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by

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**MEDICAL ERROR: OVERCOMING BARRIERS TO TRUTHFUL  
DISCLOSURE**

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DISCLOSURE**

**by**

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## **Dedication**

This dissertation is dedicated to my husband, Michael Perry Brian McKinney, Ph.D. and to my daughter Polawyn Claire McKinney, M.D. They have supported me throughout my adventures and have waited patiently for me to join them in bearing the title of doctor. Now, when I answer the phone and the caller asks for Dr. McKinney, I will happily say,  
“Which one?”

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# **Medical Error: Overcoming Barriers to Truthful Disclosure**

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The Institute of Medicine's report on medical errors revealed a degree of fallibility in health care that was previously unrecognized. One explanation for the general ignorance about the threats to patient safety and actual harms to patients is that many health-care providers are reluctant to disclose errors to patients or their family members, despite widespread agreement that telling the patient or the patient's surrogate the truth about a medical error is the physician's professional and ethical duty.

There are a number of reasons for health-care providers' decisions to conceal the truth or misrepresent what happened when medical error occurs. They range in character from the philosophical to the bureaucratic. Discussions about resolving the problems surrounding medical error tend to focus on the systemic nature of many medical errors, ways to improve patient safety, doing away with blame and punishment for erring health professionals, and reforming malpractice legislation. Although each of these explanations and solutions has its merits, all fail to adequately address the role of the culture of medicine in perpetuating the reluctance to truthfully disclose medical errors and the need for culture change in health care. There is more to culture change than tinkering with automation, organizational policies, and caps on malpractice damages.

A humanistic inquiry, this dissertation reviews and critiques explanations of what happens to the erring health professional when faced with owning up to his or her mistake, reviews and critiques the solutions to the problems surrounding medical error and deception, and offers alternative ways of understanding and addressing the policies and ethics of medical error disclosure.

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## **Introduction**

A growing body of literature about health care promises solutions to cost issues, patient safety concerns, and the enormous pressures on physicians. It is clear that all is not well with medicine. Medical errors happen too often and are costly. Medical malpractice insurance and litigation are costly. High costs affect the quality and quantity of health care available. Patients suffer from iatrogenic illnesses and injuries and the associated emotional strain of fears and unknowns.

Lack of truthful disclosure exacerbates these already unpleasant matters. Although many physicians honestly believe that bad news will negatively affect patients' health or bring unnecessary stress into others' lives, concerns about discomfort and consequences are often focused on their own needs. Physicians often withhold information or manipulate it to avoid responsibility for elements of their patients' care. This is especially problematic when the physician caused the patient's injury through medical error.

Physicians are also likely to withhold error information from colleagues and administrators. They do so out of fears for their reputations and fears that the information will be made available for use in litigation. When physicians deceive others to avoid consequences and are able to do so in substantial numbers, it raises questions about the integrity of the profession.

The patient safety movement has brought to light the need to share information about errors so that steps can be taken to avoid them in the future. When a process is flawed, the same type of error can recur regardless of who next uses the process. Failure to tell the patient and the appropriate administrators about errors does more than prevent efforts to improve patient safety. It leaves patients and their families to bear the burdens of their losses without compensation or explanation. Furthermore, it violates accreditation rules and makes informed consent for care that follows the injury impossible. If the deception is discovered, it can lead to lengthy and emotionally draining litigation, damage to the physician's reputation and career, and loss of respect for and trust in the medical profession.

The Institute of Medicine's (IOM) disturbing report on the high incidence of medical errors, *To Err Is Human: Building a Safer Health System*, shattered myths that medical errors were rare and that the number of malpractice lawsuits vastly exceeded the incidence of medical negligence.<sup>1</sup> Along with awareness that problems with patient safety were widespread came recognition that physicians were not telling their injured patients the truth about the causes of their injuries. Physicians were not only avoiding

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<sup>1</sup> The report indicates that somewhere between 44,000 and 98,000 people die every year from hospital medical errors and untold numbers of errors inside and outside of hospitals occur daily. Linda T. Kohn, Janet M. Corrigan and Molla S. Donaldson, eds., *To Err Is Human: Building a Safer Health System* (Washington, D.C.: National Academy Press, 2000).

responsibility, but also sometimes benefiting from providing the additional care their injured patients required.<sup>2</sup>

Unfortunately, most proposals for addressing the problems identified in the IOM report tend to shift attention away from the injured patient and his or her needs to focus attention on reducing physicians' concerns about liability and developing safety measures for the future. Safety measures are clearly necessary and laudable. However, they overlook another different kind of medical error, failure to take responsibility and to make amends owed to patients. Deceiving patients about their medically-caused injuries is *unethical*, whether we are talking about professional ethics or everyday ethics.

The systems approach to medical errors, a strategy borrowed from the aviation industry, has been widely promoted and supported by physicians and legislators as *the* answer to problems with patient safety.<sup>3</sup> It promises to reduce the damage to the physician's career and self-image while contributing to the development of measures to

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<sup>2</sup> Thomas H. Gallagher, Jane M. Garbutt, Amy D. Waterman, David R. Flum, Eric B. Larson, Brian M. Waterman, W. Claiborne Dunagan, Victoria J. Fraser and Wendy Levinson, "Choosing Your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients," *Archives of Internal Medicine* 166, no. 15 (August 14, 2006): 2388; Thomas H. Gallagher, Amy D. Waterman, Jane M. Garbutt, Julie M. Kapp, David K. Chan, W. Claiborne Dunagan, Victoria J. Fraser and Wendy Levinson, "U.S. and Canadian Physicians' Attitudes and Experiences Regarding Disclosing Errors to Patients," *Archives of Internal Medicine* 166, no. 15 (August 14, 2006): 1605-10; Lucian L. Leape and Donald M. Berwick, "Five Years After *To Err Is Human*: What Have We Learned?," *Journal of the American Medical Association* 293, no. 19 (May 18, 2005): 2388.

<sup>3</sup> See, for example, W. C. Deskin and R. E. Hoye, "Another Look at Medical Error," *Journal of Surgical Oncology* 88, no. 3 (December 1, 2004): 127-9; Linda W. Cranfill, "Approaches for Improving Patient Safety through a Safety Clearinghouse," *Journal for Healthcare Quality* 25, no. 1 (2003); M. Connor, P. R. Ponte and J. Conway, "Multidisciplinary Approaches to Reducing Error and Risk in a Patient Care Setting," *Critical Care Nursing Clinics of North America* 14, no. 4 (December 2002); M. S. Joshi, J. F. Anderson and S. Marwaha, "A Systems Approach to Improving Error Reporting," *Journal of Healthcare Information Management* 16, no. 1 (Winter 2002); Lucian L. Leape, "Error in Medicine," *Journal of the American Medical Association* 272, no. 23 (December 21, 1994): 14-5.

avoid future errors. It would place reports of errors beyond the reach of litigious patients, a change that physicians claim will encourage reporting of errors. Physicians assert that it is the fear of lawsuits that drives them to remain silent or mislead about their own mistakes; risk-free reporting will result in better identification of the problem areas in the health-care system and will reduce the need for defensive medicine. The rhetoric associated with this approach presupposes that physicians should not have to accept responsibility for their errors, because flawed systems are at fault and not individuals.

In this dissertation I will show that medical errors and associated matters are not as simple as many would like us to believe. Physicians deceive patients, others, and themselves about medical errors, often relying on ambiguity, shared fears and beliefs, and pressures from third parties to justify their silence or manipulations of the truth. The culture of medicine supports deception and provides a number of barriers to remedying the associated problems. Correcting the problems of medical errors and deception will require something more than new policies and procedures, new information technology, and new ways for health-care providers to avoid responsibility. It will require a culture change that empowers physicians while bringing physicians' and patients' expectations into alignment with reality. Human beings do make mistakes. Change will require physicians to exhibit honesty, accept responsibility, learn and use better communication skills, and be willing to change. It will also require laws and policies that support and reinforce these changes.

In the first chapter I will discuss one of the most basic issues associated with deception and medical error, the definition of *medical error*. I will show that the lack of clarity in this area is one of the barriers to truthful disclosure. Ambiguity enables denial of responsibility and sometimes makes interpretation of outcomes a matter of professional discretion. A plethora of terms that sometimes overlap or are used interchangeably contribute to confusion. Differing models used to describe and classify medical errors contribute insights into why there is so little agreement.

The second chapter is devoted to an exploration of the meaning of *culture of medicine*. The frequently used but rarely defined term is often offered as an explanation for physicians' thought processes and behavior. *Culture* has meanings in anthropology, sociology, and biology. Furthermore, the term *culture* has been overused to the point that it has become something of a catch-all term.<sup>4</sup> Therefore, I have considered several of the standard sociological and anthropological approaches to describing a culture and have applied those approaches to the medical profession to see how the concept fits with each approach. If the culture of medicine is to undergo change, agents of change must have some understanding of elements of the culture, how acculturation happens, and how change might take place.

The third chapter discusses physicians' tradition of withholding information or deceiving patients and various aspects of the culture of medicine that support the use of this behavior in the practice of medicine. It establishes patterns of thinking and practice

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<sup>4</sup> See, for example, Christopher Clausen, "The Culture of Culture," *New Leader* 77, no. 6 (June 6, 1994): 14-5.

associated with physicians' mainly benign use of deception in situations other than those involving medical error.

In the fourth chapter, I extend Chapter 3's discussion into the area of adverse events and medical errors. This discussion explores what motivates physicians to deceive their patients injured by medical errors and how physicians sometimes deceive themselves into denying responsibility for their errors.

Chapter 5 surveys some of the advantages and disadvantages of several of the proposed legislative and administrative changes intended to reduce pressures on physicians, facilitate disclosure, improve the physician-patient relationship, and fix the decaying moral status of the medical profession. In this chapter, I suggest additional or alternative methods for overcoming the barriers to truthful disclosure, addressing some of the communication, financial, and interpersonal issues associated with disclosure of medical errors.

Chapter 6 summarizes the previous chapters and synthesizes the meaning and implications of this work.

## Chapter 1: Medical Error

If the beginning of wisdom is knowing what to call things, defining "medical error" is a beginning that has not yet been completed.

--S. M. Dovey and R. L. Phillips<sup>5</sup>

### THE CONTROVERSY

Gallons, perhaps even tons of ink have been devoted to the topic of medical error, especially since the Institute of Medicine's (IOM) disturbing report, *To Err Is Human: Building a Safer Health System*, entered the public consciousness. A quick PubMed search on *medical errors* yields 52,703 items.<sup>6</sup> Since the beginning of 1999, the year the IOM report was released, 22,559 publications written in English on medical errors occurring in human medicine (as opposed to veterinary medicine), became part of the PubMed database.<sup>7</sup> Legal publications add substantially to the growing body of literature on the topic. There is good reason for the publishing frenzy. Research results indicate that up to 98,000 deaths in U.S. hospitals each year are caused by medical errors.<sup>8</sup> Far more patients suffer non-fatal injuries due to medical errors. The report shattered the illusion

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<sup>5</sup> S. M. Dovey and R. L. Phillips, "What Should We Report to Medical Error Reporting Systems?," *Quality & Safety in Health Care* 13, no. 5 (October 2004): 330.

<sup>6</sup> The search, conducted on March 3, 2007 included no limits on the year or type of medical errors. The publications listed include veterinary medicine.

<sup>7</sup> The March 3, 2007 search of the PubMed database limited the output to items published in English from the beginning of 1999 to March 1, 2007 on the topic of medical errors in human patients. Not all of these publications focus attention on medical errors in the United States.

<sup>8</sup> Kohn, Corrigan and Donaldson, eds., *To Err Is Human*, 26.

that harmful mistakes by health-care providers are rare.<sup>9</sup> Nevertheless, that illusion has been perpetuated, in spite of the IOM report by some members of the medical profession.

## **MALPRACTICE FEARS**

Fears about medical malpractice contribute to physicians' ways of thinking about medical errors. This section briefly explores physicians' perceptions of medical malpractice and how closely their perceptions fit with published research findings.

### **Possible Origins of Malpractice Fears**

For almost as long as there have been medical malpractice cases in the U.S., members of the medical profession have complained bitterly that they have been subjected to frivolous or vexatious lawsuits. Kenneth De Ville, author of *Medical Malpractice in Nineteenth-Century America*, writes: "In 1844 a writer for the *Boston Medical and Surgical Journal* warned that qualified physicians were 'constantly liable to vexatious suits instituted by ignorant and unprincipled persons.'"<sup>10</sup> This sentiment was widespread. Physicians claimed that far more people sued than were injured by medical errors. They attributed the lawsuits to the greed of ungrateful patients who saw the

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<sup>9</sup> Kohn, Corrigan and Donaldson, eds., *To Err Is Human*, 26. The report summarizes the results of several studies that used differing methods and criteria for identifying medical errors.

<sup>10</sup> Kenneth De Ville, *Medical Malpractice in Nineteenth-Century America: Origins and Legacy* (New York: New York University Press, 1990), 25. Here, De Ville quotes from "Accusation of Mal-Practice," *Boston Medical and Surgical Journal* 31 (11 September 1844): 123-24.

opportunity to use their own misfortune to turn the sympathy of their fellow citizens against their social betters.

Recent research has shown that only a small percentage of patients who suffer injuries due to medical negligence file claims.<sup>11</sup> However, in the nineteenth century, the claims that medical malpractice lawsuits in the United States were unfair may have had some validity.<sup>12</sup> De Ville describes the original malpractice crisis, which took place at a time when almost anyone could call himself a healer without interference from the law. Competition was fierce among the various types of practitioners: homeopaths, allopathic physicians, osteopaths, and others. It was often the case that a practitioner in direct competition with the one who had treated the patient who encouraged the patient to sue.<sup>13</sup>

De Ville explains the first *malpractice crisis* as follows:

American patients began to sue their physicians on a wide scale because of specific social, medical, and technological developments in the first half of the nineteenth century. The antistatus, antiprofessional sentiment of the Jacksonian period increasingly turned the lay public against orthodox, trained practitioners. In addition, Americans, with a long tradition of self-cure home remedy, and folk healing, had little patience with doctors who demanded deference and privilege but offered few cures. Physicians' authority and public respect also declined as a parade of alternative medical practitioners offered their services to antebellum

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<sup>11</sup> See, for example, Troyen A. Brennan, Lucian L. Leape, N. M. Laird, L. Hebert, A. R. Localio, A. G. Lawthers, J. P. Newhouse, P. C. Weiler and H. H. Hiatt, "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I. 1991," *Quality & Safety in Health Care* 13, no. 2 (April 2004): 145-51; David M. Studdert, Michelle M. Mello and Troyen A. Brennan, "Medical Malpractice," *New England Journal of Medicine* 350, no. 3 (January 15, 2004); Tom Baker, *The Medical Malpractice Myth* (Chicago: University of Chicago Press, 2005), 69.

<sup>12</sup> De Ville, *Medical Malpractice in Nineteenth-Century America*, 82; Baker, *The Medical Malpractice Myth*, 69.

<sup>13</sup> De Ville, *Medical Malpractice in Nineteenth-Century America*, 82.

Americans. Physicians exacerbated their own descent in esteem and contributed to the litigious trend. As medical men of all types became more plentiful in the 1830s and 1840s, intraprofessional competition generated conflict, and many medical men incited suits against fellow practitioners. Dramatic advances in several areas of medicine created unrealistic expectations in both physicians and patients and blurred standards of care.<sup>14</sup>

Most malpractice lawsuits of that era were associated with vaccinations, obstetrics, and orthopedic care, with fracture-dislocation cases forming the majority.<sup>15</sup> An injured limb that was shorter or misshapen after it healed was often the basis of the lawsuit. Patients often won awards even when their physician met the standard of care and the patient's outcome was as good as could be expected given the nature of the injury. Then, as now, patients expected perfection. Any outcome that was less than perfect was thought to be the result of incompetence or carelessness.<sup>16</sup> De Ville elaborates:

Although expert medical testimony was required to guide the jury's deliberations, laymen were entrusted with the tremendous power to designate the boundaries of acceptable medical behavior. Since juries made these decisions on a case-by case basis, acceptable standards of care, skill, and diligence were highly sensitive to popular conceptions of the medical profession and medical practice. Similarly, the use of physicians as medical witnesses provided an official inlet for the personal or professional prejudices of rival medical practitioners.<sup>17</sup>

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<sup>14</sup> De Ville, *Medical Malpractice in Nineteenth-Century America*, 23-24.

<sup>15</sup> De Ville, *Medical Malpractice in Nineteenth-Century America*, 8, 33. "Fracture-dislocation cases accounted for about two-thirds of the malpractice cases between 1835 and 1865."

<sup>16</sup> De Ville, *Medical Malpractice in Nineteenth-Century America*, 103-6.

<sup>17</sup> De Ville, *Medical Malpractice in Nineteenth-Century America*, 6-7.

Allopathic physicians were more likely to be targets than other practitioners, in part because of their emphasis on educational qualifications and their claims of being scientific in their healing methods.<sup>18</sup> In addition, it was not uncommon for allopathic physicians to instigate the malpractice actions against their allopathic competitors.<sup>19</sup> This activity took place before allopathic physicians agreed to avoid dissension amongst their ranks and work together to force out other competitors.<sup>20</sup>

### **Current Malpractice Fears**

Today, many mechanisms are in place to prevent medical malpractice cases without merit from succeeding. Both the plaintiff and the defendant must produce qualified expert witnesses to testify about whether or not the treating physician met the standard of care. In some states a panel of experts must determine that a case has merit before it is allowed to move forward. The attorney who pursues a case that has no merit may be severely disciplined. Other protective measures vary by state.

There are also a number of barriers to pursuing a medical malpractice lawsuit. Physician-Attorney William Sage observes that most lawyers will not consider taking a case that does not have the possibility of substantial award: “Experienced plaintiffs lawyers, who are paid on contingency, seldom accept cases with potential damages under

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<sup>18</sup> De Ville, *Medical Malpractice in Nineteenth-Century America*, 75.

<sup>19</sup> De Ville, *Medical Malpractice in Nineteenth-Century America*, 52.

<sup>20</sup> De Ville, *Medical Malpractice in Nineteenth-Century America*, 46, 50-53.

\$100,000.”<sup>21</sup> The reason is that the administrative and discovery costs are high and litigation often takes years. If the award were lower, the lawyer would probably be unable recoup expenses and her own labor costs, much less obtain compensation for the client. Furthermore, if the injured patient loses in court, the lawyer makes no money.

Despite these efforts to protect the medical profession, the belief, especially amongst physicians, that physicians have been victims of greedy lawyers and ungrateful patients has persisted. The IOM report has done little to dissuade physicians from believing that malpractice litigation results in injustices for physicians. Despite the report’s research-supported assertions that hundreds of thousands may be injured in hospitals each year and the fact that figures are not yet available for patients injured through ambulatory care or other health-care settings, physicians claim that the tort system does not serve the purpose for which it was intended and that members of the medical profession are unfairly burdened by the system’s flaws.<sup>22</sup> Much of the literature on the topic of medical error is devoted to the familiar arguments that the medical malpractice lawsuits are frivolous; awards are excessive; greed is the motive for filing a malpractice lawsuit; physicians are being driven out of practice by fear of litigation and

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<sup>21</sup> William M. Sage, "Malpractice Liability, Patient Safety, and the Personification of Medical Injury: Opportunities for Academic Medicine," *Academic Medicine* 81, no. 9 (September 2006): 823.

<sup>22</sup> See, for example, Studdert, Mello and Brennan, "Medical Malpractice," 382-92.

by soaring malpractice insurance costs because of high payouts; and tort reform is necessary to counteract these destructive influences.<sup>23</sup>

Sage points out that it is true that the malpractice system fails to serve its purpose.

However, his position conflicts with the usual message. He notes:

Underclaiming is a more worrisome manifestation of the malpractice system's failure than the "frivolous" suits that are tort reformers' *bête noire*. This is especially true for the elderly whose more complex medical histories make injury more likely but negligence harder to establish, and who have lower legal damages because of shorter life expectancy and lack of earned income.<sup>24</sup>

#### **SHAME, BLAME, AND THE SYSTEMS APPROACH**

A substantial proportion of the publications that make up the proliferating body of work on the topic of medical error supports the findings and recommendations of the IOM report. In addition to demonstrating that the startling figures on medical errors are not artifacts of the particular methodology chosen or due to the biases of particular research teams, these articles agree with the IOM report's assertion that there is a need to change the approach to dealing with medical errors from "shame and blame" to the systems approach. The shame-and-blame approach involves identifying an individual actor as the person guilty of the mistake and shaming and punishing that individual as having failed at being a physician. The individual actor is either supposed to correct his

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<sup>23</sup> Baker, *The Medical Malpractice Myth*, 1-13. Baker refers to this description of medicine's dire predicament as *the malpractice myth*. The *myth* has been used repeatedly to promote tort reform.

<sup>24</sup> Sage, "Malpractice Liability," 823.

or her own behavior to prevent future mistakes or risk losing his or her position or privileges. This process is typically internal to the institution and may have little or nothing to do with litigation initiated by the patient or patient's family.

In his book *Complications: A Surgeon's Notes on an Imperfect Science*, Atul Gawande describes an experience with the shame-and-blame approach that followed a botched emergency tracheotomy (cricothyroidotomy) he attempted to perform as a resident. His attempt failed completely to achieve its end, nearly costing a woman her life.<sup>25</sup> The chief trauma resident presented the case to the Morbidity and Mortality Conference, a weekly academic hospital ritual dedicated to the review by physicians of medical mistakes made by physicians. The attending physician, not Gawande, then stood before the group, explained what had gone wrong and described what he could have done to avoid the near-disaster. He responded to pointed, critical questions about his failings and took responsibility for them. Gawande relates the process as follows:

"This was my case," Dr. Ball volunteered from the front row. It is how every attending begins, and that little phrase contains a world of surgical culture. For all the talk in business schools and in corporate America about the virtues of "flat organizations," surgeons maintain an old-fashioned sense of hierarchy. When things go wrong, the attending is expected to take full responsibility. It makes no difference whether it was the resident's hand that slipped and lacerated an aorta; it doesn't matter whether the attending was at home in bed when a nurse gave a wrong dose of medication. At the M & M, the burden of responsibility falls on the attending.<sup>26</sup>

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<sup>25</sup> Atul Gawande, *Complications: A Surgeon's Notes on an Imperfect Science* (New York: Picador, 2002), 60.

<sup>26</sup> Gawande, *Complications*, 60.

Later, the attending physician pulled Gawande aside and informed him of what he should have done to avoid the difficulties he encountered with the surgery. In addition, he asked with disappointment and dismay why Gawande had failed to recognize the need for help and to call for it in a timely fashion. Gawande responded by telling the attending physician how he would deal with future problems of a similar nature. Gawande described his feelings following the encounter as shame, a sense that he was what was wrong, not just that he had done something wrong. He indicated that the experience was one that could easily undermine a physician's self-confidence or contribute to development of a defensive posture, if allowed to do so.<sup>27</sup> Gawande describes his experience:

I felt a sense of shame like a burning ulcer. This was not guilt; guilt is what you feel when you have done something wrong. What I felt was shame: I was what was wrong. And yet I also knew that a surgeon can take such feelings too far. It is one thing to be aware of one's limitations. It is another to be plagued by self-doubt. . . .

Even worse than losing self-confidence, though, is reacting defensively. There are surgeons who will see faults everywhere except in themselves. They have no questions and no fears about their abilities. As a result, they learn nothing from their mistakes and know nothing of their limitations. As one surgeon told me, it is a rare but alarming thing to meet a surgeon without fear. "If you're not a little afraid when you operate," he said, "you're bound to do a patient a grave disservice."<sup>28</sup>

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<sup>27</sup> Gawande, *Complications*, 61.

<sup>28</sup> Gawande, *Complications*, 61.

The authors of the IOM argue that medical errors are failures of the system that should not be blamed on individuals; changing the system to reduce opportunities for errors will improve medicine overall. The report recommends collecting data on the types of mistakes and the circumstances surrounding them so that patterns can be identified and safeguards implemented to prevent future harms. Collecting data requires health-care providers to report their own mistakes and their “near misses” to the hospital which in turn would be expected to report the mistakes to a government agency. The fear of being blamed, shamed, and punished by the institution for mistakes currently makes such reporting unattractive to health-care workers. Fear of being exposed to litigation and social and financial ruin adds to concerns about revealing mistakes. Therefore, the report recommends that mistakes be understood as opportunities to improve the system so that future patient injuries can be prevented and overall patient safety can be improved.

Patient safety becomes an abstraction, not a matter of individuals who suffer injuries and individuals who miss the mark. It becomes faceless, nameless, and simplified—a matter of engineering and bureaucracy.

Some of the publications on the topic of the systems approach argue that the systems approach is not a panacea. Although there is general agreement that many errors could be prevented by changing processes and through automation and better training, there is resistance to comparing the complexities of medicine to the mechanics of the aviation business. Furthermore, some physicians feel that such attention to external

controls diminishes their sense of autonomy. Gawande provides his thinking on the matter in the following passage:

It would be deadly for us, the individual actors, to give up our belief in human perfectibility. The statistics may say that someday I will sever someone's main bile duct, but each time I go into a gallbladder operation I believe that with enough will and effort I can beat the odds. This isn't just professional vanity. It's a necessary part of good medicine, even in superbly "optimized" systems. Operations like that lap chole [a laparoscopic gallbladder removal that nearly resulted in a serious error] have taught me how easily error can occur, but they've also showed me something else: effort does matter; diligence and attention to the minutest details can save you.

This may explain why many doctors take exception to the 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.<sup>29</sup>

### **The Malpractice Insurance Problem**

Another group of publications discusses the need to change the way physicians are insured against malpractice claims. Some high risk subspecialties pay exorbitantly high rates for malpractice insurance. Instead of general pooling of risk, malpractice insurers charge by specialty or subspecialty, placing extraordinary burdens on physicians who provide much needed services and are subject to larger than average numbers of claims and high payouts.

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<sup>29</sup> Gawande, *Complications*, 73.

Sage discusses some of the peculiarities of how medical malpractice insurance operates in the following statement:

Physicians' [malpractice] premiums are not connected to their safety records. Instead, the highest premiums are paid by a few specialties that diagnose or treat serious conditions in young patients—cases with the potential for large damage awards. The same fields—obstetrics, neurology, orthopedics, radiology, and emergency medicine—face the steepest premium increases and greatest risk of losing coverage.<sup>30</sup>

These articles discuss the need for a more equitable approach to paying for malpractice insurance. No-fault insurance, enterprise liability, and greater spreading of risk are some of the major themes.

### **Changing the Subject**

Paying attention to avoiding future harms and to keeping the medical profession financially viable is certainly important. Few would argue that improved policies, procedures, and protocols are unnecessary. Similarly, few would argue that the tort and malpractice insurance systems are flawless. However, the problem with focusing on these issues is that the injured, relatively powerless and uninformed or under-informed patient who suffers physically and emotionally from the physician's mistake is often blamed and vilified or forgotten.

Most of the publications described above rapidly sidestep the physician-patient relationship and the immediate problem of a medical error. They change the subject from

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<sup>30</sup> Sage, "Malpractice Liability," 824.

the people who are dying and who are suffering from the pain and disruptions caused by medical errors to matters that are impersonal and much removed from fixing the broken people. Planning to prevent future errors, avoiding institutional punishments, tort reform, and the high cost of malpractice litigation divert attention from what the physician owes the patient when medical error occurs. Although there is considerable agreement in ethics codes and other medical guidance materials that physicians should be honest and respectful with patients and should disclose the fact that something has gone awry, evidence indicates that patients are often purposely kept in the dark about the details of their poor outcomes and what happened to cause them.<sup>31</sup>

### **Avoiding the Subject**

Kathleen Mazor, Stephen Simon, and Jerry Gerwitz conducted a review of the literature on disclosure titled “Communicating with Patients about Medical Errors.”<sup>32</sup> They found little consistency in the data concerning disclosure of errors. When physicians were asked what they would do in response to hypothetical vignettes, most predicted that they would disclose. However, when patients who believed they had been

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<sup>31</sup> See, for example, American Medical Association, Professional Resources, Medical Ethics E.8.12 Patient Information at <http://www.ama-assn.org/ama/pub/category/8497.html> (accessed April 5, 2006). “It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients . . . . 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.”; See also, Gallagher, Garbutt, Waterman, Flum, Larson, Waterman, Dunagan, Fraser and Levinson, “Choosing Your Words Carefully,” 1585.

<sup>32</sup> Kathleen M. Mazor, Steven R. Simon and Jerry H. Gurwitz, “Communicating with Patients About Medical Errors: A Review of the Literature,” *Archives of Internal Medicine* 164, no. 15 (August 9-23, 2004): 1690-7.

injured due to medical error were asked if they had been told an error had been made, roughly 30 percent indicated that they had been told.<sup>33</sup> Older studies asked physicians and physician trainees about significant medical errors they had made in the last year; “24% of trainees had discussed the error with the patient or family, and a similar rate (21%) was found in a later study of physicians.”<sup>34</sup>

Gallagher and colleagues report that “studies in multiple countries suggest that as little as 30 percent of harmful errors may be disclosed to patients.”<sup>35</sup> Failure to disclose is not exclusive to the interactions between the American health-care and legal systems. Through a survey conducted in Missouri, Washington, and Canada, the researchers found that disclosure varies by specialty, with “surgeons more likely to have disclosed a serious error than medical specialists.”<sup>36</sup> Although the physicians surveyed generally agreed that disclosing harmful errors is appropriate, they indicated that certain factors might influence their decision to disclose. Gallagher and colleagues found that

60% reported they might be less likely to disclose if they “think the patient would not understand what I was telling him or her.” Other factors that physicians reported might inhibit disclosure included “if I think the patient would not want to know about the error” (30%), “if the patient is unaware that the error happened” (21%), “if I think I might get sued” (19%), “if I didn’t know the patient very well”

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<sup>33</sup> Mazor, Simon and Gurwitz, "Communicating with Patients ": 1691.

<sup>34</sup> Mazor, Simon and Gurwitz, "Communicating with Patients ": 1691.

<sup>35</sup> Gallagher, Waterman, Garbutt, Kapp, Chan, Dunagan, Fraser and Levinson, "U.S. and Canadian Physicians' Attitudes," 1605.

<sup>36</sup> Gallagher, Waterman, Garbutt, Kapp, Chan, Dunagan, Fraser and Levinson, "U.S. and Canadian Physicians' Attitudes," 1607.

(13%), and “if I think the patient would become angry with me if I did so” (10%). Only 23% did not report that any of these barriers would make them less likely to disclose a serious error to a patient.<sup>37</sup>

Another article written by a team headed by Gallagher and based on information gathered through the same survey as the one above revealed that physicians have differing ideas about what disclosure means, what it should entail, and under what circumstance it is most appropriate. The study indicated that physicians would reveal less to patients whose injuries were less apparent; they would be less likely to use the word *error*, less likely to offer an explicit apology, and less likely to volunteer details than if the error were more apparent.<sup>38</sup> Again, there was a difference between surgical and medical specialties. Although surgeons indicated they would disclose errors more often than respondents in medical specialties, “19% of the surgeons would use the word *error*, compared with 58% of the medical specialists; 35% of the surgeons would disclose specific details about the error compared with 61% of the medical specialists.”<sup>39</sup> Surgeons were about half as likely as their medical counterparts to say they would offer

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<sup>37</sup> Gallagher, Waterman, Garbutt, Kapp, Chan, Dunagan, Fraser and Levinson, "U.S. and Canadian Physicians' Attitudes," 1607.

<sup>38</sup> Gallagher, Garbutt, Waterman, Flum, Larson, Waterman, Dunagan, Fraser and Levinson, "Choosing Your Words Carefully," 1589-90.

<sup>39</sup> Gallagher, Garbutt, Waterman, Flum, Larson, Waterman, Dunagan, Fraser and Levinson, "Choosing Your Words Carefully," 1585.

an explicit apology and about one-third as likely to report details to prevent future errors.<sup>40</sup>

Terms and concepts such as *circling the wagons*,<sup>41</sup> *the wall of silence* or *culture of silence*, and the *hidden curriculum* characterize how physicians learn from their peers and superiors to behave in response to medical errors.<sup>42</sup> The tendency to conceal information that might be damaging to an individual's career or to the profession as a whole is apparent in these data.

Reinforcing this tendency is the lack of guidance in disclosing medical errors. Much of the literature devoted to breaking bad news remains silent about how to discuss medical errors with those directly affected.<sup>43</sup> Apparently, physicians do not consider information about medical errors bad news. This is curious since many of the reactions to news about medical errors are similar to reactions to information about serious illness or death. Anger, anxiety, shock, suspicion, and grief are common patient responses to bad news.<sup>44</sup> Physicians do not like to disclose medical errors because they fear that patients and families will exhibit some or all of these strong emotions and judge them harshly.<sup>45</sup>

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<sup>40</sup> Gallagher, Garbutt, Waterman, Flum, Larson, Waterman, Dunagan, Fraser and Levinson, "Choosing Your Words Carefully," 1585.

<sup>41</sup> See, for example, Thomas J. Krizek, "Surgical Error: Ethical Issues of Adverse Events," *Archives of Surgery* 135, no. 11 (November 2000): 1364.

<sup>42</sup> See, for example, Nancy Berlinger, *After Harm: Medical Error and the Ethics of Forgiveness* (Baltimore, Md.: Johns Hopkins University Press, 2005), 24.

<sup>43</sup> John Lantos, *Do We Still Need Doctors?* (New York: Routledge, 1997), 124.

<sup>44</sup> Robert Buckman and Yvonne Kason, *How to Break Bad News: A Guide for Health Care Professionals* (Baltimore, Md.: The Johns Hopkins University Press, 1992), 115-6, 30-31, 37-38, 45-47,

## **The Confusion**

Publications on the topic of medical error debate what should be considered a medical error, classify and count errors of various types, and propose ways to address the aspects of medical error that are viewed by authors as most important. Humans make mistakes and physicians are only human, regardless of their own or others' desires to see them as otherwise. Medical errors must exist if patient-safety measures are to have any effect. However, if the tort reform and malpractice insurance reform arguments have merit, real mistakes are so rare that the cost of malpractice insurance is not justified; injured patients are not worthy of compensation; and the legal system is arbitrary or biased against physicians. Unfortunately, many of these publications have given too little attention to the meaning of *medical error*. Distinguishing medical errors from other kinds of incidents, determining whether they are avoidable or not, deciding whether they should be compensable and how, arriving at strategies for addressing them before and after they occur, and creating understanding and agreement among those involved are all aspects of the meaning. The next section will examine some of the frequently used definitions and where they fall short.

## **THE MEANING OF MEDICAL ERROR**

Gallons of ink notwithstanding, *medical error* is a term that has evaded adequate definition. Going into the hospital for a procedure or to obtain treatment for an illness or

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51-53, 79-83.

<sup>45</sup> Buckman and Kason, *How to Break Bad News*, 19-20.

injury is never without risks. There are no guarantees that the treatment will bring about the desired effect. The paperwork that one must sign to proceed often lists daunting possibilities of pain and misery that one could experience as a natural or expected consequence of the care. Despite best efforts and good intentions, bad things sometimes happen. If the frightening risks listed in consent paperwork do not include the results of medical error, one might wonder what falls into that mysterious category. Removal of the wrong limb comes to mind. Leaving something in the body after surgery that does not belong there is an error. Accidentally disconnecting life-support machinery seems like another possibility. Surely these kinds of problems are insufficient to explain the deaths of tens of thousands of people, not to mention untold numbers non-fatal injuries. One might wonder if an injury is necessary at all for an action to be called a medical error and whether or not some of the horrors listed on the consent forms might really belong among the errors. What does *medical error* mean, really?

### **Constructing a Definition**

The meaning of *medical* seems straightforward enough. A common dictionary definition of *medical* is as follows: “of, relating to, or concerned with physicians or the practice of medicine.”<sup>46</sup> According to this definition *physician* is an integral part of *medical*. The physician’s involvement, either direct or indirect, makes an act medical in

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<sup>46</sup> See, for example, *Stedman's Concise Medical Dictionary for the Health Professions: Illustrated*, ed. John Dirckx, 4th ed. (Philadelphia, Pa.: Lippincott Williams & Wilkins, 2001), 600; *Merriam-Webster's Collegiate Dictionary*, ed. Frederick C. Mish, 10th ed. (Springfield, Mass.: Merriam-Webster, 1993), 772.

nature. Other people involved in the care of a physician's patient act in some capacity as an extension of the physician. Nurses carry out physicians' orders. Pharmacists fill prescriptions written by physicians. Laboratory technicians run tests ordered by physicians. Hospital and ambulatory-care administrative and clerical staff carry out the business operations necessary for the physician to keep necessary patient records, bill patients and third-party payors, operate and maintain facilities, and otherwise meet the bureaucratic obligations necessary for physicians to care for patients. Physicians are part of something larger. However, it is the physicians and the duties, responsibilities, skills, knowledge, and privileges that define them that are essential to the medical endeavor. Although the connection of medical to physician may seem obvious, some definitions of *medical error* fail to mention the relative importance of the physician, as you will see below.

