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Practicing Medicine within the Margins of Human Error

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There are two basic approaches to the study of medical errors. One involves the search for individual culpability and assignation of personal blame; the other, a “systems approach,” focuses on the interdependence of all members in the chain of health care delivery, and seeks organizational solutions to prevent or mitigate errors. “Systems errors” might include: problems with characteristics of job designs (eg, workload, time to execute a job, practical support to enable job performance, etc), the technical execution and accessibility of diagnostic tests or medical therapies; and, the performance of all personnel involved in the coordinated delivery of care. The recent landmark report on medical errors by the Institute of Medicine¹ characterized the vast majority of medical mistakes as system—rather than individual—errors.

A systems approach to error analysis may be supplanting the

traditional “personal approach” model. Still, the experience of most clinicians caring directly for patients who suffer a systems mistake will remain profoundly personal.

In the ethics case below, we read about a systems error. We also read about a doctor and his patient who will have to find some way to reconcile the human and ethical dimensions of the mistake within the context of their particular and private relationship.

Case: A Malignant Error in Retrospect

Ms Gordon is a 50-year-old woman who is concerned about a vague irregularity she feels within her right breast. She voices the issue to her physician, Dr Halpern, during her yearly examination. Dr Halpern palpates the area, shares the patient’s concern, orders a mammogram, and refers Ms Gordon to the breast clinic. The mammogram is read as normal, and the breast specialist, a surgeon, diagnoses the irregularity as benign

variations. One year later, during the next annual appointment, Dr Halpern palpates an irregularity in Ms Gordon’s breast. Without the clinic chart, neither Ms Gordon nor Dr Halpern can recall if the area of concern matches that of the prior year. A mammogram and a referral to the breast clinic are ordered. Within three weeks, Ms Gordon is diagnosed with metastatic breast cancer emanating from a radiographically conspicuous right breast primary tumor. Weeks later, having completed her chemotherapy, Ms Gordon attends an appointment with Dr Halpern to discuss her reactive depression. Perusing the chart before entering the exam room, Dr Halpern discovers that Ms Gordon had worried about the same location in her right breast one year before its identification as the primary site of her metastatic disease. He phones a radiologist who is familiar with the case; she informs him that there existed clear evidence of the cancer on the mammogram performed the prior year. ♦

Case Commentary

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Tracking systems, quality improvement programs, and malpractice litigation provide avenues of redress for errors such as this. They also interpose distance between those who contribute to the error and those affected by it, diluting the emotionality that close proximity is liable to generate. But Dr Halpern cannot hide in that distance; he and Ms Gordon cannot escape the pain that will be created by mutual acknowledgment of the error. Moreover, they will have to engage each other to repair the fundamental trust underlying the physician-patient relationship that the error is liable to rupture. While the error is not Dr Halpern’s—it rests on the colleagues upon whose expertise he must rely—it will certainly affect his

relationship with Ms Gordon. And even if diagnosis one year earlier would have made no prognostic difference, the consistent public health message advocating early detection and regular screening is certain to leave Ms Gordon feeling that real harm eventuated from the delay.

Whose responsibility is it to bring the error to light? Many individuals appear to have had an opportunity to identify the error. Dr Halpern phones a radiologist who is already aware of the error. We might wonder whether the surgeon who diagnosed the malignancy had an inkling that a diagnostic opportunity had been missed when he or she reviewed the patient’s previous record. Finally, we might ask if Ms

This month we begin a medical ethics column in which Dr Kate Scannell explores medical ethics. She will write and include guest commentary in future issues.

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Gordon has some obligation to advocate for herself and inquire as to whether an error has occurred.

So what should Dr Halpern do? We readily agree that he should tell Ms Gordon about the error if she inquires whether an error occurred, for we seem to be unwilling to advocate that he lie in the face of a direct inquiry. But suppose she does not inquire, and why is her initiation of the inquiry necessary? Let's assume that the error unequivocally constitutes a missed diagnosis. Is there any obligation to tell her if she doesn't ask? And isn't it possible that knowledge of the error might further jeopardize her well-being, especially in light of her reactive depression? Furthermore, we might explore how Dr Halpern would be affected if the error were successfully kept from Ms Gordon. How would his knowledge of the deception influence his future relations with her?

In her seminal book *Lying*,² Sissela Bok writes, "... whether to lie, equivocate, be silent, or tell the truth in any given situation is often a hard decision. Hard because duplicity can take so many forms, be present to such different degrees, and have such different purposes and results." She surveys various justifications for altering or omitting truthfulness with patients—for their own good or protection—from the perspectives of the patient and the physician. The deceiver's rationalizations for his or her deceit become increasingly suspect as less altruistic motivations or justifications are recognized: maintaining the paternalistic stance of power over another, the desire to avoid confrontation, and the work of initiating systems changes.

Bok posits that paternalistic deception is defensible only if the deceived consents or implies a willingness to be deceived—an exceedingly rare situation. Conceivably, would Ms Gordon agree that it is not in her best interests to know of the error? Furthermore, Bok asserts that paternalistic deception not only lacks justification, it also poses potential and significant risks for both parties. The deceived party is exposed to multiple risks of exploitation, including disruption of the relationship with the deceiver since the deceived is liable to become resentful, disappointed, and suspicious. The perpetrator of the deceit is at risk of moral degeneration as more lies and considerable energy are required to sustain the deception. Degradation of the individual's character may follow as boundaries are transgressed and lies are seen to provide easy, short-term resolutions of painful situations.

The pre-existing inequality inherent in the physician-patient relationship sets up a differential in the interpersonal relationship of power that risks a malignant imbalance if strained by deceit. According to Brody, the goal is to exercise the ethical use of power by the physician on the patient's behalf.³ To illustrate his point, he uses Fried's description of the four obligations of the physician to the patient: fidelity; humanity; autonomy; and, lucidity. The description also provides a proper refutation of paternalistic deception: "Fidelity requires that the physician always use [his] power on the patient's behalf and not to [her] detriment. Humanity requires that the physician always take into account the relative powerlessness of the sick patient while still preserving a human-to-human relationship. Autonomy requires that the physician be prepared always to share power with the patient. Lucidity requires that the physician be accountable for how [he] has used [his] power."⁴ Although Dr Halpern did not commit the error affecting Ms Gordon's care, he does owe a duty to her to see that she is made aware of the error and supported through the process of disclosure and understanding. To fail to do so risks erosion of the trusting relationship necessary to provide care for her current and future medical needs. It also risks Dr Halpern's ability to maintain a caring and supportive professional relationship with all of his patients because of the corrosive effects of deceit. Trust is a mutual covenant, a fragile but enduring promise between individuals.

Trust in the medical relationship explains why patients will expose their nakedness, allow their flesh to be cut, and ingest poisons, all in the hopes of preserving or restoring health on the physician's advice. Patients not only expect to be told the truth by the physician but also to be protected from harm. When the latter is not possible, the former is required. ❖

References

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