure where failure to do so resulted in a
Another physician with whom I spoke complained of lack of general lack of diligence and ownership for patient outcomes on the part of residents. However, unlike in the era in which Bosk’s observations took place, today’s attending physicians feel much less empowered to disqualify a resident for breaching norms, fearing a lawsuit for interference with livelihood. Thus, the use of blaming is frequently the only social control available to address normative lapses. Leape observes: “The professional cultures of medicine and nursing typically use blame to encourage proper performance. Errors are regarded as someone’s fault, caused by lack of sufficient attention or, worse, lack of caring enough to make sure you are correct.”

Leape, Truog et al., and other proponents of patient safety consistently advocate that blame is a deterrent to transparency. In the learning culture advocated by those in the quality movement, “blame” as a social control is to be replaced by systems that promote personal accountability, combined with objective assessments that describe rather than judge performance. Learning is impeded when individuals who feel punitively judged are unwilling to non-defensively and productively engage in problem-solving to correct performance that falls short of expectations.

The final error category identified by Bosk he labels as “quasi-normative” error. These are violations of norms idiosyncratic to a particular attending physician. I witness this phenomenon in MICU observations as each attending has his preferred approach for managing rounds. One runs a tight ship in which side conversations and coffee are not allowed; others are more permissive. Bosk finds that violations of these quasi-norms are tolerated at the beginning of a rotation as the trainee learns the ropes; but if persistent, such breaches can, like normative errors, be viewed as indicative of a less than diligent
character. Both normative errors and quasi-normative errors can, theoretically, be used as justification for excluding a trainee from further advancement. Rarely do errors of knowledge or judgment prove fatal to one’s career; rather, they may be used to encourage the trainee to consider another, less demanding line of medicine.

Bosk’s depiction of medical training is of a closed club in which errors are used as a form of social control over its members. While patients’ interests are reflected in normative standards, discussions of error do not extend outside the club. Another norm of the club is reflected in this telling observation: “Residents or students who were seen as excessively preoccupied with moral matters were seen as not possessing a ‘surgical personality’; the fear of being so labeled was a major deterrent to any open conversation.” While Bosk’s account is limited to surgical trainees, this group is particularly relevant to the study of error communication in that surgical errors tend to be more readily evident. The culture that Bosk describes is one in which error is commonplace; internal acknowledgement of errors is demanded for learning purposes and as evidence of professional trustworthiness; blame is ascribed for violation of professional norms; patients are safeguarded through adherence to these norms, rather than by external transparency; and trainees are more afraid of alienating supervisors than of causing harm to patients. To the extent that these conditions are present today, physicians in training learn that communication of error to patients is of less consequence than discussing it with peers. This is corroborated in research by Logio and Ramanujam. They find residents are far more likely to discuss safety incidents with peers (90%) than to file a formal incident report within the hospital (42%). Errors that go unreported to the institution are unlikely to be communicated to patients. Furthermore, inattention to
error communication in training leads to lack of skill in conducting these difficult conversations. And, since medical training is predominantly conveyed through modeling, this lack of instruction in error disclosure portends more than mere skill deficits; it also bespeaks lack of commitment to transparency on the part of elder physician role models. Changes in error communication practices will be slow to take hold until these keepers of the culture visibly adopt and collectively endorse new norms that foster transparency – both within their institutions and with patients and families.

**Infallibility.** Despite the prevalence of error in medical training and medical practice, many providers persist in the belief that perfection is attainable. Leape observes:

> Physicians are expected to function without error, an expectation that physicians translate into the need to be infallible. One result is that physicians, not unlike test pilots, come to view an error as a failure of character – you weren’t careful enough, you didn’t try hard enough. This kind of thinking lies behind a common reaction by physicians: ‘How can there be an error without negligence?’

The IOM Report takes its title from the well-known adage, “to err is human.” Yet many physicians view themselves as super-human – somehow able to overcome the shortcomings of mere mortals. Banja attributes this unrealistic self-perception to narcissism, which he describes as characterized by an individual’s inability “to integrate both positive and negative representations into his self-object representations.” He explains that those who have experienced only success, receiving only positive affirmations, or those who have compensated for a lack of adult validation by giving themselves only adulation, will be equally unable to deal effectively with failure. Failure disrupts these individuals’ sense of self, resulting in dissonance that can lead to psychological crisis or, more often, to rationalizations that are needed for protection of
self-image. In addition, because their attention is on themselves and their own emotional and psychological distress, they are unable to respond empathically to others, including patients, families, and colleagues.

It is perhaps less well known that narcissism is often accompanied by ideological rigidity, perfectionism, and compulsiveness. Banja allows that these traits exist along a continuum, with some individuals channeling them productively. As an example, he explains: “[I]f compulsiveness means paying keen and thoughtful attention to a patient’s clinical situation, it clearly seems a desirable and especially an adaptive trait. Compulsiveness becomes pathological when it is driven by inordinately masochistic ‘super-ego’ demands that are impossible to fulfill and that compromise important relationships with others.” Likewise, ideological rigidity can lead to intellectual rigor. However, it can also impede recognition of alternate points of view that may be needed in understanding what caused an error and its impact on patients and their families, as well as on other providers.

The reader may wonder what relationship such psychological explanations have to the culture of medicine. Pertinently, the medical profession attracts an inordinate share of individuals with narcissistic personalities for two primary reasons. First, the profession has historically been imbued with a heroic archetype constructed around saving lives and relieving suffering, which serves to reinforce an idealized self to which the narcissist aspires. Secondly, selection criteria have emphasized the highest standards of academic achievement, thereby attracting many with a compulsive drive to excel who have never experienced failure nor developed the resilience needed to cope with it. A medical student in the Kaldjian et al. study explained:
[As a student] you’re competing within your class, competing with yourself, and trying to reach the academic goals that you want. As a resident you’re competing to attain that certain fellowship position. You don’t get points for making mistakes; in fact, you get points taken away. It’s like the SATs. So admitting to mistakes doesn’t exactly help your career… It’s the inherent competition within our career that kind of fuels a lot of people who want to put their mistakes under the carpet and just show off their achievements and try to put themselves in the best light possible.

At the outset of this thesis, I offered an observation by Judith Andre in which she acknowledged the moral challenge of accepting one’s fallibility while simultaneously struggling against it. Nowhere is this struggle more poignant than in the practice of medicine. Joel Frader, himself a physician, observes:

[P]hysicians especially are socialized to strive for perfection or infallibility. Therefore, errors come to be seen as a failure of character for the person responsible. This, in turn, creates a psychological incentive to cover up mistakes. The fear of reprisal also has another consequence. When an individual has to hide what happens, it blocks opportunities to ‘share’ the emotional impact (sense of guilt, sorrow, and so forth) with others.¹⁸⁶

To the extent that commission of an error becomes an indictment of one’s self-worth; self-recrimination is an understandable response. Albert Wu describes the physician as the “second victim” of error. He offers this description of what goes through the doctor’s mind when error occurs:

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.¹⁸⁷

In the wake of such personal distress, learning and transparency are often sacrificed. Compounding such responses is the medical profession’s use of teaching methods that
minimize technical errors while over-emphasizing normative errors, treating them as blameworthy. Davidoff concurs: “[T]he use of shaming as punishment for shortcomings and “moral errors” committed by medical students and trainees – such as lack of sufficient dedication, hard work, and a proper reverence for role obligations – probably contributes further to the extreme sensitivity of doctors to shaming.” Other strategies for coping with shame and guilt include rationalization through “denial, discounting, and distancing” Serving as justification for non-disclosure of error, these rationalizations are signaled through the use of euphemistic language (e.g., “complication” or “incident” in lieu of “error” or “mistake”); advantageous comparisons (as in suggesting that disclosure will worsen the family’s pain); and blaming others, such as colleagues or even the patient.

I do not intend to suggest that admission of fallibility and communication to patients promise eradication of guilt. As discussed in Chapter Two, Hilfiker suffered great pain after revealing his fatal error to his patient and her husband, even in the context of a strong pre-existing patient/provider relationship. However, in the survey by Gallagher et al., 74% of physician respondents who had disclosed a serious error report feeling a sense of relief after having done so. One of the physicians with whom I spoke reported having made three memorable mistakes during more than thirty-five years in practice, two of which occurred during a time when error disclosure was not supported. He found equivalent levels of guilt and remorse in all three, a “personal corrosive effect that never goes away.” However, because transparency is more consistent with his personal faith, he believes openness facilitated his pathway to atonement. He added that mistakes are something one learns to live with: “You don’t have to get hardened.” The
perhaps unsettling truth is that neither disclosing nor concealing has the power to erase memory.