*Error is defined in Steadman's Concise Medical Dictionary for the Health*

*Professions* as follows:

**1.** a defect in structure or function. **2.** BIOSTATISTICS 1) a mistaken decision, as in hypothesis testing or classification by a discriminant function; 2) the difference between the true value and the observed value of a variate, ascribed to randomness or misreading by an observer. **3.** a false or mistaken belief; in biomedical and other sciences, there are many varieties of error, for example due to bias, inaccurate measurements, or faulty instruments.<sup>47</sup>

This definition is examined here because of its inclusion in a medical dictionary, presumably a source that would provide insight into a particular medical slant on the

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<sup>47</sup>*Steadman's*, 330.

word's meaning. Unfortunately, the definition offers little in helping one to distinguish a medical error from a non-error. "A defect in structure or function" could describe any number of end results of medical procedures. Some problems cannot be fully resolved through medical interventions. Furthermore, the concept could apply to a building, a process, a piece of machinery, or any number of other things. One might even define a disease or an injury as a "defect in structure or function." "A mistaken decision, as in hypothesis testing or classification by a discriminant function" and "the difference between the true value and the observed value of a variate, ascribed to randomness or misreading by an observer" sound remote from the ordinary functions of a physician. "A false or mistaken belief; in biomedical and other sciences, there are many varieties of error, for example due to bias, inaccurate measurements, or faulty instruments," might be a definition that applies. However, it does not appear to address adequately inadvertent or omitted actions, want of skill or knowledge, or carelessness. In fact, other than the part about measurements, actions seem to be left out altogether. Physical status, thoughts, attitudes, and machinery are considered the errors. Overall, this definition and its elements miss the mark.

The combination of the definitions of *medical* and *error* falls short in another important respect. A physician's failure to follow hospital policy about the use of cell phones or the copier may be "related to or concerned with physicians or the practice of medicine" and may represent "a false or mistaken belief" about the policy, yet the physician will not have committed a medical error. Medical errors are about what

happens or can happen to *patients*. So, the definition of *medical error* must somehow include the physician and the patient and actions or omissions that may or do have negative consequences for the patient.

Knowing that the physician and the patient are somehow involved in actions or omissions that may have negative consequences for the patient is still not enough for one to understand the meaning of *medical error*. Lacking certain resources such as transplant organs, ICU beds, certain types of imaging equipment, access to experts in certain subspecialties or to blood of a rare type may have negative consequences for a patient, yet failure to provide them will not be considered medical errors. Furthermore, as mentioned above, risks are inherent in medical care. Sometimes, physicians and those involved in assisting will do everything properly that is known to achieve the desired outcome, yet fail to achieve it.

### **The Leading Definition of Medical Error**

The 1999 report from the Institute of Medicine made a serious attempt to find a definition that would address the range of possible missteps in the hospital setting. The IOM report began its definition of *medical error* 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).*<sup>48</sup>

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<sup>48</sup> Kohn, Corrigan and Donaldson, eds., *To Err Is Human*, 28; James T. Reason, *Human Error* (Cambridge [England]; New York: Cambridge University Press, 1990). (The original is in italics.)

The authors borrowed this definition from James Reason, the error expert who wrote the materials that serve as the key sources of information for the systems approach to reducing medical error.<sup>49</sup> The definition above is hardly specific enough to apply to the actions or omissions of health-care providers where intended actions and intended outcomes are not necessarily directly linked, and the choice of plan may depend on a wide variety of external factors over which a physician may have little or no control.

Many authors who make reference to the report use this definition as the basis of their discussions about medical error. There is probably good reason to do so. Such a definition is so broad and general that it may be difficult to argue that the term *error* does not explain *any* physical misfortune suffered by the patient while under medical supervision. However, it is probably too broad. Because its focus in the first half of the definition is on intent, it is too vague. It is not clear whether the intent applies to the process or to the outcome of the process. We have all heard the saying, “The operation was a success, but the patient died.” What about the situation in which the action was carried out as intended, but an inadvertent action accompanied the intended action? Some might argue that if the intended action was accompanied by an unintended one, the execution was flawed. The following story illustrates the distinction.

A middle-aged, healthy woman underwent a routine preventive colonoscopy. A short time later, she died. The colonoscopy was carried out in the manner that other colonoscopies are carried out. The colon was not ruptured. The person carrying out the

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<sup>49</sup> Reason, *Human Error*.

procedure had no reason to doubt that the procedure was done appropriately. There were no departures from ordinary protocol. The desired end, a routine look at a colon was completed as intended. However, the patient died, and her death was the result of the colonoscopy. Movement of the scope through her intestines apparently stressed some adhesions of which no one was aware or had reason to be aware. The stress led to a tear in the woman's liver. She bled to death internally before anyone realized she had suffered damage. No one intended to cause the woman internal injuries. No one had reason to believe that an otherwise ordinary colonoscopy would have such serious consequences. The action was carried out as intended; the plan was a reasonable plan. It was the inadvertent injury that does not fit with the definition. It is arguable whether or not the injury would count as a medical error. It is probably not one.

Consider another scenario. Suppose new information becomes available in the process of an action that makes carrying out the action impossible or inappropriate. Is that an error? The plan and the intended action may have been reasonable and appropriate until the new information became available. The following story will illustrate. A man appears to be suffering from appendicitis. He has classic symptoms and is rushed to the hospital for an emergency appendectomy. Upon making an opening in the man's abdomen to remove the offending organ, the surgeon realizes that the man's intestines are consumed with cancer. There was no reason prior to the hospital visit for the patient or the physician to know of the cancer. The cancer, not an inflamed appendix, is the source of the patient's pain. The surgeon simply closes the wound without removing any tissue.

His action is not completed as intended. His plan, fine for addressing the symptoms, must change due to the unfortunate discovery. One might argue that this scenario represents a diagnostic error. However, only hindsight suggests that one might have considered other possibilities.

Another scenario, perhaps involving more rare circumstances, suggests that the IOM definition is inadequate. Suppose the intended action was not in accord with medical standards, but the procedure was carried out exactly as the physician intended. One might argue that the plan was the wrong one. However, the physician may be treating the patient in accord with the patient's wishes. The following are possible examples: (1) removal of a rejected but healthy limb;<sup>50</sup> (2) female circumcision; (3) using an ancient technique in an attempt to avoid amputation of a severely damaged limb, or; (4) using other unconventional methods for achieving a desired result when conventional methods have failed. Do these qualify as errors? Probably not.

The IOM report's message does not stop with its borrowed definition of *error*. In one portion of the report, the definition is immediately followed by:

*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*

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<sup>50</sup> There is a bizarre psychological disorder for which a few people have received amputations as treatments. The disorder is known by several names. One is *apotemnophilia*. It is considered to be similar in some respects to the disorder characterized by sexual identity that is contrary to the individual's genitalia. Gender reassignment through sex-change surgery is considered part of the treatment.

*meet the standard of care reasonably expected of an average physician qualified to take care of the patient in question).*<sup>51</sup>

The first sentence is borrowed from an article by Brennan and colleagues that reports the results of the Harvard Medical Practice Study, an investigation into the incidence of iatrogenic injuries in New York State's hospitals.<sup>52</sup> The second sentence is quoted from a follow-up article by Leape and colleagues that discussed the types and relative severity of injuries identified in the study.<sup>53</sup>

Clearly, the authors of the IOM report wanted to specify that there is something more to a medical error than executing a task in a manner other than that intended or than failing to choose the most desirable or professionally acceptable plan for the circumstances. The proximity of Reason's definition of *error* to a definition of an *adverse event* suggests that the report's authors intended some logical link between how the health-care provider arrived at a course of action, how the course of action was carried out by the health-care provider, and physical injury of the patient. Not all tasks of a health-care professional are of equal importance. The nature and severity of the consequences or potential consequences shape the meaning of term.

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<sup>51</sup> Kohn, Corrigan and Donaldson, eds., *To Err Is Human*, 28. (The original is in italics.)

<sup>52</sup> Troyen A. Brennan and Lucian L. Leape, "Adverse Events, Negligence in Hospitalized Patients: Results from the Harvard Medical Practice Study," *Perspectives in Healthcare Risk Management* 11, no. 2 (Spring 1991): 2-8. See also Brennan, Leape, Laird, Hebert, Localio, Lawthers, Newhouse, Weiler and Hiatt, "Results of the Harvard Study I," 145.

<sup>53</sup> Lucian L. Leape, Troyen A. Brennan, Nan Laird, A. G. Lawthers, A. R. Localio, B. A. Barnes, L. Hebert, J. P. Newhouse, P. C. Weiler, and H. Hiatt, "The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II," *New England Journal of Medicine* 324, no. 6 (February 7, 1991): 145.

Slight variations in carrying out a standardized set of actions may make no difference in the successful performance of the task or in achieving the goal of which the task is a part. In rare instances the *wrong* plan may result in a more favorable health outcome for the patient than a plan considered by the majority to be the *right* plan. What makes the execution of a task the appropriate execution, what makes the task successful, what makes the plan a *right* plan, matters as much as what an individual did or intended. For example, a bureaucratic rule created to codify the way things have always been done at a particular institution does not make the rule a good or beneficial rule or make complying with the rule the best way to achieve a desired end. Using an old or discredited method does not make it the *right* approach to a problem simply because it has been adopted as the official practice of a particular group.

In *Forgive and Remember: Managing Medical Failure*, Charles Bosk discusses how there may be a tendency to conflate universally accepted methods with the methods used locally or by certain individuals in positions of authority.<sup>54</sup> Failure of a resident to follow a particular attending physician's idiosyncratic technique might earn the label *mistake* or *error* even when the resident used a generally accepted method for carrying out a procedure.<sup>55</sup> When the patient is injured, the injury may be blamed on the resident's

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<sup>54</sup> Charles L. Bosk, *Forgive and Remember: Managing Medical Failure*, 2nd ed. (Chicago: University of Chicago Press, 2003), 61-6.

<sup>55</sup> Bosk, *Forgive and Remember*, xxi, 61-6.

failure to conform to the idiosyncratic technique rather than on more objective causal factors:

When breaches that all would agree are serious are treated in the same way as breaches that not all would agree are really breaches at all (or, more precisely, all would agree are only breaches on this service and only because Dr. Whoever says so), then residents have considerable interpretive room when evaluating their own behavior. Serious breaches may be dismissed as ‘just a matter of Dr. Whoever’s craziness; and trivial breaches may be overappreciated with the consequent cost of needless self-laceration and punctured self-esteem.<sup>56</sup>

Blurring of distinctions based on perceptions or preferences may color interpretations of error throughout the literature.

As mentioned above, the IOM’s definition of medical error is more than too broad; it is also too narrow. It fails to take into account the need to recognize that certain actions and aims are necessary and appropriate to a situation and to recognize the need to plan and carry out those actions and aims. This is not simply a matter of omitting steps. It is failure to fulfill certain health-care needs altogether.

When a physician fails to explain in a timely and honest fashion to the patient or patient’s family about an unexpected turn of events in the patient’s care, the physician-patient relationship may be irreparably harmed. Suspicion that the physician is guilty of a misdeed or of failing to provide adequate care can mar the patient’s recovery and lead to distrust. The following story will illustrate.

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<sup>56</sup> Bosk, *Forgive and Remember*, xxi.

A young woman underwent an emergency Caesarean section while her husband waited anxiously in the waiting room. The surgery was expected to take a short time. However, something went awry. A needle break was the cause of the difficulty. The tip was lost in her abdomen. Hours went by before it was located and removed. Meanwhile, the woman's husband, himself a physician, worried and eager to learn what was happening, was told nothing about his wife's status. Well after the woman left recovery and was in her hospital room, the couple was told that the wife had a complication that prolonged the surgery. The husband found out later about the needle break.

Whether the needle break was error is not the point of this scenario. The timing and nature of the communication are the errors of importance. After the surgeon's failure to adequately communicate, it was difficult for the couple to believe anything the surgeon said. They worried and wondered if the woman would suffer further consequences of her questionable care.

Dissatisfaction with the adequacy of IOM's definition of *medical error* has led other authors to offer alternatives. Lucian Leape, one of the most well-known writers on the topic of medical error, defines *error* as "an unintended act (either of omission or commission) or one that does not achieve its intended outcome."<sup>57</sup> The difficulty with this definition is that it leaves open the possible interpretation that every unintended outcome is due to an action or failing on a health-care provider's part. Unintended outcomes can occur from intended actions without a failing on anyone's part. An

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<sup>57</sup> Leape, "Error in Medicine," 11.

example would be an adverse reaction to a drug to which the patient had never experienced such a reaction before. Better yet, assume that a physician properly diagnoses the patient's health problem and prescribes an appropriate drug in the dosage that is appropriate for the patient's complaint; a pharmacist fills the prescription properly; the patient dutifully takes the drug as directed, but does not obtain the desired relief. The actions were intended, but they did not achieve the intended outcome. It seems a stretch to assume that the failure lies with the provider or the system, despite the fact that the drug was part of medical management. The failure was not necessarily with the patient's actions or omissions; the patient dutifully complied. Moreover, the drug is probably not to blame; its effectiveness for the general population was established statistically before it became available to prescribe. If anything, the *failure* is due to the uncertainties inherent in the interactions between a compound and a unique biological entity, a matter beyond the control of any and all of the parties involved.

Leape's definition may be inadequate in other ways. A treatment may accomplish what it was expected to do, but if the problem was not properly identified, the reduction or elimination of the problem that formed the basis of the patient's complaint may not be achieved. A person who repeatedly complains of constipation and intestinal cramping may obtain some temporary relief from a laxative. However, when the underlying cause of the complaint is a partial intestinal blockage caused by a tumor, the intended action of giving laxatives and the desired outcome of temporary relief suggest that no error has occurred. However, failure to properly diagnose the problem may be an error.

Some prefer to skirt the more difficult questions about the meaning of *medical error*. One segment of this group chooses to be ruled by a medical equivalent of “it is not wrong if you don’t get caught,” otherwise known as “no harm . . . no foul.”<sup>58</sup> If there is no obvious injury to the patient, no error occurred. This is the kind of definition that concerns proponents of the systems approach to error, because potentially harmful behaviors and processes go unrecognized. Furthermore, it encourages rationalizing that a setback or poor outcome experienced by the patient was due to something other than the physician’s own actions. The patient might be blamed for his or her own misfortune with a statement on the order of, “You had a complication.”

Others choose to see an error as a presumably good faith “mistake in reasoning, judgment, or actions [that] . . . involve[s] erring from standards of due care.”<sup>59</sup> They distinguish such errors from “harms associated with recklessness, incompetence, or negligent incapacitation (such as when the practitioner is inebriated).”<sup>60</sup> The problem with excluding the actions attributed to these conditions and considered blameworthy because they result from “a disregard for due care itself” is that establishing the presence of the mental state, the physical condition, or the competence of the practitioner may be

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<sup>58</sup> See, for example, Krizek, “Surgical Error,” 1360.

<sup>59</sup> John D. Banja, *Medical Errors and Medical Narcissism* (Sudbury, Mass.: Jones and Bartlett Publishers, 2005), 6; Virginia A. Sharpe, “Taking Responsibility for Medical Mistakes,” in *Margin of Error: The Ethics of Mistakes in the Practice of Medicine*, ed. Susan B. Rubin and Laurie Zoloth (Hagerstown, Md.: University Publishing Group, 2000), 184-5.

<sup>60</sup> Banja, *Medical Errors and Medical Narcissism*, 6; Sharpe, “Margin of Error,” 184-5.

more difficult than one might suspect.<sup>61</sup> These are typically matters for analysis and debate. In addition, excluding them from the error category may obscure important information that would be useful in designing safety measures.

### **The Need for a Clear, Workable Definition**

Designing safety systems is not the only reason one might need a definition of *medical error*. The second large body of literature mentioned above is concerned with medical malpractice, malpractice insurance, tort reform, and alternative compensation strategies. The fear of litigation and professional and financial ruin provides a recurring theme that runs throughout this literature.

Not all medical errors can be considered medical malpractice. In many instances an error is quickly discovered, and steps are taken to correct it before lasting harm befalls the patient. Some medical errors have no meaningful negative effect on the patient's health. For example, a patient may receive a drug other than the one prescribed for the patient's complaint. Due to the placebo effect the drug may achieve the desired result, despite its inappropriateness for the diagnosed condition. The drug may cause no harm to the patient whatsoever. The potential for harm existed, but the harm did not materialize. Nevertheless, an error occurred.

This error would not rise to the level of medical malpractice for one major reason. To prevail in a medical malpractice lawsuit, a patient (or the patient's representatives)

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<sup>61</sup> Banja, *Medical Errors and Medical Narcissism*, 6; Sharpe, "Margin of Error," 184-5. The quoted material is Sharpe's.

must demonstrate that the patient was harmed and that the harm was connected to and caused by the health-care provider's failure to fulfill a duty to act appropriately in accord with the legal and professional standards accepted by the relevant profession and jurisdiction.<sup>62</sup> The harm must be such that the patient experiences a compensable loss of some kind. Compensation for lost wages, medical expenses that were incurred and will be incurred because of the injury or harm, and diminished ability to function are among the various damages a patient can claim in a malpractice lawsuit. These are based on actual expenses or estimates of costs or financial losses that will occur as a result of the injury. Related to the physical injury or harm but less easily measured are damages for pain and suffering that diminish enjoyment of life. Typically, the physical injury must be established before any other damages can be considered.

A patient who was not informed of the mistake, but who learned later of the error might feel a sense of betrayal and anger toward the health-care provider. He or she might translate those feelings into an attempt to punish the health-care provider for his or her failure to fully disclose the error. The patient might even attempt to blame a less-than-

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<sup>62</sup> Medical malpractice is generally referred to as medical negligence. The basic elements the plaintiff must establish in any negligence case in order to prevail are as follows: (1) The defendant had a duty (legal obligation to act with care); (2) the defendant breached that duty; (3) the plaintiff was injured; and (4) the plaintiff's injury was proximately caused by the defendant's breach. In a medical malpractice case, the physician's duty is based on the care that would be exercised by the average, reasonably prudent physician under the same or similar circumstances. The harm has a somewhat different meaning for medical malpractice than it does for the ordinary citizen. Health-care providers often intentionally inflict wounds or other types of discomfort on patients for the purpose of achieving improved health and function of the patient. These are expected if the patient has been adequately informed. It is the unexpected injuries that result from failure to do what the ordinarily prudent health-care provider of the same type would have done that makes the act negligent. When a health-care provider intentionally and knowingly compromises his or her own competence to perform successfully or otherwise intentionally and unnecessarily endangers the patient's health, the health-care provider has intentionally breached the duty in a criminal or near criminal manner.

perfect outcome on the mistake and file a lawsuit. However, the patient would not be able to prevail in the lawsuit unless he or she could establish that the undesirable outcome was linked in a foreseeable way to the error.

Finding a workable definition for medical error is difficult because it means different things to different people and because the term, probably chosen to serve as a neutral signifier for missing the medical mark in one way or another, has become emotion-laden for patients and health-care providers alike. Another problem, despite claims to the contrary, is that sometimes it is very difficult to determine what led to an unfortunate outcome. Many investigations into medical errors work backwards from the outcome to find a possible explanation in the patient's chart.

This methodology suffers from a variety of flaws. Some important or relevant information may not appear in the chart. Errors in charting are possible. Information appearing in the chart may be misleading. Judgments on the part of the reviewer(s) may be biased or otherwise flawed. Or, actions described in the chart that seem to explain the outcome did not cause it.

One need only look at studies that compare the cause of death listed on patients' death certificates and pathologists' findings upon autopsy of cause or manner of death to learn something of the difficulties in identifying what really caused the deadly outcome.<sup>63</sup> These studies indicate that the cause of death listed on the death certificate is incorrect 24

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<sup>63</sup> See, for example, A. E. Smith Sehdev and G. M. Hutchins, "Problems with Proper Completion and Accuracy of the Cause-of-Death Statement," *Archives of Internal Medicine* 161, no. 2 (January 22, 2001): 277-84.

to 37 percent of the time.<sup>64</sup> The cause of death listed on the death certificates is not necessarily incorrect because of desires to mislead or cover up inadequate care. It is typically due to the nature of information available without invasive measures and what seems a plausible explanation for the death, given probabilities.

The quality of the data used and the method and level of analysis affect the conclusions one is able to draw. Failures or errors in charting, faulty histories provided by patients, undiagnosed conditions for which there were no complaints, idiosyncratic reactions to drugs, or any number of factors other than a desire to misrepresent can explain the discrepancies between the conclusions of one professional who relies on non-invasive measures to arrive at a cause of death and the conclusions of another who relies on the direct evidence obtained from the autopsy. Similarly, the conclusions about errors arrived at through the examination of charts can only be as accurate as the charts. Other studies using more direct methods for gathering information may offer a better picture of the numbers, types, and occasions for medical error.

Studies that make use of trained observers who identify errors based on discussions among health-care professionals and trainees in teaching hospitals may provide better insights into the incidents and situations called *medical errors* by medical professionals involved in patients' care. One such study, conducted at a large teaching

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<sup>64</sup> See Bobbi S. Pritt, Nicolas J. Hardin, Jeffrey A. Richmond and Steven L. Shapiro, "Death Certification Errors at an Academic Institution," *Archives of Pathology & Laboratory Medicine* 129, no. 11 (November 2005): 1477; Elizabeth C. Burton and Peter N. Nemetz, "Medical Error and Outcomes Measures: Where Have All the Autopsies Gone?," *Medscape General Medicine* 2, no. 2 (April 28, 2000): E2.

hospital, is discussed in Lori Andrews's article, "Studying Medical Error In Situ: Implications for Malpractice Law and Policy."<sup>65</sup> The study focused on patients hospitalized for surgical care. The reasoning behind the focus is as follows: "approximately 80% of patients' claims of malpractice revolve around an incident in a hospital. Moreover, in approximately one-third of hospital claims, surgeons are the principal defendants."<sup>66</sup> The study defines *errors* as "incidents in which a health-care provider or other hospital employee was said to have undertaken an action (or failed to undertake an action) when, at the time, an alternative, more appropriate action was possible."<sup>67</sup> To be considered an error for the study's purposes, the incident had to be "specifically characterized as an error by one or more of the health care workers discussing it."<sup>68</sup> Andrews is careful to point out that "the definition of errors did not include bad outcomes caused by the patient's condition or by an acceptable risk inherent in a particular procedure."<sup>69</sup>

Observers found a much higher percentage of errors and serious errors for the patients followed than the studies cited in the IOM report. Andrews's research led to the following results:

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<sup>65</sup> Lori Andrews, "Studying Medical Error in Situ: Implications for Malpractice Law and Policy," *DePaul Law Review* 54 (2005): 357-92.

<sup>66</sup> Andrews, "Medical Error in Situ," 359.

<sup>67</sup> Andrews, "Medical Error in Situ," 359.

<sup>68</sup> Andrews, "Medical Error in Situ," 360.

<sup>69</sup> Andrews, "Medical Error in Situ," 359.

At least one error was identified by the health care workers in the care of 480 (45.8%) of the 1047 patients in the units studied. No errors were mentioned about the care of 567 patients (54.2%). . . . Errors seriously impacted 17.7% of the patients, ranging from temporary disability to death.

The 17.7% of patients who had errors with a serious impact is significantly higher than the 3.7% rate of errors with similarly serious effects found in the Harvard Medical Practice Study of 30,121 medical records of New York hospital patients.<sup>70</sup>

The advantages of the observational approach are avoidance of certain hindsight bias and the recognition of certain errors that go uncharted.<sup>71</sup> Nevertheless, as Andrews points out, there are flaws with this anthropology-like approach. Although the educational process of a teaching hospital depends heavily on teaching to identify and correct errors, the discussions involve a degree of self-censoring. The hierarchy of authority has some influence over whose errors are discussed. The errors of senior members of the hierarchy may go unexamined, while those of the most junior members are discussed in depth. Andrews reports that “the odds of an [adverse] event being termed an error increased as the status of the person who omitted or committed the error decreased. Residents were more likely to be said to have caused errors than attendings.”<sup>72</sup>

Attempts to systematize, categorize, and operationalize *medical error* fail to take into account the mercurial nature of language, the remarkable human abilities to interpret

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<sup>70</sup> Andrews, "Medical Error in Situ," 361-2.

<sup>71</sup> Andrews, "Medical Error in Situ," 362. Andrews indicates that some physicians intentionally left out information about errors when charting to avoid litigation.

<sup>72</sup> Andrews, "Medical Error in Situ," 364.

and misunderstand, and the uncertainties that are inherent in the practice of medicine. As noted above, some definitions perpetuate the notion that medical practitioners have the ability to control far more than they actually can and that expectations of perfection are reasonable. Albert Wu reminds us of the unrealistic assumptions physicians and patients share about the promise of modern medicine:

Strangely, there is no place for mistakes in modern medicine. Society has entrusted physicians with the burden of understanding and dealing with illness. Although it is often said that “doctors are only human,” technological wonders, the apparent precision of laboratory tests, and innovations that present tangible images of illness have in fact created an expectation of perfection. Patients, who have an understandable need to consider their doctors infallible, have colluded with doctors to deny the existence of error. Hospitals react to every error as an anomaly, for which the solution is to ferret out and blame an individual, with a promise that “it will never happen again.”<sup>73</sup>

Expectations and interpretations determine whether the health-care provider has thought or acted appropriately. Unfortunately for physicians, patients, families, juries, and anyone else who comes in contact with an unexpected, unfavorable outcome or a deviation from a norm, there is little agreement about the import of actions or events, their meanings, the relationships of events, or what should happen after the action or the outcome. The physician who has acted competently and in accord with the standards recognized by his or her peers at a particular institution may be the subject of suspicion and distrust when an outcome is less than perfect. If the patient or patient’s family decides to sue for medical malpractice, the experts they hire and the jury that hears the

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<sup>73</sup> Albert W. Wu, "Medical Error: The Second Victim," *Western Journal of Medicine* 172, no. 6 (June 2000): 358.

facts may understand the situation differently. The outcome of a trial may reflect the lay public's attitudes about the physician-patient relationship as much as it reflects the jury's grasp of the facts presented.

### **Uncertainty and Flawed Interpretations**

There are several possible reasons for the differing interpretations of *medical error*. First, much of the public does not understand the scientific method, the use of statistical probabilities in arriving at conclusions, or the enormous number of factors that cannot be controlled in dealing with human bodies. Kathryn Montgomery's insightful book, *How Doctors Think*, includes an extensive discussion of the kind of science most people understand.<sup>74</sup> It is mechanical, law-like, formula driven, and exact. Unfortunately, biomedical science bears little resemblance to this mathematical perfection. The probability of a drug working a particular way in a patient is based on the way the drug has worked on a group of research subjects/patients. It does not have to work on everyone the same way or even to have the desired effect in all of the test patients to be approved for use in humans. Not all patients exhibit the same symptoms when they suffer from a particular disorder. A diagnosis is based on what is most probable given the information available. Tests ordered to help in deciding on the nature of the problem or the most appropriate course of action are rarely one hundred percent reliable. False negatives and false positives are known to occur with many kinds of tests. The best way to address a

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<sup>74</sup> See generally, Kathryn Montgomery, *How Doctors Think: Clinical Judgment and the Practice of Medicine* (New York: Oxford University Press, 2006).

particular problem is perhaps the best way known to the professional, the best way available in a particular area, the best way known to a particular specialty, or the best way known to all of medicine at a given moment, but not necessarily the best way that will ever be known.

Uncertainty compounds uncertainty in medicine. Human bodies are not machines. The facts mentioned above are easy to forget when, almost daily, one hears of medical discoveries and seemingly miraculous recoveries from once deadly diseases and injuries. Errors come to seem almost inconceivable when one sees how much medicine has been able to accomplish. For some, it seems natural to think that an outcome that is less favorable than expected must be due to a serious lapse of care or judgment on the part of the physician, or someone working under the physician's supervision. This kind of hindsight bias contributes to confusion and misunderstanding and adds to the difficulty in sorting out the meaning of *medical error*.

Physicians' confidence and kindly reassurances may add to the problem of unrealistic expectations. In *The Silent World of Doctor and Patient*, Jay Katz hints at why physicians are reluctant to share their awareness of uncertainties with patients:

Revelation of such uncertainties is difficult and disquieting. Learning to live more comfortably with uncertainty, however, has been impeded by other strongly held, although largely unexamined professional beliefs: that patients are unable to tolerate awareness of uncertainty, and that faith in professionals and their prescriptions makes a significant contribution to the optimal treatment of disease.<sup>75</sup>

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<sup>75</sup> Jay Katz, *The Silent World of Doctor and Patient* (Baltimore, Md.: Johns Hopkins University Press, 2002), xliv.

Generally speaking, physicians want to provide good health care to their patients. Their good intentions and encouraging words are sometimes interpreted by patients to include promises and guarantees that were never intended. When the patient experiences an undesirable outcome, even if it is associated with a known risk, the patient sometimes wants someone to blame.

A jumble of terminology adds to the confusion about the meaning of *medical error*. Some of the terms categorize the errors; some describe how they happen. Some of the terms are used interchangeably when perhaps they were originally not intended to be so used. Harms, iatrogenic injuries, adverse events, medical malpractice, poor outcomes, incidents, preventable errors, accidents, medical mishaps, latent errors, systems errors, slips, medical mistakes, medical negligence, sentinel events, complications, and any number of other terms are used to discuss what goes awry with patients' health or patients' care. When one considers language alone, it is not surprising that there is a lack of clarity concerning what is and is not a medical error.

The next section will examine how medical errors have been labeled and categorized in an attempt to arrive at a clearer grasp of the meaning of *medical error* than can be achieved through the brief definitions that are intended to cover all types and occasions of medical error.

## Categories and Classifications of Medical Errors

Thus far, overarching definitions of medical error have failed to capture the full meaning and scope of *medical error*. The deductive approach to exploring the boundaries of the concept has left considerable room for interpretation. Perhaps an inductive approach will assist in finding clarity. The answer to the question of what actions and omissions can be considered medical errors may be in the details.

### The Attending-Resident Version of Medical Error

Charles Bosk, a sociologist, originally published *Forgive and Remember: Managing Medical Failure* in 1979.<sup>76</sup> The book discusses his observational study of surgeons. Although this work is old, it continues to have relevance today. Like the observers discussed in Andrews's article, Bosk relies on errors as identified by health-care personnel. However, he has attempted to provide a model to assist his readers in making distinctions about how errors are perceived. His model identifies the four categories of errors he observed in the training of surgeons: technical errors, judgmental errors, normative errors, and quasi-normative errors.<sup>77</sup> These are general categories that are a matter of interpretation, often depending on the perspective of the attending in charge of the resident. Bosk observes that

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<sup>76</sup> Bosk, *Forgive and Remember*, xx.

<sup>77</sup> Bosk, *Forgive and Remember*, 37-67.

errors that were classified one way on one occasion might just as easily be classified another way on another occasion depending upon a staggeringly wide range of contextual factors: who the attending was, who the resident was, how smoothly things were going on the service when the mistake surfaced, how a request for information was managed, what time of year it was when the mistake occurred, how early or late in a rotation the mishap took place, who informed the attending of the problem, and under what circumstances.<sup>78</sup>

Although Bosk applied these terms in his study of surgeons, he claims that, in some respects, they can be generalized to all of medical training.<sup>79</sup> The categories represent superiors' way of evaluating the fitness of residents who err to advance with their careers. He is referring to a form of social control that requires surgical residents to notify their attendings as soon as they are aware of errors and of attendings to take responsibility by "putting on the hair shirt," admitting fault for a death or complication in a mortality and morbidity conference.<sup>80</sup> In both situations, the point is to demonstrate one's honesty and integrity and to explain what the individual has learned from the experience about how to avoid similar problems in the future.

Technical errors are those that occur when the practitioner's "skills fall short of what the task requires."<sup>81</sup> Residents are not expected to perform perfectly; they are in training. "For an error to be defined as technical, two conditions must be met. First the error has to be speedily noticed, reported, and treated. . . . A second condition must be

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<sup>78</sup> Bosk, *Forgive and Remember*, xx.

<sup>79</sup> Bosk, *Forgive and Remember*, xvi-xxi.

<sup>80</sup> Bosk, *Forgive and Remember*, 139.

<sup>81</sup> Bosk, *Forgive and Remember*, 37.

met for failure to be denied as technical: mistakes must not be frequently made by the same person.”<sup>82</sup>

One thing that is important to note in this discussion of technical errors is that honesty and integrity in dealing with the *patient* are not the primary focus. Proper allegiance to the superior serves as the measure of the resident’s moral stature. The patient is simply the occasion for the resident to demonstrate that allegiance. As Bosk notes, it is the patient who is expected to bear the costs of the error:

It is . . . important to remember that the costs of technical failure never shrink to zero, and it is the patient who always pays. The patient pays financially in increased hospital costs and pays personally in the discomfort of a complication. For subordinates, quick report of failure is one of the primary means of establishing that the error is not representative of its maker, that it signals only a momentary lapse, and that it occurred merely because of its maker’s inexperience.<sup>83</sup>

*Technical errors* are considered part of the learning process in a teaching setting. The resident who commits a technical error is supposed to learn how to avoid the error, or how to correct for the error quickly. However, if the concept is carried over to the established physician, the unmitigated technical error amounts to incompetence. Bosk does not explore this issue in any depth.

*Judgmental errors* occur when the physician’s treatment strategy is inappropriate to the patient’s needs. The most common types of judgmental errors are performing

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<sup>82</sup> Bosk, *Forgive and Remember*, 38.

<sup>83</sup> Bosk, *Forgive and Remember*, 39.

surgery when the patient is too ill to tolerate it and failing to operate when it is necessary.<sup>84</sup> Bosk points out that it is the seasoned physicians that “make the most and most serious judgmental errors.”<sup>85</sup> Apparently, hindsight is an important factor in the assessment of a judgmental error. The outcome drives the belief that an error occurred. Bosk asserts that “the judgment is not always incorrect in any absolute sense; the surgeon given the clinical evidence available at the time may have chosen an eminently reasonable course of action, but the result—a death or complication—forces the surgeon to consider whether some alternative might have been more profitably employed.”<sup>86</sup>

Bosk discusses another common judgmental error. This type takes place when the physician has no clear plan for addressing a chronic health problem. The patient languishes in the hospital consuming resources unproductively. It is unclear in this age of managed care the extent to which this type of error occurs. Nevertheless, it is conceivable that some physicians may make poor use of scarce health-care resources when they lack adequate treatment plans.

*Normative errors*, Bosk’s third category of medical missteps, occur “when a surgeon has, in the eyes of others, failed to discharge his role obligations conscientiously.”<sup>87</sup> According to Bosk, what this means is that this type of “mistake

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<sup>84</sup> Bosk, *Forgive and Remember*, 46.

<sup>85</sup> Bosk, *Forgive and Remember*, 45.

<sup>86</sup> Bosk, *Forgive and Remember*, 46.

<sup>87</sup> Bosk, *Forgive and Remember*, 51.

renders it impossible to consider the person making it—in legal terms—a just and reasonably prudent individual.”<sup>88</sup> Bosk finds that this type of error is attributed almost exclusively to subordinates, despite evidence that their superiors sometimes are guilty of the same shortcomings.<sup>89</sup> The reason is that those in positions of authority decide the moral worthiness of the residents to become full-fledged surgeons. However, once one achieves that full-fledged state, there is no one identified in Bosk’s observations to make those kinds of judgments about performance. The unlucky resident who fails to meet expectations in keeping the attending informed about problems quickly and honestly is guilty of this error. Such a failure is the result of *surprise*. Bosk explains:

A surprise for the attending carries with it the implication that a housestaff member was lazy, negligent, or dishonest. In practical terms, an attending finds himself surprised when he discovers for himself something about a patient that housestaff knew and neglected to tell him, or when he discovers for himself something his housestaff should have known.<sup>90</sup>

This type of surprise shows the attending that the resident does not know his proper place in the hierarchy. Other types of surprises occur when the resident fails to maintain good working relationships with support staff or when the resident is unable to obtain the cooperation of the patient or the patient’s family.<sup>91</sup> Again, these normative errors indicate

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<sup>88</sup> Bosk, *Forgive and Remember*, 51.

<sup>89</sup> Bosk, *Forgive and Remember*, 51, 7.

<sup>90</sup> Bosk, *Forgive and Remember*, 53.

<sup>91</sup> Bosk, *Forgive and Remember*, 55-6.

to the attending that the resident lacks the proper appreciation for his or her role and the rules that define it. Exposing the attending to surprise is extrapolated by the attending to mean that the resident is unable or unwilling to fulfill the responsibilities inherent in the physician-patient relationship.<sup>92</sup> Normative errors are considered the most serious errors when it comes to the resident's future. Unlike a technical error, the normative error can mean the end of one's career.

The fourth type of error Bosk describes is the *quasi-normative error*. This type of error is specific to the resident's attending. If the attending uses a particular approach, the resident must use the same approach or else be labeled insubordinate. Any deviation from the attending's preference is considered an affront to the attending physician's authority. It is an error of relationship rather than an error of method, skill, knowledge, or judgment concerning the patient's care. Only the particular attending is likely to consider the breach an error. Nevertheless, the consequences for the resident who violates the attending's rule are often equal to those for committing a normative error. Bosk explains:

Each attending has certain protocols that he and he alone follows. A subordinate who does not follow these rules mocks his superordinate's authority; his behavior is a claim that his judgment is as adequate as his superior's; and even though in no absolute sense can one claim that a mistake has been made, a subordinate who makes a quasi-normative error risks his reputation as a trustworthy recruit.<sup>93</sup>

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<sup>92</sup> Bosk, *Forgive and Remember*, 55.

<sup>93</sup> Bosk, *Forgive and Remember*, 61.

Bosk attributes the attending's favoring of a particular approach to the uncertainties that are part of every procedure. Because evidence is inconclusive concerning the best way to address a problem, one must choose based on a combination of research results and personal experience. The attending is ultimately responsible for the patient's care. Therefore, the resident is expected to act on the attending physician's behalf and not to substitute his or her own judgment about the appropriate way to treat the patient.

