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Institutional Responses to Medical Mistakes: Ethical and Legal Perspectives

ABSTRACT. Health care institutions must decide whether to inform the patient of a medical error. The barriers to disclosure are an aversion to admitting errors, a concern about implicating other practitioners, and a fear of lawsuits and liability. However, admission of medical errors is the ethical thing to do and may be required by law. When examined, the barriers to such disclosures have little merit, and, in fact, lawsuits and liability may actually be reduced by informing the patient of medical errors. Therefore, a health care institution should implement a written policy providing for disclosure of medical errors, using a process such as that outlined in the article.

I have been a health care lawyer for more than 20 years. During that time, I have been faced repeatedly with the issue of how much disclosure my client, a health care institution, should make to a patient (or a patient's surrogate when the patient lacks capacity) regarding a clinically significant medical error. In my experience, it is best for the patients, the institution, and the practitioners within it to adopt and implement a policy of disclosure in such situations.

We intuitively understand that honest admission of medical mistakes, when such mistakes are of clinical significance, is the "right" thing to do. However, in practice, health care providers do not always make such admissions (Kohn, Corrigan, and Donaldson 1999). Practitioners who choose to remain silent present various rationales for their decision. The most common reasons are that such admissions are particularly difficult for health care providers such as physicians, that such admissions may implicate other clinicians, and that such admissions may increase liability exposure (Bogner 1994, pp. 373, 379).

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This article first explores the ethical and legal foundations for the premise that the admission of clinically significant medical mistakes is the right thing to do. I then analyze the rationales for failures to make such admissions. This analysis leads to the conclusion that the premises that admission of errors by practitioners is particularly difficult or that it leads to increased liability are without objective foundation. Additionally, admission of errors rarely need implicate other practitioners if such admissions are limited to only those errors that are the responsibility of the practitioner or institution directly involved. In short, admission of clinically significant medical mistakes by practitioners and institutions is not only sound ethics, but probably also good risk management.

THE ETHICAL BASIS FOR ADMITTING MISTAKES

Although one aim of a for-profit health care institution may be to make money for its shareholders, that goal is achieved by providing health care services to those willing to entrust themselves to the care of the institution. A for-profit institution can also have an educational mission, including both the education of those in its service area on health issues and the education of erstwhile providers. The missions of non-profit health care institutions typically include providing for the health care needs of the community and providing health care education to the community and providers.

In either case, the missions of health care institutions are incompatible with "covering up" clinically significant medical errors. As Kapp (1997, pp. 758–59) said:

> Hiding or rationalizing, rather than acknowledging, medical errors is ethically harmful at least three reasons. First, it interferes with the desirable process of turning errors into educational "treasures" from which both erring physicians and their colleagues might learn and grow professionally. Second, it hurts patients by depriving them and their physicians of information that could potentially be valuable in correcting errors and otherwise improving treatment of present and future patients. . . . Patients' families may also be cheated. For instance, fear of uncovering errors that might lead to litigation probably assists in accounting for a decrease in the number of autopsies performed today, thereby diminishing many opportunities for physicians to learn, to comfort families with explanations of the patient's death, and to alert families of discovered genetic risks. Finally, purposeful deception undercuts and attacks the essential fabric of the fiduciary or trust nature of the physician/patient relationship by directly violating the ethical principle of fidelity or truthfulness.

While the "healing" mission directed toward individual patients may not be impacted adversely by failing to admit errors, particularly if the clinical consequences of the errors are insignificant or remediable, other aspects of institutions' missions are negatively implicated. An institution cannot effectively carry out its educational mission or its fiduciary responsibilities if it "covers up" errors. In order to understand clinical health care, as well as health care delivery and other policy issues, lay community members, providers-in-training, and providers all must be familiar with the occurrence and consequences of medical errors.

If the covering up of medical errors is discovered, then the institution's mission is compromised in perhaps an even more fundamental way. The mission of health care institutions, particularly charitable institutions, is grounded in trust. Patients entrust themselves to health care institutions willingly because they perceive, correctly, that the institution has a fiduciary obligation to take care of them. Honesty is at the heart of that obligation: the institution will either take good care of the patient, or explain why they failed to do so and fix it. If potential patients and the community do not trust the institution, then the relationship becomes, at best, one of suspicion, and, at worst, adversarial. In either event, the institution is unable to achieve its mission.