Self-Sacrifice. The culture of medicine reinforces the ideals of dedication and self-sacrifice as requisite for the long hours expected of trainees and practicing physicians. Recognizing that extended work hours compromise human performance, thereby contributing to error; the IOM Report recommended reductions in scheduled hours for trainees. As a result, in 2003 the Accreditation Council for Graduate Medical Education (ACGME) introduced work limits prohibiting residents from working more than 30 consecutive hours and more than 80-88 hours per week averaged over four weeks. Most outside the practice of medicine would consider even these reduced hours to be excessive. In a three-site study examining the effects of these ACGME work restrictions, Landrigan et al. found that error rates did not decline; rates of depression remained constant at close to 20%; and reported burnout remained high, having decreased from 75% to 57%. New ACGME limits were introduced for comment in 2010 with implementation to take place in 2011.

Not surprisingly, the practice of medicine is characterized by poor self-care and unfavorable work/life balance. Shanafelt reports: “Numerous global studies involving nearly every medical and surgical specialty indicate that approximately one in every three physicians is experiencing burnout at any given time.” While physician substance abuse rates of 10-15% approximate those of the general population, physician suicide rates are estimated to be at least twice that of the population at large. Clearly the self-sacrifice of physicians, deeply embedded in the culture of medicine, comes at a personal
price. Often this price also compromises patient safety, impedes physicians’ ability to relate empathically to patients, and obscures perspective needed to accept fallibility.

**Detached Concern.** Jodi Halpern describes several reasons offered by physicians to justify the professional norm of detached concern. These include defense against burnout, protection to allow performance of painful procedures, impartiality needed to treat patients equally, facilitation of the rapid care demanded by today’s medical bureaucracy, and promotion of objectivity. She argues that none of these reasons is valid. Detached physicians actually suffer more from burnout. Performing painful procedures is but a small part of one’s work, even for surgeons; and, other patient care responsibilities require rapport. Detachment is not needed to treat patients impartially; in fact, empathy may be needed to better understand differences. Empathy takes little, if any, additional time and may actually expedite communication by patients. 198 Lastly, Halpern argues that not only is objectivity illusory; but, moreover, seeking objectivity “denies the ongoing emotional field between patients and physicians.” 199 She finds emotional interactions between the parties inescapably reflected in what each chooses to pay attention to, how risks and benefits are weighed, and how views of the patient’s future are framed. While medical schools today may not employ the “desensitization” methods used merely three decades ago in which medical students watched brutal movies to immunize them to blood and gore or sexually explicit movies to curb sexual arousal when viewing naked patients, the posture of detached concern persists. This detachment operates as barrier to developing the empathy needed to appreciate patient and family isolation and suffering in the face of medical error and to express remorse and/or apology sincerely.
Professional Deference. The social controls described by Bosk are but one mechanism for ensuring conformance to professional norms in the practice of medicine. Other norms are more subtly imposed. Of relevance to the subject of error communication are norms governing physicians’ willingness to challenge one another’s professional judgment. Deference to the judgment of other physicians is of long standing, having been explicitly stipulated in the 1847 version of the Code of Ethics of the American Medical Association. In Chapter II, Article V, a section addressing treatment of a patient previously treated by another physician, the code states: “Under such circumstances, no unjust or illiberal insinuations should be thrown out in relation to the conduct or practice previously pursued, which should be justified as far as candour, and regard for truth and probity would permit.”

This perspective was reinforced in an influential 1934 article on malpractice suits by Stetson and Moran. They admonish: “One must remember that, whenever a patient is dissatisfied with results, all that is necessary to start a lawsuit is the comment of some doctor, criticizing the work of a previous physician.”

The chairman of the New Haven Medical Society is quoted in this article as saying: “As to the percentage of suits started by indiscreet or malicious remarks of another doctor, it is hard to estimate. Our committee, as you will note, put it at 75 per cent.”

A 2003 report of the AMA Council on Ethical and Judicial Affairs (CEJA) implies that such deference is no longer appropriate. In addressing errors committed by others, the CEJA committee writes: “Yet, it is clear that even if a physician is not responsible for the harm, that physician still has the ethical obligation to be honest and forthcoming with information pertaining to the patient.” However, these ethical guidelines may hold little sway in the face of deeply embedded cultural norms.
Marilynn Rosenthal reports that physicians are typically slow to take action against peers even when they are known to suffer from impairments such as substance abuse, mental illness, or even stroke. She attributes this reluctance to a combination of “professional etiquette” and respect for clinical freedom that pervades the medical profession. The more respected the impaired colleague, the more likely his colleagues are to employ informal means, or “Protective Support” to compensate for his weaknesses. Direct confrontation and reporting to institutional hierarchy are viewed as last resorts. If reporting colleagues’ impairments is problematic, disclosing their errors to patients is even more so.

Neil Calman explains how he became indoctrinated in the implicit code of professional deference in his third year of medical school. He offers the case of a patient who had received what appeared to be a successful double heart valve replacement and aortic graft. A few weeks later the patient developed an infection, suspected to have been attributable to a batch of cardiac catheters contaminated with the candida fungus. A second surgery was performed to replace the graft, which proved to be the source of the infection. Shortly after the surgical team advised the family of the success of this second operation, the patient coded and resuscitation failed – the cardiac arrest resulting from failure to adequately monitor post-surgical potassium levels, a common risk of cardiovascular surgery. Calman, admitting an inappropriate attraction to the patient’s daughter, had taken a special interest in the patient’s case, a fact not lost on the surgical team. The surgeon in the case put his arm around Calman’s shoulder and said: “Son, I’ve been very moved by the interest and concern you have shown for this patient. I also know that you realize that nothing good would come out of the family’s knowing about
the catheter problems or what happened just now. No one needs to know.”

Calman was present when the surgeon offered condolences to the family, though not sure whether he was part of the medical team or part of the family at whose home he had shared dinner. His role became clear when the surgeon turned and asked Calman if he could stay with the family for a while. Calman explains: “He was deputizing me – an act that subconsciously sucked me deeper into the underworld. I was now responsible for maintaining the charade that ‘we had done everything we could.’”

After the patient’s funeral, Calman gave up his attraction to the daughter because it was an unpleasant reminder of the secrets he bore. He adds: “I knew I could not violate the laws of the secret society of medicine into which I had just begun my initiation. Being invited into the sanctity of this dungeon of deception was part of the honor of becoming a doctor. It made me feel special – an entrusted colleague, a real doctor.”

Though plagued years later by moral doubt, Calman admits that he continues to observe this professional deference: “When I discover another physician’s mistake, I only discuss it if the doctor is employed by me or is formally under my supervision. We physicians are afraid to turn up the heat on others, lest we fry in our own fire.”

Calman’s commentary is compelling in that it demonstrates both how professional deference is conveyed from generation to generation of physicians as well as how students and others in subordinate roles, such as nurses or pharmacists, can be subtly coerced into the veil of silence. Wu et al. confirm this proscription against questioning peers’ actions, observing: “Social norms militate against disclosing when a colleague makes a mistake. From an early age, we are socialized against ‘tattling’ on our peers. In addition, physicians may fear that disclosure would lead to libel suits.”

Bryan Liang,
commenting on a case wherein a PCP discovered that a surgeon had performed surgery on the wrong vertebral column, subsequently concealing that fact with incorrect documentation, argues that disclosure of colleagues’ presumed errors to patients should not be mandated for three reasons: error does not equate with negligence, physicians may not be qualified to comment on standards of care in another specialty, and such reporting would impede a full and frank analysis of the error, including contributing system factors. In a contrary commentary, David Stuart Smith argues that, “all participants in the care of a patient have a responsibility to make sure that the correct procedure is done to the correct patient.”

Thus Smith represents the more contemporary view espoused by CEJA; however, Liang’s concerns are not totally without merit. As discussed in Chapter Three, it is as unethical to portray as error an action that has not been unambiguously determined to be so, as it is to withhold disclosure.

The Mortality and Morbidity Conference. The Mortality and Morbidity Conference (M & M) offers one forum in which professional deference is often abandoned, albeit behind closed doors. Antecedents of the M & M construct, generally attributed to Codman, have been embedded in the culture of medicine since the early twentieth century. Bosk provides insight into the complex social dynamics of M &M as a medium for addressing errors at the hospital in which he was an observer. He notes that normative and quasi-normative errors are seldom explicitly addressed in this forum to avoid encouraging concealment. Public support of a subordinate in M & M, accompanied by scolding in private, can be used by an attending to foster indebtedness from the subordinate. And, when an attending takes the lead in M & M – thus “putting on the hair shirt” – it is often viewed as a heroic act, intended to demonstrate a public show of humility. Alternatively,
an attending may step in to prevent a subordinate from reflexively acknowledging errors. Bosk notes: “[T]he hair shirt might become too attractive for the subordinate. He might wish to wear it too often and therefore not be self-critical enough to see how his performance can be improved, or he may never learn to discriminate between those failures which he can and cannot control.”210 Truog et al. offer added insight into the tendency of some practitioners to accept responsibility for errors too readily: “Clinicians with less power may accept blame as an expression of their perceived or actual lack of status in the hierarchy.”211 Assumption of blame is distinguishable from acceptance of responsibility. The former engenders sympathy or promotes catharsis; the latter promotes accountability.