If Bosk's observations hold true, there is even more reason to be confused about the meaning of *medical error*. His work raises the question of whether medical error is an issue of patient safety or an issue of professional identity. System errors were not on Bosk's mind when he conducted this study more than twenty years ago. He notes that instead of focusing attention on the causes of errors, he examines "how surgeons account for errors once they have occurred."<sup>94</sup> In the case of some *errors*, there is even a question of whether or not an error occurred; the unexpected negative outcome prompts the assumption that an error caused the outcome, despite good evidence that the course of action taken was reasonable. Bosk's model is based on the blame-shame approach to medical error, a part of medical culture that he thinks may be closely tied to a sense of professional responsibility and professional allegiance.<sup>95</sup>

Bosk's model does not lend itself to any kind of standardization. There is a kind of "because I said so" authoritarianism built into the model that would make it difficult

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<sup>94</sup> Bosk, *Forgive and Remember*, xxiii.

<sup>95</sup> Bosk, *Forgive and Remember*, xxiii-xxiv.

for an outsider to grasp the criteria for identifying an error or for distinguishing an error from a non-error. Furthermore, it is difficult to gain insight into which events and processes labeled errors would be preventable.

### **Defining Medical Error by Type**

Eric Thomas, a physician, and Robert Helmreich, a psychologist, provide another model for categorizing errors.<sup>96</sup> They base their model on errors originally identified in the airline industry. Along with their model, they provide a critique of any approach based solely on voluntary reporting. According to this model, there are five categories or types of errors. They are as follows: (1) *violation errors*, (2) *procedural errors*, (3) *communication errors*, (4) *proficiency errors*, and (5) *decision errors*.<sup>97</sup> The authors indicate that the advantage of the classification system is that it acknowledges that “different interventions are required to prevent and mitigate different types of error.”<sup>98</sup>

A *violation error* is very much like it sounds. It is a “conscious failure to adhere to procedures or regulations.”<sup>99</sup> Violation errors are sometimes a matter of haste, sometimes due to a culture of noncompliance, sometimes the result of a sense of

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<sup>96</sup> Eric J. Thomas and Robert L. Helmreich, "Will Airline Safety Models Work in Medicine?," in *Medical Error: What Do We Know? What Do We Do?*, ed. Marilyn M. Rosenthal and Kathleen M. Sutcliffe (San Francisco: Jossey-Bass, 2002), 217-34.

<sup>97</sup> Thomas and Helmreich, "Will Airline Safety Models Work?," 222-3.

<sup>98</sup> Thomas and Helmreich, "Will Airline Safety Models Work?," 223.

<sup>99</sup> Thomas and Helmreich, "Will Airline Safety Models Work?," 222.

invulnerability, and sometimes due to poorly thought out procedures or regulations.<sup>100</sup> The choice to break or circumvent the formally accepted rules in medicine probably happens frequently. Studies in the airline industry indicate that violation errors make up about one-half of all errors.<sup>101</sup> Given the long hours, the stress of emergency situations, and the heavy burdens of documentation and monitoring in medicine, it would not be surprising to find that the figures are similar for physicians and other health-care providers. Conscious violations may involve something as simple as choosing not to document immediately because of time pressures, then failing to follow up because of fatigue or other time pressures. Choosing not to check another's work is another violation that could easily create the opportunity for a patient injury. Because these types of errors may not be reflected in a patient's chart, they may have been overlooked in studies that relied on chart reviews to identify medical errors.

The appropriate remedy for preventing this type of error in the future may require reallocating resources to make shortcuts unnecessary, rewarding compliance, forcing compliance through automation, and various other measures that are in line with the systems approach to error prevention.

In contrast to violation errors, *procedural errors* occur when the health-care provider attempts to comply with procedures, but fails to execute the procedures properly. The problem may lie with the individual or with the procedure. The individual

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<sup>100</sup> Thomas and Helmreich, "Will Airline Safety Models Work?," 223.

<sup>101</sup> Thomas and Helmreich, "Will Airline Safety Models Work?," 223.

may not fully grasp the procedure's intent or details and may carry out the procedure incorrectly. Or, the procedure may need to be changed because it is in some way flawed or inadequate.

*Communication errors* are what one would expect, failures in the exchange of information. Omissions, ambiguities, inaccuracies, and misinterpretations are errors that can result in other types of errors. The communication errors the authors discuss are internal to the functions of the team, organization, or system. They do not appear to apply to communications between insiders and their clients or customers, or in the medical setting, between physicians and patients.

*Proficiency errors* result from deficits in skills or knowledge needed to meet the challenges of a situation. The reason for the error is lack of competence to carry out the task. Further training and education may be the appropriate remedy to prevent future errors, also weeding out individuals who lack the ability to perform at the required level would help to prevent this type of error.

Thomas and Helmreich define a *decision error* as a decision made by the professionals involved that "unnecessarily increases risk."<sup>102</sup> Although the authors offer no example, David Hilfiker's famous story about his decision to not send a pregnant patient for an ultrasound may be the kind of error the authors intended.<sup>103</sup> Hilfiker examined a woman who appeared to be pregnant, but the pregnancy tests were negative.

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<sup>102</sup> Thomas and Helmreich, "Will Airline Safety Models Work?," 222.

<sup>103</sup> David Hilfiker, *Healing the Wounds* (Omaha, Neb.: Creighton University Press, 1998), 55-9.

He concluded that the woman was carrying a fetus, but the fetus was dead. He did not send the woman to have an ultrasound because the cost of the test was relatively high and the testing site was a considerable distance from where the woman lived. Hilfiker was trying to be sensitive to the family's financial situation. Ultimately, he removed the contents of the woman's uterus and made a terrible discovery. The pregnancy tests had been wrong; the fetus had been alive until he carried out the procedure. His decision to forgo ordering the ultrasound increased the risk of being wrong about the fetus, a risk that was realized with painful clarity for all involved.

The Thomas-Helmreich model has certain advantages over Bosk's model. It is less value-laden and more focused on an analytical approach to categorizing errors. Of course, the authors' goals are different. Bosk discusses threats to relationships within a hierarchy and how the hierarchy addresses infractions of expectations within its ranks. Tradition and the culture of medicine are important contextual matters that any attempts to define medical error must take into account. Thomas and Helmreich's model is oriented toward prevention. Theirs is a general model not designed specifically for medical issues. Its primary flaws are as follows: it does not provide for overlaps in categories; it does not address communication issues with the patient, and it does not acknowledge the problems of ambiguity in distinguishing errors from other kinds of occurrences.

## The All-Purpose Error Model

James Reason, the error researcher whose work draws on the fields of psychology and jurisprudence and reviews investigations into the mechanisms of human fallibility since the late nineteenth century, provides a careful, nuanced look at definitions and models of human error in general.<sup>104</sup> Reason's work is prominent in the literature on medical error, despite the fact that his model was not designed specifically for use in the health-care setting. Reason divides errors into two basic types: *active errors* and *latent errors*.<sup>105</sup> Active errors are those that one usually thinks of as errors. They are the acts and omissions that can be directly linked to an incident Reason calls an *accident*, a negative consequence of an error. Latent errors are those aspects of a process that invite mistakes. They are due to inadequate measures in place to manage and monitor environmental factors, relationships, and transitions. The latent errors are often discovered to be important contributing factors in active errors. The thinking behind identifying latent errors is that if mechanisms were in place to force compliance with policies and procedures, to prevent dependence on memory, to facilitate communication, or to prevent the effects of distractions and other kinds of factors that contribute to missteps, many accidents could be averted.<sup>106</sup>

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<sup>104</sup> Reason, *Human Error*.

<sup>105</sup> Reason, *Human Error*, 173.

<sup>106</sup> Reason, *Human Error*, 25.

Many authors who have drawn on Reason's work discuss his generic error-modeling system (GEMS), the system that explains the cognitive mechanisms of errors.<sup>107</sup> It is made up of three familiar types of errors: skill-based slips and lapses, rule-based mistakes, and knowledge-based mistakes.<sup>108</sup> These types do not always stand alone. Some errors have elements that fit with more than one cognitive mechanism.<sup>109</sup>

Reason states the following: "Ernst Mach (1905) put it well: 'Knowledge and error flow from the same mental sources, only success can tell the one from the other.'"<sup>110</sup> The point of this statement is that many errors are errors of cognition. The way one stores, retrieves, processes, and applies information plays an important role in any action. Memory, attention, habit, generalization, framing, bias, expectations, automatic reactions, and use of rules are some of the mental processes that contribute to both successes and failures. One cannot simply do away with certain cognitive mechanisms to reduce errors. They are adaptive and often beneficial. The successes associated with them reinforce their use.

Reason's *skill-based errors* occur as a result of *inattention* or *overattention*. Inattention can happen in a variety of ways and for numerous reasons. The overarching problem that leads to this type of error is failure to monitor, especially "when the current

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<sup>107</sup> Reason, *Human Error*, 61-8.

<sup>108</sup> Reason, *Human Error*, 53-6.

<sup>109</sup> Reason, *Human Error*, 66-8.

<sup>110</sup> Reason, *Human Error*, xvi.

intention is to deviate from common practice.”<sup>111</sup> *Overattention* occurs “when focal attention interrogates the progress of an action sequence at a time when control is best left to the automatic ‘pilot.’”<sup>112</sup> Reason states:

[M]istimed checks . . . can produce at least two kinds of wrong assessment. Either one concludes that the process is further along than it actually is, and as a consequence, omits some necessary step . . . (omission). Or, one decides that it has not yet reached the point where it actually is and then repeats an action already done . . . (repetition).<sup>113</sup>

Reason’s *rule-based errors* involve the misapplication of good rules or the application of bad ones. The misapplication of good rules can result from misplaced focus, rigidity, familiarity, misinterpretation of the evidence or the need, and conflicting information. The application of a bad rule does not necessarily mean that the result will be an error. However, a bad rule can invite problems. What makes a rule a bad rule is that it: (1) is inelegant, clumsy, or generally inefficient, (2) overgeneralizes or does not take into account important details, (3) is unnecessarily risky, or (4) is based on thinking or actions that have little to do with the problem at hand (e.g., rules based on superstition, fantasy, or wishful thinking).<sup>114</sup>

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<sup>111</sup> Reason, *Human Error*, 68.

<sup>112</sup> Reason, *Human Error*, 73.

<sup>113</sup> Reason, *Human Error*, 73.

<sup>114</sup> Reason, *Human Error*, 79-86.

Reason's *knowledge-based errors* occur when the person in a decision-making position must reason through a problem for which he or she has little or no experience. The problem solver attempts to draw on whatever knowledge he or she has to arrive at strategies for devising an answer. Reason suggests several ways that this type of error occurs. *Selectivity* is the source of one type. It occurs if "attention is given to the wrong features or not given to the right features."<sup>115</sup> Another type, *workspace limitations*, has to do with how much information one can deal with at a time and the order in which one processes information. The *out-of-sight-out-of-mind* type occurs when "one gives undue weight to facts that come readily to mind" or "ignores that which is not immediately present."<sup>116</sup> *Confirmation bias* happens in a situation of ambiguity when one is unwilling or unable to abandon an interpretation, even when there is evidence that contradicts it. *Overconfidence* occurs when one is so certain about his approach that he or she focuses on information that confirms the chosen plan and ignores evidence that contradicts it. Other ways knowledge errors occur have to do with the way the problem-solver compiles evidence that supports a chosen plan. Finding correlation and causation when the evidence will not support it, attempting to simplify when it is not warranted, and jumping to conclusions before symptoms have been carefully identified and evidence has been considered logically fit into this category.

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<sup>115</sup> Reason, *Human Error*, 42-61.

<sup>116</sup> Reason, *Human Error*, 42-61.

## **Adaptation of the All-Purpose Model to Medicine**

Leape borrows substantially from Reason and others to fine-tune the extension of error identification and prevention, originally developed for other contexts, to fit with medical reality. Because of his focus on systems errors and avoidance of the shame-and-blame approach, the categories of errors he identifies are less subjective and less hierarchy-dependent than those described in Bosk's work. They apply to all health-care workers, including administrative staff, and concentrate on how errors come about, rather than on how individuals and groups react to an error once it has been identified. Several authors who have written on the topic of medical error rely heavily on Leape's model.

Leape's model is made up of three categories one may recognize from Reason's work: slips, mistakes, and latent errors. The first two types of errors are cognitive in character, whereas latent errors are more related to external factors such as working conditions, which include quality of management, availability and usability of equipment, organization of supplies, mechanisms for recording and retrieving information, and any number of other environmental and contextual factors that influence the process and flow of work in the health-care setting.<sup>117</sup>

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<sup>117</sup> Lucian L. Leape, "Error in Medicine," in *Margin of Error: The Ethics of Mistakes in the Practice of Medicine*, ed. Susan B. Rubin and Laurie Zoloth (Hagerstown, Md.: University Publishing Group, 2000), 100-3.

According to Leape, errors of cognition account for the majority of medical errors that are currently known.<sup>118</sup> Because humans rely on mental maps, called schemata (schema), to carry out familiar tasks and to make most decisions, they sometimes make assumptions they should not, fail to pay close attention to what they are doing, misinterpret situations in a ways that fit with habit or bias, or otherwise use shortcuts in thinking that result in unintended acts.<sup>119</sup> A well-worn path of thinking is more likely to be taken than an unfamiliar one. A disruption of thinking along a less familiar path can lead to reversion to a more familiar one.

*Slips* are skill-based errors. Leape asserts slips are unconscious errors associated with automatic or habitual actions. They occur with lapses of attention and unintentional “monitoring failures.” Leape mentions several types of cognitive misfires that qualify as slips: (1) *capture*, (2) *description errors*, (3) *associative activation errors*, and (4) *loss of activation errors*. Capture occurs when “a more frequently used schema takes over from a less familiar one.”<sup>120</sup> Description errors occur when “the right action is performed on the wrong object.”<sup>121</sup> Turning on the wrong burner on the stove or flipping on the switch to the garbage disposal when one intended to turn on a light are common examples of this type of error. Another is absent-mindedly trying to insert one’s house key into the car’s

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<sup>118</sup> Leape, "Error in Medicine," 99.

<sup>119</sup> See Hilfiker, *Healing the Wounds*, 55-66.

<sup>120</sup> Leape, "Error in Medicine," 101.

<sup>121</sup> Leape, "Error in Medicine," 101.

ignition. “Associative activation errors result from mental association of ideas, such as answering the phone when the doorbell rings.”<sup>122</sup> The fourth type of slips may be more familiar. “Loss of activation errors are temporary memory losses,” such as forgetting one’s goal after initiating an action.<sup>123</sup> For example, one might be discussing an issue with another, but after a brief distraction, forget what he or she was talking about. The error amounts to losing one’s train of thought.

Leape notes that distracters creating the conditions for slips can be external or internal. Preoccupations or physiological states are as likely to disrupt attention as environmental conditions or interruptions by others.

*Mistakes*, Leape’s other set of cognitive errors, come in two varieties: *rule-based errors* and *knowledge-based errors*. Rule-based errors occur when the professional chooses the wrong rule, either because of an incorrect assessment of the problem or because a frequently-used rule seems to be adequate for the situation. Leape refers to these as “errors of misapplied expertise.”<sup>124</sup>

The main crisis in *The Spirit Catches You and You Fall Down* by Anne Fadiman provides an illustration of the rule-based type of error.<sup>125</sup> A caring and competent pediatrician at a California hospital repeatedly treated the infant daughter of a Hmong

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<sup>122</sup> Leape, “Error in Medicine,” 101.

<sup>123</sup> Leape, “Error in Medicine,” 101.

<sup>124</sup> Leape, “Error in Medicine,” 101.

<sup>125</sup> Anne Fadiman, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* (New York: Farrar, Straus and Giroux, 1997; reprint, 2000).

couple for epileptic seizures. The family's approach to treatment was based on their cultural beliefs about the meaning of epilepsy and about what they thought was best for their daughter. Due to their wariness of Western medicine, they did not always comply fully with the pediatrician's recommendations.

According to the author, the Hmong people understand epilepsy as both a blessing and a curse. Those who exhibit the symptoms have been selected to serve as a connection between the spirit world and the living and to provide spiritual leadership to others. The physician understood the epilepsy as a disorder that should be scrupulously kept in check because failure to do so could lead to a neurologically devastating event. These differences in perception resulted in poor communication and confusion on both sides.

The day came when the child was brought into the emergency room with uncontrollable seizures. The pediatrician who had treated her so many times before concluded that his prediction of a disastrous seizure event had come true. Recognizing that the results of the devastating seizures were beyond his skill to treat, he had the child transferred to specialists at another hospital.

It was only after the transfer that the pediatrician's error came to light. He had not taken her temperature or considered the meaning of certain test results and symptoms. His history with the child led him to assume that the devastating seizures were the result of the parent's non-compliance in administering anti-seizure medication. The little girl's terrible state was actually brought on by septic shock caused by infection. Unfortunately, the physician's judgment was clouded by his expectations and habits in addressing the

needs of his frequent patient. He followed a rule that he had developed for treating that particular patient.

The second type of mistake, the knowledge-based error, occurs when the health-care professional is faced with a problem for which he or she has no readily available rule. The situation requires problem solving and includes applying inadequate or faulty knowledge to plan or act.<sup>126</sup>

There are several sub-categories of knowledge-based errors.<sup>127</sup> Errors resulting from poor memory and overgeneralization are associated with what Leape calls *memory bias*. One tends to remember patterns that have worked in the past or to place too much emphasis on a failure in the past. This emphasis on what sticks in one's memory can lead to a distortion in one's perceptions and in determining the best response to the problem at hand. Other mechanisms of distortion that problem solvers apply include: *available heuristic*, *confirmation bias*, and *overconfidence*. Again, these concepts are based on those in Reason's work. *Available heuristic* refers to settling on one's first thoughts about resolving the problem. In diagnosing an illness, the physician may stop exploring possibilities as soon as he or she settles on a disease that fits the symptoms.

Unfortunately, the simplest explanation for the symptoms may not be the right one.

*Confirmation bias* refers to ignoring evidence that is contrary to one's own hypothesis.

Errors associated with this bias do not require that the physician's hypothesis be entirely

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<sup>126</sup> Leape, "Error in Medicine," 101.

<sup>127</sup> Leape, "Error in Medicine," 101.

wrong; the patient may suffer from multiple disorders while the physician assumes there is only one. *Overconfidence* is demonstrated when the physician believes he or she has taken the correct action and looks for evidence to support the action's efficacy.

These types of mistakes and the mechanisms that define them can co-exist and overlap. They are ordinary human shortcuts in thinking that can easily occur in stress-inducing situations.

*Latent errors* are called the “accidents waiting to happen.”<sup>128</sup> These result from flaws in planning, design, organizational structure, information flow, maintenance, and management decision-making. They often involve several people and a string of events. It is this type of error that the systems approach can best address. These are the errors that occur when there is no fail-safe mechanism to prevent errors or when existing mechanisms are flawed, ignored or circumvented, or otherwise inadequate to do what they are intended to do. Standardization, automation, continuous reporting and monitoring, improved training and communication, frequent equipment testing, use of safety checklists, and any number of other changes in the ways the organization functions and tasks are carried out can reduce the likelihood of these types of errors or lead to early detection so that corrective measures can be taken to minimize harm.

The goals of both Reason's and Leape's models appear to be related to identifying causes of errors and how errors happen rather than discussing them in terms of professional relationships or categorizing them according to the interventions needed to

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<sup>128</sup> Leape, "Error in Medicine," 102.

prevent future errors. Their contributions indicate something of the complexity of errors. Unfortunately, they fail where Bosk succeeds; they do not take into account the kinds of errors that are associated with the hierarchy and the social pressures built into medicine.

### **Attention and Error**

Reason and Leape both indicate that *attention* is an important factor in many errors. Almost all errors, including latent errors, the mishaps that can be largely attributed to gaps in management and problems with the work environment, involve some aspect of this cognitive element. In philosopher Alan R. White's analytical work on attention concepts, aptly titled *Attention*, the author carefully explores the nuances of meaning in the use of attention language, language that clarifies the meanings and influences of awareness, consciousness, care, inadvertence, negligence, intent, mistake, accident and other terms that arise in the discussion of medical error.<sup>129</sup>

White asserts the following:

Attending to doing something refers to two actions, attending to the activity and doing the activity. If this were not so, how does one explain that a one can conduct an activity without paying attention to what one is doing? It is possible that one can carry out an activity out of habit, automatically, or in a distracted manner in which one's mind is not focused on one's own actions. Attending is an intentional action, but an action that may occur in different ways or may have different meanings depending on the context or the object of the attention.<sup>130</sup>

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<sup>129</sup> Alan R. White, *Attention* (Oxford: Basil Blackwell, 1964).

<sup>130</sup> White, *Attention*, 14-6.

The point of this statement is that attention is not a simple concept. When one exhibits inattention, one may be focusing differing levels of awareness on one's own activities. Tied up with attention is intention, attitudes about the importance of one's primary actions, lack of awareness about peripheral actions and influencing factors, depth of focus on details, quality of reflection in deciding what to do and how to do it, and the extent of consideration of the consequences of one's actions. All of these meanings of attention have some application to the categories and causes of medical error.

Because medical error is central to this line of inquiry, it may also be useful to understand White's views on use of the terms *mistake* and *accident*. According to White,

[w]e may 'make a mistake' *when* doing something . . . or we may make a mistake *by* doing, or omitting to do, something . . . . Only in the second case can it be said that we have 'mistakenly' done something, that 'it was a mistake' to have done it for that the deed itself 'was a mistake'. Hence, mistaken beliefs fall under this second case.<sup>131</sup>

Medical errors involve both varieties of mistakes. An action carried out incorrectly can be as harmful to a patient as an inappropriate act carried out correctly. White goes on to say:

When we make a mistake, of whatever kind, there is always some description of our deed under which it is something we quite intentionally did. It is also, however, something which is in some way wrong. It may be wrong either because it is objectively incorrect or because it is under another description, something which we have done instead of what we intended to do. In the first case it is mistakenly done, in the second case it is also done by mistake. I cannot do

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<sup>131</sup> White, *Attention*, 131.

something by mistake unless it is other than what I intended to do, but what I mistakenly do may or may not be what I intended to do.<sup>132</sup>

This statement points out how confusing the concept of intention may be when trying to sort out the meaning and culpability of medical error. The intended action, the intended execution of the action, and the intended outcome can be completely separate. The action may be poorly thought through. The attempt to carry out the action may fail or may be accompanied by unintended actions. The outcome may be other than what was expected to follow from the actions or other than appropriate to fulfill the perceived need.

White clarifies as follows:

Since what we do by mistake is unintentional and unknowing, we cannot do anything both by mistake and deliberately. What we mistakenly do, however, may be quite intentional and we may or may not know that in doing it we are making a mistake.”<sup>133</sup>

He distinguishes mistakes from accidents. As mentioned above, Reason calls the result of medical error, the harm the patient experiences, an accident. White writes:

Mistakes are something we make; accidents befall us. Accidents happen in the course of doing something else; mistakes may also consist in the very commission of the deed. Hence beliefs may be mistaken, but not accidental. The law rightly distinguishes accident from mistake as the unintended from the intended. In mistake, something is intentionally done; in accident, there need be no intention anywhere.<sup>134</sup>

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<sup>132</sup> White, *Attention*, 131.

<sup>133</sup> White, *Attention*, 131.

<sup>134</sup> White, *Attention*, 131.

Following Reason's logic while using White's distinction one can conclude that the patient suffers an accident that results from the health-care provider's medical error. Could this distinction play a role in attitudes and beliefs about to whom a health-care professional owes a duty when he or she commits a medical error? The patient suffered from an accident, an unintentional event; whereas, the health-care provider's intention has to do with a professional activity that is a poor choice or is carried out in an unacceptable or injurious manner.

A physician is expected to meet the professional standard of care. Failure to meet that standard opens the physician to liability. *Care* is one of the attention concepts White addresses. Because *care* can mean medical management, diligence, positive affect, and a variety of other things, it may be useful to sort out the way the term is used in relation to medical error.

White discusses *care* as follows:

Physicians *care* for patients or provide medical *care*. Here, *care* refers to providing a particular variety of *attention*. Lack of *care* can mean indifference about the outcome, or it can mean carrying out an action inattentively so that the outcome is not what was desired or expected. If a physician does not *care* about the patient, he or she may still provide adequate medical attention, yet feel no personal connection to the patient as an individual. However, if the physician does not care what happens to the patient, the physician is indifferent to the patient's needs or wellbeing and may provide inadequate *care*. To do something with *care* can mean giving close attention to carrying out an action. However, a *careless* action may be executed with close attention, but without regard to the consequences, or without awareness that one is carrying out the wrong plan.<sup>135</sup>

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<sup>135</sup> White, *Attention*, 75-8.

Once again, the language one uses in discussions of the meanings and types of medical error provides opportunities for different interpretations according to what one prefers to understand. The standard of care, ill-defined as it is for any particular procedure, may also be ambiguous in general. Built into White's analysis is the possibility of construing care to mean respect for the patient and for the physician-patient relationship, competence, attention to detail, reasoned decision-making, well-executed actions, good goal-setting, and self-monitoring and evaluation. Perhaps all of these interpretations are intended in standard of care. However, that is less than clear.

White further distinguishes carelessness from inadvertence. He writes:

Carelessness . . . is a failure to pay attention to certain risks and their insurances to which one ought to pay attention in order to manage successfully what one is doing. Inadvertence, on the other hand, is a lack of attention to certain fine details in my performance, which results in some untoward happening. For instance, in passing the sugar I did not give such detailed attention to my bodily movements as to prevent the knocking over of my neighbour's cup.<sup>136</sup>

White goes on to discuss inattention to the deed, inattention to the manner of the deed, inattention to the preparation for the deed, impulsiveness, impetuosity, lack of deliberation, inattention to the effects of the deed, inattention to the circumstances of the deed, and kinds of ignorance that contribute to one's participation in a mistake. All of these explorations of inattention point to the many opportunities for the individual to err through inadequate attention. They also show how difficult it could be to share understanding about what happened to cause an undesired outcome.

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<sup>136</sup> White, *Attention*, 80.

Some researchers have recognized the problems inherent in the interpretations and assumptions about the meanings of terms. Of course, one's purposes influence how one understands the terminology. Most of the authors mentioned above define *medical error* with the hopes of encouraging the development of mechanisms for monitoring and measuring the factors that have contributed to or may lead to patient injury. Their goals include: reducing the influence of environmental and social factors that create opportunities for distractions and distress, creating methods that force health-care professionals to take the steps necessary to prevent errors, automating to improve communication and to standardize information, and creating a culture that encourages error reporting and is supportive of health-care professionals who suffer psychologically after learning they have harmed their patients. Bosk's use of the same or similar terminology is intended to describe the sociology of surgical training, the relationships among surgeons and residents and the ways residents come to share the values of the specialty.

As mentioned above, the perceptions, beliefs, and interpretations of events by patients sometimes differ from those of physicians. Although physicians sometimes set aside recognition of their own fallibilities and the inherent uncertainties of medicine in order to practice with a degree of confidence, patients and their families are often unaware of the gaps in knowledge, the gray areas, and the enormous number of variables involved in successfully diagnosing and treating humans. Physicians recognize that although their actions or omissions may contribute to a less than optimum outcome for

the patient, there are differences among medical error, preventable medical error, and medical malpractice.

On the patient-family side of the medical-error issue is the recognition that one person's iatrogenic infection or injury is not enough to force change onto a profession or its supporting institutions. Until the large studies of medical error became public, there was little acknowledgement of a need to change beliefs, attitudes, or responses to complaints about the inadequacies of safety measures and about self-policing of the medical profession. As mentioned above, many who work in the medical field still believe that the real problem with medicine is with the tort system and not with shortcomings in healthcare.

### **The Legal Interpretation of Medical Error**

There are a number of ways medical errors have been classified. Some classification systems address the part of the medical encounter associated with the error. Some address the types of cognitive lapses that led to the error. Some address the character of the lapse or failure. Perhaps it would be easier to arrive at a definition of *medical error* by looking at what might count as a medical error.

I will begin with legal theories and categories. Because negligent medical errors are the intended basis of physician liability, it may be helpful to examine the various types of lawsuits that are often called medical malpractice lawsuits, and the types of medical errors and situations that form the basis or the reason for the legal action. They include the following: (1) failure to obtain informed consent, (2) breach of

confidentiality, (3) failure to diagnose or treat in accord with medical standards, and (4) abandonment.

When a physician fails to disclose an important risk to the patient and the undisclosed risk materializes in the form of physical harm to the patient, the physician has breached the duty of *informed consent*. The patient-plaintiff must prove that the physician had the duty to disclose according to the jurisdiction's requirements; the physician breached the duty; the patient was injured when the risk materialized; and the patient would not have consented if he or she had known of the risk. When a surgeon removes the wrong limb or a misidentified, functioning organ, the physician has also breached informed consent, because no consent was obtained to remove the specific body part. Such errors may be due to inadequate communication between the physician and the patient or due to administrative glitches that create opportunities for inadequate transfer of information. Misreading of imaging or test results may also lead to this breach of professional and legal standards.

*Breach of confidentiality* is an error of medical communication of another kind. The health-care professional who makes the patient's confidential health information available to someone who is not authorized to receive it has erred by damaging the patient's trust in the health-care professional and the medical profession and by potentially creating opportunities for other harms to befall the patient such as discrimination or damaged reputation.

*Medical negligence*, the physician's failure to exercise the average degree of skill, care, and diligence exercised by members of the same specialty or subspecialty under the same or similar circumstance, defines medical malpractice. The wayward physician who, for whatever reason, fails to do what a reasonable physician of the same type would do, is liable if the harm that results is a foreseeable result of the lack of due care the physician exhibits. Whether fortunate or unfortunate, establishing what the reasonable physician would do under the circumstances usually requires expertise beyond that of the ordinary citizen or jury member.

Diagnostic errors are more common sources of litigation than are problems with informed consent. With this type of medical malpractice, the patient-plaintiff must prove the same four elements—duty, breach, causation, and injury—as one would find in any case of medical negligence. Diagnostic errors happen for a number of reasons. Failure to order a test indicated by symptoms is one. Failure to administer a test safely is another. Failure to read test reports is yet another. Making assumptions about who does and does not suffer from a disorder can result in a failure to diagnose it, (e.g., only males can have bleeding disorders; breast cancer is extremely rare for pre-menopausal women and non-existent in men, and women rarely have heart attacks). Other misinterpretations of information can lead to incorrect diagnoses. Arriving at a conclusion about the cause of the symptoms without giving adequate thought to alternative causes is thought to be behind many diagnostic errors.

Medication errors can easily follow from an incorrect diagnosis. The choice of medication can exacerbate the patient's health problem if the diagnosis is wrong. For example, giving insulin to an unconscious diabetic because the physician assumes the patient's blood sugar is too high could be fatal if the unconscious state was brought on by extremely low blood sugar. Medication errors that follow from incorrect diagnoses are not the most well-known.

Probably the more common types of medication errors involve poor memory, poor handwriting, poor calculations, or poor skills or inadequate care in administration. The names of several drugs sound alike. Relying on one's memory in prescribing the appropriate drug or the appropriate amount can lead to errors. Even if the correct drug is prescribed, it does not necessarily mean that the pharmacy dispensed the proper one. Oral communication failures can lead to medications errors, but poor handwriting is often blamed for much confusion and error. In order to be beneficial, a prescribed drug must be administered properly. Improper administration may involve failure to administer, administering at the wrong time (too frequently, too infrequently, or when it will interact with another substance), or administering via the wrong method (e.g., i.v., instead of intramuscular administration). Yet another medication error or set of errors involves prescribing and administering a drug that is contraindicated (e.g., a drug to which the patient's chart indicates the patient is allergic). This discussion of medication errors is not exhaustive. There are numerous opportunities and paths for accomplishing a medication

error.<sup>137</sup> Although medication errors are probably the most common medical errors, there are other types of treatment errors.<sup>138</sup>

Surgical errors are the types of treatment errors that often lead to lawsuits.<sup>139</sup> Because anesthesia errors, actually medication and monitoring errors, typically occur during surgical procedures, they are sometimes categorized with surgical errors. Similarly, other types of procedures are often included in this category, (e.g., transfusing the wrong blood type). Damaging a structure while removing, repairing, or examining another due to insufficient skill, knowledge, or care is one basis of a lawsuit. Leaving a foreign object in the body is another. Carelessly introducing infection is yet another. The last ones that come to mind have to do with timing. The surgeon who chooses to do surgery on the patient who is too sick to withstand the procedure or whose surgery is delayed so long that the surgery will no longer produce benefit may be liable. Of course,

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<sup>137</sup> See generally, Rhonda G. Hughes and Eduardo Ortiz, "Medication Errors: Why They Happen, and How They Can Be Prevented," *Journal of Infusion Nursing* 28 (March 2005): 14-24; A. G. Winterstein, T. E. Johns, E. I. Rosenberg, R. C. Hatton, R. Gonzalez-Rothi and P. Kanjanarat, "Nature and Causes of Clinically Significant Medication Errors in a Tertiary Care Hospital," *American Journal of Health-System Pharmacy* 61, no. 18 (September 15, 2004): 1908-16; John Morrissey, "Encyclopedia of Errors. Growing Database of Medication Errors Allows Hospitals to Compare Their Track Records with Facilities Nationwide in a Nonpunitive Setting," *Modern Healthcare* 33, no. 12 (2003): 40; Neil M. Davis and Michael R. Cohen, *Medication Errors: Causes and Prevention* (Philadelphia, Pa.: George F. Stickley 1983), 1-18.

<sup>138</sup> Hughes and Ortiz, "Medication Errors," 14; Nick Barber, M. Rawlins and B. Dean Franklin, "Reducing Prescribing Error: Competence, Control, and Culture," *Quality & Safety in Health Care* 12 Suppl 1 (December 2003): i29.

<sup>139</sup> David M. Studdert, Michelle M. Mello, Atul A. Gawande, Tejal K. Gandhi, Allen Kachalia, Catherine Yoon, Ann Louise Puopolo and Troyen A. Brennan, "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine* 354, no. 19 (May 11, 2006): 2026.

removing the wrong body part is also surgical in nature. However, as mentioned above, it is usually an error of consent unless it is also done without reasonable care.

Sometimes errors in conducting medical interventions are accompanied by administrative errors. The loss or mixing of records, mislabeling of specimens or test results, and inadequate or inaccurate recordkeeping can lead to one patient being mistaken for another. Unnecessary and unwanted procedures and treatments may be administered to the patient's detriment. Or, needed procedures or treatments may be forgone.

The examples provided for categories of errors associated with stages of medical care are not exhaustive. However, they probably cover the majority of mishaps that lead to medical malpractice lawsuits.

These types of errors are easier than others for the lay public to understand. It is in part because they represent aspects of the physician-patient relationship and the patient's experience on an individual level. The technical aspects of procedures and the whys and hows of medical errors may remain baffling, but the patient can point to the part of the relationship where the physician or health-care provider working under the physician's supervision failed to meet expectations.

The model is useful in that it may identify aspects of the physician-patient relationship that need improvement. The fact that they point to specific health-care providers indicates that society expects physicians and supporting individuals and institutions to be accountable directly to harmed parties. The flaws in this model lie with

focus on individual cases. Some cases address legitimate cases of medical negligence; some end in the decision that no medical negligence occurred. Some cases actually lack merit, that is to say, they lack any credible evidence that medical negligence occurred. These are far fewer in number than some would like the public to believe. Removal of bad doctors, improvement of safety for future patients, and compensation for un-litigated injuries get lost amongst other trees in an unrecognized forest. That is the reason results from the Harvard study and others similar to it came as a shock to the medical profession and to the public.

### **An Alternative Approach**

It is far easier to find flaws with others' definitions and models than it is to arrive at one's own. Nevertheless, I will attempt a contribution. Medical error is a variance from the professionally or institutionally expected behavior on the part of one acting under the authority of a physician (including the physician), that potentially or actually has an unexpected negative impact on the health or wellbeing of the patient. Here, *variance* means a deviation (from). Expected professional or institutional behavior means *compliance*, acting in accord with rules, protocols, procedures, and policies (no violations); *competence* and *care* acting with the professionally or institutionally expected levels of appropriateness, accuracy, skill, knowledge, and attention; *communication*, acting in a manner that adequately and accurately communicates information necessary to fulfill the requirements of compliance and competence and for

patient/family understanding; *coordination*, acting in a manner that allows for the organization to function effectively and efficiently.

The advantages of this definition/model are as follows: (1) it takes into account both acts and omissions; (2) it suggests the types of interventions that would be needed for improvement; (3) it allows for both active and latent errors by including the coordination component; (4) it includes a communication component that covers both institutional communication and physician-patient communication; (5) it specifically expresses expectations as an element in assessing quality of work; and (6) it mentions a care element that covers a wide range of relationship and attention factors.

This model is not without flaws. As noted above, expectations can be inappropriate or out of line with reality. Furthermore, expectations may be inadequately established due to lack of awareness of need or may be evolving as new information becomes available. Without some sort of feedback mechanism, such as recording complaints, adverse events, and known or suspected errors, expectations may remain too high or too low. Nevertheless, expectations are essential to the meaning of error.