The institution has a specific patient-based ethical obligation to admit clinically significant mistakes. A health care institution has an obligation to inform individual patients or their surrogates of issues that have implications for the patients' health status or course of treatment. If an error has a clinical consequence, the patient needs to know it in order to participate meaningfully in continuing treatment decisions. The lawsuit of a professional football player against his team and team doctors is a high-profile example (*Krueger v. San Francisco Forty-Niners*, 189 Cal. App. 3d 823, 234 Cal. Rptr. 579 (Cal. Ct. App. 1987)). The player asserted that had he been accurately told the extent of his knee injury he would not have continued playing as the team and the team doctors encouraged. He played on and was permanently crippled. The court ruled that he had a cause of action against both the team and the team doctors, though neither had caused the original injury. It can hardly be gainsaid that a hospital has more of a fiduciary obligation to its patients than does a professional football team to its salaried employees.

THE LEGAL BASIS FOR ADMITTING MISTAKES

The legal obligation for certain direct clinical providers, such a physicians, to admit mistakes with clinical consequences is clear. The doctrine of informed consent is imbedded in the health care law of the United States. This doctrine places an obligation squarely upon the physician to inform the patient of their condition and the risks, benefits, and alternatives to the treatment being recommended. This obligation includes within it the obligation to inform the patient of current medical mistakes with clinical consequences, whether committed by the physician or not, since the patient needs the information in order to give adequate informed consent, particularly in the area of continued reliance on certain providers (see, e.g., LeBlang and King 1984; Vogel and Delgado 1980; Kapp 1997).

Although the institution may not have a direct legal duty to disclose clinically significant medical errors under the doctrine of informed consent, in most states the institution has a legal obligation to ensure that adequate processes are in place for legitimate informed consent to occur. This duty certainly encompasses a legal obligation to guarantee that there is an adequate process in place for patients to receive the necessary information concerning clinically significant medical errors to give adequate informed consent to their continuing, post-error treatment (see, e.g., *Thompson v. Nason Hospital* 527 Pa. 330, 591 A.2d 703 (1991)). Moreover, the institution often does have a direct legal obligation to report significant medical errors to third parties, such as the Joint Commission on Accreditation of Health Care Organizations (JCAHO), if the error is a "sentinel event," which JCAHO (2000) defines as "an unexpected occurrence involving death or serious physical or psychological injury," or to a state agency if state statutes so require (for a representative example, see 28 Pa. Code Section 51 et. seq.). Although it has not been directly tested in court, it appears likely that a court would hold that an institution has a legal obligation to ensure that patients are appropriately informed of clinically significant medical errors.

As a practical matter, institutions are better served to assume the obligation to disclose errors to patients as a result remedial processes such as that of the JCAHO or state reporting requirements, rather than have that obligation placed upon them by the courts in a punitive fashion, as has happened to physicians. In a landmark case, the failure to disclose a clinically significant error was held to create a cause of action distinct from the underlying malpractice claim resulting from the error itself (*Simcuski v. Saeli*, 44 N.Y.2d 442, 377 N.E.2d 713 (N.Y. 1978)). According to the

lawsuit allegations, a surgeon inadvertently severed a shoulder nerve during a procedure. Instead of admitting the error and providing available treatments, the surgeon told the patient that the loss of sensation and motility was a common surgical aftereffect that would wane with physical therapy. The patient did not discover this was misinformation until the damage was permanent and the period in which a malpractice case could be brought against the surgeon had passed. The patient sued the surgeon for both malpractice and fraud after the three-year malpractice statute of limitations had run, but within the six-year statute of limitations for fraud. The court held that the suit was timely and also held that if the patient could prove that the surgeon had been intentionally deceitful and thereby had deprived the patient of potential relief of the condition, the patient could recover damages for fraud, including potentially punitive damages, in addition to or *without having to prove* malpractice.

BARRIERS TO ADMITTING MISTAKES

Three frequently cited barriers to informing patients of medical errors are: (1) the provider's difficulty in confessing mistakes; (2) the fear of implicating other providers; and (3) the possibility of liability exposure.