Other reports suggest that M & M culture varies from hospital to hospital. In Gawande’s training, the chief resident ran M & M and presented all cases; residents sat on the sidelines, not publicly challenged for their errors. Gawande describes M & M as a vehicle to discourage both self-doubt and denial in that it highlights the inevitability of error while fostering acceptance of responsibility.212 By contrast, Berlinger reports that Danielle Ofri, in describing her experiences as a resident, finds M & M to be a victimizing experience in which trainees are forced into the spotlight and called to task for their errors.213 Similarly, an intern respondent in the study by Kaldjian et al. states: “Morbidity and mortality conferences were just brutal. We wouldn’t go; we wanted nothing to do with them. The students would actually sometimes go to see the residents they didn’t like just get toasted.”214 This forum, which is immune to legal discovery, holds the potential to serve as a vehicle for internal transparency and learning from mistakes by both the responsible parties and those seeking to avoid the same errors in the
future. However, M & M is equally susceptible to becoming a forum for scapegoating and humiliation, thus inducing denial and concealment of error.

**Horror Stories.** Bosk describes the role of what he calls “horror stories” as another mechanism for exerting social control. He found that these exaggerations can be used to instill fear, gain a sense of belonging through shared experience, and engage in one-upsmanship (as in ‘my first central line experience was worse than yours’). They can also be used to establish rank. Trainees commonly exchange horror stories about attendings; however, when an attending shares a horror story with a trainee, it serves as an invitation into “the club.”

Horror stories may contribute much of the lore surrounding M & M. I submit that fear of malpractice litigation, which is disproportionately high compared to its incidence, may also be fueled by larger-than-life horror stories. Saks reports that physicians tend to overestimate by thirty-fold the incidence of malpractice litigation. Fear of malpractice litigation is consistently raised as the principal justification for not disclosing error to patients. 77% of respondents in the study by Lamb et al. identified it as a main barrier. Davidoff contends: “Indeed, much of the extreme distress of doctors who are sued for malpractice appears to be attributable to the shame rather than to the financial losses.” This connection to shame provides the emotional fuel needed to sustain a horror story.

As noted in Chapter One, not all error results in adverse outcomes. Additionally, of the errors that do produce adverse outcomes, not all are caused by negligence. Theoretically, only negligent errors should be subject to litigation. Studdert et al., in a comprehensive study of the incidence of negligence and litigation, demonstrate that this
theoretical relationship does not hold. Of the severe medical injuries identified in their study, only 33.3% were deemed attributable to negligence and only 16.7% of these resulted in lawsuits. Notably, 83.3% of patients who had potentially legitimate legal claims elected not to pursue them. However 4.3% of the patients whose adverse events were deemed not to have been caused by negligence did elect to litigate. Even if many of these claims prove unsuccessful, practitioners will incur legal expenses, loss of time caring for patients, loss of earnings, and potential threats to reputation. Figure 3 below depicts the unpredictable relationship between error, negligence and litigation.

This randomness in the relationship between error and litigation, together with the unpredictability of juries, exacerbates the disproportionate fear experienced by practitioners. An emergency physician, commenting on the current malpractice system in a recent newspaper editorial, complains: “And so we haul our doctors up for public
ridicule and threaten their livelihoods with a costly process that amounts to a high stakes roll of the dice.” One of my interviewee physicians explained: “There are two things that stick with you – making an error and being sued when you didn’t make an error.” Clearly, given the pervasiveness of expressed concern about litigation and the threat it poses to physicians’ ability to practice, the fears surrounding malpractice are not unfounded. However, the medical horror story serves as the medium through which fear of litigation is amplified and perpetuated.

In this section of the chapter, I have devoted considerable attention to mixed messages arising from the culture of medicine. When not brought into explicit awareness, culture will trump efforts to effect change in strategy and practice. In the vernacular of change management: “Culture eats strategy for lunch.” This view is echoed by Kirch and other leaders in the field of medicine who are seeking to effect change. In addition, because culture includes normative elements, it, more than any other source of mixed messages, holds the potential for creating moral confusion in physicians seeking to “do the right thing.” Thus, shifting relevant cultural norms in the practice of medicine will arguably be the most critical element in advancing error communication to patients.

Mixed Messages Regarding The Impact of Error Communication on Litigation

Clearly there are patients and families with justifiable malpractice claims who elect not to pursue litigation. The question then becomes, what role does communication of error play, if any, in influencing these decisions? In 1994 Vincent et al. published an oft-cited study of medical malpractice litigants in the U.K. They find a number of
reasons that prompted individuals to sue, the main four being: to prevent similar incidents in the future; to gain a more thorough explanation of what happened and why; to obtain financial relief, either for pain and suffering or to provide ongoing medical care; and to hold responsible the individuals and institutions who committed negligence. Only the second of these – gaining further information – would be clearly satisfied by error communication. The others might be adequately addressed if early compensation were to accompany a comprehensive communication such as that described in Chapter Three, including admission of responsibility and assurances about measures taken to prevent future recurrences. Hickson et al. find similar rationale expressed in their study of mothers with closed malpractice claims whose infants had suffered permanent brain damage or death in Florida between 1986 and 1989. 34% of the respondents report having been advised by medical personnel that their child’s problem(s) was caused by medical care. The most frequently offered reason, cited by 33% of the participants, for initiating litigation is influence from someone outside the family. 24% of respondents say they needed money to pay for long-term care of their child; 24% believe their physicians were not completely honest about what happened; and 19% want to prevent future malpractice. Again, an offer of compensation coupled with comprehensive error communication would probably mitigate these stated reasons for seeking legal redress. Additionally, as noted in Chapter Three, some researchers find that tone of voice and friendly demeanor may be more important than content in influencing patients to refrain from taking legal action against their healthcare providers. Still, no strategy can serve as an impervious guarantee against litigation.
While space does not permit a thorough review of the legal history pertaining to error disclosure, it appears well settled at law that a physician has a duty to disclose an error when the error requires a change in subsequent treatment. Further, some courts have found that the duty to disclose error in treatment is analogous to the duty to provide informed consent, reasoning that it is as important to reveal what *has* happened as it is to explain what *will or might* happen. Historically, a physician’s apology or expression of regret in the context of error disclosure was treated as an admission against self interest, thereby excepted from the hearsay rule. Senators Hillary Clinton and Barack Obama jointly sponsored legislation in 2006, titled the National Medical Error Disclosure and Compensation (MEDiC) Act, to promote reform that encouraged disclosure, apology and immediate negotiation of compensation following commission of a medical error. Savings expected from reduced legal defense costs were to be used to reduce malpractice insurance premiums and promote patient safety initiatives. While the MEDiC Act did not gain traction in Congress, 36 states have implemented so-called “apology laws” specifically designed to exempt expressions of apology from being used against the apologizer in subsequent tort proceedings. Only 8 of these statutes hold expressions of error to be inadmissible along with expressions of regret, remorse and apology. In these jurisdictions, a statement such as the following would be excluded from evidence in a malpractice proceeding: “Things might have turned out better had I been more up to date on current treatment options.” This statement would be considered a full apology in the framework set out in Chapter Two. In the remaining 28 jurisdictions, only expressions of regret or remorse (meaning statements such as “I regret that this happened to you.”) are excluded. Thus the term “apology” statutes can be misleading. Because 71% of these
laws were passed after 2005, there has been little research to determine their impact on litigation awards, patient safety or error communication.

Proponents of apology statutes claim that apology reduces likelihood of litigation. The Sorry Works! Coalition has garnered attention as an advocacy group that supports apology as a patient satisfaction initiative. Such a position holds intuitive appeal given the data presented above regarding litigants’ stated motives for initiating legal action. One medical malpractice trial attorney reveals: “I would never introduce a doctor’s apology in court. It is my job to make a doctor look bad in front of a jury, and telling the jury the doctor apologized and tried to do the right thing kills my case.”