Perhaps the most serious difficulty with trying to find a way of understanding error is not in abstract definitions or in categorizing errors, but rather in identifying errors. The reason one might need a definition is to be able to distinguish an error from a non-error, a preventable error from one that is not preventable, a compensable error from one that is not, and an error that should lead to discipline from one that should not. It would seem that what is necessary for this type of inquiry is a standardized decision

model or procedure. Such a procedure is beyond the scope of this dissertation. However, to be beneficial to health-care professionals, health-care organizations, and patients, the procedure should be as transparent as possible, and documentation of how the process works should be widely distributed. Without this kind of transparency, both health-care providers and injured parties will, no doubt, find any results of an investigation into an adverse event suspect unless the finding fits with their preferences.

## Chapter 2: The Culture of Medicine

The previous chapter discussed the difficulties in defining medical error in the U.S. It may seem odd that a profession that has built its reputation on its connections to science and its aspirations of relieving suffering would have so many differing views of what is and is not a medical error. There seem to be medical errors of a social nature, medical errors of incompetence, medical errors due to technical missteps, medical errors due to mechanical failures, and medical errors resulting from intentional violations of procedures or protocols. Whether an error happened or not or is worthy of note depends to a large extent on who has the power to decide.

The lack of a clear definition of *medical error* is actually consistent with the culture of medicine. The culture of medicine helps to explain many of the things that happen in health care and why they happen as they do. I specifically write about American medicine, although there are many similarities with the profession as it exists elsewhere. I will attempt to briefly explain what I mean by *culture of medicine*, an oft used and rarely-explained term. My purpose in doing so is to show that certain ways of thinking and acting grow out of the social and environmental influences associated with entering and being a part of the medical profession.

## Finding a Definition of Culture

First, one needs to know what *culture* means. In some contexts the term refers to refinement and artistic endeavors. However, in the context I will address, *culture* refers to the characteristics of a group that are perpetuated through a learning process and that set the group apart from others. This is not a simple matter. Anthropologists and sociologists struggled for years with the question of how to define *culture*, often disagreeing about what distinguishes one group from another. Sociologists tend to refer to *societies* instead of *cultures*; however, the terms are often synonymous. A common dictionary definition of *culture* is “the sum total of ways of living built up by a group of human beings and transmitted from one generation to another.”<sup>140</sup>

This is far from the only definition. Alfred Kroeber and Clyde Kluckhohn, well-known anthropologists, once published a book that discussed 164 definitions of *culture*, making use of both sociologists’ definitions and those of anthropologists.<sup>141</sup> In his famous article “Thick Description: Toward an Interpretive Theory of Culture” Clifford Geertz discusses the nebulous characterizations of culture.<sup>142</sup> He quotes from, paraphrases, and comments on some of the definitions of *culture* Kluckhohn used in his book *Mirror for Man*; *culture* means:

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<sup>140</sup> Jesse Stein, ed., *The Random House College Dictionary*, rev. ed. (New York: Random House, 1975), 325.

<sup>141</sup> Alfred L. Kroeber and Clyde Kluckhohn, *Culture: A Critical Review of Concepts and Definitions* (New York: Random House, 1952).

<sup>142</sup> Clifford Geertz, “Thick Description: Toward an Interpretive Theory of Culture,” in *The Interpretation of Cultures* (New York: Basic Books, 1973), 4.

(1) “the total way of life of a people”; (2) “the social legacy the individual acquires from his group”; (3) “a way of thinking, feeling, and believing”; (4) “an abstraction from behavior”; (5) a theory on the part of anthropologists about the way in which a group of people in fact behave; (6) a “storehouse of pooled learning”; (7) “a set of standardized orientations to recurrent problems”; (8) “learned behavior”; (9) a mechanism for the normative regulation of behavior; (10) “a set of techniques for adjusting both to the external environment and to other men”; (11) a precipitate of history”; and turning, perhaps in desperation, to similes, as a map, as a sieve, and as a matrix.<sup>143</sup>

Geertz takes a somewhat different approach to defining *culture*. He defines it as:

an interworked system of construable signs (what, ignoring provincial usages, I would call symbols), culture is not a power, something to which social events, behaviors, institutions, or processes can be causally attributed; it is a context, something within which they can be intelligibly—that is, thickly—described.<sup>144</sup>

I have relied heavily on textbook definitions, most of which are borrowed from *Sociology* by Donald Light and Suzanne Keller.<sup>145</sup> However, I have divided the prevailing definitions of *culture* into five general categories that synthesize information from other sources. The categories are as follows:

1. language and meanings,
2. traditions and symbols,
3. values and beliefs,

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<sup>143</sup> Geertz, "Thick Description," 4-5.

<sup>144</sup> Geertz, "Thick Description," 14.

<sup>145</sup> Donald Light, Jr. and Suzanne Keller, *Sociology*, 2nd ed. (New York: Alfred A. Knopf, 1979).

4. norms and social roles, and
5. knowledge and tools.<sup>146</sup>

These categories sometimes overlap considerably (expect some repetition).

However, the perspectives often differ. Although social scientists group these perspectives or approaches to *culture* differently, the concepts that populate the categories, however ordered, are roughly the same.<sup>147</sup> I will touch on each of the categories I have chosen to use to show that *culture of medicine* is a meaningful term and that the culture of medicine *contributes* to the ways physicians, as a group, tend to think, feel, and behave; as Geertz suggests by his definition, the culture of medicine is a context of meaning.<sup>148</sup>

According to Light and Keller, the medical profession technically is a *subculture*.

“Members of a subculture share a set of norms, attitudes and values that gives them a distinct identity within the dominant culture.”<sup>149</sup> They indicate that “subcultures grow among a group of people who are isolated together outside the conventional world—

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<sup>146</sup> See, for example, Light and Keller, *Sociology*.

<sup>147</sup> Kroeber and Kluckhohn, *Culture: A Critical Review of Concepts and Definitions*. Kroeber and Kluckhohn use six categories to group the various definitions they discuss: historical, normative, psychological, structural, descriptive, and genetic. I do not address the genetic elements; they are irrelevant to this dissertation.

<sup>148</sup> *Culture* is an overused term that for many has lost meaning. See, for example, Clausen, "The Culture of Culture," 14-5. Some suggest that discussions of culture are really about essentialism or stereotyping. To some extent they are correct. Patterns of behavior observed in a group can lead to assumptions that all members of the group behave in exactly the same way. This is an unfortunate mistake. Nevertheless, recognizing patterns can be valuable. Culture is often invisible to those who are part of it. Bringing certain assumptions and behaviors into consciousness can facilitate change.

<sup>149</sup> Light and Keller, *Sociology*, 100.

isolated physically . . . or isolated by what they do and think, by their world of meaning.”<sup>150</sup> Of course, the medical profession is not the only source of a career-related subculture. Light and Keller tell us:

Whereas corporate careers build on (and even exaggerate) existing qualities, other careers (such as medicine-psychiatry in particular—law, the military, and police work) require resocialization. Training programs are consciously and unconsciously designed to strip away the self-images and perspectives that have resulted from previous socialization, and to replace them with a new outlook and self-image.<sup>151</sup>

According to Light and Keller, there are six stages that make up this resocialization process. They are as follows:

1. The new entrant is “made to feel different.”<sup>152</sup>
2. The new entrant is discredited to undermine his or her existing self-image. The entrant’s values are challenged or attacked.
3. This causes the initiate discomfort and confusion. The goal of this disorienting process is to cause the initiate to align with the new group’s way of thinking and behaving.
4. Either the initiate drops out or stops resisting.

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<sup>150</sup> Light and Keller, *Sociology*, 100.

<sup>151</sup> Light and Keller, *Sociology*, 134.

<sup>152</sup> Light and Keller, *Sociology*, 134.

5. As the initiate begins to conform to expectations he or she begins to develop a sense of competence, again. “The more individuals play at being what they hope to become . . . the more sense the new moral order makes.”<sup>153</sup>
6. “Finally, the individual internalizes the world view of the career, and accepts its norms and values as his or her own.”<sup>154</sup>

Whether one calls the ways of physicians a culture or a subculture is not particularly important. The point is that physicians are resocialized to share in a way of experiencing the world that is separate from that of the general population.

Please keep in mind that groups are not monolithic. There is variation within the group. The group’s world view, behavior, technologies, structure, and relationships to other groups can change slowly over time or rapidly in response to conditions in the social or physical environment. Furthermore, within the group are smaller sub-sets that have their own specialized ways. For example, physicians who practice internal medicine differ from radiologists who, in turn, differ from surgeons. The ways they practice medicine influence their respective ways of dealing with patients and with addressing patients’ health problems.<sup>155</sup> Nevertheless, a culture typically maintains elements of its identity despite changes in the world around it or changes within it.

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<sup>153</sup> Light and Keller, *Sociology*, 135.

<sup>154</sup> Light and Keller, *Sociology*, 135.

<sup>155</sup> There is a joke that was told to me by a pathologist that reflects some of these differences. “Internal Medicine doctors know everything and do nothing. Surgeons know nothing and do everything. Pathologists know everything and do everything, but the patient is already dead.”

## **Five Ways of Looking at Culture**

In this section I will briefly discuss a way of conceptualizing culture. Then, I will show how the model applies to the medical profession.

### **Language and Meaning**

#### ***Language and Meaning***

Light and Keller offer the following definition of language: "A language is a system of verbal and in many cases, written symbols with rules for putting them together."<sup>156</sup> They claim that "it is impossible to overestimate the importance of language in the development, elaboration, and transmission of culture."<sup>157</sup> Some assert that the language one thinks in and uses to communicate shapes the way one perceives the world.<sup>158</sup> Because language is the primary way one expresses thought, language shapes the meaning one is able to share with others. This understanding of language is associated with the meanings the group in question attaches to various aspects of the physical world

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<sup>156</sup> Light and Keller, *Sociology*, 90.

<sup>157</sup> Light and Keller, *Sociology*, 90.

<sup>158</sup> This is commonly known as the Sapir-Whorf Hypothesis, developed by Edward Sapir and Benjamin Whorf, anthropological linguists. For a discussion of the hypothesis and its origins, see Harry Hoijer, "The Sapir-Whorf Hypothesis," in *Readings in Anthropology*, ed. Morton H. Fried (New York: Thomas Y. Crowell, 1968), 404-17. Wittgenstein's work concerning language games and the logic of language provides support for this statement in a different way than the Sapir-Wharf Hypothesis. One of Wittgenstein's most famous statements is: "The limits of my language mean the limits of my world."

and to the social interactions in which members of the group engage.<sup>159</sup> Shared meanings serve to enforce group cohesion. Those who do not speak the language or share the meanings peculiar to the group are excluded. Aspects of language used within the group may reflect and enforce how relationships are understood including status, roles, and norms. Vocabulary, word preferences, slang, pronunciation, and dialect convey information about individuals and how they relate to one another. How members of the group address one another and address outsiders may reveal information about the relationships within and outside the group.

The ways language can be said to shape and reinforce culture are myriad. I have mentioned only a few to provide background so the reader can consider whether or not the concept is a good fit with the ways physicians live and transmit information to the next generation. Assuming that this concept of culture applies to the medical profession, one must determine how it applies.

### **Medical Language and Meanings**

In the U.S. medical professionals speak two languages; the language that makes them part of the more general American culture,<sup>160</sup> and a specialized language that is largely incomprehensible to the lay public and makes physicians part of a smaller, more

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<sup>159</sup> Kroeber and Kluckhohn, *Culture: A Critical Review of Concepts and Definitions*, 224-44.

<sup>160</sup> This statement assumes that members of the American culture generally speak English.

exclusive group.<sup>161</sup> Some of the words from this second language may look or sound familiar to the non-medical person; however, pronunciations and meanings may differ from what is used in the general culture. For example, *centimeter* looks and means the same in terms of measurement as a member of the lay public would expect, but health-care professionals pronounce the first syllable “sahnt” instead of the familiar “sent.” A similar example can be found with the word *umbilicus*. The ordinary American would place the emphasis on the second syllable and pronounce all of the vowels as short vowel sounds. However, the health-care professional places the main emphasis on the third vowel sound and uses a long vowel sound in the third syllable (um.bi’li.kus versus um.bi’li’kus). Some examples of familiar words that have meanings other than those used by non-physicians are as follows: humor, piles, waterfall, tunic, abduct, table, brawny, spud, cleavage, snare, clubbing, show, gravel, marker, and sensitivity.<sup>162</sup>

Much of the language of medicine is technical short-hand that allows health-care professionals to communicate efficiently with a high level of precision. The names of body parts and functions, diagnostic processes, diseases and injuries, treatment procedures and mechanisms, and other aspects of their profession are elaborately detailed. Sometimes, otherwise recognizable language is reduced to acronyms or shortened forms, making them inaccessible to the uninitiated (e.g., a UTI is a urinary tract infection; a CBC is a complete blood count, CNS is the central nervous system). Non-

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<sup>161</sup> See, for example, Buckman and Kason, *How to Break Bad News*, 42.

<sup>162</sup> For further information, see *Steadman's*.

members of the group would ordinarily have little need for these terms and usages in their daily lives.

Some medical language has been Latinized for the purpose of excluding non-members and mystifying the practice of medicine. According to Simon Sinclair, author of *Making Doctors: An Institutional Apprenticeship*, until the late 1700s, British physicians used ordinary language with patients and other physicians most of the time (81 percent).<sup>163</sup> However, “by 1800, 79% of diagnoses were made in Latin.”<sup>164</sup> It was this type of language that Paul Starr writes about when discussing Thomsonian practitioners’ charges against members of the allopathic medical profession: “‘Many doctors’, said Thomson, ‘have learned just enough to deceive people, and to keep them in ignorance by covering their doings under a language unknown to their patients.’”<sup>165</sup> As medicine moved from a philosophical and theoretical approach toward diseases to a more science-based approach, the use of specialized terminology enhanced physicians’ assertions that only they were legitimate in their claims of being learned and knowledgeable.<sup>166</sup> Physicians also use Latinized language in writing prescriptions. Doing so would prevent the patient from attempting to prepare his own remedies from substances that might otherwise be readily available. The typical patient was and is usually unable to interpret

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<sup>163</sup> Simon Sinclair, *Making Doctors: An Institutional Apprenticeship* (New York: Berg, 1997), 52.

<sup>164</sup> Sinclair, *Making Doctors*, 52.

<sup>165</sup> Paul Starr, *The Social Transformation of American Medicine* (n.p.: HarperCollins, 1982), 52.

<sup>166</sup> Starr, *Social Transformation*, 58-9.

the terms and abbreviations used to communicate the physician's directions to pharmacists.

Latinized terms are not the only special language that physicians speak. Inner circles of physicians learn and use slang that expresses emotional distancing from certain patients and for expressing an *us-versus-them* mentality.<sup>167</sup> Patients who suffer from multiple-system failures or disastrous social circumstances are sometimes referred to as *train-wrecks*.<sup>168</sup> A patient who is on the verge of dying is *circling the drain*. A patient who is drug-seeking is called a *turkey*. A severely burned patient may be called a *crispy critter*. Suspected hypochondriacs are referred to as *crocks*.<sup>169</sup> In his infamous novel, *House of God*, Samuel Shem revealed some of the slang terms of his time in residency, including: *turf* and *gomer*.<sup>170</sup>

At times, the way physicians use language serves to blame the victim for his or her misfortunes. "You developed a complication," or "she ruptured her uterus," are examples of this type of language use.<sup>171</sup> The communication suggests that the patient

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<sup>167</sup> Sinclair, *Making Doctors*, 14.

<sup>168</sup> Mary-Jo DelVecchio Good, Cara James, Byron J. Good and Anne E. Becker, "The Culture of Medicine and Racial, Ethnic, and Class Disparities in Healthcare," *Russell Sage Working Papers* 199 (2002): 603.

<sup>169</sup> Sinclair, *Making Doctors*, 34.

<sup>170</sup> *Turf* means "to get rid of, to get off your service and onto another, or out of the House altogether." "Gomer is an acronym: Get Out of My Emergency Room. . . . Gomers are human beings who have lost what goes into being human beings." Samuel Shem, *House of God* (New York: Dell, 1988), 37, 59.

<sup>171</sup> See, e.g., Sinclair, *Making Doctors*, 264-5.

demonstrated volition in developing and exhibiting problems or symptoms. Built into this type of statement is a denial that the patient's health care, or inadequacies thereof, may have contributed to the patient's emerging health issues.

Language serves a function beyond setting physicians apart from others. It provides meaning to the patient's complaints. The physician listens for the *relevant* parts of the patient's narrative to begin the process of diagnosing the patient's complaint.<sup>172</sup> The physician gives meaning to aspects of the patient's story while ignoring or giving little value to information that the physician believes will not assist with the diagnosis.<sup>173</sup> This extraction and translation of the patient's story into medical language and meaning helps to construct new understanding for the patient. As Starr states, "professionals not only advise actions but also evaluate the nature of reality and experience, including the 'needs' of those who consult them."<sup>174</sup> The physician who can name the disorder with an unfamiliar term may provide the patient with validation and a sense that what is known can be managed. Many a patient with vague symptoms has gone from physician to physician in search of a name for their discomfort. For some, the name alone provides relief from the frustration by indicating that their complaint is not the product of the

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<sup>172</sup> See, for example, Kathryn Montgomery Hunter, *Doctors' Stories: The Narrative Structure of Medical Knowledge* (Princeton, N.J.: Princeton University Press, 1991), 51-68; Jeffrey M. Borkan and William L. Miller, "Storytelling in Medicine," in *Patients and Doctors: Life Changing Stories from Primary Care*, ed. Jeffrey Borkan, Shmuel Reis, Dov Steinmetz, and Jack H. Medalie (Madison, Wisc.: University of Wisconsin Press, 1999), 3.

<sup>173</sup> Montgomery, *How Doctors Think*, 76, 107-8.

<sup>174</sup> Starr, *Social Transformation*, 13.

patient's imagination.<sup>175</sup> Unfortunately, the patient who hears from the physician, "Nothing is physically wrong," sometimes feels misunderstood and unsupported due to the physician's unwillingness or inability to validate the patient's complaint by giving it a name.<sup>176</sup> Similarly, the physician who refuses to listen to the patient's explanation for the symptoms or to the psychosocial elements of the patient's experience connected to the disease manifestations may find that the communication failure results in patient dissatisfaction and non-compliance with whatever recommendation the physician makes. In other words, the weight and meaning the physician gives to the patient's interpretation of his or her own distress has an impact on both the relationship and the patient's health.<sup>177</sup>

Among others, Howard Brody asserts that "*every encounter between doctor and patient is a cross-cultural event.*"<sup>178</sup> The physician's conception of the world and the patient's understanding of the world are sometimes so different as to be incompatible. As Hunter writes: "A silent tug-of-war over the possession of the story of illness is frequently at the heart of tension between doctors and patients, for that tension is in part a struggle over who is to be its author and in what language, a struggle for the

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<sup>175</sup> Howard Brody, "Reflections," in *Patients and Doctors: Life-Changing Stories from Primary Care*, ed. Jeffrey Borkan, Shmuel Reis, Dov Steinmetz, and Jack H. Medalie (Madison, Wisc.: University of Wisconsin Press, 1999), 68-9.

<sup>176</sup> Montgomery, *How Doctors Think*, 65-6.

<sup>177</sup> Good, James, Good and Becker, "The Culture of Medicine and Racial, Ethnic, and Class Disparities in Healthcare," 600-6.

<sup>178</sup> Brody, "Reflections," 67.

interpretation of life (and death) events.<sup>179</sup> Sinclair explains how this kind of problem can arise in an ordinary encounter between a physician and a patient:

“[O]bjective” language promotes greater intersubjectivity [among physicians], leading indeed to an element of unspoken communion, a communion that leaves the patient out. Unfortunately, the physicians may believe they are communicating effectively with patients.<sup>180</sup>

An extreme example of the type of the language-culture gap that can arise between the physician and patient or patient’s family can be seen in Anne Fadiman’s book *The Spirit Catches You and You Fall Down*.<sup>181</sup> The Hmong family portrayed in the book consistently interpreted their child’s health problems and need for treatment differently than the physicians providing her care. The misunderstandings were due to a clash of world views and inadequacies of communication skills. The world view of the physicians caring for the child fit with Brody’s statement that “among the critical features of the exceedingly complex medical culture is a need to see the world as a composite of problems with solutions, where the ‘right’ solution is often independent of which person has the problem.”<sup>182</sup> Unfortunately, one of the physicians in the Hmong child’s case made the transition to understanding the patient as a person with a history and life beyond the realm of medicine at an inopportune time by concluding that the patient’s life context

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<sup>179</sup> Hunter, *Doctors' Stories*, 14.

<sup>180</sup> Sinclair, *Making Doctors*, 28.

<sup>181</sup> Fadiman, *The Spirit Catches You and You Fall Down*.

<sup>182</sup> Brody, "Reflections," 67.

was driving her symptoms instead of a massive infection. For that reason, the physician attempted to solve the wrong problem based on assumptions about the individual and her family rather than standard protocols.

Physicians often choose their words carefully when discussing treatment decisions and unpleasant news with patients. Sometimes, the language they use is clinical and abstract, avoiding to some extent the personal and emotional aspects of the information.<sup>183</sup> Sometimes, it is guarded, intended to conceal as much as it reveals. Concern about the legal implications of the information often drives the physician's choice of words; meeting the legal requirements, without inviting unwanted questions or unwelcome responses is the anxious physician's goal.

The physician-patient relationship is not the only relationship affected by language and meaning. Language contributes to the understanding and enforcement of the hierarchical relationships among health-care providers. The attending physician is of higher rank than the resident; the resident is of higher rank than the medical student; third- and fourth-year medical students are of higher rank than first- and second-year students. Meanings are attached to the titles associated with each stage of the training process that indicate something about what the individual has accomplished to attain the status and to whom the individual must show a degree of deference. Relationships between physicians and other health care workers are also enforced through language, albeit not necessarily technical language. The physician who scribbles a prescription or

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<sup>183</sup> Buckman and Kason, *How to Break Bad News*, 9.

writes one that that does not conform to standard treatment guidelines often enforces his or her authority through wrathful and disrespectful language toward the nurse or pharmacist who questions the prescription. The fear of being labeled incompetent leads the questioning health care worker to quietly accept the physician's directive, despite concerns about the patient's safety.<sup>184</sup>

The impacts of language and meanings in the medical profession go well beyond the samples I have provided. They serve to shape physicians' approaches to professional relationships, to problem-solving, and to maintaining a professional identity. However, medical language and meanings do not set physicians apart entirely from others that work with them to provide health care. Nurses, physician assistants, and other health-care personnel may understand and use much of the same language and interpretations. Their knowledge of the specialized language and understanding is closely related to their work with physicians. Language and the meanings physicians give to words, symptoms, and situations help to define the culture of medicine. However, they do not seem sufficient to fully describe physicians as a group. They set physicians apart from the lay public, but not others who share more or less in the language and meanings. Language and meanings fail to explain certain behaviors and traits that come to mind when one thinks about how physicians can be distinguished from other groups.

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<sup>184</sup> Hunter, *Doctors' Stories*, 93.

## Traditions and Symbols

### *Traditions and Symbols*

Traditions and symbols provide another window into what defines a culture. History, rituals, secrets, legends, metaphors, images, physical items, social structures, learning processes, socially transmitted information, oaths and codes, modes of dress, and habits are among the elements of this approach to defining culture. Traditions link the present to the past. Symbols convey meaning. As Deborah Stone states in her book *Policy Paradox: The Art of Political Decision Making*, “The meaning of a symbol is not intrinsic to it, but is invested in it by those who use it.”<sup>185</sup> She goes on to say that “any good symbolic device, one that works to capture the imagination, also shapes our perceptions and suspends skepticism, at least temporarily.”<sup>186</sup>

Stories can serve as both traditions and symbols. Stories about the origins and legendary leaders of a group, how the group established its territory, and its trials and triumphs help to establish a group identity, a common background. Stone discusses the use of narratives to explain how the world works, *synecdoche* (using a part to represent the whole) for providing examples and metaphors to imply both stories and possible remedies to problems, and ambiguity to lead people to believe they share some common

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<sup>185</sup> Deborah A. Stone, *Policy Paradox: The Art of Political Decision Making* (New York: W.W. Norton, 1997), 137.

<sup>186</sup> Stone, *Policy Paradox: The Art of Political Decision Making*, 137.

ground.<sup>187</sup> These rhetorical devices are used to sway outsiders as well as to reinforce group cohesion.

Rituals that demonstrate initiation to the membership, allegiance to the group, and identification with the group contribute to the sense of shared experience and group cohesion. They may include the story-telling, rites of transition from one life-stage to another, celebrations of achievement, socially acceptable ways of investigating and punishing rule infractions, methods for foretelling the future, ways of worship, and any number of other socially recognized actions with the goal of demonstrating membership, enforcing social control, and perpetuating the social structure.

The social structure of the group indicates something about what the group values and how power and authority are distributed for purposes of transmitting knowledge and maintaining order. Those who control resources and decision-making power determine who will serve others and under what circumstances. The leader or leaders control the flow of information and who is allowed to attain or maintain membership in the group and what they must do to become or remain part of the group or to be denied membership or forced out. The divisions of labor within the group may contribute to the level of prestige the person fulfilling a particular function holds in the eyes of the group. In some groups, race, gender, age, size, or other characteristics are factors used by the group to assign social worth, social position, or social opportunities.

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<sup>187</sup> Stone, *Policy Paradox: The Art of Political Decision Making*, 137-62.

Secrets and knowledge that are restricted to members of the group provide a sense of isolation from and superiority to the uninitiated. Specialized language, sacred symbols, guarded texts and tools, and explanations of mysteries are among the kinds of things that are kept from outsiders. The knowledge may be used as a shield or a sword, depending on the situation or the circumstances. The secrets provide the source of the group's power and authority. The uninitiated are not permitted access to the secrets and are punished if they obtain it without the group's leave.

There are a number of ways that the group ideals are transmitted to initiates. Oaths and codes guide conduct concerning what members of the group expect from one another and from themselves. They indicate what the group understands as good and bad, right and wrong, worthy of reward or punishment, and to some extent how the individual will be rewarded or punished under the appropriate circumstances. The image of the ideal group member and certain emblems or icons serve as a form of branding, making members of the group and the group as a whole identifiable and associated with certain traits, abilities, or ways of behaving. Costumes, coats of arms, colors, adornments, titles, and possessions stand for the power, authority, social connections, and qualities the group wants to claim and wants others to believe they possess.

The various types of customs and symbols mentioned above are not exhaustive. They suggest some of the many ways a group perpetuates its character and creates in its members a sense of history and belonging.

## Medicine's Traditions and Symbols

Medicine has many traditions and symbols that generate group identity, exclusivity, authority, and power. It has its legendary figures, its rituals and oaths and codes, its image and branding, its secrets, and its narratives and world view. It has science as its main metaphor, its claim to legitimacy and power, its battle cry against those who would intrude on its territory.

Physicians claim connections to healers, theorists, observers, scientists, and charismatic teachers of healing arts going back to Hippocrates time and before. Galen, Vesalius, Harvey, Rush, Pasteur, Osler, and other innovators and discoverers are the historical figures who gave authority to medicine and helped to develop the knowledge and ideals that give modern medicine its character. Drugs and magic, obscure knowledge and connections with life's mysteries, cures and miracles are all part of the healer's memory and mystique. Limiting entry into the healer's knowledge and ways has long separated healers from others. Gaining access to the special abilities possessed by healers has required the sick and injured to afford healers special rights, privileges, and powers.<sup>188</sup> In England, the source of American medicine's founders, there was never a head physician.<sup>189</sup> The medical profession—unlike the military, the Church, and the

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<sup>188</sup> Starr points out that American physicians enjoy a level of respect, authority, and income unmatched in other societies and other periods of history. Nevertheless, healers have often been allowed certain types of intimacy with their patients unavailable to most others. Touching, witnessing life-changing events, and learning individual or family secrets are among these types of intimacy. See, Starr, *Social Transformation*, 6.

<sup>189</sup> Sinclair, *Making Doctors*, 64.

law—was not an extension of the monarch to whom they “were bound by personal oath of loyalty.”<sup>190</sup> The medical profession has a long tradition of autonomy, independence, authority, and power.

Today’s American physicians, like the healers that preceded them, possess specialized knowledge and experience that are available only to those who are able to demonstrate intelligence and a degree of dedication to attain membership in the group. Would-be physicians must pass certain tests and undergo a rigorous training under the supervision of other physicians in order to join the ranks of physicians. Some of that training is formal and some of it is learned through immersion and trial and error. At least one physician-author, William T. Branch, Jr., refers to this approach as the *informal curriculum*. He is not talking about symbols alone, but also the ordinary day-to-day interactions that medical students observe and, to some extent, internalize as what really happens in medicine, “the lack of compassion, the blurring of ethical boundaries, the treating of patients like objects, and other moral quagmires that probably affect the education of medical students at least as powerfully as the hidden curriculum of symbols does.”<sup>191</sup> The *informal curriculum* and/or the *hidden curriculum*—the way certain attitudes, beliefs, and practices are transmitted to trainees and are reinforced among physicians through social pressures and informal methods—are part of the tradition. In

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<sup>190</sup> Sinclair, *Making Doctors*, 64.

<sup>191</sup> William T. Branch, "Deconstructing the White Coat," *Annals of Internal Medicine* 129, no. 9 (November 1, 1998): 741.

*After Harm: Medical Error and the Ethics of Forgiveness*, Nancy Berlinger describes the hidden curriculum as it applies to medical errors as follows:

In the rigid hierarchy of clinical medicine, medical students learn by observing interns, who learn by observing residents, who learn by observing attendings. This hidden curriculum transmits powerful messages about what to say and do—and what never to say and do—on the subject of mistakes.<sup>192</sup>

The hidden curriculum teaches more than how physicians expect other physicians to deal with errors and patients injured by errors. However, many of the fears and uncertainties associated with the practice of medicine find as their focus malpractice litigation and the belief that concealing one's own mistakes and those of others is in the best interests of the profession.

As mentioned above, medicine has found its legitimacy and authority through its claims to science. In *Medicine in America: A Short History*, James L. Cassedy discusses how science became the central metaphor for the American medical tradition:

Early in the twentieth century, regular medicine finally succeeded in overcoming much of the sectarian competition, gaining new public confidence, and assuming a position as the keystone of a formal medical establishment. Subsequently, until the 1990s, it has been vigorously consolidating and extending its power in the establishment by identifying closely with the methods and knowledge of modern laboratory science and attempting to dominate the nation's health outlook and policies with its conservative agenda.<sup>193</sup>

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<sup>192</sup> Berlinger, *After Harm*, 24.

<sup>193</sup> James H. Cassedy, *Medicine in America: A Short History* (Baltimore, Md.: Johns Hopkins University Press, 1991), 156.

Hunter asserts that science is a metaphor used by the profession and does not truly characterize the medical process. She argues that medicine differs from science in the treatment of individual patients in that the physician practices what she calls clinical casuistry, a form of reasoning that takes into account all of the physician's knowledge and experience and applies it to a particular biological entity that may not fit neatly with the generalization derived from science due to the uncertainties inherent in the gap between theory and practice and the gap between the abstract and the concrete.<sup>194</sup> She states that "physicians must always act on incomplete knowledge of the patient who is before them, and they are still, therefore, necessarily empirical."<sup>195</sup> Her point, I believe, is that the physician must engage in interpretation about what she observes in the patient and extrapolation from what is known through scientific research, then, make what amounts to educated guesses, testing hypotheses directly on the patient to determine what will happen. Too many unknowns make predictions perilous.

According to Kathryn Montgomery Hunter, author of *Doctors' Stories: The Narrative Structure of Medical Knowledge*, medicine is an interpretive endeavor rather than a science:

Medicine, for all its reliance on esoteric knowledge and sophisticated technology, is not a science. This ought not to be a controversial or even a surprising statement, yet many physicians are likely to find it unacceptable.<sup>196</sup>

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<sup>194</sup> Hunter, *Doctors' Stories*, 28-9.

<sup>195</sup> Hunter, *Doctors' Stories*, 29.

<sup>196</sup> Hunter, *Doctors' Stories*, xvii.

She elaborates by stating: “medicine is passed on as a traditional practice: interpretive, diagnostic, concerned with the identification and treatment of disease.”<sup>197</sup>

Later in the same work, Hunter clarifies:

Medicine’s claim to science . . . is a part of its magic and serves as its rational, disinterested ideal. In a secular age that can summon to its aid almost as little religion as sorcery, “science” is the locus of what there is of the unexpected and miraculous in our lives, and the miraculous (or some faith in it) may be equally necessary for patient and for physicians in an imperfect uncertain death-defying field.<sup>198</sup>

Hunter’s point is that there is room in medicine for alternative interpretations of symptoms, for a variety of treatment options, for different techniques for carrying out procedures, and for differing professional opinions. As suggested above in the discussion of the difficulty in defining medical error, this room for interpretation and multiple approaches to addressing a set of issues serves the needs of the profession. In spite of some explicit protocols, policies, and procedures, physicians often rely on their own experience and observations to arrive at conclusions about how to practice medicine and how to treat a particular patient. This independence is considered by many physicians an essential aspect of the profession.

Science is one source of legitimacy for the medical profession, but there are others. Laws and codes are among them. Many of physicians’ special rights, privileges,

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<sup>197</sup> Hunter, *Doctors' Stories*, xxi.

<sup>198</sup> Hunter, *Doctors' Stories*, 25.

and obligations are enforced by codes and laws. These writings make clear to all who read them how physicians are supposed to behave, what special actions they are allowed to take, and how others are to be prevented from or punished for encroaching on physicians' special realm. They give weight to the assertion that physicians are professionals. As Starr points out, professionals are gatekeepers.<sup>199</sup> As professionals, physicians determine whether or not the patient's complaint is worthy of further exploration or attention. They serve as the learned intermediaries who decide whether the patient should have access to tests and procedures, certain drugs, and hospital care. The person who seeks certain goods and services must obtain them through the help of a physician, if they want to avoid potential punishment.

Under codes and laws, physicians are sometimes permitted to carry out activities that would be considered heinous crimes if carried out by someone who lacks the credentials and the proper intentions and permissions. Certain types of touching of a child might be considered molestation were it not for the healing intent and the physician's special status. Removing another's body parts while he or she sleeps would violate laws against intentionally injuring others.

Physicians' obligations under laws and codes are weighty ones. Physicians are expected to examine carefully, diagnose correctly, apply the proper treatment in the appropriate way, and quickly and adequately address any new problems that arise in the patient's care. The physician is expected to know about recent developments in the field

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<sup>199</sup> Starr, *Social Transformation*, 11-3.

and to be able to use them with expertise that will stand up to scrutiny. Generally speaking, physicians are expected to provide perfect, state-of-the-art health care. Failure to do so may lead to legal problems and substantial financial and social losses for the physician. In addition, codes and laws address physicians' obligations to act in morally acceptable ways that fit with the goals of the profession.

Medical symbols serve several purposes, including reminding physicians and others about the moral obligations, the powers, and the virtues of the profession. As Peter Berger and Thomas Luckmann, authors of *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*, state:

To underline its authority the medical profession shrouds itself in the age-old symbols of power and mystery from outlandish costume to incomprehensible language, all of which, of course, are legitimated to the public in pragmatic terms. Meanwhile, fully accredited inhabitants of the medical world are kept from "quackery" (that is, from stepping outside the medical subuniverse in thought or action) not only by powerful external controls available to the profession, but by a whole body of professional knowledge that offers them "scientific proof" of the folly and even wickedness of deviance. In other words, an entire legitimating machinery is at work so that laymen will remain laymen, and doctors doctors, and (if at all possible) that both will do so happily.<sup>200</sup>

Physicians wear white coats. The choice of white is hardly practical. Anyone who has worn white knows that it is a poor choice when one is involved in messy activities, and practicing medicine can be a messy occupation. The white coats physicians wear

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<sup>200</sup> Peter L. Berger and Thomas Luckmann, *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* (New York: Anchor Books, 1967), 88.

serve as symbols of their authority and purity.<sup>201</sup> The coat's dimensions have meaning. If the coat is short, the person wearing it is a medical student. If the coat is long, the person wearing it holds a medical degree. The coat serves as a uniform that alerts others to the wearer's status. Its color, lack of practical purpose, and length suggest its religious or cult-like connections. The coat serves as a priestly robe; the hospital serves as the temple devoted to healing.

John Banja discusses the physician's white coat as follows:

While the physical dimension of the coat itself are significant—the length of the coat reflects one's rank and authority, . . . the white color of the coat is taken to symbolize cleanliness, science (as in the “laboratory” coat), and healing. Add to this, as Delese Wear points out “the Western cultural meanings of whiteness—life, purity, innocence, superhuman power, goodness—and it is easy to see how the white coat became the favored garment for physicians.”<sup>202</sup>

Hunter also mentions the white coat's significance as a symbol, while pointing out that science is also a symbol: “Medicine's claim to science, like the white coat that manifests that claim, is a part of its magic and serves as its rational, disinterested ideal.”<sup>203</sup> White and cleanliness and purity and angels add up to powerful suggestion that physicians are benign, trustworthy, and extraordinary.

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<sup>201</sup> Dan W. Blumhagen, “The Doctor's White Coat. The Image of the Physician in Modern America,” *Annals of Internal Medicine* 91, no. 1 (July 1979): 170-4; Branch, “Deconstructing the White Coat,” 740-1.

<sup>202</sup> Banja, *Medical Errors and Medical Narcissism*, 154.

<sup>203</sup> Hunter, *Doctors' Stories*, 25.