At the risk of sounding unsympathetic, the thesis that it is particularly difficult for providers, especially physicians, to admit to errors has nothing more than subjective support from some providers themselves. Many of us, regardless of profession, dislike having to confess error. Although the experience may be educational for others, or ourselves, it is often accompanied by shame, a fear of potential punishment, or a feeling that power or stature has been lost. Using this aversion as a rationale for not following through on an ethical and legal obligation to patients in our charge is not acceptable to society and certainly has never been advanced successfully as a legal defense in a malpractice or deceit claim.

The desire to avoid implication of other practitioners is a more concrete barrier. Although there may be times when a qualified practitioner can assess the appropriateness of prior care with a high degree of accuracy, particularly when an obvious error is involved, complete certainty about whether and by whom a mistake was made is rare. A study has shown that practitioners who engage in retrospective reviews of care differ widely in their assessments (Localio et al. 1996). Rather than offering speculation in the guise of information or assessment, the better course is to confine observations about prior care to an assessment of the patient's current condition. However, such practice should not be used as an ex-

cuse for not informing the patient of errors that are the responsibility of the present practitioner or institution. An excellent and frequent example is that of a foreign body left in a surgical patient. Once discovered, usually the best course of action (unless the patient is exceptionally frail) is to remove it, which obviously requires another surgery. The risks, benefits, and alternatives (essentially, leave it in or take it out) should be explained to the patient, and, if consented to, the procedure should be performed expeditiously. It is neither required nor clinically useful to engage in a discussion of whose fault it is, particularly since blame often can be allocated fairly to more than one member of the surgical team. In my experience as a hospital lawyer, if the patient tolerates the second procedure well and is not charged for the second procedure, then little or no liability attaches. (As an aside, the patient sometimes wants the charges for the original procedure written off. If the second procedure goes well, I do not usually do so; in more than 20 years that decision has yet to cost the institutions in question.)

There is a very specific dilemma with this situation: Does an institution have an obligation to inform the patient of a clinically significant error by a member of its staff, including medical staff, even if the staff member objects to the provision of the information? Clearly, in light of the physician's obligations regarding informed consent, the best alternative is to convince the physician to inform the patient directly if it is physician error that is involved. Often the involvement of a medical staff officer or committee can be useful in encouraging the physician to meet this obligation. However, if the staff member persists in refusal, then as the legal officer of an institution, I assert that the institution's ethical and legal obligations require disclosure over the objections. Using the specific example of the New York case mentioned above, I think it likely that if the institution knows of an error and its potential consequences and fails to inform the patient, then the institution has the same legal exposure for fraud as the erring physician.

The final barrier is the perception that disclosure increases liability exposure. There has been some study of this contention. The weight of the available analysis by lawyers, risk managers, and practitioners is that a policy of dealing honestly and forthrightly with the patient reduces liability exposure. Kapp (1997) provides an excellent survey of the available literature and studies, including the opposing arguments.

Although actual liability exposure will be unique to each incident and each decision to reveal or conceal, experience has taught me that over

time an honesty policy is less costly. A simple decision tree illustrates this point. The choices are to tell the patient or not tell the patient. If the patient is told, a claim may result, but the claim cannot include sustainable allegations of lack of informed consent or dishonesty by the providers. Moreover, if the patient is told and the error is corrected, the patient may be less inclined to sue, and if there was no damage as a result of the error, probably does not have a sustainable cause of action.

On the other hand, if the patient is not told, there are two possibilities. First, the error may never be discovered, in which case liability is entirely avoided. However, in light of the increasing third-party reporting requirements, the increasing sophistication of patients, and the apparently increasing proliferation of plaintiff's malpractice lawyers, non-discovery is not a good bet, and becomes increasingly risky as the level of clinical consequence of the error increases. The second possibility, that the patient is not told and does discover the error, has considerable negative consequences. The patient is likely to be more hostile and suit-prone because of the legitimate feeling that the physician's and institution's fiduciary obligations to him or her has been violated. As illustrated by the New York case cited above, there are additional potential causes of action, such as fraud for the failure to be forthright. These additional counts potentially increase the cost of settling or trying the case. The erring providers are, in the hands of a skilled plaintiffs attorney, made to look extremely unsympathetic at trial. Juries are notoriously punitive to providers perceived to be dishonest. Furthermore, in many states, such as New York and Pennsylvania, "mere" medical malpractice does not expose the practitioner punitive damages; fraud does (*Simcuski v. Saeli*, 44 N.Y.2d 442, 377 N.E.2d 713 (N.Y. 1978)). Finally, publicity about the event, and the potential loss of public trust in the institution, can be disastrous.