What this attorney does not add is that his plaintiff might not know that an error had been committed but for the apology. While much has been written about the overall benefits of effective communication in the physician/patient relationship, there are few empirical data to support claims of reduced litigation from apology. Furthermore, Rebecca Dresser argues that prevention of litigation, while admirable as an aim to promote transparency, may place an unfair burden on families for whom court action is their sole avenue for financial recompense to cover additional costs of care. She also asserts that apology could increase litigation to the extent that patients not previously aware of an error are made aware of potential claims. In a study involving experts in the medical malpractice arena (patient safety and legal researchers, hospital risk managers, malpractice insurers, plaintiffs’ attorneys, etc.), Studdert et al. find that predicted deterrence of litigation attributable to communication would be offset by resulting stimulation of litigation. Moreover, their simulation predicts a 5% chance that claim volume would decrease and a 95% chance that it would increase. Predicted
compensation costs follow a similar pattern under the assumption that claim levels would be unchanged by communication. These authors acknowledge the likelihood that amounts would be reduced by offers of early compensation, as settlements without litigation typically result in lower punitive damages. However, even under this reduced claim level assumption, there remains a 34% chance that total costs would at least double. 237

The Studdert data notwithstanding, several healthcare systems have reported cost savings from error disclosure coupled with early compensation. The first such savings were documented by the Veterans Health Administration (VA) in Lexington, Kentucky, which began a policy of error disclosure in 1987 after losing two sizable malpractice judgments totaling $1.5 million. This policy includes providing instruction to patients and their families about seeking compensation for injuries resulting from error. Kraman and Hamm report that in the seven-year period from 1990-1996, this facility paid out a total of $1,330,790 in claims. 238 These savings ($1.3 million over seven years as compared to $1.5 million over two years) do not include what they call the “hidden costs” of litigation – defense fees, including expert witnesses, travel, and other incidental expenses. The success at this VA facility prompted adoption of a disclosure policy at the VA nationwide. Still, there are a number of factors present in the VA system that might prevent these results from being generalized to the private sector. For instance, individual providers, as federal employees, are protected from personal tort liability. Also, while included in the National Practitioner Data Bank, they are not required to purchase malpractice insurance. Further, punitive damages are not recognized in litigation against federal agencies.
A more generalizable model is offered by the University of Michigan Healthcare System (UMHS), the only other healthcare institution to publicly report quantifiable financial benefits from a disclosure policy. In 2001 the UMHS Risk Management department began a practice of admitting fault and offering compensation in all cases where an internal investigation revealed that medical error had occurred. By 2003, this approach was fully integrated with the system’s patient safety efforts.\(^\text{239}\) The UMHS practice is driven by three principles:

1. Compensate quickly and fairly when unreasonable medical care causes injury.
2. Defend medically reasonable care vigorously.
3. Reduce patient injuries (and therefore claims) by learning from patients’ experiences.\(^\text{240}\)

As discussed in Chapter One, the UMHS definition of error is based on “reasonableness” of care provided. To determine reasonableness, the institution convenes panels of caregivers, drawing from over twenty specialties, who rigorously examine each case—knowing that any decision to exonerate a colleague will have to withstand potential litigation. Openly challenging the professional deference norm within medicine, Boothman et al. observe: “[T]he idea that UMHS faculty and staff would be served best by early, honest reviews rather than grudging admissions of error following years of litigation was made part of the claims management culture in a conscious way.”\(^\text{241}\) The work of these committees, whose explicit purpose is to assist in the claims process, is treated as discussions taken in anticipation of litigation and therefore exempted from legal discovery.

As a result of this program, average annual paid claims have dropped to 31.7 as compared to 53.2 before implementation.\(^\text{242}\) Lawsuits have dropped to 17.0 per year on
average from a pre-implementation rate of 38.7 per year.\textsuperscript{243} Median time to resolution also dropped, from 1.36 years before implementation to .95 year after implementation. Total liability costs dropped as a result of reduced legal expenses and lower patient compensation, with mean monthly liability costs dropping from $18.91 to $7.78 per $1000 in operating revenue, including a significant reduction in costs associated with lawsuits and a very minimal drop in costs for non-lawsuit settlements.\textsuperscript{244} Equally significant, the UMHS program is rated highly by both physicians and trial lawyers. 98\% of faculty physicians fully approve of the approach and 55\% report that is a significant factor in their decision to stay at the UMHS.\textsuperscript{245} 100\% of members of the medical malpractice plaintiffs’ bar practicing in Southeast Michigan rated the UMHS as the best or among the best for transparency. 71\% admitted that their settlement amount for cases at UMHS was less than anticipated and 86\% agreed that transparency allowed them to make better decisions about which claims to pursue.\textsuperscript{246} In addition, UMHS was recognized by the Leapfrog Group as one of the 65 top hospitals in the country in patient safety and quality.\textsuperscript{247}

These results are impressive; however one should exercise caution regarding replicability. The UMHS is self-insuring and its physicians are employed by the hospital system; thus they avoid apportionment of culpability issues that can arise when the hospital system is represented by a different medical malpractice insurer than the involved practitioners. When one defendant believes it can assign blame to another, there is little motivation to accept responsibility. Nor should one underestimate the leadership commitment needed to achieve the UMHS integrated approach, requiring culture change as well as alignment of patient safety, patient satisfaction, risk management, post-incident
support, and provider training. The reported experience of Baystate Health, a three-hospital system in western Massachusetts that initiated an error disclosure program in 2006, openly points to some of these integration challenges. For instance, they found that publication of their program created patient expectations that all adverse events, regardless of cause, would be addressed. Many physicians were uncomfortable with patients receiving the results of internal investigations. And, one social worker described the early offer of compensation as “hush money.”

Truog et al. report that several other systems have attempted error disclosure initiatives; among these are: Catholic Healthcare West, Kaiser Permanente, Geisinger Health System, Brigham and Women’s Hospital in Boston, the University of Illinois Medical Center, Stanford University, and Harvard Medical School in conjunction with their medical malpractice insurer, CRICO/RMF. There is no way to determine whether the absence of measurable results from these systems reflects a lack of favorable cost savings as predicted by Studdert et al., lack of attention to quantification, or merely the desire to preserve confidentiality. COPIC Insurance Company, a malpractice insurer in Colorado, trains and supports its insured physicians in communicating with patients. Reportedly, they have had no increase in claims among participating physicians as compared to those who do not.

The healthcare systems listed above have made a public commitment to transparency in the communication of medical error both internally and externally to patients and their families. While this list remains relatively small, other systems may be equally committed to transparency without having publicized their intentions. Still, it is fair to say that progress has been slow, especially in light of the fact that the Joint
Commission first issued guidelines requiring the disclosure of sentinel events in 2001. Practitioners and healthcare systems seeking to justify communication of error based solely on the prospect of curtailing financial risk will encounter mixed evidence.

Institutional Mixed Messages

Institutional mixed messages arise when the values, strategies, policies and practices that are espoused by leaders do not play out as intended. These variances can occur for a number of reasons. In some cases the values will come into conflict with one another or with extra-organizational realities. In others, that which is espoused produces unintended consequences when translated into action. And, as is often the case, leadership’s vision can be lost in translation as it is cascaded throughout the organization, much like in the childhood game of telephone. Given the inordinate complexity of healthcare delivery, such mixed messages are to be expected. However, some can prove particularly detrimental to espoused leadership endorsement of medical error communication. Above I discussed how the tenor of M & M, if used for shame and blame, will have a chilling effect on providers’ willingness to acknowledge and report errors internally, which in turn ensures that errors will not be communicated to patients. Even more damaging than the blame ascribed behind the closed doors of M & M is public scapegoating of practitioners when error occurs. Such was the case with Julie Thao and the transplant surgeon, Dr. James Jaggers, in the Jesica Santillan case, as described in Chapter One. Many institutions have sought to eradicate this “shame and blame” culture through implementation of a program known as “Just Culture,” developed by David Marx and endorsed in the NQF disclosure guidelines cited in Chapter Three.
This program includes an algorithm designed to distinguish between errors described as “human errors” (which are essentially slips and lapses), those that involve at-risk behavior (conscious disregard of a policy or procedures), and those that involve reckless behavior. Particular attention is given to management accountability for system contributors to error such as when policies are disregarded because they have become outmoded or are impracticable. The algorithm specifies that individuals who commit unintentional “human errors” should be consoled; those who engage in at-risk behaviors should be coached; and those who commit reckless behaviors should be subject to disciplinary action. Thus only actions deemed to be both intentional and unjustifiable are considered blameworthy.

This Just Culture Algorithm™ (JCA) was developed, in part, to counteract earlier efforts to address the issue of blame within healthcare institutions. Illustrating how leadership intentions can be misconstrued when translated into action, some institutions that sought to follow the IOM’s admonition to replace assignment of individual blame for error with a systems-oriented view found that refrain from blame was being interpreted by front line managers to mean that they could not hold employees accountable for their actions. Thus the JCA seeks to clarify the conditions under which supervisory action, from coaching to discipline, is appropriate to address at-risk and reckless behaviors.