The physicians are not the only ones whose status is symbolized by attire. The patient's physical examination sometimes requires the patient to change from his or her ordinary clothing into a skimpy cotton or paper gown that generates accessibility, vulnerability, and uniformity. Through this change to the patient-costume, the individual is readied for an encounter that is both intimate and impersonal. The person becomes one who is ready to submit to the physician's authority and is dependent on the physician to demonstrate good will. Whatever the patient's social status, his attire symbolizes his change to suppliant. It is interesting to note that the physician adds body covering while the patient is asked to remove most of his.

The medical profession's rituals come in several varieties. Among them are initiation rituals, communication rituals, data-gathering and recording rituals, decision-making rituals, and practice rituals. There are rituals associated with the fact-learning aspects of becoming a physician. White coat ceremonies, match day celebrations, and graduation exercises are readily identified rituals relating to meeting educational requirements. Each licensing test is another ritual. These rights of passage serve to reward accomplishment or to weed out those who are not fit to take the next step.

The physical examination is a ritual physicians engage in with patients. The process of the examination follows a routine format and is often performed cursorily. The physician asks a few questions, peers in orifices, listens to heart and lungs, feels for swollen glands, and sometimes checks reflexes, presses on the patient's abdomen, and

makes note of visible signs of pathology. If there is something the physician thinks is unusual or suspicious, divination rituals of testing or imaging follow.

If the physician is still in training, he or she is required to engage in the ritual of *presenting* the patient to a superior, give an account of the patient's history, health complaint, vital signs, and other pieces of data in a standard format that allows comparisons of the data to known features of possible ailments. Hunter asserts that "[s]o standardized is the case presentation that with local variants—such 'rehumanizing' details as 'man' for 'male' or the inclusion of the patient's occupation and family role, 'an accountant living at home with her husband and teenaged son'—the pattern prevails wherever Western scientific medicine is taught."<sup>204</sup> She describes the ritualized aspects of the presentation narrative as follows:

Case presentations are, in fact, highly conventional narratives. They are strictly ordered and their language is meant to be narrowly descriptive and toneless in order to sort out the patient's subjective report of discomfort and abnormality from the physician's more objective view of the case. This flatness aids the emotional detachment felt necessary to the continued and resourceful care of the ill; it also highlights the pattern of the evidence so that the physician can more readily identify the intellectual puzzles posed by the illness.<sup>205</sup>

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<sup>204</sup> Hunter, *Doctors' Stories*, 56.

<sup>205</sup> Hunter, *Doctors' Stories*, 6-7.

The trainee is often quizzed, challenged, or *pimped* by a superior about features of diseases, diagnostic tests, and possible treatments as part of this ritual training process.<sup>206</sup> Sinclair refers to this method as teaching through humiliation.<sup>207</sup>

Rituals that involve physicians are not limited to marking the milestones of their own or others' achievements or to the routines they engage in for the typical patient. Physicians often preside over the most important events of life. They witness and take an active part in births. They often do the same at deaths. The rituals they follow may not look the same for each physician or for each patient. Nevertheless, a physician's involvement makes the event part of a ritual. His or her presence and associated activities make the event official in the eyes of the public.

There are rituals for when something goes awry with a patient's treatment. Hunter reminds her readers that the mortality and morbidity (M & M) conference is a ritual method of dealing with cases involving unexpectedly unpleasant outcomes, a bonding and teaching ritual that is intended to model and reinforce professional assumption of responsibility and provide for a way for the erring physician to confront the issue of the bad outcome by confessing and moving beyond the incident.<sup>208</sup> Bosk refers to the M&M conference as the "hair-shirt ritual," a process of "self-criticism, confession, and

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<sup>206</sup> *Pimping* is a form of quizzing that is intended to humiliate the trainee by demonstrating that the trainee's knowledge is inferior to that of the superior.

<sup>207</sup> Sinclair, *Making Doctors*, 26.

<sup>208</sup> Hunter, *Doctors' Stories*, 80.

forgiveness.”<sup>209</sup> In *Complications: A Surgeon’s Notes on an Imperfect Science* Atul Gawande describes one M & M conference that dealt with a mistake he made in the emergency room during his residency.<sup>210</sup> There was a set pattern to the process. The hierarchy of physicians determined who spoke and how the case was presented to peers. The language used was unemotional, factual, and efficient. Although Gawande had been the person who exercised questionable judgment in treating the patient, it was his superior, the attending physician, who made the presentation and accepted responsibility for the misadventure that endangered the patient’s life. After relating the basic story of the event, the M & M conference presenter responded to questions from his audience about details of the event and what he should have done or would do in the future under similar circumstances. Once his questioners were satisfied with the answers they received and the proceedings were concluded, all returned to the business of caring for patients. Although the error was discussed in detail in the M & M conference, the information discussed was not shared with outsiders.

Berlinger faults the M&M conference ritual

because it excludes the patient, whose roles as injured party and as human agent of forgiveness are usurped by the erring surgeon’s superior. (The surgeons who participate in this ritual do not perceive this failure, because they would not expect patients to be part of their community and its professional rites.) The patient has no role, no voice and no representation within this private ritual and

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<sup>209</sup> Bosk, *Forgive and Remember*, 178.

<sup>210</sup> Gawande, *Complications*, 47-55.

cannot rely on it for justice and for the possibility of being able to forgive and to heal.<sup>211</sup>

She does not suggest that patients be made part of this ritual. Her point is that the patient does not seem to matter. Forgiveness is only sought from colleagues, not from the injured party.

Rituals often are related to secrets; they often remind the participant of the secrets the group protects. Secrets are an important part of the medical profession. Physicians have gained access to many of these secrets over time through dissecting cadavers, testing vaccines and drugs on themselves and others, apprenticing themselves to other physicians, and attempting daring procedures under dire circumstances. These secrets have been protected by the profession's barriers to entry, use of jargon, and unwritten rules about the work environment. Only an elite group is allowed to enter the training process. Only those who can pass the tests and endure the rigorous training process while maintaining a good public reputation are permitted to join the ranks of physicians. Those who are not part of the profession are punished if they claim to have the ability to offer what physicians offer without proof of their legitimate access to the secrets and privileges of physicians. Although medical journals are available at libraries and for purchase by non-physicians, many secrets are preserved because uninitiated readers lack the specialized knowledge and experience to adequately interpret what they read. The group is bound by shared knowledge and allegiance to the profession and its obligations.

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<sup>211</sup> Nancy Berlinger and Albert W. Wu, "Subtracting Insult from Injury: Addressing Cultural Expectations in the Disclosure of Medical Error," *Journal of Medical Ethics* 31, no. 2 (February 2005): 89.

Physicians' oaths serve as traditions, initiation rituals, reminders of the ideal image of the physician, and expectations for conduct. They represent the group's publicly shared vision and its intention to self-regulate. They also serve as statements to outsiders that the group represents noble endeavors and goals and its members should be revered for their contributions to society in general. The oaths are like vows of devotion and sacrifice taken by those entering religious orders, reminding both insiders and outsiders of the priest-like function of the healer and the hardships he or she is willing to endure to be of service. They provide guidance about how the world of the physician is supposed to function.

Stories also provide guidance. The stories physicians tell through the policies they support provide insight into physicians' understanding of the way the world actually works or how it should work. Despite evidence that refutes claims that the numbers of lawsuits are large and the amounts of awards are excessive, stories about the need for tort reform continue. Far fewer patients file lawsuits than are injured through medical negligence, and awards are rarely out of line with medical and litigation costs.<sup>212</sup> According to the Legal Director of the Center for Justice and Democracy, Geoff Boehm, "the number of medical malpractice cases being filed per capita has dropped over the

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<sup>212</sup> The IOM report was released in 1999 and published in 2000. In spite of the messages about the large number of errors, physician groups campaigned for damage caps at the national level, blaming the excessive number of medical malpractice lawsuits for any number of ills in the health-care system.

last ten years, as have tort filings generally.”<sup>213</sup> He bases this statement on data from the National Center for State Courts.

These stories are symbolic of the belief that physicians are persecuted by greedy patients and lawyers. Their purpose seems to be to instill fear that health care will become unavailable to all but the very wealthy and that the medical profession is in jeopardy of collapse. Their goal is to protect and enhance the social and economic status of the profession.

Traditions and symbols provide part of the context for physicians, a sense of continuity and belonging and guidance for how to maintain good standing in the medical community. They provide signposts and reminders about how physicians are supposed to act and believe, yet do not provide insight into certain attitudes and assumptions that grow out of the process of coming of age in the profession. In many ways, they are as much for the benefit of outsiders as they are for members, and do not necessarily fit with the ordinary thinking and behavior of physicians.

## **Values and Beliefs**

### ***Values and Beliefs***

According to Light and Keller, “values are the general ideas people share about what is good or bad, right or wrong, desirable or undesirable.”<sup>214</sup> The values and beliefs

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<sup>213</sup> Geoff Boehm, "Debunking Medical Malpractice Myths: Unraveling the False Premises Behind "Tort Reform", " *Yale Journal of Policy & Ethics* 5 (Winter 2005): 358.

of a group are important to interpersonal relationships. They provide both express and implied mechanisms for social control. Expectations about behavior are conveyed through the group's communication and understanding of what is good or bad, right or wrong, superior or inferior, normal or abnormal, important or trivial. Values and beliefs range from religious doctrines to social conventions and from stereotypes to superstitions. They serve as explanations for interacting with others in particular ways, as with etiquette or recognition of rank, and as guidelines for measuring success or failure in the group's eyes. Assumptions and attitudes about how the world works or should work accompany these ideas and behaviors.

### ***Medicine's Values and Beliefs***

Generally speaking, physicians believe that their work is noble and generous, that helping the sick and injured is important, and that society should recognize their contributions by showing respect and deference. These beliefs have been shaken to an extent by lawyers, ethicists, hospital administrators, government regulators, and third-party payers, the strangers at the bedside that have changed the way medicine is practiced. Nevertheless, the beliefs are implied in physicians' laments about scarce resources, limits on professional discretion, and the need for tort reform.

In addition to holding beliefs that are at times at odds with the bureaucracies in which they function, physicians hold values and beliefs that sometimes set them apart from their patients. Many physicians find it difficult to understand why patients might

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<sup>214</sup> Light and Keller, *Sociology*, 86.

consider an approach to a health problem other than what the physicians recommend or believe is the most medically appropriate. Some of this belief grows out of medicine's emphasis on objectivity and science; some grows out an expectation of being rewarded for their intelligence and their identification with what is good and right. Their good intentions, their dedication, and their desire to succeed can place them at odds with patients who reason differently, have different priorities, and, in some instances, demonstrate what a reasonable person would consider poor judgment or wishful thinking. Their belief is that the patient should accept the physician's judgment and comply. Most of the time, society supports the physician's belief.<sup>215</sup> The non-compliant patient is often seen by peers as begging for more serious health problems.

Physicians tend to believe that their extensive training should entitle them to superior incomes, social status, and authority. This, as Starr notes, is largely an American phenomenon.<sup>216</sup>

Attempts to limit competition, devalue alternative approaches to healing, and avoid the influence of outsiders support this view. The American public has generally agreed with the physicians.

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<sup>215</sup> See, for example, Robert Kagan and Romaine Clifton, "Communicating with Patients," *American Journal of Clinical Oncology* 27, no. 6 (December 2004): 547-9; Kathleen M. Mazor, Steven R. Simon and Jerry H. Gurwitz, "Communicating with Patients About Medical Errors: A Review of the Literature," *Archives of Internal Medicine* 164, no. 15 (August 9-23, 2004): 1693; Berlinger, *After Harm*, 30-2.

<sup>216</sup> Starr, *Social Transformation*, 6.

Starr attributes physicians' authority to legitimacy, dependence, occupational control, and the ability to influence perceptions of reality.<sup>217</sup> Their legitimacy comes from their superior competence, their position in relation to the state, their professed values as a group, and their use of scientific concepts and methods.<sup>218</sup> Physicians' legally recognized status, the requirements they fulfill to become part of the profession, the control they hold over who can enter and remain in the profession, and the language, knowledge, and technology they use contribute to their authority.

The dependency of which Starr writes creates a double-edged sword. Although physicians and patients both tend to believe that physicians should be able to relieve suffering, cure illness, and perform perfectly, physicians' hold conflicting beliefs about what is reasonable and possible and what will happen if they are unable to fulfill expectations. On the one hand, physicians recognize that uncertainty is inherent in the practice of medicine; there are some things for which physicians have nothing to offer; and one can strive for perfection, but humans make mistakes. On the other hand, physicians believe that perfection is possible, but they should not suffer "blame and shame" if something goes wrong.<sup>219</sup> When the physician errs, he or she experiences shame and fear due to the belief that colleagues will condemn and the patient will litigate,

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<sup>217</sup> Starr, *Social Transformation*, 9-16.

<sup>218</sup> Starr, *Social Transformation*, 15.

<sup>219</sup> The majority of recent literature on the topic of the systems approach to patient safety and medical error claims that the culture of blame and shame is the reason that physicians do not report medical errors and the reason that little progress has been made to improve patient safety. See, for example, Kohn, Corrigan and Donaldson, eds., *To Err Is Human*; Gawande, *Complications*, 57.

leading to financial, social, and emotional ruin. According to Studdert, “physicians through their professionalization and training conflate negligence and moral turpitude.”<sup>220</sup> In his article “Medical Errors: Causes, Cures, and Capitalism” physician-lawyer Keith Myers offers a similar perspective: “Physicians are taught to feel shame for any mistake and to accept the entire blame.”<sup>221</sup>

If this is true, physicians’ fears are as much about living up to their own ideals as they are about others’ reactions. Baker calls this blaming of outside influences for fears one has about one’s own uncertainty and professional competence *fear displacement*. He suggests that physicians’ fears about blame, malpractice litigation, and social and financial ruin may be a way of avoiding anxieties about lack of control and inability to live up to expectations of perfection.<sup>222</sup> Myers mentions this us-versus-them mentality in connection with disclosing error as follows: “admitting error so that it can be used against you is either foolish or masochistic. It is tantamount to giving aid and comfort to the enemy.”<sup>223</sup> Many authors also claim that defensive medicine, the ordering of multiple tests that run up medical costs, is the result of seeing the patient as an adversary or potential adversary. At any rate, the fear of ruin sometimes leads to perceiving the patient

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<sup>220</sup> David M. Studdert and Troyen A. Brennan, “No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention,” *Journal of the American Medical Association* 286, no. 2 (July 11, 2001): 218.

<sup>221</sup> Keith Myers, “Medical Errors: Causes, Cures, and Capitalism,” *Journal of Law and Health* 16, no. 2 (2001): 262.

<sup>222</sup> Baker, *The Medical Malpractice Myth*, 17-8.

<sup>223</sup> Myers, “Medical Errors: Causes, Cures, and Capitalism,” 265.

as an opponent, a potential threat, making it difficult to fulfill the ideals of relieving suffering.<sup>224</sup>

Banja attributes these contradictory beliefs to what he calls *medical narcissism*. It is the need for perfection and to feel in control that initially attracts many to medicine. The training reinforces those beliefs and values. Central to the conflicting beliefs about how the world of the physician should operate is fear, fear of the uncertainty that is inherent in the practice of medicine. Out of the fear comes the stress of attempting to fulfill expectations under pressured circumstances when so many variables are beyond the physician's control. Banja explains that "the medical narcissist is notable for 1) his or her lack of empathy for patients, 2) a compulsive and insistent treatment-oriented focus that winds up 'subtracting' the patient from his or her disease, and 3) a communication/relational style that seeks to control the patient's beliefs, feelings, and actions."<sup>225</sup>

He claims that because of the stressors involved in medical training, physicians are encouraged to believe that they should be compulsive, distant, unemotional perfectionists who should be omniscient, indestructible, and imperturbable.<sup>226</sup> They should demonstrate impressive skills, abilities, and accomplishments without showing

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<sup>224</sup> Michael S. Woods and Hilda J. Brucker, *Healing Words: The Power of Apology in Medicine* (Oak Park, Ill.: Doctors in Touch, 2004), 8. Michael Woods relates how he felt when sued for malpractice. His anger and fear led to treating patients warily, always keeping in mind that they may litigate.

<sup>225</sup> Banja, *Medical Errors and Medical Narcissism*, 48.

<sup>226</sup> Banja, *Medical Errors and Medical Narcissism*, 55-80; Myers, "Medical Errors: Causes, Cures, and Capitalism," 261.

any signs of the toll the process takes on them physically or emotionally.<sup>227</sup> They are taught to believe they should live up to these expectations in order to overcome their feelings of vulnerability and helplessness, their fears of making mistakes and drawing criticism, and their fears of losing the hard won right to an above average income and to the respect of others in their profession.

Although Hunter uses different rhetoric, she appears to agree with Banja's assessment of physicians' beliefs and values. She asserts that physicians have the need to "reify the patient," that is, to objectify the patient in order to focus on treating the ailment rather than the patient's story, and to avoid the emotional pain of identifying with the patient.<sup>228</sup> In addition, she states: "Physicians have a low tolerance for uncertainty. Their need for certainty may come to rest with the force of conviction: opinion among physicians is often expressed as strong belief."<sup>229</sup> She asserts that:

Skepticism is the mark of [physicians'] profession. With each case they are taught the tentativeness of their knowledge and the uncertainty of their practice. They also learn how these difficulties are accommodated in the daily life of medicine.<sup>230</sup>

In practice this skepticism is often modified because physicians, who cannot risk being paralyzed by doubt or failure of memory, need a clear procedural path. Rules of

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<sup>227</sup> Banja, *Medical Errors and Medical Narcissism*, 55-80.

<sup>228</sup> Hunter, *Doctors' Stories*, 136-7.

<sup>229</sup> Hunter, *Doctors' Stories*, 37.

<sup>230</sup> Hunter, *Doctors' Stories*, 36.

thumb are often conveyed dogmatically, codifying the knowledge a resident needs to possess as a habit of practice.<sup>231</sup>

The beliefs and values that grow out of fear and stress lead to specialization, “excessive use of medical technology that is blind to the needs of the patient,”<sup>232</sup> and the rituals and habits that help the physician “negotiate the gap between theory and practice.”<sup>233</sup> These rituals and habits include “hedged assertions, probability reasoning, focus on uncertainty as a research problem, requests for consultation, Socratic teaching, deciding not to decide, gallows humor, and ‘hyperrealism.’”<sup>234</sup> The stress of dealing with emotionally trying situations leads the physician to use defense mechanisms in order to minimize the effects of the fear and doubt that are ever-present in their professional lives.

Eric Thomas and Robert Helmreich provide other insights into the beliefs and values of physicians. They compared the culture of pilots with the culture of physicians to determine whether there were any parallels or similarities between the two. They did so because the patient safety literature makes much of the need to apply the methods and strategies used to reduce errors in the aviation industry to medicine.<sup>235</sup> The authors discuss the work of Helmreich and Merritt as follows:

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<sup>231</sup> Hunter, *Doctors' Stories*, 36.

<sup>232</sup> Hunter, *Doctors' Stories*, 38.

<sup>233</sup> Hunter, *Doctors' Stories*, 33.

<sup>234</sup> Hunter, *Doctors' Stories*, 33.

<sup>235</sup> Thomas and Helmreich, "Will Airline Safety Models Work?," 217.

Using questionnaires with comparable content, they found similarities between the cultures [of pilots and doctors working in operating rooms] in both positive and negative values. Positively, both groups are proud of being members of an elite professional group that requires extensive training and selective qualification. Negatively, both pilots and doctors tend to deny personal vulnerability, endorsing items indicating that their decision making is as good in emergencies as under normal conditions, that they can leave behind personal problems when working, and that their performance is not degraded by working with inexperienced personnel. (A significant percentage of doctors also deny the deleterious effects of fatigue on performance.) These aspects of professional culture have implications for patient and aircraft safety. Professional pride motivates individuals to do their best, but the perception of invulnerability may reduce perceptions of the need for teamwork and for the practice of countermeasures against error.<sup>236</sup>

In the air travel business, pilots are evaluated frequently and quality control is a daily matter. Thomas and Helmreich point out that despite medicine's ever-changing technology and greater complexity than is found in the airline industry, medicine is lax in the areas of evaluation and quality control.<sup>237</sup> Physicians address concerns about colleagues' in circuitous and often informal ways, avoiding direct confrontation, if possible.<sup>238</sup> Rosenthal and Sutcliffe attribute this lack of willingness to pursue improvements to "the medical profession's deep training for and commitment to autonomy, self-regulation, and knowledge monopoly and all that accrues from these essential characteristics, particularly suspicion and distrust of administrative incursions

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<sup>236</sup> Thomas and Helmreich, "Will Airline Safety Models Work?," 217-8. Citing Robert L. Helmreich and A. C. Merritt, *Culture at Work: National, Organizational and Professional Influences* (Aldershot, U.K.: Ashgate, 1998).

<sup>237</sup> Thomas and Helmreich, "Will Airline Safety Models Work?," 218-30.

<sup>238</sup> Thomas and Helmreich, "Will Airline Safety Models Work?," 218-9.

into medical territory.<sup>239</sup> Some also claim that the identification with an erring physician is so strong, that it is easy to imagine being in the same position.<sup>240</sup> Therefore, compassion and avoidance are natural reactions.

Books written by physicians in residency bolster these scholars' claims about the values and beliefs transmitted through medical training. Biographical accounts by Dr. X, Atul Gawande, Perri Klass, and Danielle Ofri bear striking similarities.<sup>241</sup> Recurring themes include: struggling with uncertainty, learning without much guidance, dealing with intimidation by superiors, making burdensome sacrifices, receiving inadequate social and emotional support, finding ways to depersonalize relationships with patients, and striving for excellence and appreciation in a demanding and often unforgiving environment.

One of the most important beliefs that physicians hold is that they should be able to rely on their own judgment to determine what information and services they should provide to the patient.<sup>242</sup> The physician believes that she should be able to choose to

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<sup>239</sup> Marilyn M. Rosenthal and Kathleen M. Sutcliffe, "Struggling to Understand, Struggling to Act," in *Medical Error: What Do We Know? What Do We Do?*, ed. Marilynn M. Rosenthal and Kathleen M. Sutcliffe (San Francisco, Calif.: Jossey-Bass, 2002), 238.

<sup>240</sup> Gawande, *Complications*, 23; Neil S. Calman, "No One Needs to Know," *Health Affairs* 20, no. 2 (March/April 2001): 247-8.

<sup>241</sup> Gawande, *Complications*; Perri Klass, *A Not Entirely Benign Procedure: Four Years as a Medical Student* (New York: Penguin Books/Plume, 1987); Danielle Ofri, *Singular Intimacies: Becoming a Doctor at Bellevue* (Boston, Mass.: Beacon Press, 2003); X, *Intern* (New York: Harper & Row, 1965).

<sup>242</sup> This is commonly known as physician autonomy. See, for example, Beverly Jones, "Nurses and The 'Code of Silence'," in *Medical Error: What Do We Know? What Do We Do?*, ed. Marilyn M. Rosenthal and Kathleen M. Sutcliffe (San Francisco, Calif.: Jossey-Bass, 2002), 90.

accept some patients and not others, to decide when to see patients, and to decide what level of detail to provide the patient about the diagnosis or treatments.<sup>243</sup> The range of the physician's discretion has been limited by informed consent requirements, utilization reviews, institutional policies and the like.<sup>244</sup> The relatively recent emphases on patient autonomy, cost-cutting, and quality control have contributed to the substantial reduction of physicians' discretion.<sup>245</sup> Nevertheless, physicians see themselves as something other than hired-help, technicians, and drug dispensers. Their independence and judgment is part of what sets the practice of medicine apart from other occupations.<sup>246</sup> It is from these beliefs that some physicians conclude the patient and his family are incapable of grasping the intricacies of health issues and the ambiguities and gravity of the patient's situation will cause them too much distress.

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<sup>243</sup> The law supports the physician's right to refuse to accept a patient (see, *Hurley v. Eddingfield*, 59 N.E. 1058, 1058 (Ind. 1901) ("In obtaining the State's license (permission) to practice medicine, the State does not require, and the licensee does not engage, that he will practice at all or on other terms than he may choose to accept.") except when the physician has a contractual obligation with a third-party to provide services, such as in an emergency room (See *Hiser v. Randolph*, 617 P.2d 774, 777-78 (Ariz. 1980); *Millard v. Corrado*, 14 S.W. 3d 42, 47-48 (Mo. Ct. App. 1999), *Hand v. Tavera*, 864 S.W.2d 678, 679-80 (Tex. Ct. App. 1993). The law also prohibits discrimination on the basis of disability under the Americans with Disabilities Act. See *Bragdon v. Abbott*, 118 S.Ct. 2196 (1998).

<sup>244</sup> See, for example, E. Haavi Morreim, *Holding Health Care Accountable: Law and the New Medical Marketplace* (New York: Oxford University Press, 2001).

<sup>245</sup> For discussions of the changes that began in the second half of the 20<sup>th</sup> century as a result of scandals, rising health-care costs, and financial innovations see David J. Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making*, Social Institutions and Social Change (New York: Aldine de Gruyter, 2003); Morreim, *Holding Health Care Accountable*.

<sup>246</sup> See, for example, Lantos, *Do We Still Need Doctors?*, 6-7.

Physicians' beliefs and values go a long way toward explaining their ways of coping with patients' needs, patients' and colleagues' expectations, mistakes, and delivering bad news.

## **Norms and Social Roles**

### ***Norms and Social Roles***

Norms are about *shoulds*, how one should behave, look, think, feel, believe, and otherwise live to meet the expectations of or fit in with a particular group.<sup>247</sup> That does not always mean that the individual who fits the norm exhibits only positive traits and behaviors. Norms are somewhat like stereotypes. A sociology textbook aptly titled *Sociology*, by Donald Light and Suzanne Keller defines norms as “shared standards of desirable behavior.”<sup>248</sup> Later they add that “some norms are situational—that is, they apply to categories of people in specific situations.”<sup>249</sup> These authors explain that “[s]ocial norms govern our emotions and perceptions. For example, people are *supposed* to feel sad and act depressed when a member of their family dies.”<sup>250</sup> One who does not is thought to be heartless. The person who violates norms is considered foreign, uncouth, irresponsible, ignorant, wrong-headed, eccentric, mentally disabled, dangerous or

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<sup>247</sup> Light and Keller, *Sociology*, 83.

<sup>248</sup> Light and Keller, *Sociology*, 83.

<sup>249</sup> Light and Keller, *Sociology*, 83.

<sup>250</sup> Light and Keller, *Sociology*, 84-5.

otherwise inappropriate or out of step with expectations.<sup>251</sup> Norms are the expected characteristics or behaviors that are thought to typify a group.

Roles are related to norms. As in a play, a person assumes a role when he or she acts in a particular position in a relationship. An individual often assumes several roles in a day. He can fulfill the roles of parent, spouse, employee, customer, driver, housekeeper, cook, and a number of other roles on a regular basis. There are certain ways of fulfilling roles that are considered appropriate and usual. Some of these usual ways are a matter of habit, just the way members of the group usually do things; some are codified or standardized; some are so ingrained that members of the group are unaware that any alternative is possible. Some are considered a matter of morality. Along with a role comes a certain status, particular responsibilities, and sets of behaviors, attitudes, and styles of reacting.<sup>252</sup> When one fulfills a role in a way that meets with most of the positive expectations, he is often admired for the way he fulfills the role, whatever the role may be. He is a good employee, or a good father, a good dancer, or a good baker. When he fulfills the less favorable non-group members' expectations that are thought to typify the group or the role, one might say something like, "that is just the way they are" or "all (members of the group or people fulfilling the role) are like that."<sup>253</sup>

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<sup>251</sup> Light and Keller, *Sociology*, 85-6.

<sup>252</sup> Light and Keller, *Sociology*, 56.

<sup>253</sup> For example, one might say, "all trial lawyers are spin-doctors" or "all legislators trade favors."

## Medicine's Norms and Roles

There are norms associated with being a physician. Physicians are expected to be careful, intelligent, diligent, devoted, honest, respectable, knowledgeable, attentive, skillful, altruistic, trustworthy, and to possess many other virtues. Ideally, a physician is supposed to know everything about health or to know her limits well enough to refer to a more experienced or more qualified physician when the patient's need requires. The physician is expected to exercise sound judgment based on science and, to some extent, on experience. Physicians are expected to be in control and confident, capable of keeping a cool head in a crisis and of acting efficiently and effectively under pressure. Buckman, writing from the physician's perspective, supports this view as follows:

As professionals, we add further fuel to that human desire to blame the messenger by reinforcing the idea that all deterioration and death must be attributable to a failure of the medical system or the staff. This is not a deliberate stance, but is a side effect of the attitude that modern medicine has "a pill for every ill." Over the past few decades, the medical profession has entered into a reciprocating relationship with the general public that has fostered the illusion that all diseases are fixable. Inadvertently, we seem to be denying the idea that death is inevitable (although, as somebody once said, *despite all the best interventions of modern medicine, the death rate will always remain the same—precisely one per person*). We therefore allow (however passively) the mantle of omnipotence to rest on our shoulders.<sup>254</sup>

On the less appealing side, physicians are thought to be compulsive perfectionists who sometimes are so intent on "saving" patients or treating symptoms that they overlook the patient's overall health and the efficacy of carrying out tests and treatments,

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<sup>254</sup> Buckman and Kason, *How to Break Bad News*, 21.

especially at the end of life. They are often overly optimistic or pessimistic<sup>255</sup> and tend to feel frustrated or incredulous when patients fail to follow their directives. Because of their many achievements and education, many believe that patients are too ignorant to make informed, well-reasoned decisions about their own health care and should be guided or cajoled into making the “right” choice.<sup>256</sup> Physicians tend to have a distorted view of lawyers, the legal system, and the number of malpractice claims that are made each year, believing that medical negligence is less prevalent than it actually is and attributing blame to ungrateful, greedy patients and their lawyers for the high cost of medical malpractice insurance and health care in general.

The role of the physician is that of a benevolent authority who has wherewithal to solve problems, to reduce suffering, and to fix what is broken. The physician is expected to take in a jumble of information, make sense of it, and turn it into a plan for restoring the sick or injured person to health and happiness. He is the powerful person who, with the stroke of a pen, can, if he chooses, give a patient a form of access to the mysterious mechanics and machinery of the medical world.

In the hospital, the person in the physician role is expected to make decisions, manage patients’ care, delegate to others, and maintain accurate records in compliance with a great number of rules, regulations, policies, and laws. She is not an employee, but

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<sup>255</sup> Elizabeth B. Lamont and Nicholas A. Christakis, "Prognostic Disclosure to Patients with Cancer near the End of Life," *Annals of Internal Medicine* 134, no. 12 (June 19, 2001): 1096-103. See also, Buckman and Kason, *How to Break Bad News*, 110.

<sup>256</sup> Katz, *The Silent World of Doctor and Patient*, xiv, 165-206.

an independent entrepreneur who uses the hospital's facility and services to enhance the care she provides to the patient. Therefore, she is responsible for making sure that the patient's medical needs are met.

The physician's role is complemented by the patient's role. The patient is expected to recognize the physician's authority, give weight to the physician's advice, and, once an understanding has been reached, to comply with whatever directives the physician provides. In a sense, the physician is expected to be something on the order of the patient's teacher, parent, coach, military leader, or guru. To this listing, Kathryn Montgomery adds priest, friend, advocate, engineer, carpenter, plumber, detective, and mechanic.<sup>257</sup> The physician is the guide through the potentially treacherous unknowns of health problems and health care.

Robert Buckman, author of *How to Break Bad News*, provides the physician's perspective:

We are perceived as having a great deal of control over our patients' lives (we tell them when they need tests, when they need to go to hospital, when they can leave, and so on), we enjoy professional privilege (including access to the intimate details of our patient's lives and anatomies) and social status (good income). All these things are seen as setting the professional apart from the lay person, and are important (to varying degrees) in the professional relationship, because to some extent they depersonalize us and allow the patient to feel that he or she is dealing with the mainstream of medical science not just an ordinary person with a stethoscope or a thermometer.<sup>258</sup>

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<sup>257</sup> Montgomery, *How Doctors Think*, 178.

<sup>258</sup> Buckman and Kason, *How to Break Bad News*, 20.

Within the profession, the physician's role is to act as a member of a close-knit community by providing mentoring to initiates, avoiding conflicts with competitors, sharing information about research, and reinforcing the ideals and ethics of the profession. As with members of a guild, physicians are supposed to cooperate to maintain the reputation, integrity, and power of the profession.

Part of the physician's role is to look like a physician, clean, tidily dressed, wearing either a white coat over nice clothing or the solid color scrubs that only physicians at the facility wear, with a simple hairstyle and little or no jewelry. This conservative look conveys the physician's sensible, serious nature and time constraints that limit the opportunity for elaborate grooming rituals. A physician, who spikes his hair, wears heavy gold chains, sports a variety of piercings, and wears shorts, a t-shirt, and sandals to the office or hospital would violate norms.

Behavioral norms for physicians include hiding evidence of strong emotion or weakness.<sup>259</sup> The physician is supposed to maintain a pleasant demeanor and manner, yet demonstrate a certain emotional distance or detachment from the patient. She is expected to be able to cope with distress without assistance, work long hours without complaining, maintain composure when dealing with difficult patients and their families, and resist the temptations to self-medicate, accept sexual advances from patients, or react to frustrations with aggression.

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<sup>259</sup> See, for example, Montgomery, *How Doctors Think*, 171-5.

In general, the role and norms associated with being a physician place tremendous pressures on physicians to be perfect, perform perfectly, give generously of their time and energies, and do so in an environment that does little to help them cope.<sup>260</sup>

## **Knowledge and Tools**

### ***Knowledge***

Enough has already been said about the specialized nature of medical knowledge. Sometimes the knowledge is transferred through classroom teaching or practical instruction. However, much of the knowledge that is transferred comes to be seen as obvious. Everyone in the group knows it, because it is the culture's way of being in the world. It is the only way to do things that makes sense. It seems so natural that few give this knowledge a moment's thought. Although other ways may be recognized, members of the culture generally agree that the culture's way is the right one, the best one, or the one they must live with unless they move to the home of another culture.

Montgomery discusses this concept of common sense citing the work of Pierre Bourdieu and that of Clifford Geertz.<sup>261</sup> She describes Bordieu's concept of *habitus* as follows:

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<sup>260</sup> See generally, Darell A. Campbell and Patricia L. Cornett, "How Stress and Burnout Produce Medical Mistakes," in *Medical Error: What Do We Know? What Do We Do?*, ed. Marilyn M. Rosenthal and Kathleen M. Sutcliffe (San Francisco, Calif.: Jossey-Bass, 2002), 37-57.

<sup>261</sup> Montgomery, *How Doctors Think*, 162-4.

[It is] the individual's cultural predisposition to perceive or know or act. *Habitus* informs an individual's learned but unreflective practices, practices that are not only shaped by culture but shape and perpetuate it, too. It is an ingrained orientation that reinforces what can and cannot be thought in the culture. It thus, according to Bourdieu, is "the engine of social stability and psychic cohesion, individual identity; a subtle probability calculus that invokes a knowable future for members of the culture" Inherited and absorbed, *habitus* is a culture's embodied history, internalized as second nature and so forgotten as history"; as such "it gives practices their relative autonomy" and their "retrospective necessity."<sup>262</sup>

Central to this idea is that one who belongs to the culture is blind to other possibilities.

The knowledge just seems right, appropriate, normal.

While noting similarities to Bourdieu's idea of *habitus*, Montgomery discusses Geertz's work with specific reference to the concept of common sense:

Now common sense, as Geertz points out, is uncommonly complicated. Contrary to its implicit claim, it is not common at all. It is not the unmediated apprehension of reality or a grasp of the matter-of-fact, available-to-all-comers meaning of experience. Instead, Geertz says, it is a "relatively organized body of considered thought," "a cultural system," that, while varying in content from culture to culture, characteristically denies in every culture that it is interpretive at all. "As a frame for thought, and a species of it, common sense is as totalizing and dogmatic as any other"; only the stylistic features, marks of attitude, and shadings of tone ("of course") of these "frames for thought," he believes, are cross-cultural."<sup>263</sup>

In American culture, it is general knowledge that rocks are inanimate objects, illness is not caused by evil spirits, and people cannot will a change in the weather. Some creatures can be pets, but are unacceptable as food (e.g., dogs, insects, monkeys). The

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<sup>262</sup> Montgomery, *How Doctors Think*, 163-4.

<sup>263</sup> Montgomery, *How Doctors Think*, 164.

differences, in terms of knowledge, between American culture and other cultures only become evident when customs, values, habits, meanings, or other aspect of culture clash.

### ***Tools***

Most social scientists understand tools as items related to the production of food, objects, or wealth, the material and technological aspects of life. A hunter-gatherer group may make use of relatively crude hand instruments in providing for their material needs. Weaponry, building utensils, food preparation implements, and technologies for moving or carrying items are all part of the tools used in this most basic type of production.

Beliefs, rituals, and social events are often associated with the tools and methods of production. The hunter-gatherer group mentioned above may undergo ritual preparations for a hunt that require the use of other, less obvious tools of production. Group members may change their appearance, ingest substances to enhance their bravery and prowess, plan strategies, worship deities, and make, repair, and test implements while engaging in contests of skill and strength. In some sense, these activities and mechanisms they use to achieve their desired ends are also tools.

In fact, the entire social structure of a group can be expressed in terms of tools. An idea, the way of transmitting information, the means of demonstrating power and position, and the methods of maintaining social order are all tools.

According to Itamar Even-Zohar, an authority in the fields of cultural studies, and semiotics, there are two types of tools, *passive* and *active*:

“Passive” tools are procedures with the help of which "reality" is analyzed, explained, and made sense of for and by humans.