Because each situation is extremely fact-based, there is unlikely to be conclusive agreement on the effect of disclosure on liability. But it has never been demonstrated effectively that a policy on non-disclosure reduces liability; the weight of opinion is that the opposite is true. Therefore, the liability issue cannot be used as an effective counterweight to the legal and ethical obligation to disclose.

INSTITUTIONAL PROCESS FOR HANDLING ERRORS

Institutions should adopt written policies providing appropriate mechanisms for disclosing medical mistakes that have clinical consequences for patients. The benefit of a written policy is twofold: first, it makes the

institution's stance a matter of public record; second, it reduces the possibility of individualized responses to situations that might arise.

Let us examine again the case of the foreign body—e.g. a clamp—left in a patient following surgery, assuming in this case the existence and implementation of an institutional policy on disclosure. The policy should provide that once a mistake has been identified, the attending physician should be immediately notified by administration, risk management, or nursing, unless he/she is already aware. An initial immediate discussion with the attending by a member of one of the aforementioned groups should focus on at least two points: the clinical course to address the mistake and the timing and content of the disclosure to the patient/surrogate. Then there should be disclosure to the patient pursuant to the policy.

The attending should be the discloser, and the disclosure should take place as soon as the patient's clinical condition permits. Ergo, the patient is informed by the surgeon that a clamp was left behind, and that infection can develop around it, or it can move, or cause other problems. The risks and benefits of leaving it or removing it, in light of the patient's clinical condition, are discussed between patient and doctor. The surgeon recommends a course of action, and the patient consents or refuses. Assuming the agreed action is removal, the surgery takes place. The patient may, under the circumstances, prefer that another surgeon perform the procedure, and, assuming another physician with the necessary expertise is available, the patient's desire should prevail. Conceivably, the patient may want the procedure to be performed at another facility, either by the same or a different surgeon. In this case, the clinical implications of moving the patient should be discussed thoroughly with him or her. If the desire remains, it should be honored, and the institution should be prepared to bear any costs involved.

Discussion of fault adds nothing to this process and should be explicitly avoided. For the purpose of determining the clinical course, there is no need to even identify the original surgical team, although a request by the patient that others be used should be honored, and the patient easily can find out later whether it was through review of the medical records.

The attending surgeon should be strongly encouraged to be the discloser, as the attending knows the clinical course best and presumably has the strongest relationship with the patient. If the attending is unwilling to inform the patient and is unwilling to designate another willing physician to do so, then disclosure should be made by an appropriate institution-employed physician or medical staff officer, and the same process should

be followed. It is important that the discloser be a physician so that the best possible discussion of the clinical issues can be achieved. Furthermore, in most states, true informed consent can only be as a result of discussion between a patient and physician (see *Valles v. Albert Einstein Medical Center* 758 A.2d 1238 (2000)). Physician disclosure also has the added benefit of focusing the discussion on clinical issues as opposed to management or liability issues.

Generally speaking, the attending should not have the authority to "veto" disclosure. The only exception would be an assertion that the patient is so frail that disclosure will cause clinical harm. Such an assertion should be carefully reviewed by a physician not involved in the patient's care, and should be upheld only in a genuinely apparent case.

In order for the institution to be able to disclose clinical information to a patient over the attending's objection, it is important that the policy be in writing and that all medical staff members be aware of the institution's policy. The policy should also provide that as disclosure is institution policy, those who promote or participate in such disclosure are immune from institutional retaliation and will be protected by the institution.

CONCLUSION

Providers and institutions have a legal and ethical duty to disclose their own medical errors when there are clinical consequences. Although such a policy may cause discomfort, perhaps conflicts between institutions and their staff, and in rare circumstances increased liability, there are no countervailing factors of sufficient weight to mitigate the appropriate execution of that duty.

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