Still, even a theoretically sound program such as this can give rise to mixed messages in its implementation. In attendance at the session in which I received training in the JCA was a member of the North Carolina Board of Nursing. She related the story of one hospital system that, under community pressure for a scapegoat, discharged a nurse who had committed an unintentional human error – despite having implemented a
JCA program. Through this one action, all faith in the leadership’s commitment to the values of a “just culture” was lost. I would add that in many institutions, JCA training has been targeted toward management of nursing staff and other ancillary service providers, not toward physician leadership. This, too, conveys a powerful mixed message about who will be held accountable when error occurs. Interestingly, Blendon et al. find that physicians are twice as likely as patients to ascribe shared blame to nurses when analyzing a vignette wherein the physician prescribed an antibiotic to which the patient had a documented allergy. This phenomenon may be even more prevalent in rural hospitals. Cook et al. find that only 8% of physicians identify nurses as partners in decision-making. Yet 90% of physicians, administrators and pharmacists report that nurses are the primary guardians of patient safety, with only 22% finding this to be a shared responsibility. Such beliefs could not exist if not reinforced by institutional culture. The trainer in the JCA session I attended, a nurse who also holds an MBA, indicated that while physicians find the JCA appealing in theory, they often find it unworkable in light of the malpractice climate they face. Once again, the fear of litigation as an impediment to error communication is perpetuated – even in the implementation of a strategic institutional initiative.

Thus far I have highlighted more obvious institutional mixed messages such as scapegoating. However, deterrents to error communication are often far more subtle. For instance, when an academic institution that purports to endorse transparency with regard to error simultaneously precludes the documentation of ethics consults in the medical record, citing risk management concerns, the message received by practitioners is that avoidance of risk trumps all other considerations. This same institution subscribes to a
service that predicts practitioners’ risks of litigation based on patient satisfaction feedback. One physician I interviewed, a young attending who prides himself on patient rapport, was surprised to learn that his name appeared on the list of providers at high risk of being sued. Further investigation revealed that patients who complained about him also complained generally about other providers and other aspects of their experience at this institution; however, only he was mentioned by name. This puzzling circumstance went unexplained until his department head discovered that the named provider was consuming business cards at a higher rate than his peers. Once he stopped handing out cards to patients, he was no longer named in patient complaints and he dropped off the litigation risk list. When the mere threat of litigation prompts institutional decisions at odds with patient care, such as not divulging a provider’s name, practitioners deduce that prevention of legal action is of paramount importance. Understandably, they also doubt the level of institutional support for communication of error, given its attendant risk of litigation. These subtle mixed messages can undermine senior leadership’s intentions, leaving them perplexed about the failure of their strategies and policies to materialize as planned. Communication of medical error, colliding as it does with the culture of medicine, requires institutional leadership that relentlessly communicates its intentions; ensures that its processes, policies and practices are aligned accordingly; and seeks to uncover actions that contradict those intentions.

Mixed Messages from the Patient Safety/Quality Movement

In my Introduction I addressed two important cultural disconnect between medical practice and the patient safety/quality movement pertaining to communication of error. The medical practitioner who has erred, or is concerned that he may have erred, is
faced with decisions in the here and now about how to convey the outcomes of his actions to the patient and the patient’s loved ones – decisions that are often emotionally gripping for both parties in this dyadic interaction. Further, he views his actions through a prospective lens – assessing whether they were reasonable under the circumstances, knowing what he knew at that time. By contrast, the patient safety/quality orientation is predominantly systemic – a cognitive, non-emotional activity focused on how to prevent this error from occurring to theoretical others in the future. Practitioners’ actions are viewed through the lens of hindsight, seeking opportunities for correction of practices that, in retrospect, proved problematic. Transparency in this latter context is directed toward institutional and extra-institutional reporting for the purpose of measuring and improving collective outcomes. Though the patient safety movement has of late come to recognize the need for communication of error to patients and loved ones, such recommendations remain deeply embedded in the larger scheme of quality improvement activities. This dichotomy between the dyadic/current orientation of medical practice and the systemic/preventive orientation of the patient safety movement frequently leaves practitioners with the impression that their experiences and perspectives are not adequately reflected in the safety professionals’ calls for transparency.

There are other respects in which the patient safety/quality movement is greeted with mixed reviews from physicians. One of my interviewees recited the familiar refrain, “We’re not airline pilots.” He then proceeded to decry over-reliance on evidence-based practices (EBP) as a substitute for clinical judgment. By contrast, another interviewee, a neonatologist, indicated that a notebook of EBP serves as the “bible” in his department. Still, few would argue with commentators who suggest that EBP has been inconsistently
adopted in many segments of the medical community. Some physicians doubt the scientific rigor of proposed guidelines; others find methods of dissemination ill adapted to today’s busy practice demands. Many practitioners view guidelines regarding communication of error in the same vein as EBP guidelines due to their shared origins in the patient safety/quality movement. Consequently it is not surprising that error communication has likewise not been uniformly adopted despite endorsement by the NQF, the Leapfrog Group, and The Joint Commission.

One mixed message, in particular, looms large. There is concurrence within the patient safety/quality community about the importance of eliminating blame attendant to error in the practice of medicine. The IOM Report states: “Health care organizations should establish nonpunitive environments and systems for reporting errors and accidents.” Leape concurs: “This bad apple mentality has helped to create a culture of silence in health care regarding errors in which health care workers hesitate to report errors to their healthcare organizations or discuss them with colleagues lest they be seen as the bad apple that needs to be removed from the barrel.” Truog et al. observe: “Despite continuous efforts to encourage clinicians to see that most medical errors are the result of flawed systems of care, blame persists as a powerful force.” Contrasted with this, CMS in 2008 began denying full payment for services related to several “preventable events” derived from NQF’s list of serious reportable events (SREs). Since then, CMS has extended the list of events receiving reduced reimbursement; and several private insurers have followed the lead of CMS, some denying reimbursement for all SREs recognized by NQF. Intended as an incentive for improved patient safety, this federal policy is interpreted by many practitioners to be punitive in its impact. While
these payment practices did not originate within the patient safety/quality movement, they are based on frameworks developed by NQF and have been widely endorsed by organizations such as the Leapfrog Group. Thus the espoused commitment to nonpunitive response to error, intended to foster transparency, has been contradicted by current and continually expanding reimbursement practices that penalize providers and institutions for errors, with a potentially chilling effect on error reporting and disclosure to patients.

In this chapter I have illuminated several of mixed messages that practitioners receive with regard to communication of medical error, providing ample countervailing rationale for those who seek to justify concealment from patients and their loved ones. In my final chapter I will offer several suggestions for developing a robust, integrated program in support of transparency.
CHAPTER SIX

CONCLUSION

Courage is the price that Life extracts for granting peace. The soul that knows it not knows no release from little things; knows not the livid loneliness of fear.\textsuperscript{263}

– Amelia Earhart

I set out in this thesis to examine the gap between public policy, ethics, and medical practice with regard to communication of medical error to patients and their loved ones. To date, much of the conversation surrounding medical error has been driven by public policy, propelled by publication of the IOM’s \textit{To Err is Human} and the numerous public policy initiatives it spawned. Despite federal investment of an estimated $50 million annually in patient safety research,\textsuperscript{264} there appears to be only minimal advancement in communication of error to patients. This is attributable to a number of factors. First, scant attention is paid in the patient safety movement to patient communication of error; rather, the focus is on reporting of error – first within institutions, then externally to the Joint Commission and to payors such as CMS. Thus compliance is emphasized over respect for patients and maintaining trust in the patient/provider relationship. Secondly, the preventive orientation of the patient safety/quality movement does not align with the immediate, patient care context in which medical practice takes place. Thus providers are inclined to regard recommendations for communication of error with the same skepticism as EBM recommendations, as in: “You just don’t understand my world.” Similarly, these providers may perceive the systems
approach that underlies patient safety research to be inapplicable in the dyadic clinical care settings in which they practice.

While continuous quality improvement initiatives offer documented, quantifiable patient safety benefits; reliance on patient safety as the impetus for error communication has proven ineffective. I posit that advancing communication of medical error will require reliance on its ethical foundations, which I detailed in Chapters Two and Three. Only the force of a moral imperative is strong enough to counter the powerful sway that the culture of medicine exerts on its practitioners. The provider who wishes to “do the right thing,” but seeks to do so only after all risks have been eliminated, will be immobilized. Instead, he will need to summon his courage to act, even in the face of mixed messages and potential threats to self interest. In the words of Mark Twain: “Courage is resistance to fear, mastery of fear – not absence of fear.” Dwyer observes that physicians routinely face physical risks in practice, such as treating patients with highly infectious disease; but many are less inclined to engage in the kind of risks that threaten self-interest such as speaking up to challenge existing norms. He urges responsible adherence to the maxim: *primum non tacere* – “first, do not be silent,” suggesting that cultivation of this habit begins in medical school.265 As I noted in the last chapter, breaking the “wall of silence” around medical error will not guarantee alleviation of guilt. However if Earhart is correct, peace of mind – more than relief from guilt – may be the ultimate reward for courageous action.