This perspective is in fact based on the hermeneutic tradition: it views “the world” as a set of signs which need to be interpreted in order to make some sense of life. .

. .

"Active" tools are procedures with the help of which both an individual and a collective entity may handle any situation encountered, as well as produce any such situation.<sup>264</sup>

This conception of tools is more about how things are understood and accomplished rather than about merely the material and technological aspects of a group’s way of life. Both views of tools provide insights into the ways a culture works.

### ***Medicine’s Knowledge and Tools***

Physicians’ knowledge is in constant flux as new discoveries are made and new technologies are developed. Nevertheless it is controlled by the profession in the manner it is distributed and used. The majority of the knowledge transfer in medical training occurs through independent study of texts, simulations, hands-on experience with patients, and the so-called mentoring process. However, the unwritten and unspoken pieces of knowledge shared by physicians are not necessarily rational or based on scientific evidence, yet they are considered knowledge. One such bit of knowledge is that the way medicine must be practiced today precludes talking with and educating the

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<sup>264</sup> Itamar Even-Zohar, "Culture as Goods, Culture as Tools," Tel Aviv University, <http://www.tau.ac.il/~itamarez/works/papers/papers/good-tools.pdf#search='Zohar%20tools%20culture'> (accessed January 11,, 2007).

patient. There is not enough time. However, long before managed care (1938), Richard Cabot wrote: “You can do more good by a long detailed talk with the patient. But this takes time and energy that under the ordinary organization of out-patient clinics you cannot give.”<sup>265</sup> Apparently, the shared knowledge about time constraints has been part of the medical profession for a long time. Another piece of shared knowledge is that informed consent is not entirely realistic; one would need to be a medical professional to understand the implications of a treatment decision.<sup>266</sup> Yet another is that physicians in training must work long hours to learn what they need to know to treat patients. Never mind that research shows that a sleep-deprived person is impaired in ways similar to those associated with being legally drunk.<sup>267</sup>

The things physician know, whether they are learned from books, in the classroom, or from observations and experience limit what can be considered by members of the profession as real, legitimate, meaningful, or even knowable. Medical education, training, and ongoing emersion in the work causes the physician to think of the medical way of knowing as common sense. As Montgomery puts it, medical knowledge’s

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<sup>265</sup> Richard C. Cabot, *Honesty* (New York: The Macmillan Company, 1938), 48.

<sup>266</sup> See, for example, Katz, *The Silent World of Doctor and Patient*, 166-9.

<sup>267</sup> See, for example, J.Todd Arendt, Judith Owens, Megan Crouch, Jessica Stahl and Mary A. Carskadon, "Neurobehavioral Performance of Residents after Heavy Night Call vs after Alcohol Ingestion," *Journal of the American Medical Association* 294, no. 9 (September 7, 2005): 1025-33.

givenness is based on years spent studying biology and more years of hospital apprenticeship with examination iled on examination well into the physician's late twenties and thirties, long after college classmates have been made partners, started businesses, begun families. It is "common" only to others in medicine and then often only to members of the same subspecialty.<sup>268</sup>

### ***Medicine's Tools***

The physicians' implements and utensils vary by specialty. Surgeons may use knives, saws, clamps, retractors, and various other manually operated devices to remove sick or damaged parts or to rebuild or replace parts that are malformed, worn out, or malfunctioning. Pathologists may use microscopes as much as they use dissection instruments. Radiologists may use images or machines that make the images to produce valued results. All who become physicians learn to use the few basic items considered necessities for conducting a physical examination: a thermometer, a stethoscope, an otoscope, a blood pressure cuff (sphygmomanometer), a medical chart, a prescription pad, medical journals, and an examination table. Many of the tools physician rely on are sophisticated devices developed and often operated by engineers and technicians. The physician's tools are the products of these devices and efforts. Medicine's technologies are almost magical in how they can peer into the inner workings of a patient and create changes that often are of life and death magnitude.

Gadgetry and technologies are only a small part of the methods physicians use to analyze and explain reality to their patients and to handle and produce situations.

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<sup>268</sup> Montgomery, *How Doctors Think*, 165.

Physicians witness, interpret, and provide remedies for aspects of the world that their patients need help to understand. Physicians serve as oracles, predictors of what is to come, what can be expected. They draw on research, experience, observations, trial and error, rituals, drugs, admonitions, and bodily invasions to address patients' problems and to exact changes. Of course, specialized language and ritualized procedures for communicating certain types of information are vital to the profession.

## **OVERVIEW**

These brief glimpses into the meanings of medical culture are intended to show that physicians are trained to think, feel, act, and react in ways that are different from non-physicians. Their attraction to the field and their extensive socialization processes lead to a set of assumptions, beliefs, and perceptions that may be invisible to the physicians, themselves. Because of their strong identification with the profession and their near-total immersion into a world that is separate from the world of non-physicians, physicians may fail to see the implications of their actions and beliefs, resulting in barriers to change.

### **Chapter 3: Deception and Disclosure**

The previous chapter discussed the culture of medicine and its meanings and manifestations. Clearly, there is more to the culture of medicine than its effect on how physicians think about addressing illnesses and injuries. The culture of medicine affects how physicians communicate, how they relate to others, what they believe about how the world works, and who they are and are supposed to be. In addition to the high ideals and the sense of community that are part of belonging to the profession, secrecy, fear, perfectionism, uncertainty, and a variety of defense mechanisms for dealing with them often become part of the physician's way of life. Along with membership in the culture of medicine comes *power*, the power of knowledge, the power of privilege, and to some extent, the power of control over people, information, and access to health-care goods and services.

This chapter is devoted to discussing the tension in the culture of medicine between maintaining physicians' power and sharing information with patients and others. The relevant information the physician controls and manipulates may include the diagnosis, the treatment options and their risks, the patient's status or prognosis, the lack of a diagnosis or a known treatment for the patient's complaint, the inappropriateness of a course of action requested by the patient, or the competing interests of the patient and third parties. The chapter addresses a long tradition in medicine of using deceptive

measures to avoid confrontation or unpleasant emotional reactions, to persuade toward a particular course of action, to encourage a particular outlook, or to otherwise exercise control in the health-care realm. It also discusses deception from perspectives within and outside medicine, some of the reasons physicians deceive or are perceived as deceiving, and the concept of disclosure and its role in changing the culture of medicine.

## POWER

*Power* is often defined as the right, the ability, or the position to influence or rule.<sup>269</sup> It is synonymous with strength, authority, dominion, control, and command.<sup>270</sup> *The Healer's Power* by Howard Brody includes a discussion of three types of power held by physicians, *Aesculapian*, *charismatic*, and *social*.<sup>271</sup> *Aesculapian* power refers to the healer's power that comes from the specialized knowledge and tools of the healing arts.<sup>272</sup> Brody claims that *charismatic power*, the personal power that grows out of talents and personality, has a divine source or is innate and specific to the individual.<sup>273</sup> *Social power* is the power of social position and economic status.<sup>274</sup> If, as Brody suggests,

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<sup>269</sup> Webster's New World Dictionary of the American Language, ed. David Bernard Guralnik and Joseph H. Friend (Cleveland, Ohio: World Publishing, 1966), 1145.

<sup>270</sup> Webster's New World Dictionary of the American Language, 1145.

<sup>271</sup> Howard Brody, *The Healer's Power* (New Haven, Conn.: Yale University Press, 1992), 16-20.

<sup>272</sup> Brody, *Healer's Power*, 16-20.

<sup>273</sup> Brody, *Healer's Power*, 16-20.

<sup>274</sup> Brody, *Healer's Power*, 16-25.

physicians possess power in all of these areas, they have a great deal to protect. In order to maintain his power, the physician must protect his personal identity, his social status, his income, and access to the skills and knowledge that support his self-image and way of life.

Power is only theoretical or potential unless it is exercised in some way. Therefore, if a physician possesses these powers and wants to be recognized for them, he or she must be able to demonstrate leadership, exhibit knowledge-based decisions that others will follow, control or restrain others' actions, find favor with or a sense of belonging among others in positions of privilege, and be acknowledged as deserving deference. To maintain power, he or she must claim legitimacy through merit, solidarity with supporters, and recognized-value in the social order. All of these are elements of various sociological definitions of *power*.<sup>275</sup> In addition, they are often recognized as necessary to being part of the profession.<sup>276</sup>

Power itself is generally neutral. Its use can be beneficial or destructive. Sometimes the intent and circumstances surrounding its use can make all the difference in how an action is perceived by both the actor and those who can only make assumptions about the actor's intentions. The kinds of power Brody describes can be used to benefit others, to harm them, or some mixture of the two. The uses to which physicians apply

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<sup>275</sup> "Power (Sociology)," [http://en.wikipedia.org/wiki/Power\\_\(sociology\)#Five\\_bases\\_of\\_power](http://en.wikipedia.org/wiki/Power_(sociology)#Five_bases_of_power) (accessed November 26, 2006).

<sup>276</sup> Starr, *Social Transformation*, 15.

their special power help to shape the ethical dimensions of an encounter with a patient. They contribute to the context in which information is (or is not) exchanged.

## **DECEPTION AND TRUTH-TELLING**

Deception is a natural tool and by-product of a culture that hopes to maintain its power in a changing environment. Exaggeration, understatement, misdirection, and prevarication provide ready defenses against those who would question the legitimacy of or want to challenge the power. Before exploring in greater depth the ways physicians have made use of deception to protect and defend their individual power, and that of the profession as a whole, I will touch on the meanings and morality of deception and their importance in the physician-patient relationship.

A dictionary definition of *deceive* is as follows: “to make (a person) believe what is not true; delude; mislead.”<sup>277</sup> It ranges from bald-faced lies to little white ones and from silence to subtle selective omissions. The goal may be to harm, to spare another’s feelings, or simply to ease or facilitate a social encounter. The motivation may range from a desire for personal benefit or avoidance of personal discomfort to a desire to be generous, kind or protective. There may be more than one motivation for an action. The deceiver may not always be aware of his own motivations due to his belief system or his unwillingness to examine his own reasoning.

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<sup>277</sup> Webster's New World Dictionary of the American Language, 379.

Some claim that inherent in deception is the intent to cause another to believe something other than what the deceiver believes to be true.<sup>278</sup> Not everyone agrees with this statement. They suggest that deception, though it may have all the markings of trickery, evasion, or pretense, does not necessarily convey an untruth.<sup>279</sup>

It is sometimes possible to frame a statement in way that provides a perspective with which a patient would agree, but if the statement were made differently, the patient would disagree. Tact, euphemisms, and indirect references to sensitive matters make use of this type of framing. For example, the patient in the emergency room with internal injuries who asks if she is going to die may be told, “We will not know the extent of your injuries until we do exploratory surgery.” The patient has been subjected to an evasion that conveys the truth. The physician talking to the patient may, in fact, believe the patient’s chances of survival are slim. Instead of speculating, the physician responds with facts. The patient may have been deceived as to the physician’s personal concerns about the patient’s condition, but would not have been deceived concerning the uncertainty of his or her condition. Had the physician said, “No. You are going to be fine,” the physician would have deceived the patient about both speculations and facts.

Perhaps a more compelling example involves gender identity and the androgen insensitive patient. When the patient seeks medical assistance due to infertility, the physician is faced with the problem of what to tell the patient about the source of the

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<sup>278</sup> Sissela Bok, *Lying: Moral Choice in Public and Private Life* (New York: Pantheon Books, 1978), 13.

<sup>279</sup> Jennifer Jackson, *Truth, Trust, and Medicine* (New York: Routledge, 2001), 72-107.

problem. The patient's personal and sexual identity could be shattered and relationships could be damaged or destroyed if the physician fails to exhibit sensitivity in communicating. The genetic male who appears to be a female in all other ways may experience psychic injury for which recovery may be extremely difficult or impossible. When asked about the nature of the problem, the physician may weigh the risks of revealing the presence of testicles against telling the patient that she will never be physically capable of reproducing and choose the latter without further explanation.

Anita Natarajan argues that telling the patient about the androgen insensitivity may negatively affect the patient's present autonomy in order to make possible the patient's future autonomy as the person the patient believes herself to be.<sup>280</sup> In focusing on the matter for which medical assistance was sought—determining whether child-bearing can be made possible, rather than on the underlying cause—the physician is not conveying an untruth. The patient is not misled about her ability to procreate, but as Jackson says, is kept from learning the truth. She is deceived, but not lied to. The patient's gender or genetic makeup may never have been something about which the patient had doubts or concerns.

A *lie* is a deception, but a deception need not be a lie. There appears to be a continuum from the truth to the darkest lie with a vast area of gray in between. Deception has its own vocabulary describing the strategies deceivers use. Richard Clarke Cabot

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<sup>280</sup> Anita Natarajan, "Medical Ethics and Truth Telling in the Case of Androgen Insensitivity Syndrome," *Canadian Medical Association Journal* 154, no. 4 (February 15, 1996): 568-70.

included a number of terms for deception in his book *Honesty*. He defines *prevarication* as the attempt to convey a false impression to one's hearer by words that in some other sense are true.<sup>281</sup> For example, imagine a patient facing gallbladder surgery asking his physician about how much experience the physician has with the procedure. The physician who has only removed two gallbladders during her career responds that she has a great deal of experience with the procedure. The physician is not lying; she held the camera many times during laparoscopic cholecystectomies. However, she is misleading the patient about her experience with the aspects of the procedure that require a surgeon's skill. "*Equivocation* is the use of a word which has two meanings. The equivocator intends that the hearer shall grasp one meaning while the other is true in the case in hand."<sup>282</sup> "By *evasion* one avoids saying anything on a subject that he does not wish to talk about. This can be done by changing the subject."<sup>283</sup> Deception can involve maintaining silence, leaving out an important detail, giving more weight to one piece of information over another, creating ambiguity, feigning certainty, or any of a great number of ways of distorting information. (There is, of course, the somewhat paradoxical exception of self-deception, in which one believes one thing, but somehow convinces himself to believe another. That discussion will come later.)

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<sup>281</sup> Cabot, *Honesty*, 9.

<sup>282</sup> Cabot, *Honesty*, 49.

<sup>283</sup> Cabot, *Honesty*, 49.

Cabot states that “a lie is an attempt to deceive without consent.”<sup>284</sup> He indicates that deception is not always without consent. Plays, jokes, fiction, and illusions are examples of deceptions to which one consents for the purposes of entertainment.<sup>285</sup> In the medical realm, some patients do not wish to know the truth about their conditions.<sup>286</sup> They give their consent by asking to be misled or kept uninformed. In some cultures, it is considered inappropriate for the patient to know the details about his health or to make decisions about his care.<sup>287</sup> In these cultures the family makes decisions for the patient, taking into account the impact of a decision on the good of the family and not on the patient alone. The consent to be deceived is implied by the traditions followed by the patient’s family. (Of course, it is unwise to assume that the patient follows the traditions of her ethnic group or other group with which she appears to identify. It is best to ask the patient how much she wants to know. Furthermore, it is best to do so in private so that coercive family members cannot impose their choices on the patient.)<sup>288</sup>

Lies, also known as fabrications or deliberate false statements, are typically considered evils. However, even an outright lie, under extreme circumstances, can be

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<sup>284</sup> Cabot, *Honesty*, 8.

<sup>285</sup> Cabot, *Honesty*, 21.

<sup>286</sup> Although she was aware of her diagnosis of cancer, my mother did not want to make decisions about her care. She found details stressful and indicated that she felt unprepared to evaluate the possible implications of treatment options.

<sup>287</sup> Ruiping Fan and Benfu Li, "Truth Telling in Medicine: The Confucian View," *Journal of Medicine and Philosophy* 29, no. 2 (April 2004): 179-93.

<sup>288</sup> Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001), 62.

morally justified. Sissela Bok, Jennifer Jackson, and various other philosophers who are against lies in general draw on the famous murderer-at-the-door scenario to demonstrate that there can be an exception to the rule.<sup>289</sup> In that scenario, a known murderer with murderous intent arrives at person A's door seeking the whereabouts of another A harbors within her home. The person who is asked for the information, A must decide whether to tell the truth and endanger the hidden friend, or to lie, and in doing so, prevent a murder. For most, the lie would not be immoral under these dire circumstances. Furthermore, unless the truth-teller was coerced, telling the truth might be considered blame-worthy behavior.<sup>290</sup>

There may be instances in which telling a lie to avoid causing another pain can be justified. I learned of an example recently. A man suffering from memory loss due to dementia would frequently ask the whereabouts of his wife. His wife had died some years before. Each time he was told of his wife's death, he suffered the grief again. Although his family members, fine upstanding people, generally favored telling the truth, they arrived at the conclusion that telling the old man that his wife had died served no beneficial purpose. Despite the fact that the old man would soon forget what he had been told, the pain he experienced each time he learned of his wife's demise diminished his quality of life. Therefore, his family members decided to tell him that his wife was out

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<sup>289</sup> Bok, *Lying: Moral Choice in Public and Private Life*, 39; Jackson, *Truth, Trust, and Medicine*, 67-70.

<sup>290</sup> Bok, *Lying: Moral Choice in Public and Private Life*, 41-2.

engaging in some plausible activity. This would satisfy the old man's curiosity and allow him to continue with his day without the unnecessary pangs of sorrow.

There are features of this example that are worth noting. There was no evil or coercive person creating a dangerous dilemma. The old man cannot be considered competent. The news did not provide any opportunity for making future changes in his life or for making preparations for his death. The knowledge of his wife's demise, though painful in the moment, would soon be forgotten; the old man did not have the capacity to learn of the deception and subsequently feel betrayed. The relationships that might suffer belonged to the people surrounding the old man rather than relationships with the old man. The information created pain in others' lives that served no meaningful purpose; no healing could be promoted and no amends could be made. Finally, the repeated infliction of pain would be cruel, making questionable the moral value of truth-telling in this situation.

My point is not that lies should be considered acceptable as a rule. Instead, it is to point out that deception is not a simple matter.<sup>291</sup> The same can be said for withholding information or telling the truth. Withholding information may or may not be deceptive. It depends on the situation, the information, and the duty one owes to the person from whom information is withheld. Silence about a matter may be maintaining one's own privacy or demonstrating wise judgment about who should have the information, under what circumstances they should have it. If someone who had no right to have my credit-

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<sup>291</sup> Jackson, *Truth, Trust, and Medicine*, 41-64.

card number asked for it, I would feel no compunction about remaining silent. However, when one's duty is to place another's interests ahead of one's own, and providing the information is necessary to meet the duty, withholding the information is probably deceptive. It is certainly a breach of the duty and a violation of trust.

An obvious example can be found in biomedical research. The researcher owes a duty to the human subjects involved in the testing of a treatment for a serious illness, to others who would make the treatment available to the public, and to the segment of the public who would undergo the treatment. Withholding information that the treatment is dangerous and has caused the deaths of several people is deceptive and a breach of trust.

*Telling the truth* is another of those concepts that has different meanings for different people. It may mean *not lying*, that is, not fabricating or intentionally expressing something that one knows is not the case. It may mean exhibiting *candor*, which in some instances may involve tactlessness or verbal abuse. It may mean communicating information that is *verifiable through scientific methods*. It may even mean expressing what one perceives or believes whether or not the perceptions or beliefs have any connection to the socially constructed reality.<sup>292</sup> Under some circumstances *telling the truth* may mean *informing*. Telling the truth, regardless of one's preferred definition, is not always good or beneficial. It can damage relationships and unnecessarily inflict pain.

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<sup>292</sup> A man suffering from hallucinations or delusions may be *telling the truth* when he tells you that the six-foot-tall white rabbit he sees standing next to him is his best friend named Harvey who likes to consume alcohol and is capable of stopping time. The fact that others cannot see the large rabbit and do not believe the rabbit exists does not make the man's statement any less an accurate account of what he sees or believes. Henry Koster, "Harvey," (U.S.A.: 1950).

As with any communication, mutual understanding is a process that requires the use of discretion and attention to the audience's needs and abilities at a given time.<sup>293</sup> One cannot simply assume that what he says is equal to what the audience heard and understood. As should be clear from the differences in definitions mentioned above, people can include the same words in their vocabularies but have different ideas about what they mean.

The circumstances, the intent, the goal, the action taken, the importance of the outcome, and the impact on relationships all matter in assessing the meaning and the moral value of the communication.<sup>294</sup> If the truth is delivered without clarity and compassion or a deception is discovered later, good intentions may count for little. The goal of generating benefit or avoiding harm may fail miserably. Relationships may be permanently damaged or destroyed.

Physicians are not known for their communication skills. Studies show that physicians often interrupt patients after 18-23 seconds, leaving many with unexpressed concerns and the feeling that the physicians are lacking in sensitivity and empathy.<sup>295</sup> Various researchers report that, instead of the iatrogenic injury, patient dissatisfaction

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<sup>293</sup> The humanities are largely devoted to efforts to communicate and to interpret others' communications. Consider rhetoric and hermeneutics.

<sup>294</sup> Jackson, *Truth, Trust, and Medicine*, 41-64.

<sup>295</sup> Howard B. Beckman and Richard M. Frankel, "The Effect of Physician Behavior on the Collection of Data," *Annals of Internal Medicine* 101, no. 5 (November 1984): 692-6; Kim M. Marvel, Ronald M. Epstein, Kristine Flowers and Howard B. Beckman, "Soliciting the Patient's Agenda: Have We Improved?," *Journal of the American Medical Association* 281, no. 3 (January 20, 1999).

with physicians' level and quality of communication is the reason behind the desire to litigate for medical malpractice.<sup>296</sup> Furthermore, physicians learn ways of stating matters that deflect responsibility from themselves or the field of medicine. Berlinger mentions a few phrases used to discuss errors: "a mistake is a 'significantly avoidable accident,' or is an 'inevitable occasional untoward event,' or an 'unfortunate complication of [a] usually benign procedure.'"<sup>297</sup> Kathryn Montgomery mentions a curious expression sometimes used in the treatment of cancer; the patient is said to have "failed chemo," when the failure had nothing to do with the patient's efforts.<sup>298</sup> It is one of a number of phrases that have the effect of blaming the patient for her misfortune.

What one says (or does not say), how it is said, why it is said, and what it all means to the sender and to the recipient are all aspects of communication that can complicate relationships. Perceptions matter. This is not a profound statement, but it bears repeating. When one person in a dyad holds the majority of power in exchanges of information, that person has the greatest responsibility in making certain that the communication is successful and not misleading.

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<sup>296</sup> See, for example, Elisabeth Macdonald, "An Introduction to Basics," in *Difficult Conversations in Medicine*, ed. Elisabeth Macdonald (New York: Oxford University Press, 2004), 3-4; Buckman and Kason, *How to Break Bad News*, 9.

<sup>297</sup> Berlinger, *After Harm*, 24. quoting from Melvin Konner, *Becoming a Doctor: A Journey of Initiation in Medical School* (New York: Penguin Books, 1988), 97, 356; Klass, *A Not Entirely Benign Procedure: Four Years as a Medical Student*, 115.

<sup>298</sup> Montgomery, *How Doctors Think*, 199.

## Deception Defined

When physicians do not disclose or do not fully and clearly reveal important information about the patient's health or health care as expected or required by ethics or law, their actions or omissions *may* be characterized as deception. The trust relationship that supposedly is inherent in the physician-patient relationship may be threatened by the physician's choice to be less than forthright with the patient or the patient's representative about issues material to the patient's health.

Health-care providers are not the only ones who deceive; patients often conceal health information that is relevant to their health care. Sometimes they deceive health-care providers about their lifestyles, their symptoms, their compliance with physician recommendations, and any number of other matters. The consequences for the patient's health may or may not be important. Like physicians who deceive, patients do so to please, to avoid shame or embarrassment, to preserve a self-image, or otherwise to gain benefit or avoid harm.<sup>299</sup> However, because of the physician's power and professional responsibility in the physician-patient relationship, the physician is held to a higher standard than the patient.<sup>300</sup> In general, the physician is expected to act in the patient's best interests. Paternalism was once generally considered acceptable, but the meaning of *best interests* today is and has for some time been a matter of debate. However, acting in

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<sup>299</sup> Charles Ford, *Lies!, Lies!, Lies!: The Psychology of Deceit* (Washington, DC: American Psychiatric Press, 1999), 87-102.

<sup>300</sup> This is both a matter of law and of professional ethics. The physician who fails to reveal risks and alternatives may be liable for malpractice. Anyone who claims to be member of a profession obligates herself to meeting standards that are beyond those of the ordinary person.

the patient's best interests rarely means ignoring the patient. It typically involves both listening to what the patient says and looking for evidence of confirmation or for alternative explanations and interpretations through questioning, observation, and testing.

At one time, the patient's best interests were thought to be whatever the physician decided they were.<sup>301</sup> The justification for this view was (and sometimes still is) that patients lack the knowledge and emotional stamina to deal with serious issues. Their illness and fear render patients child-like, dependent, and generally lacking in ability to make reasoned judgments.<sup>302</sup> Furthermore, the distress that would likely result from being told bad news or called on to make important decisions could lead to despair and rash, self-destructive behavior.<sup>303</sup> In addition, costs and time constraints make educating the patient about the diagnosis, treatment options, their implications, and the probable course and outcome of the ailment unreasonable, given practice conditions.<sup>304</sup> Therefore, it is up to the physician to do whatever the physician believes will best fulfill his duty to the patient as a medical professional. The patient's job is to trust the physician's judgment.

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<sup>301</sup> Heta Hayre, *The Limits of Medical Paternalism* (London: Routledge, 1991), 1.

<sup>302</sup> Mary Ann Krisman-Scott, "An Historical Analysis of Disclosure of Terminal Status," *Journal of Nursing Scholarship* 32, no. 1 (First Quarter 2000). For a fictional account of the argument, see Brody, *Healer's Power*, 5-8.

<sup>303</sup> Bok, *Lying: Moral Choice in Public and Private Life*, 234-5.

<sup>304</sup> This lament is common among practitioners. Many blame the time constraints on managed care and the need to see a patient every ten to fifteen minutes. However, the lament is a longtime tradition. See Cabot, *Honesty*, 148.

One need only look to Benjamin Rush's version of medical ethics to find support for this assertion. His statement concerning medical ethics not only described how the physician should behave, but also that patients should comply faithfully with whatever the physician recommends. According to Chester Burns, Rush outlined the proper patient behavior in accord with his belief that physicians should not have to deal with non-compliant and unreasonably demanding patients. Burns writes:

Rush delineated a host of moral duties for patients (Rush 1811, 253-54). Patients should prefer physicians whose "habits of life" were regular and who were not devoted to pleasure at "the theater, the turf, the chase." They should choose educated doctors, and each family should designate one physician with responsibility for the care of the entire family. Patients should send for the physician in the morning but be ready to receive him at any time of the day. They should not oppose the clinical judgments of their doctors, and they should obey the doctor's advice about prescriptions. They should speak well of a doctor's services and pay fees promptly.<sup>305</sup>

Much has changed since Rush's time, and the right of patients to play a greater role in their health-care decisions is widely recognized. However, fulfilling expectations about acting in the patient's best interests has become complicated. Because of the influences of managed care and third-party payers, malpractice insurers, hospital risk managers, and others who have intervened in the physician-patient relationship, the physician is likely to experience conflict about whose interests he or she is really

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<sup>305</sup> Chester R. Burns, "Setting the Stage: Moral Philosophy, Benjamin Rush, and Medical Ethics in the United States before 1846," in *The American Medical Ethics Revolution: How the Ama's Code of Ethics Has Transformed Physicians' Relationships to Patients, Professionals, and Society*, ed. Robert B. Baker, Arthur L. Caplan, Linda L. Emanuel, and Stephen R. Latham (Baltimore, Md.: Johns Hopkins Press, 1999). Burns quotes from Benjamin Rush, *Sixteen Introductory Lectures to Courses of Lectures upon the Institutes and Practice of Medicine, with a Syllabus of the Latter* (Philadelphia, Pa.: Bradford and Innskeep, 1811).

supposed to serve.<sup>306</sup> Profits, personal income, utilization reviews, practice guidelines, contract restrictions, facility policies, and a variety of other pushes and pulls distract physicians from being patient advocates and virtuous, autonomous decision makers. Deception can become a coping mechanism for the physician who must deal with the various pressures of modern practice.<sup>307</sup>

### **Deception as a Tradition in Medicine**

Deception is nothing new in medicine, nor has it been limited to particular types of information. It has been used to inspire hope, avoid blame, fend off competition, maintain confidentiality, defraud, persuade, and generally avoid confrontation or discomfort. Some of these deceptions reflect common practices of the past; some describe extraordinary circumstances; and some continue to be used with some frequency by particular practitioners, certain groups of practitioners, or practitioners working in certain communities. Sometimes, physicians tell terribly injured patients in the emergency room that everything is going to be fine. Or, they tell dying patients they will be better soon. They tell patients harmed by medical error they had complications without mentioning *error*. They accuse competitors of incompetence, quackery, or nefarious activities.<sup>308</sup> They tell a patient's family that the perfect donor is not a good candidate to

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<sup>306</sup> See generally, Morreim, *Holding Health Care Accountable*.

<sup>307</sup> Morreim, *Holding Health Care Accountable*, viii.

<sup>308</sup> Starr, *Social Transformation*, 87-8.

donate an organ so the would-be donor can avoid the discomfort of refusing to donate. They tell organ donation organizations that a patient's situation is more serious than it is to improve the patient's chances of receiving an organ. Some physicians have submitted documentation for reimbursement for treatments that were not administered or for treatments that are not justified under the payer's criteria.<sup>309</sup>

Physicians have emphasized benefits, downplayed risks, promised results, or suggested that dire consequences are in the patient's future to convince patients to undergo procedures.<sup>310</sup>

For the most part, the physicians who have deceived patients and others claim to have done so with the good of their patients at heart. They assert that the deception has been intended to serve three main medical purposes:

1. to reduce suffering,
2. to promote healing, and
3. to maintain confidentiality. In other words, through deceptive action or inaction, physicians have attempted to act with beneficence.

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<sup>309</sup> Insurance fraud and false claims to the U.S. government can result in criminal and civil penalties. Physicians do not always take the consequences for their careers into account when submitting claims for reimbursement.

<sup>310</sup> One of the most famous lawsuits along these lines is *Hawkins v. McGee*, 84 N.H. 114, 146 A. 641 (1929), the "hairy hand case" in which a physician guaranteed that a skin graft would make the patient's severely damaged hand one hundred percent perfect. The patient was convinced by the physician's promises. However, the procedure made the hand worse. The patient sued for breach of contract because the physician failed to fulfill his promise.

However, not all of physicians' uses of deception have been so altruistic in intent. Like any other group of people, physicians have among them some who care more for their own needs and comforts than they do for those of others. These physicians sometimes do so in ways that tarnish the image of the profession. This self-interest has come in the form of defamation, fraud, puffing, and denial of responsibility.

Deception to promote physicians' self-interest was more clearly evident when allopathic medicine did not hold the political, social, and economic power that came with state licensing and legislative regulation, and competition with alternative practitioners was fierce.<sup>311</sup> Physicians claimed superiority over competitors in their methods, skills, and knowledge, emphasizing the scientific nature of their own endeavors while maligning other types of practitioners as frauds and charlatans.<sup>312</sup> In fact, most curatives used by healers of the era lacked efficacy. However, by banding together, claiming legitimacy, and vigorously attacking the work of others, allopathic physicians managed to dominate the market.<sup>313</sup>

Gaining power through reducing competition was only part of the reason for self-interested deception. Maintaining or improving income was almost certainly on their minds. When fee-for-service was the mode of payment for physicians' services,

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<sup>311</sup> Starr, *Social Transformation*.

<sup>312</sup> De Ville, *Medical Malpractice in Nineteenth-Century America*, 29, 46, 52, 82.

<sup>313</sup> One of the people who avidly promoted the medical profession, vilified alternative healers, and made the AMA the voice of the medical profession was Morris Fishbein, the editor of JAMA and author of many books and articles. Morris Fishbein, *Morris Fishbein, M.D.; an Autobiography* (New York: Doubleday, 1969).

physicians sometimes provided more tests and treatments than were necessary in order to increase their incomes. The unwary patient, accustomed to following the physician's dictates, would rarely question whether the administrations were efficient or necessary. When the costs of health care began to rise and abuses came to light, managed care and other health-care finance innovations were created to bring costs under control.

Such measures have not always been successful. Physicians have been known to deceive the third-party payers for the benefit of both patients and themselves.<sup>314</sup> A 2004 study by Werner, Alexander, Fagerlin and Ubel explored physicians' willingness to lie to obtain treatment coverage for patients and the public's willingness to endorse physicians' deception of insurance companies.<sup>315</sup> Researchers asked jurors to give their opinions about whether the physicians should lie for the patients in hypothetical scenarios to obtain insurance coverage for the patients' treatment. The same survey was sent to physicians, most of which worked solo or in small practices. The study's results showed that 11 percent of the physicians endorsed deception, while 26 percent of the members of the general public (jurors) endorsed deceiving insurers.<sup>316</sup> Only 5 percent of the

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<sup>314</sup> See, for example, Rachel M. Werner, G. Caleb Alexander, Angela Fagerlin and Peter A. Ubel, "Lying to Insurance Companies: The Desire to Deceive among Physicians and the Public," *American Journal of Bioethics* 4, no. 4 (2004): 53-9; D. H. Novack, B. J. Detering, R. Arnold, L. Forrow, M. Ladinsky and J. C. Pezzullo, "Physicians' Attitudes toward Using Deception to Resolve Difficult Ethical Problems," *Journal of the American Medical Association* 261, no. 20 (May 26, 1989): 2980-5.

<sup>315</sup> Werner, Alexander, Fagerlin and Ubel, "Lying to Insurance Companies," 53-9.

<sup>316</sup> Werner, Alexander, Fagerlin and Ubel, "Lying to Insurance Companies," 55.

physicians surveyed worked in a managed care setting.<sup>317</sup> Previous studies found that up to one-third of the physicians surveyed about their actual behavior had exaggerated a patient's need for care in order to obtain insurance coverage for the patient.<sup>318</sup> More subtle forms of deception for self-interest and self-deception have also long been part of the profession. Personal biases and prejudices, denials of fatigue or impairment, eagerness to gain experience in new techniques, and face-saving measures to avoid responsibility are among these many subtle forms of deception. Many of these fall into the category of self-deception.

### **Self-Deception**

According to Mike W. Martin, there are five types of self-deception, willful ignorance, systematic ignoring, emotional detachment, self-pretense, and rationalization.<sup>319</sup> Physicians and patients are both subject to these phenomena. For example, both physicians and patients have deluded themselves into believing that the practice of medicine is science and should function in a mechanistic manner. In other words, the physician should be able to plug the patient's symptoms and test results into a

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<sup>317</sup> Werner, Alexander, Fagerlin and Ubel, "Lying to Insurance Companies," 55.

<sup>318</sup> Werner, Alexander, Fagerlin and Ubel, "Lying to Insurance Companies," 53. Physicians sometimes label a test such as a mammogram as diagnostic when it is in fact for screening purposes when the insurer covers diagnostic testing, but not screening. Occasionally, a physician will give a code to a diagnosis that indicates a more serious condition than the patient has. This may be because the physician believes the patient needs more care than the appropriate code would permit, or because the physician wants to be paid more than the appropriate code pays.

<sup>319</sup> Mike W. Martin, *Self-Deception and Morality* (Lawrence: University Press of Kansas, 1986), 6-11.

formula and the proper diagnosis and treatment will automatically reveal itself. As Montgomery writes, aside from the fact that one cannot identify generalizable patterns from a single subject, the science physicians and patients delude themselves about is not the version that arrives at probabilities and correlations; it is the Newtonian, law-like version, “the replicable, invariant, universalizable description of the material world.”<sup>320</sup> She remarks that “[i]f medicine were a science in the old-fashioned positivist sense, its laws could be programmed, and diagnosis could be determined and choice of treatment decided entirely by computer. There would be no need for physicians.”<sup>321</sup>

An additional self-deception involves the commercialization of medicine. It leads some patients to view themselves as consumers who believe they should pay a price and receive products and services with expected outcomes. Pharmaceutical companies have come to use this perception to enhance sales of their products by marketing directly to the public. Commercialization of another kind has often created unrealistic expectations and conflicts that create discomfort. Managed care has at times pitted physicians’ incomes against patients’ needs and physicians’ expertise against the insurer’s bottom line. The standard of care now comes in different versions that are dependent on managed care guidelines and the utilization review process.

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<sup>320</sup> Montgomery, *How Doctors Think*, 31.

<sup>321</sup> Montgomery, *How Doctors Think*, 34.

Morriem has written about this problem in “Redefining Quality by Reassigning Responsibility.”<sup>322</sup> She notes that the public and physicians expect the standard of care to reflect the newest techniques and technologies, whether they have proven as the most effective or not. The managed care insurers, attempting to limit costs, sometimes create tension by denying coverage of these innovations in health care. The courts have unrealistic expectations about uniformity of quality in health care that made more sense in a time when the flow of health-care money was more abundant and physicians were not restricted in the types of care they were permitted to offer patients. This clash of commercialism and unrealistic expectations places an unfair burden on physicians.

Physicians feel the pressures associated with unrealistic expectation and with being in the middle. Sometimes they rely on both deception and self-deception to maintain some degree of equilibrium.

*Willful ignorance* is the form of self-deception that involves quashing any thoughts that something might be wrong or amiss, never questioning, not making waves.<sup>323</sup> The person who exhibits willful ignorance may suspect something, but does not want to know. In medicine, willful ignorance can come in many forms. The physician who observes a breach of standards by a colleague may not question the behavior. The

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<sup>322</sup> See generally, E. Haavi Morreim, "Redefining Quality by Reassigning Responsibility," *American Journal of Law and Medicine* 20 (1994): 79-104.