I do not mean to imply that the entire burden for courageous moral action should rest solely on the individual practitioner. On the contrary, if advancing medical error disclosure is, as I suggest, a fundamentally moral imperative; then institutions have a
concomitant duty to encourage and engage in ethical action. To those who might question the practicability of a morally grounded institutional change initiative, I submit that institutional structures provide an ideal platform from which to launch realignment of interests across multiple stakeholders. Rathert and Phillips concur, stating: “We propose that medical error disclosure policies in the organization can reflect a values-based ethical environment, as opposed to one that is primarily compliance-based.” They, too, find the moral imperative underlying error disclosure to be more compelling than the compliance framework underlying the patient safety movement. Accordingly, in the last part of this chapter I will turn my attention to offering suggestions for implementing values-guided organizational change. However, I would be remiss if I did not first address the societal influence typically cited as the most imposing barrier to communication of error: fear of medical malpractice liability.

May and Aulisio suggest that there are two primary purposes for the medical malpractice system: “(1) to deter inappropriate, incompetent, or unprofessional conduct, and (2) to compensate victims for losses incurred.” The current medical malpractice system is ineffective in both respects. First, it is highly inefficient as a method for compensating victims of medical error; as noted in the previous chapter, over 80% of those with legitimate claims do not avail themselves of the tort system. Meanwhile, a small proportion of patients (less than 5%) who suffer adverse events not attributable to error may be unjustly enriched. Secondly, the value of the current system as a deterrent to intentionally reckless behavior is questionable given this low incidence of legal action. Those inclined to reckless, risky behavior will find the odds of risk to be decidedly in their favor. Correspondingly, many of the practitioners against whom legal action is
commenced have committed errors of execution or planning in the course of performing to the best of their ability with the best of intentions, albeit with undesirable outcomes. In some instances, no error was committed and an adverse event ensued nonetheless. Still, many of these non-negligence cases are settled by insurance companies to avoid the costs of litigation or the unpredictability of jury verdicts, especially when the harm is particularly tragic. In addition to these deficits, the system provides a convenient rationale for avoiding communication of error to patients and families, even though the fear of litigation may be disproportionately high.

As a result, some have argued that a no-fault system such as that employed in the U.S. for workers’ compensation would be preferable. While space does not permit a comprehensive review of potential no-fault schema, conceptually such a system would compensate all victims of preventable medical error based on predetermined reimbursement levels or on actual projected costs of care. Some proposals would allow assessment of punitive damages; others would not. Tort action could remain an option in cases of gross negligence. Studdert and Brennan, both influential in the patient safety movement, argue that such a system is both economically viable and would contribute to more transparency in reporting errors, both institutionally and to patients.268 They note that in Sweden, where a no-fault system has been in effect for several decades, physicians are involved in assisting patients to file claims in 60-80% of cases.269 However, Danzon cautions against extrapolating from the Swedish experience. First, he notes that the Swedish system, known as Patient Compensation Insurance (PCI), is not a traditional no-fault, or “strict liability,” system. In contrast to U.S. workers’ compensation insurance, which is purchased by employers and covers any work-related injury regardless of cause,
PCI is a voluntary insurance paid for by potential beneficiaries, and outcomes are not compensable if arising from treatment that was medically justified and conformant to the standard of care.\textsuperscript{270} Interestingly, PCI claims data reported by the administering agency to the health care institution typically includes only the patient’s name and a description of the procedure, but does \textit{not} include the provider’s name.\textsuperscript{271} Thus the physician’s reputation is not threatened, as it is by the U.S. malpractice system. Incident follow-up is at the discretion of the institution, and many choose not to do so; there is no incentive for post-hoc analysis – hence quality improvement – since claim costs are not borne by the institution. Workers’ compensation insurance in the U.S. is experience-rated, thus providing employers with an incentive to improve worker safety. As another point of difference, physicians in Sweden are government employees; consequently their livelihood is not threatened by a PCI claim as that of a U.S. physician charged in a medical malpractice claim would be. Danson also observes that the Swedish culture is thought to be less litigious.\textsuperscript{272} While the Swedish model serves the aim of providing rather expeditious compensation to patients, it appears unrelated to enhancing patient safety and may even fall short of fulfilling the ethical needs served by communication and apology.

Despite uncertainty about its outcomes, I remain a proponent of developing a no-fault type of system in the U.S., provided that it addresses needs for patient compensation, transparency, and quality improvement. The MEDiC legislation sponsored by Clinton and Obama would have provided funds for experimentation with various models of alternative dispute resolution. However, prospects for medical
malpractice reform appear slim. Even caps on non-compensatory damages face fierce battles in state legislatures, as is currently the case in North Carolina.

Nevertheless, while appropriately designed tort reform might help mitigate some physician concerns about error communication, such as those regarding potential loss of income and livelihood, excessive time involved in contesting claims, and fear of the fickle jury awards, I argue that such reforms would not be sufficient to overcome potent barriers to communication of error posed by the culture of medicine. If fear of malpractice liability were the dominant force it is purported to be, then one would expect more transparency in countries with less onerous malpractice climates. Yet Gallagher et al. find that attitudes toward disclosure in Canada mirror those in the U.S., despite the fact that Canada has a significantly less burdensome malpractice environment. Dewees et al. report that the U.S., Canada, the U.K., and Australia experienced comparable growth in malpractice litigation in the 1970’s and 1980’s; yet the U.S. remains far more litigious: “Claims frequency in the United States is five times that in Canada, severity is one-third greater, and insurance fees are about ten times greater.” Thus, liability risk alone cannot explain attitudes toward error disclosure. Infallibility, perfectionism, professional deference, detached concern, and, above all, conflation of error with moral culpability – all kept alive through the medium of the horror story – act as powerful cultural inhibitors to error communication to patients and their loved ones.

Yet the culture of medicine is not impenetrable. Health care institutions have demonstrated the ability to play a pivotal role in shifting the culture with regard to communication of error. When institutional leaders exhibit the moral courage to take actions that appear, at least initially, to be contrary to the entity’s financial interests and
reputation, this sends a demonstrative message to their practitioners. Leaders at Catholic Healthcare West (CHW) recognized that the values hanging on their wall – core values pertaining to, “dignity, collaboration, justice, stewardship, and excellence” – would be nothing beyond words on a wall if error were not communicated to patients and/or patients’ families. Thus a change initiative ensued, led jointly by leaders in risk management, legal services, and ethics education. Bayley reports that they started by gaining commitment from CHW’s Corporate Members (representatives of sponsoring congregations) and the Board of Directors. The “Mistake Project” that emerged from this meeting led to interviews, the purpose of which was to uncover examples wherein the institution’s espoused values regarding error disclosure were not being followed.

Armed with these examples, the CHW change leaders developed initiatives which were communicated over the course of several months throughout the 48-hospital system. Bayley observes: “Eventually, of course, real culture change must be a top-down effort that is met by bottom-up initiatives, such as clear disclosure policies at the local level and practices of claims settlement marked by fairness and respect.” In my experience, this involves keeping lines of communication open between those in leadership and those on the front lines. While leading a similar multi-disciplinary cultural transformation at an energy utility, I observed as members of our executive team rolled out the company’s newly articulated values at “challenge sessions” in which every employee throughout the organization was given an opportunity to provide examples that contradicted the values espoused. I vividly recall the courage of one accountant who asked the Chief Financial Officer why the company kept two sets of books – one that portrayed the company’s financial picture favorably for Wall Street analysts and one that portrayed it more grimly
for the state utility commission when seeking permission to raise rates. Faced with such a direct question in a public forum, the CFO had no choice but to promise more consistency and transparency – a promise he famously kept. He turned what could have been an embarrassing “horror story” into a “hero story.” Word of this challenge, and the action it compelled, swept across the company grapevine.

Similarly, the leaders at CHW tackled a number of difficult issues – one of which was the preferential treatment afforded to high profile providers (e.g., seeking to get them dismissed from lawsuits in which they bore some responsibility or excluded from reports to the National Practitioner Data Bank). More generally, physicians are portrayed as the most challenging stakeholders in the CHW change initiative, highlighting the tension between the hospital system’s dependence on them as revenue generators and their dependence on the system for the venue and other resources needed to treat patients.

Some physicians expressed concern that CHW’s commitment to disclosure would ‘hang them out to dry.’ In personal conversation with me, Carol Bayley explained that one strategy for addressing this included enlisting the support of key medical malpractice insurers, who in turn influenced their insured physicians.

As noted above, the alignment of practices and policies is essential to supporting culture change. However, culture is ultimately transformed in the same way it is sustained – through stories. The “horror stories” so much a part of the culture of medicine must be replaced with “hero stories” – stories portraying not merely the institution’s formal leaders, but more importantly, stories that originate from its informal leaders. In any intentional change initiative, it becomes essential to identify who these informal leaders are. In the case of advancing communication of error, informal leaders
will include practitioners who both are early adopters of change and garner the respect of peers. Bayley concurs:

Some of the most moving stories have been offered by physicians who have made mistakes, integrated the lessons from them into their practice and come to resolution about them within themselves. Far more than elected or appointed leaders, these physicians, I believe, will be the real leaders in cultural change, if they can find ways to share these very intimate experiences with their colleagues.dın

These stories serve to overturn the norm of error as transgression, replacing it with a new norm favoring transparent communication of error.

The design and progress of culture change will be different in each system. Leaders within the UMHS demonstrate their courage in a different manner. Underlying their desire to act ethically are the stated values of “fostering consistency and predictability for patients, medical staff, lawyers, and courts.”adin Boothman points out that the “deny and defend” approach creates uncertainty, anxiety, and lost productivity for all parties to a legal action, while virtually ensuring that quality improvement will be suspended throughout the course of the litigation. Though UMHS enjoys the advantages of a structure in which their physicians are direct employees of the system, the culture of medicine remains a potential threat to change. UMHS leadership gains physician cooperation by standing firm on the three principles cited in the previous chapter. Chief among these is their commitment to mount a vigorous defense to litigation when the care provided is deemed to have been reasonable. However, in order to fulfill this commitment, the system must maintain a rigorous process of internal review that explicitly countermands the tacit professional deference code of medicine. Also needed in the UMHS approach is a cadre of trained coaches to support physicians as they prepare to communicate error to patients and loved ones. Notably, UMHS has involved patients
Boothman tells of one patient who participated in making a teaching video, the purpose of which was to both prevent replication of the error that occurred in her case and to convey the mediation process used to arrive at an early settlement. On that video, the patient describes her reactions to the meeting in which she was given a chance to tell her story, hear her physician’s story, and receive his apology:

After that night (of the meeting), I left there like I was on a mountaintop. I felt like I had finally been heard, they listened…If that had been the end of the legal pursuit, that would have been fine with me. I was perfectly satisfied that night. What that apology meant to me was that they had listened finally and I had been heard. I can’t even describe how euphoric I felt when I left that meeting.²⁸⁰

Notably, this was the patient’s reaction after receiving a settlement of $402,900 as contrasted with an original settlement demand of $2 million. This patient’s attorney also appeared on videotape, describing the meeting as follows:

Instead of adversarial, it was conversational. It was instead of trying to figure out what claims and defenses needed to be, I found myself trying to figure out some higher calling, what’s the right thing to do here? What’s the best thing to do here?... (My role) changed from advocate to warrior to counselor is the best way that I can describe it. (W)e are attorneys and counselors and the counselor part got emphasized, in fact became the dominant, ascendant part just as soon as it became clear the University Hospital was gonna take a different approach to this case.²⁸¹

When potential horror stories are turned into hero stories and are promulgated throughout a system, the culture begins to shift. I hasten to add that, as Carol Bayley advises, the UMHS principled approach to values-based change requires more than vocalized leadership commitment; it is supported by numerous, integrated “bottom-up initiatives” – from risk management, patient safety, patient relations, medical education, and others – all of which involve training professionals to ably fulfill their roles in the new approach to transparency. This alignment of internal as well as external stakeholders (such as
medical malpractice insurers and members of the plaintiffs’ bar) is not to be minimized. The change initiative itself becomes a stakeholder, requiring coordination, communication, continual reassessment and course correction.

Cultural transformation is not easy, particularly when a culture is as deeply entrenched as the culture of medicine. Yet, as the two stories above illustrate, change is not impossible. To be sure, there are individual physicians with the moral courage to act ethically, rising above the norms and practices of their profession. But if the aim is to change the culture, not merely buck the culture, then aligned institutional action is required. In the context of institutional change, both formal and informal leadership is required, and hero stories may emerge from either.

Formal leaders are heroic in their articulation and steadfast support of institutional values, especially when those values demand actions that conflict with financial or other institutional interests. Few will forget Johnson and Johnson’s decision to withdraw Tylenol® from store shelves in 1982 when faced with contamination from external sources. Nor will the public soon forget this same company’s 2010 delayed response in recalling liquid pediatric products found to have been contaminated during manufacturing.282 The actions of formal leaders are magnified, whether exemplifying or undermining their espoused values.

Those who hold formal positions of leadership also demonstrate heroism through their willingness to remain in dialogue with stakeholders at all levels in order to relentlessly root out, humbly acknowledge, and visibly rectify actions that are contrary to espoused values. Translating vision into action requires vigilant attention. For instance, in the case of error communication, Truog et al. repeatedly reference the importance of
the disclosure coach, someone who is trained both to prepare practitioners for
communication and to ensure that the practitioner receives the same empathic attention to
his emotional needs as the patient and family members receive for theirs. Absent this
personalized attention and investment in resources, the disclosure initiative becomes
merely a set of actions to do rather than a transformation that takes place within
practitioner, prompting him to shift his beliefs about himself, about his role, and about his
institution. These new beliefs in turn contribute to the formation of new cultural norms.
Informal leaders exhibit heroism through their willingness to experiment with newly
articulated institutional values in action, serving as role models for others. Typically,
colleagues are far more willing to follow the lead of someone they trust and respect than
they are to accept the exhortations of distanced formal leaders. In this respect, the
propagation of institutional culture change mirrors the propagation of culture in medicine,
relying on demonstration and mentorship. In all likelihood, these informal leaders are the
same courageous individuals who would elect to follow their own ethical compass, even
when it leads them to act outside the norms of their profession. Yet as individual actors,
their choices are theirs alone – with little impact on changing practice. This incremental
progress is what we have witnessed to date in the arena of error communication.
However, when these individuals’ choices are supported by espoused institutional values
and by the integrated programs and processes needed to operationalize those values;
when their actions explicitly challenge accepted cultural norms and are celebrated as hero
stories; then their collective action invites accelerated cultural transformation on a wider
scale. Thus bridging the gap between transgression and transparency in error
communication requires moving beyond its patient safety roots and nurturing individual
and, importantly, institutional commitment to the moral foundations of truthfulness and trust in the practice of medicine.
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5 IOM Report 1 addresses only reporting of errors internally within institutions and externally to patient safety organizations. IOM Report 2 offers one statement about communicating “complications” to patients on p. 45 and calls for “no secrets” in the context of transparent communication with patients on p. 63 and p. 79.


11 IOM Report, 1.

12 Brennan et al., ibid.


Leape 2000, ibid., 95.


IOM Report, 2.


Lamb, ibid., 76

Lamb, ibid., 79


“General medicine” here refers to internal medicine – general and all subspecialties, plus family medicine.


Blendon et al., ibid., 1934.


Leape 1994, Ibid., 1856.

IOM Report II, 64.

Schein, ibid., 132-34.

Truog, ibid., 15.


I will employ the masculine pronoun in all references to physicians in this paper, in part to preserve the anonymity of my interviewees, who were of both genders.

IOM Report, 28.


Gallagher et al. 2003, ibid., 1003.

Jon R. Waltz, “The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation,” *DePaul Law Review* 18 (1968): 408-420, 409. Brennan et al., ibid. at 370 employ the more traditional community standard rule in conjunction with the standard of care to define negligence; this locality rule, however, continues to lose favor.


Ibid.

Note: I have added the words “caused by medical management” to their diagram for clarification; this is consistent with their statement, “For our purposes in this book, the definitions of the terms “error” and “adverse event” that we use are the ones adopted by the Institute of Medicine in its report To Err is Human.” The IOM definitions are cited on pages 20-21 of this thesis.

56 Truog, et al., ibid., 14.

57 Ibid.

58 IOM Report, 36.


60 Cook, et al., ibid., 36.


62 IOM Report, 54.

63 Leape 1994, ibid., 1853.

64 IOM Report, 54.

65 Leape 1994, ibid., 1853.

66 Ibid.

67 IOM Report, 54.

68 Leape 1994, ibid., 1853.

69 IOM Report, 55.
Leape, 1994, ibid. 1854.

Leape, 2000, ibid., 97.


Bok, ibid., 33.

Bok, ibid., 34.

Bok, ibid., 37.

Bok, ibid., 38.