<sup>323</sup> Martin, *Self-Deception and Morality*, 7.

erring physician's place in the hierarchy may make questioning difficult, so the observer attributes the observed behavior to the other physician's superior expertise.

The physician may sense that certain corporate practices may be inappropriate or potentially harmful to patients, yet make no effort to question the practices to avoid interfering with a financially beneficial relationship.

*Systematic ignoring* occurs when one *knows* an action is wrong, but refuses to acknowledge that it is wrong.<sup>324</sup> This go-along, get-along version of self-deception amounts to refusing to give the appropriateness of any action attention. An example of systematic ignoring in medicine involves impairment. Both the physician and others around him choose to believe that there is nothing extraordinary or worthy of concern about the physician's occasional erratic behavior or excessive consumption of prescription drugs.

In *Complications*, Atul Gawande describes the downfall of a colleague who injures patient after patient without recognizing or acknowledging that he has a serious problem.<sup>325</sup> Those around the physician notice that he is being sued and that he does not appear at M&M conferences. Nevertheless, the physician continues to be permitted to operate. His long-standing reputation as a fine surgeon is allowed to slowly erode, while colleagues who look the other way are reminded that they could find themselves in the same position one day.

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<sup>324</sup> Martin, *Self-Deception and Morality*, 7-8.

<sup>325</sup> Gawande, *Complications*, 88-98.

One might say that telling a harmed patient that she has suffered a complication instead of an error falls into this category. The physician knows that the injury was the result of a mistake, but refuses to explicitly say anything that would make the patient aware of the injury's cause. The physician chooses to believe he has told the truth to the patient and to ignore the fact that he has left out important information about cause and responsibility.

*Self-pretense* involves struggling to believe that behavior that one knows is wrong is acceptable or permissible, sometimes reassuring oneself and others who express qualms in hope of restoring confidence.<sup>326</sup> In medicine self-pretense may take place when the physician lies to obtain insurance coverage for a patient, knowing full well that the patient is not eligible and that lying is wrong. The physician tries to convince herself the lie is not bad; the insurance company is wrong and unfair. She sees herself as the patient's advocate whose deception is justified; the patient needs the health-care services more than the insurance company needs huge profits. At the same time, she knows that gaming the system harms the system as a whole, and the whole is made up of patients like hers.

Another example might be the older physician who reassures a resident or medical student that there is no need to tell the patient or the patient's family that the patient's adverse event is due to error because telling will only add to the family's distress. The older physician's reassurances encourage the resident to believe that the

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<sup>326</sup> Martin, *Self-Deception and Morality*, 8-9.

patient and the patient's family need to be protected from their own emotions and are incapable of acting reasonably and rationally in the face of adversity.

*Emotional detachment* occurs when a person recognizes his own fault, but hardens himself against any emotions and is sometimes dismissive of the seriousness of his misdeed.<sup>327</sup> Physicians may be especially adept at forms of detachment due to their frequent exposure to unpleasant sights, sounds, and feelings and the tendency to harden themselves against the hardships they and their patients encounter daily. Carrying emotional detachment over to the physician's own shortcomings or misdeeds may seem to him an appropriate reaction, given that it is a successful strategy for dealing with other types of potentially upsetting matters.

The physician who manipulates the patient into agreeing to the physician's preferred treatment knows he is violating rules and another's rights, but brushes off criticism as nonsense by claiming that the patient is incapable of making an informed decision, anyway. He justifies his approach by noting that he has the training and experience to weigh the risks and benefits far better than the frightened patient who knows almost nothing about medicine. He hardens himself against the patient's personal and family needs. His assumption is that patients should not be allowed to make bad decisions or decisions based on non-medical considerations. Furthermore, he sees informed consent as a legal construct that has no place in real medicine. He is emotionally detached from the specifics of the patient's situation and is unwilling to

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<sup>327</sup> Martin, *Self-Deception and Morality*, 8.

consider the possibility that the patient may actually prefer an approach that is more or less risky, more or less costly, more or less invasive, or more or less emotionally taxing.

Another example is the resident who lies to the patient about his role in performing a surgery but feels no guilt. Instead, the resident justifies the lie by slyly saying the surgeon is in charge, even though the resident knows he will be the one who holds the scalpel. The resident justifies his deception by claiming that the experience he gains will be used for the benefit of others.<sup>328</sup> He knows that lying to the patient is wrong, but he distances himself from the patient as an individual and emphasizes his potential service to patients in general.

*Rationalization*, perhaps the most familiar of the types of self-deception, amounts to succeeding at convincing oneself that a wrong is not a wrong.<sup>329</sup> Ambiguity helps to make rationalization easier. When a physician convinces herself that the patient will be unable to cope with bad news and withholds the unpleasant information, it is probable that the physician has rationalized to some extent to avoid her own emotions or the emotional reaction she would expect to encounter. The physician believes that she is actually doing the right thing and that telling the patient would be a harmful wrong.

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<sup>328</sup> Gawande, *Complications*, 23.

<sup>329</sup> Martin, *Self-Deception and Morality*, 8.

## Old Patterns Continue

### *Terminology*

As mentioned above, it was not uncommon in the past for physicians and others to lead patients to believe that they would recover when, in truth, the physician expected them to die from their illnesses or injuries. When the patient's diagnosis was cancer, once considered a death sentence with serious stigma attached, physicians avoided discussing the diagnosis. In both instances physicians asserted that they chose to mislead the patient out of a desire to spare the patient from fear and despair. They believed that they knew how patients would react if they were told the truth.

Sometimes, the language to which physicians have become accustomed as part of their profession may fail to communicate what they intend to convey to the patient. It is also possible that some physicians use clinical language to avoid unpleasant reactions, fully aware their audiences may not grasp the meanings behind the messages.<sup>330</sup>

Buckman explains:

When we do speak to patients we have a tendency to use what the patients regard as jargon. Of course, to us it is a highly efficient language and a way of transmitting precise (sometimes) information in a short time. To the patient it is an unintelligible language that doctors hide behind to avoid the pain of telling bad news or other painful or worrying information. Studies show that jargon confuses and alienates the patients, often leading to misunderstanding and misinterpretation. In fact, just over half of our patients will misunderstand

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<sup>330</sup> Paul Starr states that John C. Gunn, author of a medical guide for family use, "maintained that Latin names for common medicines and diseases were originally made use of to astonish the people' and aid the learned in deception and fraud." (*Social Transformation*, page 34).

significant portions of what we say, and on average 50 per cent of what is said is forgotten.<sup>331</sup>

Unfortunately, physicians need not consciously intend to deceive to communicate in a way that achieves the effect of deception. The example below is from my own family. I am not certain what the physician in this case intended.

A couple of years ago, I attended a cousin's funeral. Renal cancer took her life. The funeral brought to mind my only visit to her home, two short years before her death. She had recently returned home from the hospital where surgeons had removed one of her kidneys. She seemed happy and was recovering nicely from the extensive procedure. I knew nothing about why she had needed surgery. As we visited, she mentioned that she would see an oncologist in the coming week. My response was, "Oh, so it was cancer!" She was shocked that I would suggest such a thing, replying, "They didn't say that! They didn't say that!" I could scarcely believe what I was hearing. She did not know what an oncologist was, and apparently, no one had discussed with her the nature of her health issues. She had no concept of the seriousness of her condition or that radiation and chemotherapy were in her future. I felt somewhat guilty that I caught her off guard in a room filled with people and revealed more than her physician had by explaining that an oncologist is a cancer doctor. Why her health-care providers failed to mention the word *cancer* is something of a mystery.

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<sup>331</sup> Buckman and Kason, *How to Break Bad News*, 42.

Whether the physician consciously intended to deceive my cousin is irrelevant. She felt she had been deceived and was both astonished and appalled. My mention of cancer may have revealed more than she would have wanted her family and guests to know. She was completely unprepared for dealing with the medical and social aspects of a serious chronic illness. The physician had not spoken to her in language she could understand.

It is possible that her physician did not fully explain her condition because she appeared to be an intelligent woman, and he assumed a level of sophistication that she, in fact, did not possess. It is equally possible that he did not want to upset her by uttering the dreaded “C” word. Or, perhaps he wanted to avoid an emotionally-charged situation that could take a great deal of time and energy to address. We will never know. Either way, it was clear she did not know all she needed to know to make informed decisions about her care and her future.

Although many believe that *cancer* has lost much of its stigma and its connection with an inevitably painful death, not all physicians seem to share the belief. Perhaps the example above is evidence. Some physicians still adhere to the notion that cancer patients should not be told anything about the expected course of their illness. Concern about robbing the patient of hope is the usual justification for avoiding discussing the severity of the disease, its likely progression, and the statistics associated with life-expectancy. My sister’s experience provides an example.

Diagnosed with a particularly aggressive form of cancer, my sister underwent surgery, chemotherapy, and radiation. Her physicians at the cancer center where she was diagnosed and treated failed to discuss the stage of her disease or any statistics associated with treatment and survival. Approximately one year after completing her course of treatment and moving to another state, she began to suffer from symptoms that led to the discovery that the cancer had metastasized to her brain and other sites. I was with her when she received the news of her new tumors from her new oncologist. While I was present, she asked her oncologist about what she could expect her future to be like. He failed to mention that she was suffering from stage IV cancer and that cure was unlikely, but treatments with chemotherapy and radiation may be able to control the disease for a time, perhaps even years. The oncologist ignored her request and changed the subject.

Two sets of physicians in two different states failed to inform my sister about the severity of her illness. They had given her reason to believe that she would be cured and her life would return to normal after a period of aggressive treatment and recovery. When the new symptoms emerged, my sister and her husband began to have doubts. They had grown frustrated that they could learn nothing from the oncologist about what to expect.

Because I had researched the matter extensively, I was able to respond to their request for information. I provided them with medical information from reliable medical websites that indicated how the disease was staged and data on survival rates. Although the information I provided was less than pleasant, it allowed them to think realistically about the future and to engage in important planning. My sister and her husband

experienced some grief about what was happening in their lives, but they were grateful for the information and the opportunity to prepare.

## **Placebos**

Prescribing placebos is a type of deception that falls into this attempt to please or avoid unpleasantness.<sup>332</sup> Physicians have prescribed placebos for all manner of ailments, both real and imagined. According to Cabot,

“a *placebo* is a ‘bread pill,’ made not of bread but of milk sugar or some other harmless substance. It is given because the doctor thinks the patient will not be contented if we give him nothing even though there is no known medicine that can benefit his troubles.”<sup>333</sup>

Many a physician has diagnosed a child’s illness as a mild viral infection, but has prescribed antibiotics to quiet the demands of an insistent parent. The patient who is overly anxious about a physical discomfort or whose personal upsets or fears become translated into worries about health may gain comfort and a sense of control from a harmless treatment.

In some instances, placebos have achieved the desired result of relieving symptoms as successfully as the best treatments available. As long as the patient is not aware that the treatment is an inert substance or an actual treatment that has no known

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<sup>332</sup> For a general discussion of placebos, see: Kathleen M. Boozang, "The Therapeutic Placebo: The Case for Patient Deception," *Florida Law Review* 54 (September 2002): 687-746.

<sup>333</sup> Cabot, *Honesty*, 148.

benefit for the patient's complaint, he or she may find the encounter with the physician satisfactory and the treatment meaningful. The treatment may achieve benefits beyond the physician's expectations. The placebo effect is a well-documented phenomenon.<sup>334</sup>

### ***Misdirection***

Placebos are not the only tools at the physician's disposal for avoiding unpleasantness and providing reassurance in an encounter with a patient. Surgeons in training have been known to deceive patients into believing that another surgeon is carrying out their procedure. Atul Gawande, author of *Complications*, describes his deception of patients during his residency:

Before each operation, I go over to the preoperative holding area in my scrubs and introduce myself to the patient. I do it the same way every time. "Hello, I'm Dr. Gawande. I'm one of the surgical residents, and I'll be assisting your surgeon." That is pretty much all I say on the subject. . . . Very occasionally, patients are taken aback. "No resident is doing my surgery," they say. I try to reassure. "Not to worry. I just assist," I say. "The attending surgeon is always in charge."

None of this is exactly a lie. The attending *is* in charge, and a resident knows better than to forget that. . . .

Yet to say I just assisted remains a kind of subterfuge. I wasn't merely an extra pair of hands, after all. Otherwise, why did I hold the knife?<sup>335</sup>

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<sup>334</sup> An interesting article that draws on brain imaging research instead of self-reporting shows that the placebo effect is not the result of report bias. See generally Tor D. Wagner, James K. Rilling, Edward E. Smith, Alex Sokolik, Kenneth L. Casey, Richard J. Davidson, Stephen M. Kosslyn, Robert M. Rose and Jonathan D. Cohen, "Placebo-Induced Changes in fMRI in the Anticipation and Experience of Pain," *Science* 303, no. 20 (February 2004): 1662-7.

<sup>335</sup> Gawande, *Complications*, 23.

Gawande's deception is not a small one, nor is it harmless. Although physicians in training must gain experience somehow, the patient did not place his trust in the fledgling physician. He probably chose the best surgeon he could find to carry out the procedure. His trust was based on the knowledge, skills, personal traits, and social status of the chosen surgeon rather than on the powers possessed by a trainee. If the patient in Gawande's story learned of the deception, he would probably feel betrayed twice, once by the attending physician and once by Gawande. The surgeon's responsibility in supervising the resident would offer little comfort in the event of a mishap.

### ***Feigned Certainty***

In the *Silent World of Doctor and Patient*, Jay Katz discusses yet another kind of deception that may apply to uncomfortable situations in a wide range of settings.<sup>336</sup> Katz relates a conversation he had with a surgeon about the appropriate treatment for breast cancer. Katz and the surgeon agreed that there were many uncertainties associated with the various treatments for the disease. Then, when asked to describe how the surgeon discussed treatment of breast cancer with a patient, the surgeon expressed absolute confidence to the patient that radical surgery was the proper choice and urged her to undergo the procedure. When Katz pointed out that they had just agreed that there were uncertainties about the best treatment, the surgeon claimed that his patients "do not have the capacity to understand such complex matters and, moreover, such conversations

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<sup>336</sup> Katz, *The Silent World of Doctor and Patient*.

[about uncertainties and treatment options] would cause them anxiety and intolerable pain.”<sup>337</sup>

My point in including this anecdote is that physicians may show confidence and certainty to patients that are not warranted and may deceive in connection with unfavorable estimations of patients’ abilities to make reasoned decisions. Katz sums up the problems as follows: “the certainty [the surgeon] had expressed about the choice of treatment seemed to be powerfully related not to matters of medical knowledge but to his views about patients and the proper management of the physician-patient relationship.”<sup>338</sup> Implied in this statement and explicit in others Katz makes is that physicians may deceive themselves as much as they deceive their patients in order to maintain the illusion of power and control in the guise of certainty. Their disclosures to the patient include their own biases, self-interests, and fears. Katz identifies this denial of uncertainty as a defense mechanism against the stresses of exposing patients to substantial risks.<sup>339</sup>

## **Disclose and Disclosure**

*Disclosure* is considered the favored alternative to deception. My copy of *Steadman’s Concise Medical Dictionary for the Health Professions* does not include a definition of *disclosure*. This seems an odd omission given the importance of the term in

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<sup>337</sup> Katz, *The Silent World of Doctor and Patient*, 167.

<sup>338</sup> Katz, *The Silent World of Doctor and Patient*, 169.

<sup>339</sup> Katz, *The Silent World of Doctor and Patient*, 170-4.

the medical literature leading up to and since the release of the Institute of Medicine's *To Err is Human*. Disclosure and reporting are central to the concerns discussed in this body of literature. The physician *discloses* potentially unappealing or unpleasant news to the patient or the patient's family members; whereas, sharing the same sort of information with hospital administrators and regulatory bodies is called *reporting*. There is a distinction that is less than clear. Therefore, it seems necessary to explore the meaning of *disclosure*, how it fits with physician behavior, and its role in medicine's culture.

I'll start with dictionary definitions. An ordinary *Webster's New World Dictionary* defines *disclose* as follows: "1. to uncover; bring into the open. 2. to reveal; make known."<sup>340</sup> According to *Black's Law Dictionary*, *disclose* means: "to bring into view by uncovering; to expose; to make known; to lay bare; to reveal to knowledge; to free from secrecy or ignorance, or to make known. *See* Discovery."<sup>341</sup>

Implied in these definitions is that something is hidden and potentially surprising, shocking, or damaging. I chose to include a legal definition for two reasons. The first is that no medical definition of *disclose* was readily available; the second is because of the legal implications for physicians who mislead or fail to make available certain information to patients or their representatives. In addition, the law has played an

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<sup>340</sup> *Webster's New World Dictionary of the American Language*, 417.

<sup>341</sup> *Black's Law Dictionary: Definitions of the Terms and Phrases of American and English Jurisprudence, Ancient and Modern*, 6th ed. (St. Paul, Minn.: West Publishing, 1990).

important role in shaping expectations of and boundaries for interpreting the concept. I will address some of these matters later in this chapter.

As mentioned in the chapter titled “The Culture of Medicine,” healers have closely guarded their specialized knowledge and secrets to protect their special status. Part of that special status has been the bond between the physician and the patient created by the secrets they share. A translation of the Hippocratic Oath reveals the following: “All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal.”<sup>342</sup> This part of the oath is a promise not to *disclose* information. In the context of maintaining confidentiality, the term seems apt. The intimate information about the patient obtained in the process of diagnosing his ailment and providing treatment is secret. The physician is given access to the information with the understanding that he or she is not to share it with anyone who has no right to it. The information may be embarrassing. It may open the patient to criticism or discrimination. It may destroy relationships. It may result in fear, violence, or ostracism. It may create hardships for others by association.

A promise not to disclose information about the patient’s life and health is a promise that encourages the patient to trust in the physician’s wisdom and discretion. It encourages the patient to be open with the physician about matters she would not

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<sup>342</sup> W.H.S. Jones and E.T. Withington, *Hippocrates*, 4 vols. (Loeb Classical Library, 1923-31; reprint, 1957-1959).

otherwise reveal. The information the patient shares may be essential to proper identification of the ailment and its treatment. Inappropriate disclosure can undermine the trust of the physician-patient relationship and the medical profession in general.

Curiously, in medicine as it is currently practiced, the term *disclosure* is frequently used in a different way. It is generally used when referring to a situation in which the physician may want to keep information from the *patient* or others who could have concerns about the physician's professional integrity. Recently, there has been widespread concern about physicians' business interests that may conflict with providing adequate or appropriate care to patients. Physicians have been asked to reveal potential conflicts of interest that may cast the shadow of doubt on their own honesty or objectivity.<sup>343</sup> There is no longer a belief that physicians should be trusted simply because they belong to a particular profession and promise to maintain the patient's confidentiality and privacy.

Although trust has always been an important factor in maintaining the physician-patient relationship, withholding information from the patient, revealing only convenient facts, and otherwise distorting the truth probably date back to the origins of Western

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<sup>343</sup> Physicians who write articles or deliver talks are asked to disclose relationships with commercial entities, usually pharmaceutical companies. The assumption is that the disclosure will do away with any concerns about having a financial benefit from the message delivered. Another instance of required disclosure involves physicians' financial interests in proprietary specialty hospitals. The State of Texas requires physicians who are owners of the hospitals to reveal their ownership to the patient at the time of referral and to indicate that alternative facilities are available. I fill out these documents when I present a continuing medical education class or publish materials for physician readers.

medicine. Early works in the Hippocratic tradition discourage sharing bad news with the patient out of concern that upsetting news will worsen the patient's condition.<sup>344</sup>

Many equate disclosure with truthfulness or honesty. Other terms have been used to describe the approach physicians should use when discussing bad news or other important medical information with the patient. Openness and transparency are among the most popular.

Jennifer Jackson, author of *Truth, Trust, and Medicine*, observes:

Until quite recently, truthfulness has not [been] featured in medical or nursing codes. It does not seem to have been any significant part of the Hippocratic tradition—unlike confidentiality, which has always been seen as a strict duty owed by doctors to their patients. But nowadays it gets explicit attention.<sup>345</sup>

Codes of ethics and principles of professionalism indicate that honesty with patients is of great importance. The American Medical Association (AMA) states in its Principles of Medical Ethics: "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."<sup>346</sup> Furthermore the AMA's Council on Ethical and Judicial Affairs recommends in its CEJA Report 2-A-06: "Withholding medical information from patients without their knowledge

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<sup>344</sup> Stanley J. Reiser, "Words as Scalpels: Transmitting Evidence in the Clinical Dialogue," *Annals of Internal Medicine* 92, no. 6 (Jun 1980): 838.

<sup>345</sup> Jackson, *Truth, Trust, and Medicine*, 4.

<sup>346</sup> Council on Ethical and Judicial Affairs AMA, "Principles of Medical Ethics," <http://www.ama-assn.org/ama/pub/category/2512.html> (accessed January 31, 2007).

or consent is ethically unacceptable.” This recommendation specifically addresses the use of therapeutic privilege.<sup>347</sup> This concept will be explained below.

As Jackson suggests, changes have taken place over time. Nevertheless, many physicians shared the view that patients should not be informed, even as medicine moved toward efficacy and technological sophistication. Reiser writes that Thomas Percival, the famous 19th century physician, claimed that the patient and the patient’s family expected to be shielded from the harm that would result from the truth about the patient’s health.<sup>348</sup> Concurring in this opinion was the famous physician Oliver Wendell Holmes (father of jurist Oliver Wendell Holmes), who Reiser quotes as follows: “Your patient has no more right to all the truth you know than he has to all the medicine in your saddlebags. . . . He should get only as much as is good for him.”<sup>349</sup>

Somewhere along the way, instead of being associated with maintaining the patient’s confidentiality, disclosure came to be associated with revealing information that the patient might want or need to know about his own health and care or health-care provider. The secrets that physicians protected were no longer only secrets about what physicians thought and knew about their patients’ needs, they were secrets about the physicians. It is almost as though physicians included the patients among those who had

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<sup>347</sup> Council on Ethical and Judicial Affairs AMA, "Withholding Information from Patients (Therapeutic Privilege)," [http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja\\_recs\\_2a06.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_recs_2a06.pdf) (accessed January 31, 2007).

<sup>348</sup> Reiser, "Words as Scalpels," 837-8.

<sup>349</sup> Reiser, "Words as Scalpels," 838.

no right to know what the physicians had learned in the course of attending to the patients.

Of course, not all physicians were in favor of withholding or distorting information as a general rule. Often, it was clear that someone had to be told at some point about the patient's needs and what might be expected in the patient's future. The cooperation of family members was necessary, if the physician expected to continue seeing the patient. However, the details of who, when, what, and how someone was told were open to question. Some physicians actually went so far as to advocate for openness and honesty with the patient. They were in the minority.<sup>350</sup> Worthington Hooker was one such physician.<sup>351</sup> He was not entirely against withholding information, but thought it appropriate only if there was no deception involved.<sup>352</sup> Richard C. Cabot devoted an entire book to the topic of being honest but careful with the information one gives to patients. Titled *Honesty*, his book includes the following:

Truthfulness about diagnosis, then, must extend far beyond naming the disease (provisionally or finally). It must include saying nothing that gives a false idea of disease as the physician himself knows it, or of the medicines and surgical operations thus far known. When the physician gives no more drugs to patients than he gives to himself or his own family, and advises no operation that he would

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<sup>350</sup> See, for example, Reiser, "Words as Scalpels."; Krisman-Scott, "Disclosure of Terminal Status."

<sup>351</sup> Jackson, *Truth, Trust, and Medicine*, 18.

<sup>352</sup> Reiser, "Words as Scalpels," 139.

not submit himself, his wife, or his children to, we can believe that he is practicing medicine with few or no deceptions.<sup>353</sup>

One might ask why there might have been any controversy about disclosure before financial issues in medicine became so complicated.<sup>354</sup> After all, for a long time the practice of medicine was not associated with a large income and there was not much to tell patients, or anyone else.<sup>355</sup> As Starr states:

The means of distinguishing different diseases were not yet available; physicians no less than the public were prey to what may seem outlandish theories. The “natural” properties attributed to plants and other objects were often derived from ancient symbolic doctrines that had little to do with their physician properties.<sup>356</sup>

A physician might have recognized the pattern of an illness or the severity of an injury, but have nothing beneficial to offer beyond a few comfort measures and social support. Statistical probabilities of risks and outcomes were not available. Treatments were not scientifically tested and approved as effective. Physicians of the distant past were no more psychic than their current counterparts, as far as we know. Except for long-term relationships with patients, there was little that would give them any way of

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<sup>353</sup> Cabot, *Honesty*, 139.

<sup>354</sup> Managed care created pressures for physicians through capitation arrangements and contractual agreements to withhold information about some treatment options. Physician-researchers often have complicated arrangements with industry related to funding their research. In addition, many physicians provide consulting services of various types with organizations. Of course, physicians also sometimes invest in businesses.

<sup>355</sup> Starr, *Social Transformation*, 6-7, 36.

<sup>356</sup> Starr, *Social Transformation*.

predicting their patients' possible reactions to their professional opinions and administrations.

The answer to the question about the controversy was and is *trust* and *morality*. Many feel betrayed if they discover they have been deceived, even if the goal of the deception is benign. Of course, the deception must be something beyond the social niceties of good manners and civility. When one greets another with, "How are you?" and the reply is "fine," there is usually no attempt to deceive with the reply, even when one is feeling poorly or having a terrible day. The exchange is merely a ritual. However, one who deceives about a matter of some importance may cause more harm than he can imagine.

Lawrence Grouse relates such an experience in his anecdote "The Lie." He writes of an emergency room scene in which he is tensely addressing the medical needs of a young woman who has been kicked in the stomach by her horse. Her internal injuries appear serious; she is in shock and bleeding internally. Despite her frightening condition, she calmly asks if her injuries are serious and if she will live. He tells her that everything will be fine. She presses, asking if he is sure. He lies and says he is sure. After surgery to repair her lacerated liver and to remove a ruptured kidney, several transfusions of blood donated by the physicians and nurses overseeing her care, and two weeks of closely monitored care, Grouse is pleased to find a happy, ambulatory patient. As they have coffee together, Grouse tells the young woman about the emergency room events. He ends his story by telling her about how worried he was that she would not survive: "I

have to admit that I thought you were a goner.”<sup>357</sup> She remembers everything, including his reassuring statement of certainty that all would be well. Much to his surprise, she becomes angry and cries inconsolably about the deception. Despite the fact that his intention was to comfort and reassure, he violated her trust, causing unforeseen sorrow and distress.<sup>358</sup>

Some argue that the patient’s health may have benefited greatly from the deception; one’s psychological state has a strong impact on health. There is a considerable body of research that supports this view. Nevertheless, it may have been possible to provide reassurance and comfort without asking the patient to believe something the physician did not believe was true. The physician could have responded in the following manner: “We will not know the full extent of your injuries until we do surgery. Our surgical team is skilled and dedicated; they will take good care of you. We all are eager to help you back into the saddle.”

Most deception in medicine may simply be wrong, an offense against society. Controlling the flow and nature of information is a source of power, a way of encouraging dependence or of exploiting others for one’s own ends. Although medicine has long been considered a moral endeavor involving self-sacrifice and a desire to help others, protecting the secrets and special knowledge of the profession has always been

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<sup>357</sup> Lawrence D. Grouse, "The Lie," in *A Piece of My Mind: A Collection of Essays from the Journal of the American Medical Association*, ed. Bruce B. Dan and Roxanne K. Young (Los Angeles: Feeling Fine Programs and Alfred A. Knopf, 1988), 25-7.

<sup>358</sup> Grouse, "A Piece of My Mind," 27.

part of the medical tradition.<sup>359</sup> Just what counts as the secrets and special knowledge of the profession and how they are protected can mean the difference between helping and manipulating.

### **Diagnosis, Prognosis, and Disclosure**

It has become necessary for healers to share some of their special information with the uninitiated. However, the sharing has often come at a price. One who gains access can use the knowledge to compete for the same social benefits. Revealing too much to the person in need of healing has at times been thought to undermine the potential benefits of the treatment. Revealing information about the patient to others who have no right to know has long been considered a violation of the special bond between healer and patient.<sup>360</sup> Loss of power and privilege, loss of the mystique, and sometimes loss of livelihood or worse have followed the healer's sharing of specialized, confidential, or unpleasant information.

Apparently, at one time, physicians thought words like cancer and dying were too disturbing and negative for a patient to hear. In "A Historical Analysis of Disclosure of Terminal Status," Mary Ann Krisman-Scott discusses the patterns of disclosure and deception concerning terminal illness over the period from 1930 to 1990.<sup>361</sup> She observes

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<sup>359</sup> Montgomery, *How Doctors Think*, 168.

<sup>360</sup> The Hippocratic Oath includes a promise to maintain confidentiality.

<sup>361</sup> Krisman-Scott, "Disclosure of Terminal Status," 49-51.

that it was normal for a physician not to tell a patient that death was the expected end of his or her illness. The physician's concern was that sharing the knowledge would rob the patient of all hope, making the patient's final days unbearable.<sup>362</sup> Others joined in the deception believing that they were being kind and thoughtful by sparing the patient the truth. Their justification of their conspiracy of silence or denial was that they wanted the patient to have a good death.

Telling a dying patient of her health status was thought to cause far more than distress or depression; it was considered an invitation to rash behavior. If the bad news did not result in greater pain and rapid deterioration, it would embolden the distraught patient to commit suicide.<sup>363</sup> Preserving the patient's hope and avoiding an extreme emotional response were not the only reasons for withholding grim predictions; physicians did not want to be punished for bad news or inaccurate interpretations of the patient's condition.<sup>364</sup>

There was power in controlling information and decision making. The physician could take credit for positive changes, avoid blame for poor outcomes, and maintain credibility and social status by creating differing expectations. Reiser states that medieval physicians were wont to maintain an optimistic façade for the benefit of the seriously ill

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<sup>362</sup> Krisman-Scott, "Disclosure of Terminal Status," 48-50.

<sup>363</sup> Fan and Li, "Truth Telling in Medicine: The Confucian View," 182. "In mainland China it has been observed that some hospitalized patients have either killed or attempted to kill themselves on receiving a diagnosis of cancer." See also, Buckman and Kason, *How to Break Bad News*, 19.

<sup>364</sup> Buckman and Kason, *How to Break Bad News*, 15-32.

patient while painting the patient's future in grim tones for friends and loved ones. He suggests that the reasons for doing so were two-fold. The first was to encourage the patient to improve while allowing the family to make necessary preparations for the patient's impending demise; the second was to preserve the physician's reputation regardless of the outcome.<sup>365</sup>

Although a patient might not be told of his impending demise, it was unlikely that the patient was always, or even usually, unaware of his status.<sup>366</sup> Before the middle of the 19<sup>th</sup> century, dying was not usually concealed behind hospital doors away from ordinary life; it was a family affair that involved the entire household. Many would have known the signs of dying from seeing others go through the process. Others who observed their own decline would have suspected that they were dying without having their suspicions confirmed.

The "Death of Ivan Illych" by Tolstoy, though a work of fiction, illustrates this point.<sup>367</sup> Illych, a low level magistrate dying from an unnamed disease, reveals his frustration in the false cheerfulness exhibited by his physician and members of his family. All except a young man of lower social status brought in to help Illych with his most basic needs refuse to discuss what is happening to Illych.

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<sup>365</sup> Reiser, "Words as Scalpels," 837.

<sup>366</sup> Krisman-Scott, "Disclosure of Terminal Status," 47.

<sup>367</sup> Leo Tolstoy, *The Death of Ivan Illych*.

Those who had participated in misleading a dying patient about his health may have had little reason to believe a physician who supplied them with the same kinds of denials and reassurances.<sup>368</sup> Cabot writes of a an encounter with a young woman who, when asked to keep quiet about the impending death of another, indicated that she had been involved in such deceptions before and would never believe a physician who told her everything would be fine, because she knew that doctors lied all the time. In addition, keeping patients in the dark or providing reassurances that were unfounded may have been harmful. The patient could be deceived into believing that there was no urgency to settle personal matters and assist in planning for surviving family members' future.

Sharing bad news with the patient or the patient's family is often difficult for the physician.<sup>369</sup> Bad news stands for all that physicians try to overcome. Physicians tend to think of being unable to overcome the patient's illness as a failure.<sup>370</sup> They have devoted their lives to trying to ease others' discomfort, not to dispensing it.<sup>371</sup> They often have armored themselves against emotional reactions to suffering and pain to be able to treat patients.<sup>372</sup> Informing the patient or the patient's family of dire news may leave the physician vulnerable to his audience's frightening emotions and those that the physician

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<sup>368</sup> Cabot, *Honesty*, 144.

<sup>369</sup> Buckman and Kason, *How to Break Bad News*, 15-32.

<sup>370</sup> Buckman and Kason, *How to Break Bad News*, 21.

<sup>371</sup> Buckman and Kason, *How to Break Bad News*, 18.

<sup>372</sup> Buckman and Kason, *How to Break Bad News*, 25-8.

may experience in response.<sup>373</sup> Helplessness and lack of control are feelings many physicians want or need to deny.

The controversy over revealing bad news continues to some extent. Although it is rarely recognized as valid, physicians have retained the right to invoke *therapeutic privilege*, a common law exception to the patient's right to informed consent. (There is only one other exception, the emergency exception. It allows the physician to proceed with providing care if the patient is unable to give consent due to incompetence or unconsciousness when there is an imminent threat to life or function and no one is immediately available to serve as the patient's surrogate.) The therapeutic privilege allows the physician to withhold information from the patient the physician believes would be harmful to the patient. Typically, *harmful* in this context means that the patient might commit suicide or might otherwise experience such distress from the information that his judgment would be seriously impaired.

Obviously, this exception directly contradicts the patient's right to make informed decisions about his own health care. It invites abuse from the physician who believes that informed consent is a waste of time and almost any patient is poorly equipped to make sound judgments about medical care. In *Canterbury v. Spence*, a famous lawsuit about

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<sup>373</sup> Buckman and Kason, *How to Break Bad News*, 18, 23.

informed consent, the court expressed concern that the privilege “might devour the disclosure rule.”<sup>374</sup>

The case involved a young man who underwent a surgery on his back to relieve pain. He was not warned that paralysis was a possible risk of the procedure. Due to either the procedure or inadequate post-surgical care, he suffered paralysis. Subsequently, he sued. Dr. Spence, the young man’s physician said that he did not inform patients of such small risks because “[h]e felt that communication of that risk to the patient is not good medical practice because it might deter patients from undergoing needed surgery and might produce adverse psychological reactions which could preclude the success of the operation.”<sup>375</sup>

The court arrived at the conclusion that when a physician invokes the privilege in response to a claim of non-disclosure, the patient should not have to bear the burden of proving the physician wrong in his assessment that the patient was too ill or emotionally fragile to cope with disturbing news or decision making about the course of care that was in his own best interests, especially in light of the fact that the physician is the one who possesses any evidence in the matter.<sup>376</sup> (Dr. Spence’s justification was found an inadequate and inappropriate use of the privilege.) Instead, the physician would have to demonstrate that his use of the so-called privilege was justified based on credible

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<sup>374</sup> *Canterbury v. Spence*, 464 F.2d 772, 789 (1972).

<sup>375</sup> *Canterbury v. Spence*, 778.

<sup>376</sup> *Canterbury v. Spence*, 791.

evidence and careful documentation. Therefore, use of the therapeutic privilege is fraught with peril for the physician and must only be used under rare circumstances. In summary, telling the patient is better than not telling the patient.

Cross-cultural interactions have created uncertainties about who to tell. In some cultures it is considered inappropriate to tell the patient about the seriousness of his health problems. Instead it is up to the family to make decisions about what course the patient's treatment should take. In "Truth-telling in Medicine: the Confucian View," authors Ruiping Fan and Benfu Li discuss a Chinese perspective on disclosure of bad news. They write:

Chinese medical ethics, . . . remains committed to hiding the truth as well as to lying when necessary to achieve the family's view of the best interests of the patient. This ethics requires that, for any serious adverse diagnosis (such as cancer) or fatal prognosis, the physician must first inform a close member of the patient's family. Then it is up to the family to decide whether and how to tell the truth to the patient.<sup>377</sup>

Bad news, especially news about the patient's risk of death is sometimes thought to bring the event to fruition. This self-fulfilling prophesy is associated with spiritual or religious beliefs and the power of words.

Of course, there is a danger in making assumptions about an individual based on her cultural milieu, her physical characteristics, or even her cultural identification. Individuals often deviate in some ways from the group with which they most closely

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<sup>377</sup> Fan and Li, "Truth Telling in Medicine: The Confucian View," 180.

identify. Furthermore, surrounded by other group members, some give in to social pressures. Therefore, it is essential to ask the patient privately, if possible, whether she wants to know, how much she wants to know, and who she wants to make her health-care decisions.<sup>378</sup>

## **Informed Consent**

The legal concept of *informed consent* arose in response to recognition that physicians sometimes abused their patients' trust.<sup>379</sup> They did so by placing their own interests ahead of those of their patients or subjecting patients to risks of harm without warning. The change imposed from outside the profession raised protests about interference with professional discretion and unreasonable demands on physicians.