Jackson, ibid. at 56.


Zembaty, ibid., 9.

Zembaty, ibid.

Zembaty, ibid., 16.


Ibid., 328.

Bok, ibid., at 22.


Bok, ibid., at 92.

Jackson, ibid. at 11.

Jackson, ibid. at 13.

Jackson, ibid. at 13.
91 Jackson, ibid. at 16.


94 Ibid.


96 Gore and Gregory, ibid.


100 Hall, et al., ibid., 614.

101 Hall, Ibid., 475-76.


104 Morse, ibid., 3.

106 CRICO/RMF DVD, ibid.


112 CRICO/RMF DVD, ibid.


114 Gallagher et al. 2003, ibid., 1004.

115 Gallagher et al. 2003, ibid., 1003.

116 Ibid.


118 Ibid.


120 Lamb et al., ibid., 77.


CRICO/RMF DVD, ibid.


CRICO/RMF DVD, ibid.


Ibid.


Lazare, ibid., 31.

Lazare, ibid., 32.

Lazare, ibid., 33.
Andre, ibid., 62.

Andre, ibid., 65.


Lazare, ibid., 34-35.

Lazare, ibid., 35.

Lazare, ibid., 75-98.

Gawande, ibid., 59.

Lazare., ibid., 98-117.

Lazare., ibid., 127.


The Joint Commission defines twenty-eight “sentinel events,” which are deemed serious and largely preventable events, including such occurrences as patient abduction, ventilator death, maternal death, and wrong-patient, wrong-site or wrong-procedure surgery. The complete list can be found at: http://www.jointcommission.org/assets/1/18/SE_Data_Summary_4Q_2010_%28v2%29.pdf reporting of most sentinel events to The Joint Commission is voluntary.

The National Quality Forum developed a list of serious reportable events (SREs), comparable though not identical to the Joint Commission’s list of sentinel events. While the NQF has no administrative authority, it has successfully advocated with several states to obtain mandatory reporting of SREs, the complete list of which can be found at: http://www.qualityforum.org/Calendar/2010/01/National_Voluntary_Consensus_Standar ds_for_Serious_Reportable_Events_in_Healthcare--Comment_on_the_Revised_SRE_Definition--_2010-01-04.aspx (Accessed March 1, 2011). SREs are often referred to as “never events,” stemming from description of SREs as, “preventable, serious, and unambiguous adverse events that should never occur.” There is, however a 2011 proposal to change “never” to “not,” based on some expert
opinion that perfection is not feasible. For more details, see:


151 Truog, et al., ibid. 75.

152 Truog, et al., ibid., 74-91.

153 Truog, et al., ibid., 76.


155 Ibid.

156 Truog, et al., ibid., 85.

157 Truog et al., ibid., 87.


159 Truog et al., ibid, 78.


161 Gallagher, et al., 2009, ibid., 2.


167 Gallagher 2009, ibid., 3-4.


169 Dudzinski, et al., ibid., 978.


173 Truog, et al., ibid., 131.


176 Bosk, ibid., 40.

177 Bosk, ibid., xxiv.


179 Leape 1994, ibid., 1852.

180 Bosk, ibid., 248.


182 Leape 1994, ibid., 1851.

183 Banja, ibid., 219.
184 Banja, ibid. 47-85.

185 Banja, ibid., 76.


190 Banja, ibid., 33-34.

191 Gallagher et al. 2006, ibid., 1608.


193 Ibid., 253-54.


198 Halpern, ibid., 15-16.

199 Halpern, ibid., 25.


Morse, ibid.


Calman, ibid., 247.

Ibid.


Bosk, ibid., 144.

Truog, et al., ibid., 99.


Berlinger, ibid., 22-23.

Kaldjian, et al., JGIM ibid., 946.

Bosk, ibid., 103-110.

Lamb, et al., ibid., 78.

Davidoff, ibid., 623.

Studdert, et al., ibid., 216.


Robertson, ibid., 216-218.


McDonnell and Guenther, ibid., 812.

Truog, et al., ibid., 46.


Dresser, ibid., 6.


Ibid.

Studdert, et al. 2007, ibid., 221.


Boothman, et al., ibid., 139.

Boothman, et al., ibid., 140.

Kalachia, et al., ibid., 215.

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Kalachia, et al., ibid., 217.

Boothman, et al., ibid., 146.

Ibid.


Truog, et al., ibid., 53.
250 Truog, et al., ibid., 23.


253 Cook, et al., ibid., 40-41.


257 Joint Commission on Accreditation of Healthcare Organizations, “Comprehensive Accreditation Manual for Hospitals.”

258 IOM Report, 180.

259 Truog, et al., ibid., xiii.

260 Truog, et al., ibid., 98.


263 Donald M. Goldstein and Katherine V. Dillon, Amelia: A Life of the Aviation Legend, Brassey’s Ltd.: United States (1997), 38.


269 Studdert and Brennan, ibid., 219.


271 Danzon, ibid., 222.

272 Danzon, ibid., 223.


276 Bayley, ibid., 151.

277 Ibid.

278 Bayley, ibid., 155.

279 Boothman, et al., ibid., 139.

280 Boothman, et al., ibid., 158.
281 Ibid.

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NTL (National Training Laboratories), UA (University Associates), and Designed Learning: numerous workshops in consulting skills, team development and training design
Myers-Briggs Type Indicator - Certification
Bar-on EQ-i (emotional intelligence instrument) – Certification
Drexler-Sibbitt Team Performance Inventory – Certification
The Leadership Circle (360-degree feedback instrument) – Certification

COMMUNITY SERVICE

Court Appointed Special Advocate for child abuse and neglect, Washtenaw County, Michigan, 1988-1992

Council on Child Abuse and Neglect of Southern Ohio, Cincinnati, Ohio, Hotline Volunteer, 1994-1997

Guardian ad Litem for child abuse and neglect, Orange County, North Carolina, 1999-2007

American Heart Association, Orange and Durham Counties, North Carolina, Heart Gala Volunteer, 2004-2006

Chapel Hill-Carrboro City Schools, Volunteer (Project Graduation, School Improvement Plan Committee), 2003-2007
Deborah Love was born March 7, 1952 in Detroit, Michigan. She completed her undergraduate work at the University of Michigan in Ann Arbor, Michigan, where she received a Bachelor of Arts in Spanish, with High Distinction, in 1975. Concurrent with her first corporate job, she began her graduate studies at the University of Michigan, Graduate School of Business Administration, transferring from part-time to full-time in her final semester. She earned her MBA with a concentration in Organizational Behavior and Industrial Relations in 1978, whereupon she accepted an entry level position in Labor Relations with Ford Motor Company. Two years later she accepted her first position in a healthcare firm with Warner-Lambert/Parke-Davis, Pharmaceutical Research Division where she worked for nearly seven years. During this time she obtained her Juris Doctorate degree in the evening program at the Wayne State University School of Law in Detroit, Michigan with a concentration in Labor and Employment Law. She received her J.D. in December, 1984 and was admitted to the State Bar of Michigan in May of 1985.

Discovering rather quickly that she would rather invest her energy in seeking to prevent rather than merely resolve employee relations conflicts, upon receiving her J.D. she turned her attention to leadership development, team building, organizational change, and executive coaching. Since 1988, as both an internal and external consultant, her focus has been on supporting leaders who believe that thriving employees and sustainable business performance go hand-in-hand. For half of her career she has practiced in a healthcare context – in the pharmaceutical, medical device, and health care delivery arenas. Upon graduation with her M.A., she hopes to shift the context of her work exclusively to healthcare delivery – consulting in clinical ethics, enhancement of physician/patient communication skills, and the integration of clinical and organizational ethics.

Beyond formal degree work, she gained extensive grounding in human dynamics, including the humanistic approach developed by family systems therapist, Virginia Satir, and the principle-based approach to psychology pioneered by George Pransky. She also gained experience in process improvement and whole system engagement. Also of note, for nearly 15 years she served as a volunteer court-appointed guardian ad litem in cases of child abuse and neglect, where she gained experience working with families under stress.

After staring her own consulting practice in 1997, she could live anywhere she chose, so she and husband and daughter moved to Chapel Hill, North Carolina, where she resides today. Deb has a daughter, aged 21, who will graduate from the University of North Carolina at Chapel Hill in 2011; a grandson aged 19 who is a sophomore at Duke University; a granddaughter in Ohio who is completing her sophomore year in H.S.; and three grandchildren in Texas – a granddaughter in second grade and twins (one boy, one girl) in kindergarten. In addition, Deb has a 3 year old godson, whose mother she accompanied to Viet Nam for the adoption. When not studying, working or visiting with family and friends, Deb is an avid golfer and fan of professional baseball and college athletics.