Prior to the changes mentioned above, the physician held the power to determine just how much information was good for the patient. Until recently, the standard courts used in most states to determine whether the patient received sufficient information about procedures, risks, and alternatives to make informed decisions was the professional standard. In other words, it was members of the medical profession who determine what information the patient needs to know to make an informed decision. The power may no longer have resided with the individual physician, but for the most part, the power

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<sup>378</sup> See, for example, Dominic T. Keating, Kayser Nayeem, J. J. Gilmartin and Shaun T. O'Keeffe, "Advance Directives for Truth Disclosure," *Chest* 128, no. 2 (August 2005): 1038.

<sup>379</sup> The term informed consent was first used in a lawsuit decided in 1957 called *Salgo v. Stanford University*. Consent was used earlier, but informed consent came into being in law with this case. The concept was not new. It dates back to the Nuremberg Code. However, it did not have any legal weight until much later.

continued to belong to those who had been initiated. In other words, the patient was told what a competent, reasonable physician would tell the patient about the risks and alternatives under the circumstances. This is still the case in many states.

It was not until the second half of the twentieth century that the general public began to express its objections to the medical profession's paternalism. Before then, with few exceptions, both physicians and patients simply expected the physician to make decisions about treatments and the patient to go along with whatever the physician decided.<sup>380</sup> It was only when litigation led to the conclusion that patients should be informed of risks, and clear abuses of research subjects came to light under the guise of discrimination against certain vulnerable populations, that the medical profession was forced to change its attitudes about the physician's role in the physician-patient relationship.

The medical profession was not alone in its loss of power to outsiders. The public objections to elitism extended far beyond the medical realm. Americans began to exhibit suspicion toward authority, to make demands for personal rights, and to believe that technological developments should increase their ability to experience greater control over their own lives.<sup>381</sup> What happened to physicians was symptomatic of what happened

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<sup>380</sup> Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making*, 1.

<sup>381</sup> The civil rights movement, the women's movement, legal innovations related to informed consent, revelations about unethical human subjects research, the Watergate scandal, widespread availability of television and telecommunications (including the internet) that allowed rapid exchange of information, beliefs that the most serious diseases in the West had been conquered, distaste for the Vietnam War and the associated propaganda and misinformation, and other events and innovations all worked

during the same time period to many who held power over the lives of others. Many traditional relationships and long-accepted ways of doing things no longer held the same value.

Some physicians do not believe that informed consent is anything more than bureaucratic interference into physicians' business. Their argument is that patients are not equipped to make informed decisions; patients lack medical knowledge and are often unable to cope even with ordinary decision-making due to their health problems and concerns about the future. The concept of informed consent as a process rather than an event has either escaped these physicians' attention or has been ruled out by them as impossible due to time constraints and other necessities of the practice of medicine. Furthermore, some physicians boast that they can convince patients to do almost anything they want patients to do. The point of their boasting is that informed consent is an unrealistic idea.

Although informed consent was imposed by outsiders and is enforced through litigation, it is not universally practiced and continues to meet with skepticism concerning its value and purpose.<sup>382</sup>

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together to change perceptions of authority figures.

<sup>382</sup> Albert R. Jonsen, Mark Siegler and William J. Winslade, *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*, 5th ed. (New York: McGraw Hill, 2002), 54-5.

## OVERVIEW

Physicians hold a great deal of power in the physician-patient relationship. It is power that is often of great benefit to patients, but is sometimes abused. In the exercise of professional discretion and through the uses of their position, it is possible for physicians to manipulate others by manipulating the information they share or choose not to share with others. Physicians have been engaging in this kind of manipulation since antiquity. It is part of the Hippocratic tradition. It has been important to the history and development of the culture of medicine as we know it.

Much of the time, physicians' deceptive actions or omissions are intended to soften harsh news, reassure, protect, or move patients toward health. Occasionally, a wayward physician will circumvent laws, regulations, policies, and other social boundaries for personal enrichment or benefit. Sometimes, it is difficult to know where to draw a line between ethical and unethical behavior due to extraordinary circumstances and the inherent ambiguities of the medical endeavor.

Deception and truth-telling are not simple matters in medicine. A physician has legitimate power that comes from knowledge and experience, personal attributes, and social status. Maintaining power requires restricting information. Providing enough information to satisfy the patient's needs requires exercising discretion about what and how much information can and should be shared. Too little information can lead to suspicion and resentment; too much information can result in unnecessary fears. The way information is presented can inspire trust or destroy it. The truth can be painful; a

discovered deception can be costly emotionally and financially for all involved. Finding the right way to balance the patient's autonomy and the physician's beneficence requires reflection, observation, and skill.

Physicians can easily deceive themselves into believing they are justified in hiding information from patients. They may judge their patients' best interests to fit with serving their own interests. They may underestimate patients' ability to cope to avoid their own discomfort with emotionally-charged situations. Cabot discusses this behavior as follows:

In a good many cases the doctor is not governed by what he believes are the patient's wishes, but lies because he finds lying easier and pleasanter for himself. When sick people have to grieve over hard truth and when it is the doctor who has to bring this truth to them, he is by no means a heroic figure. He feels insignificant because in fact he is so. He has been a great figure, in command of a critical situation. Now he is no longer the powerful and benevolent general but just one more helpless private, looking on like the rest at what he cannot help. No one likes to feel crestfallen or to stand powerless and watch another suffer. They may assess their patients' needs according to their own financial interests.

They may place blame elsewhere to avoid recognizing their own shortcomings and accepting responsibility.<sup>383</sup>

Disclosure is often thought to be the remedy to counteract physicians' power over the patient and control over health-care information. It suffers from definition problems and an unfortunate association with abuses and cover-ups. Its role in medicine has been largely forced on the profession by those who do not share physicians' power; these

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<sup>383</sup> Cabot, *Honesty*, 152-3.

outsiders have diminished physician's power by imposing legal and ethical limits on physicians' behavior.

Through measures such as requiring informed consent, outsiders have brought change to the culture of medicine. That change has been less than uniform across the profession and has been observed sometimes in a superficial manner. Nevertheless, the change is real and shows no signs of reversing.

## Chapter 4: Deception and Medical Error

The previous chapter discussed the power of the physician to manipulate and control through deception and the concept of disclosure, its evolution, and how it has contributed to change in the culture of medicine. This chapter will discuss disclosure and deception as they apply to medical error and some of the psychological and social factors that currently serve as barriers to further culture change in medicine.

### DISCLOSURE AND MEDICAL ERROR

*Disclosure*, as it will be discussed in this chapter, refers to telling the patient or patient's family about a medical mistake that resulted in injury to the patient. One might think of this type of disclosure as an extension of breaking bad news. As mentioned above, *disclosure* does not appear in *Stedman's Concise Medical Dictionary*, a well-known reference for medical terminology.<sup>384</sup> Nevertheless, health-care professionals have made attempts to arrive at a workable definition. Mary Ann Krisman-Scott discusses her investigation into the meaning of *disclosure* as follows:

The review of literature does not offer an explicit definition of disclosure. However, the predominant attributes and dimensions of the concept were identified. A definition synthesized from the readings is: disclosure is the act of telling, making known or public. It contains five dimensions or attributes: who tells, when to tell, whom to tell, how to tell, and how much to tell. Consensus in

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<sup>384</sup> *Stedman's*.

the literature is that the physician is the only individual who has the right and responsibility to tell patients that they are dying.<sup>385</sup>

When the physician informs the hospital's risk management department of an adverse event, it is called not disclosure it is called *reporting*. *Reporting* is typically defined as giving a formal account of or an official presentation of the facts.

*Merriam-Webster's Collegiate Dictionary* offers a number of definitions. However, the definition for the verb appears as follows:

**1 a** : to give an account of ; RELATE **b** : to describe as being in a specified state <~ed him much improved> **2 a** : to serve as carrier of (a message) **b** : to relate the word or sense of (something said) **c** : to make a written record or summary of **d** (1) : to watch for and write about the newsworthy aspects or developments of : COVER (2) : to prepare or present an account of for broadcast **3 a** (1) : to give a formal or official account or statement of <the treasurer ~ed a balance of ten dollars> (2) : to return or present <a matter referred for consideration> with conclusions or recommendations **b** : to announce or relate as the result of investigation <~ed no signs of disease> **c** : to announce the presence, arrival or sighting of **d** : to make known to the proper authorities <~ a fire> **e** : to make a charge of misconduct against ~ *vi* **1 a** : to give an account : TELL **b** : to present oneself **c** : to make, issue, or submit a report **3** : to act in the capacity of a reporter.<sup>386</sup>

*Stedman's* medical dictionary does include *report*. It is "a formal account, oral or written, of conditions, events, or actions."<sup>387</sup>

The two terms appear throughout the medical literature. The context in which each is used seems to matter greatly. The works that focus on the systems approach to patient safety urge reporting. Proponents of patient autonomy urge full disclosure.

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<sup>385</sup> Krisman-Scott, "Disclosure of Terminal Status," 48.

<sup>386</sup> *Merriam-Webster's Collegiate Dictionary*, 993.

<sup>387</sup> *Steadman's*, 850.

However, in the case of medical error, many physicians are reluctant to do either. The patient safety literature indicates that the reason that physicians fail to report is that they fear that the information will be subject to discovery, the legal process by which parties to a dispute gain access to information in the possession of their opponents. Physicians fear discovery because they fear malpractice litigation. Important to this argument is the general perception by members of the medical profession that most medical malpractice lawsuits treat physicians unfairly. The argument made by authors of articles that support the systems approach is that reporting of medical errors must be protected from discovery so that physicians will report. If physicians feel safe enough to report, patient safety can be improved and future errors will be prevented. The argument against full disclosure to the patient or patient's surrogates is similar; fear of malpractice litigation and of the potential consequences of losing leads to a willingness to remain silent or to provide a slanted or misleading view of what happened to the patient.

There is something curious about the language differences. *Black's Law Dictionary's* definition of *report* is as follows: "to give an account of, to relate, to tell, to convey or disseminate information."<sup>388</sup> *Disclose* is more emotionally charged, more value-laden than *report*.<sup>389</sup> To disclose is to give up the power inherent in secreting the knowledge and to face consequences. To report, on the other hand, is a dispassionate and

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<sup>388</sup> *Black's Law Dictionary*, 1300.

<sup>389</sup> There is an alternative meaning for *report* that is relevant to medical errors, yet applies in a different context. To *report* another usually means to make the proper officials aware of some sort of wrong doing or violation of rules. Reporting an errant or impaired colleague is another matter that causes physicians distress.

bureaucratic function that lacks tension or drama. The difference in the language suggests that physicians fear *reporting*, because they fear it will lead to *disclosure*.

## **BARRIERS TO CHANGE**

Physicians' motivations to deceive can be divided into four major categories, economic, cultural, psychological, and political. These categories overlap considerable, but may provide insights into the drivers of behavior.

### **Economic**

The public assumes that physicians have handsome incomes. Many physicians do have above average earnings. Generally speaking, physicians forgo comfortable incomes for several years to be able to obtain the training they need to address their patients' health issues. The typical physician earns a bachelor's degree, attends four years of medical school, and serves a three-year residency, the first year of which the physician-trainee is called an intern. The average debt load of a person who has just completed medical school is \$130,500.<sup>390</sup> If the physician chooses to enter a sub-specialty, he or she may engage in additional years of training through fellowships. Although residents and fellows are paid, the pay is low relative to the number of hours worked, the services provided, and the types of risks they encounter. New residents earn on average \$43,266

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<sup>390</sup> AMA, "Medical Student Section: Medical Student Debt," American Medical Association, <http://www.ama-assn.org/ama/pub/category/5349.html> (accessed February 15, 2007).

per year.<sup>391</sup> It is only after several years of being established as a physician that most achieve the kinds of financial comfort typically associated with being a member of the profession.

Naturally, not all members of the public believe that physicians should earn high incomes. Some are envious of established physicians' incomes and are suspicious of anyone who has achieved a degree of financial success and social status. Others, who see injustice in the way health-care is distributed, feel suspicion toward a group that appears to provide an obstacle to the social change that promises to benefit society as a whole. These and patients who have suffered injury due to medical error and the silent treatment or worse may see physicians' incomes as the heart of the medical deception problem. Their concerns and suspicions are not entirely unfounded.

One of the concerns patients and their families have about injuries resulting from medical error is the question of who will pay for the associated losses and future needs. The patient whose recovery is delayed may need more treatment, may suffer loss of income, and may be unable to meet family obligations. Often physicians and hospitals expect to be paid for the additional care made necessary by the error. Leape and Berwick elaborate:

In health care, perversely, under most forms of payment, health care professionals receive a premium for a defective product; physicians and hospitals can bill for

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<sup>391</sup> Julie Fresne, Matthew Shick and Raj Sabharwal, "Medical Student Education: Cost, Debt, and Resident Stipend Facts," American Association of Medical Colleges, <http://www.aamc.org/students/financing/debthelp/factcard06.pdf> (accessed February 15, 2007).

the additional services that are needed when patients are injured by their mistakes.<sup>392</sup>

The unwillingness to admit errors and to compensate patients unless they take legal action is another indicator that physicians and hospitals expect to be paid for care made necessary by medical errors.

Those whose injuries result in permanent damage may be unable to resume normal activities and may need ongoing health care throughout their lives. When the patient dies due to medical error, the surviving family members may be left without a primary earner, and may be confronted with medical expenses and funeral expenses. Furthermore, they may suffer the loss of the benefits of their relationship with the deceased patient.

Physicians also wonder who will pay. They are uncertain whether medical malpractice insurance will cover the injury. Some worry that if the medical malpractice insurer pays, the future of their career will be threatened. A payout of any amount associated with a written complaint or demand for payment leads to having one's name placed on a national database and sometimes also on a state database.<sup>393</sup> Managed care companies look to those databases for information about whether or not to contract with a

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<sup>392</sup> Leape and Berwick, "Five Years after *to Err Is Human*," 2388.

<sup>393</sup> Under the Health Care Quality Improvement Act of 1986, 42 U.S.C. 11101 et seq., malpractice awards and settlements, disciplinary actions, and other types of performance-related information must be reported to the National Practitioner Data Bank. This information is not available to the general public. It is used for licensing, hospital privileges, insurance plans, and other entities authorized to examine physicians' credentials.

physician. Hospitals search those databases as part of the process to determine whether a physician's hospital privileges should be granted or renewed. The state databases are sometimes available to the public. A patient can gain access to some information about the physician's performance to decide whether to seek the physician's services. A report to one of these databases could be damaging to the physician's reputation. A physician could even have his or her license suspended or revoked. An entire career could be destroyed by compensating a patient or a patient's family for a medical error.

That fear of loss sometimes leads physicians to become angry and bewildered, because the consequences for a mistake seem to them out of proportion to the misdeed. As Hall asserts, concern about being sued goes beyond payouts and winning or losing; "physicians are treated by the litigation process in a way that undermines their sense of being trusted and respected professionals, which threatens their sense of standing in society."<sup>394</sup> Sometimes, they question whether a misdeed occurred at all; much of the time, the standard of care is a matter of opinion.<sup>395</sup> They often see themselves as the victims when patients want, not only payment for losses, but also free health care. Some suggest that physicians' feel this way because they have already paid their dues; paying

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<sup>394</sup> Mark A. Hall, "Can You Trust a Doctor You Can't Sue?," *DePaul Law Review* 54 (Winter 2005): 311.

<sup>395</sup> This is one of the many concerns about medical malpractice litigation. For some matters, the standard of care is clear, or at least it is clear when a physician fails to act in a responsible way toward the patient. However, in many instances, there is no single way to achieve the desired result. It is for this reason that a medical malpractice lawsuit is often referred to as a battle of the expert witnesses. Morreim, *Holding Health Care Accountable*, 5. For a discussion about how physicians misjudge errors, see Marshall B. Kapp, "Medical Error Versus Malpractice," *DePaul Journal of Health Care Law* 1 (1997): 756.

anything beyond the high costs in time, energy, and money expended in attaining credentials seems unfair.

Patients may see the problem differently. They may assume that if the physician had carried out his or her tasks with the appropriate level of care and attention, the outcome would be good.<sup>396</sup> The seemingly miraculous benefits of science have led the public to expect clockwork precision and perfection. Their unrealistic expectations may result in disappointment and anger, but not in compensation. Instead of suffering negative consequences for errors, physicians are rewarded. As long as no attempt is made to prove negligence, physicians are paid for the additional care they provide. There is no incentive for physicians to tell the truth and no reason for them to make special efforts to prevent errors.

Physician-lawyer Bryan Liang offers a somewhat different view that provides an explanation for physicians' lack of willingness to disclose. He asserts that disclosure can have negative consequences for the physician even before litigation is considered. He points to the fact that many malpractice insurers include statements in their contracts called *cooperation clauses* that prohibit admissions of error or culpability.<sup>397</sup> He argues that such disclosures may result in the physician's loss of malpractice coverage. This type

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<sup>396</sup> Buckman and Kason, *How to Break Bad News*, 19-21.

<sup>397</sup> Bryan A. Liang, "The Adverse Event of Unaddressed Medical Error: Identifying and Filling the Holes in the Health-Care and Legal Systems," *Journal of Law, Medicine & Ethics* 29 (Fall/Winter 2001): 353; Bryan A. Liang, "Promoting Patient Safety through Reducing Medical Error: A Paradigm of Cooperation between Patient, Physician, and Attorney," *Southern Illinois University Law Journal* 24 (Spring 2000): 558-60.

of information encourages physicians to remain silent or to distort information in ways that prevent change.

Not everyone agrees with Liang's assertion. John Banja argues that he has been unable to find compelling evidence that malpractice insurers have enforced the clause against a physician who has disclosed error or will enforce the clause in the future.<sup>398</sup> Relying on lawsuits, legislation preventing the use expressions of sympathy or regret as evidence of liability, and his own interpretations of informed consent law and fraud, Banja refutes Liang's alarming message. David Hyman and Charles Silver point out that Liang offers no examples of cases to support his assertions.<sup>399</sup>

In their law review article "The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?," authors Hyman and Silver challenge the arguments associated with failure to disclose and the unfairness and ineffectiveness of medical malpractice litigation as arguments of convenience lacking in empirical support. They claim the arguments are plausible rather than accurate and fit with the self-interests of physicians, but have little to do with actual observed behaviors. Statements to the effect that tort law discourages disclosure and prevents the development of effective safety measures appear throughout the patient safety literature and figure

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<sup>398</sup> John D. Banja, "Does Disclosure of Medical Error Violate the Medical Malpractice Insurance Cooperation Clause?," Agency for Healthcare Research and Quality, <http://www.ahrq.gov/qual/advances/> (accessed August 4, 2006).

<sup>399</sup> David A. Hyman and Charles Silver, "The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?," *Cornell Law Review* 90 (May 2005): 946.

prominently in the IOM report's justifications for its recommendations. Hyman and Silver point out that there are no scientific studies that show the relationship between the possible threat of litigation and the willingness or lack thereof to disclose or report medical errors, and suggest comparing US data on error disclosure with data from countries with lower malpractice insurance rates and less malpractice litigation. They take the step of comparing available information from the U.S. and the United Kingdom where insurance rates are substantially lower and instances of litigation are fewer to find that "physicians in the United Kingdom are also reluctant to disclose medical errors to patients."<sup>400</sup>

Thomas Gallagher and colleagues have also called into question the validity of assertions about the role of malpractice litigation in chilling disclosure. Between July 2003 and March 2004, they collected information about what physicians believed "should not be disclosed, barriers to disclosure, and respondents' experience with disclosure,"<sup>401</sup> and about attitudes and expectations concerning malpractice litigation and its relationship to disclosure. They compared survey results from two states considered to be suffering from malpractice crises (Washington and Missouri) with those from Canada.

The results of their study indicate that U.S. and Canadian physicians share similar attitudes, beliefs, and experiences concerning disclosure of errors despite substantial

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<sup>400</sup> Hyman and Silver, "The Poor State of Health Care Quality," 928-30.

<sup>401</sup> Gallagher, Garbutt, Waterman, Flum, Larson, Waterman, Dunagan, Fraser and Levinson, "Choosing Your Words Carefully," 1585-91; Gallagher, Waterman, Garbutt, Kapp, Chan, Dunagan, Fraser and Levinson, "U.S. and Canadian Physicians' Attitudes," 1607-9.

differences in malpractice climates. “Canadian physicians practice in a much less litigious environment.”<sup>402</sup> They are “sued approximately one quarter as frequently as their U.S. counterparts,” pay malpractice premiums that are far lower than the U.S. physicians surveyed, and benefit from tort reforms and a legal environment less conducive to malpractice litigation.<sup>403</sup> In other words, when comparing U.S. physicians with physicians who already enjoy the advantages U.S. physicians seek as encouragement for openness and honesty in disclosing and reporting medical errors, these researchers find there are no meaningful differences in attitudes and beliefs. This suggests that the measures U.S. physicians seek will not produce the promised revelations and improvements in patient safety.

Gallagher and team conclude: “[T]he medical profession should consider whether the culture of medicine itself represents a more important barrier than the malpractice environment to the disclosure of harmful medical errors to patients.”<sup>404</sup>

This sentiment is echoed in Leape and Berwick’s work:

Complexity, professional fragmentation, and a tradition of individualism, enhanced by a well-entrenched hierarchical authority structure and diffuse accountability, forms a daunting barrier to creating habits and belief of common

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<sup>402</sup> Gallagher, Waterman, Garbutt, Kapp, Chan, Dunagan, Fraser and Levinson, "U.S. and Canadian Physicians' Attitudes," 1606.

<sup>403</sup> Gallagher, Waterman, Garbutt, Kapp, Chan, Dunagan, Fraser and Levinson, "U.S. and Canadian Physicians' Attitudes," 1606.

<sup>404</sup> Gallagher, Waterman, Garbutt, Kapp, Chan, Dunagan, Fraser and Levinson, "U.S. and Canadian Physicians' Attitudes," 1610.

purpose, teamwork, and individual accountability for successful interdependence that a safe culture requires.<sup>405</sup>

Furthermore, these authors conclude that “the primary obstacles to achieving . . . [patient safety goals] for the patients who depend on physicians and health care organizations are no longer technical; the obstacles lie in beliefs, intentions, cultures, and choices.”<sup>406</sup> Although Leape and Berwick specifically refer to efforts toward patient safety through error reporting, the reasons for failing to report errors are closely related to the reasons for failing to disclose errors to patients or their families.

Hyman and Silver state that the reason for physicians’ unwillingness to admit their mistakes also has little to do with received wisdom about shame and blame. The authors claim that the real reason for hiding errors is that there are insufficient economic incentives for health-care providers to change their culture and processes to prevent errors; malpractice litigation is and can be a deterrent to poor practices.<sup>407</sup> They suggest that, instead of too much malpractice litigation, there is too little.

As mentioned above, Sage appears to agree with in part: “Underclaiming is a more worrisome manifestation of the malpractice system’s failure than the “frivolous” suits that are tort reformers’ *bête noire*.”<sup>408</sup>

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<sup>405</sup> Leape and Berwick, "Five Years after *to Err Is Human*," 2387.

<sup>406</sup> Leape and Berwick, "Five Years after *to Err Is Human*," 2390.

<sup>407</sup> Hyman and Silver, "The Poor State of Health Care Quality," 991-3.

<sup>408</sup> Sage, "Malpractice Liability."

Hyman and Silver support their views with evidence from patient safety efforts made by anesthesiologists. Bad press, malpractice litigation, and rapidly rising medical malpractice insurance rates prompted the American Society of Anesthesiologists to set mandatory standards.<sup>409</sup> They developed patient safety measures to reduce errors and, ultimately, associated costs.<sup>410</sup> Substantial pressure from outside the profession was necessary to overcome tradition. In other words, medical malpractice litigation served as a deterrent to medical negligence and led to patient safety measures. Furthermore, the patient safety measures grew out of attention to and reporting of the mistakes that led to patient injuries and deaths. The reduction in errors resulted in a great reduction in the number of lawsuits filed against anesthesiologists and, in turn, reductions in medical malpractice insurance premiums for the practitioners of the specialty.

Although movement toward change in the field of anesthesiology came from within, the financial pressures created by medical malpractice claims and high malpractice insurance rates, and the negative reputation anesthesiologists obtained due to their numbers of errors provided necessary incentives.

The great success story to which advocates of the systems approach point, the Veterans' Health Administration, had a relatively poor safety record and under-reporting and disclosure of errors before external interventions, even though the health-care

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<sup>409</sup> See, for example., Joint Commission on Accreditation of Healthcare Organizations, "Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury," Joint Commission on Accreditation of Healthcare Organizations, [http://www.jointcommission.org/NR/rdonlyres/167DD821-A395-48FD-87F9-6AB12BCACB0F/0/Medical\\_Liability.pdf](http://www.jointcommission.org/NR/rdonlyres/167DD821-A395-48FD-87F9-6AB12BCACB0F/0/Medical_Liability.pdf) (accessed February 14, 2007).

<sup>410</sup> Hyman and Silver, "The Poor State of Health Care Quality," 917-23.

professionals in that system cannot be sued individually for malpractice. According to Hyman and Silver, the improvements resulted from greater scrutiny by external agencies and risk management, along with clear expectations and benchmarks for evaluating the quality of care.<sup>411</sup> They state: “The fact that these problems were addressed in response to external oversight makes clear that external monitoring and feedback are important and necessary tools for improving quality.”<sup>412</sup>

If Hyman and Silver are correct, physicians must examine (or be forced to examine) their traditional way of thinking to see how they create the problems they want to avoid. Furthermore, something other than the threat of malpractice litigation may be operating to perpetuate non-disclosure and deception.

New wrinkles on the economic front are contributing to physicians’ concerns. Some third-party payors are refusing to pay for services if they believe the patient has been the victim of an error.<sup>413</sup> This appears to be a movement in the direction proposed by Hyman and Silver. However, it is not clear how physicians will interpret the change. Instead of making cover-ups less appealing; it may make them more so. If physicians are inclined toward silence or distortion, they may need to think twice about the implications of their actions.

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<sup>411</sup> Hyman and Silver, "The Poor State of Health Care Quality," 933-5.

<sup>412</sup> Hyman and Silver, "The Poor State of Health Care Quality," 936.

<sup>413</sup> See, for example Robert Kazel, "Minnesota Insurer Won't Pay Hospital For "Never Events"," *American Medical News*, November 8 2004; Leape and Berwick, "Five Years after *to Err Is Human*," 2389.

Government programs that serve as third-party payors, such as Medicare and Medicaid, may at some point decide to interpret claims for reimbursements related to errors as false claims.<sup>414</sup> False claims violate federal law and leave the physician and the institution where the patient received treatment vulnerable to heavy fines, other penalties, and potential loss of federal funding.<sup>415</sup> Without federal funding most hospitals would not be able to stay in business. Law professor Joan Krause's law review article on the topic, "Medical Error as False Claim" suggests the possibility that false claims litigation may become more important as hospitals and other health-care organizations as standards for patient safety begin to take shape.<sup>416</sup>

Other third-party payors may also take legal action against physicians who submit claims for reimbursement for the patient who is injured by a medical error. They could build a case for fraud against the physician.<sup>417</sup>

## **Cultural**

Hyman and Silver note that outside pressure was necessary to move physicians out of another pattern of deceptive behavior. That outside pressure also came in the form of medical malpractice litigation and negative publicity. For centuries physicians did not

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<sup>414</sup> See generally Joan H. Krause, "Medical Error as False Claim," *American Journal of Law & Medicine* 27, no. 2-3 (2001): 181-201.

<sup>415</sup> False Claims Act, 31 U.S.C. § 3729.

<sup>416</sup> Krause, "Medical Error as False Claim," 200-1.

<sup>417</sup> Banja, "Does Disclosure of Medical Error Violate the Medical Malpractice Insurance Cooperation Clause?."

inform patients about treatment risks and alternative treatment options. It was considered unethical for the physician to share information with patients about their care. Jackson provides support by quoting a statement attributed to Hippocrates concerning the traditional approach to keeping the patient in the dark. She writes:

Doctors are advised to be secretive – towards their patients, not just on their behalf (keeping their confidences): “concealing most things from the patient, while you are attending to him . . . turning his attention away from what is being done to him; . . . revealing nothing of the patient’s future or present condition”. (Hippocrates, *Decorum XVI*: 296-7, 298-9).<sup>418</sup>

Economic issues no doubt have some influence over physicians’ reluctance to fully disclose errors. The culture of medicine may play a substantial role. Chapters 2 and 3 address some aspects of the cultural motivations for physicians to deceive. Nevertheless, the cultural reasons for deceiving patients and others about medical errors warrant a closer look.

Sometimes the physicians who withhold information or mislead the patient or the patient’s surrogate about adverse events and the circumstances surrounding their development explain away their behavior as beneficence. They claim to deceive for the purpose of reducing suffering. This approach dates back to at least the 18<sup>th</sup> Century. Jackson writes about John Gregory and his work as follows:

Frank admission of having made a mistake to one’s patients is not advised: ‘A prudential regard indeed for the patient’ safety may make it necessary to conceal

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<sup>418</sup> Jackson, *Truth, Trust, and Medicine*, 11.

any embarrassment or mistakes from him, lest it alarm him and lose his confidence . . . ' (McCullough 1998: 106, cf. 75).<sup>419</sup>

Thus, physicians' deception of patients with regard to medical errors is often an extension of their use of deception about bad news in general. It grows out of the same kinds of traditions, perceptions, and beliefs that have driven other disclosure choices for centuries. The reasoning is shown below along with some of the aspects of the culture of medicine they reflect.

1. The patient and his or her family will be better off not knowing, because the injury cannot be undone, and they will lose faith in the medical profession if they know. As long as the error is not obvious or severe, they may never know.
  - a. The physician must maintain authority.
  - b. The physician must protect the medical profession.
  - c. The physician must do whatever he or she believes is in the best interests of the patient.
2. The patient and his or her family will experience unnecessary anger and grief, if they are told. They would not be able to cope or to make good decisions about the patient's future care, if their judgment is clouded by emotions.
  - a. Patients and their families are child-like and cannot understand medical matters.

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<sup>419</sup> Jackson, *Truth, Trust, and Medicine*, 13. Quoting from *John Gregory's Writings in Medical Ethics and Philosophy of Medicine*, ed. L. B. McCullough (Dordrecht: Kluwer Academic, 1998).

- b. Patients and their families should be protected from emotions; they cannot cope with bad news.
  - c. The patient and his or her family will not understand; they are incapable of understanding that medicine is fraught with uncertainties and things can easily go wrong. Explaining to them would be fruitless and would take time and attention away from other patients.
- 3. Physicians do not have time to talk to patients and their families.
- 4. Patients and families have unrealistic expectations.
- 5. Physicians must appear competent and must not show weakness.
- 6. No one will benefit by knowing; only harm will result.
- 7. Physicians are smarter and less emotional than others; therefore, they are better judges of what should be done.
- 8. Physicians are not supposed inflict harm.
- 9. Therefore, it is in the best interests of the patient and his or her family to be deceived about the circumstances and causes of the injuries.
- 10. Physicians are selfless and act for the benefit of others.
- 11. Patients and their families do not want or need to know everything about the patient's care.
- 12. Accidents happen. In addition, there are so many ambiguities in medicine that one cannot be certain that an error caused the injury.

There is also reasoning that reflects the physician's concerns about maintaining a place in the culture of medicine. It goes something like this:

1. Making it officially known that I have committed an error will lead colleagues to be critical, questioning my character and my competence as a physician. I may have to face humiliation in a Mortality and Morbidity Conference. If I bend the truth or remain silent, my colleagues may be unwilling to jump to the conclusion that an error occurred; complications happen frequently. Furthermore, they are reluctant to point fingers, knowing that they could be next. Everybody makes mistakes.
  - a. Physicians must be perfect, infallible. Errors are a sign of bad character.
  - b. Physicians must not show weakness and must always appear competent.
  - c. Physicians will maintain the code of silence, if given the opportunity.
  - d. Physicians must keep secrets; it is part of being a physician.
2. My reputation will be damaged beyond repair. I will lose referrals. If I am sued and lose, my income will suffer, and I may lose hospital privileges and insurance contracts. My malpractice insurance rates will increase. My name will be placed in databases that henceforth will have an impact on my career.
  - a. Being a physician is an identity, not an occupation.
  - b. Physicians should have superior incomes because of their extensive training and important role in society.
  - c. Physicians are authority figures.

- d. Medical malpractice lawsuits are unfair to physicians.
- 3. I will lose confidence and begin to think of patients as adversaries.
  - a. Physicians should show confidence and maintain a professional demeanor.
  - b. Physicians should exhibit compassionate detachment toward patients.
- 4. Therefore, it is best to remain silent or to mislead the patient, the patient's family, colleagues, and administrators.
  - a. Physician autonomy is central to the profession.
  - b. Avoiding litigation and criticism is necessary to maintain autonomy.

Neil Calman describes his experience of learning the seductive tradition of deceptive silence about medical error in his essay "No One Needs to Know."<sup>420</sup> As a medical student, Calman became friends with patient who underwent open-heart surgery. After the patient developed an infection that led to additional surgery, the patient died. The infection was probably caused by a contaminated catheter and the patient's death resulted from inadequate post-surgical care. The surgeon in charge took Calman aside and told him that nothing good could come out of letting the family know about the error. With mixed feelings, he joined what he calls the "underworld of medical secrecy."<sup>421</sup> He explains the physician's reasoning behind lack of openness about medical errors:

What keeps any doctor I have ever known from discussion of medical mistakes with patients is a set of redoubtable barriers. First, there is tacit agreement among

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<sup>420</sup> Calman, "No One Needs to Know," 243-9.

<sup>421</sup> Calman, "No One Needs to Know," 246.

physicians that mistakes are an inevitable part of practicing medicine. . . . We physicians are afraid to turn up the heat on others, lest we fry in our own fire.

Then, we have the specter of medical liability lawsuits. Who would reveal errors to a patient and initiate the years-long process of defending a medical liability lawsuit? The financial burden of such an action and the public humiliation involved are insurmountable for most physicians and deter a more honest reckoning of medical errors among physicians and between physicians and patients.

Finally, like most doctors, I went into medicine to be a helper and healer. Scrutiny by colleagues and the process of discussing my mistakes openly with others compel me to relive, over and over, the pain of having played a role in injuring someone who entrusted me with his or her life. A prolonged probing of my errors would force a level of self-doubt that would affect future decisions and could prove immobilizing.<sup>422</sup>

In his book *Healing Words*, Michael W. Woods discusses seven sets of beliefs and behaviors that the medical profession encourages through its training processes, despite their negative effects on physician-patient relationships. They involve superiority, inflexibility, and control and beliefs and behaviors associated with maintaining and enforcing their status. Each of the seven contributes in its own way to physicians' reluctance to be honest with themselves, their colleagues, and their patients or patients' families about unfavorable outcomes and errors.

The first belief-behavior set that Woods discusses is competition.<sup>423</sup> The training process encourages the belief that would-be physicians that they are engaged in a zero-sum-game, and winning is essential to success. To some extent, the people who enter

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<sup>422</sup> Calman, "No One Needs to Know," 248.

<sup>423</sup> Woods and Brucker, *Healing Words*, 12.

medicine self-select by having already adopted this view. They compete to achieve individual goals, rarely showing a desire to assist the weaker, more vulnerable of their fellow students to achieve the same degree of success as themselves. Success means being set apart from others, rather than being one of a group that cooperates to meet a common goal. Being in charge, having power, acting as an authority figure, and possessing mastery that others lack are parts of the physician's professional identity. The belief is made manifest by assigning tasks to others rather than asking for their assistance, keeping their own counsel, denying weakness or lack of knowledge or ability, and maintaining a self-image as a winner, while seeing others as inferior. By seeing others as less capable, physicians tend to resent challenges to their knowledge or opinions.

Woods's second belief-behavior set is related to competition and the sense of superiority.<sup>424</sup> It concerns the hierarchical nature of medicine. Woods describes the relationships of the various ranks in medicine, noting that those of lower ranks can expect "that they'll be shown little respect from anyone who's attaining a higher rank."<sup>425</sup> He provides a glimpse of this lack of respect for lower ranks in the medical hierarchy in the following statement: "medical students are often belittled and sometimes even abused by interns, residents and attending physicians."<sup>426</sup> Unfortunately, this pattern of behavior invites physicians to treat others with lesser knowledge and experience, including patients

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<sup>424</sup> Woods and Brucker, *Healing Words*, 12.

<sup>425</sup> Woods and Brucker, *Healing Words*, 12.

<sup>426</sup> Woods and Brucker, *Healing Words*, 12.

and other health-care professionals, as inadequate, deserving of disdain, and in need of guidance.

The third set Woods discusses is mistaking control over others as having leadership qualities.<sup>427</sup> Because physicians hold a particular position in the health-care hierarchy (authority over nurses, allied health workers, medical trainees, and patients) they expect agreement, cooperation, and compliance. However, medical training does not foster team-building and consensus-building. The emphasis on position and authority in the medical profession can lead to stunted growth in the area of persuasion. Building these kinds of relationships is time-consuming. It requires showing respect for others and giving up some control. Because physicians are not encouraged to develop in these areas, they may resort to manipulation and deception to achieve their desired ends when others are unlikely to agree.

The fourth belief-behavior set addresses physicians' a lack of flexibility in the medical hierarchy.<sup>428</sup> Physicians are taught to be decisive and scientific authority figures who frown on the *subjective* and the *softer sciences*.<sup>429</sup> Their concentration on finding the *right* answer to the problem as they see it can preclude taking other circumstances and perceptions into account. Once again, they may find deceiving the patient to obtain cooperation easier than changing their own views or taking the time to persuade.

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<sup>427</sup> Woods and Brucker, *Healing Words*, 13.

<sup>428</sup> Woods and Brucker, *Healing Words*, 13.

<sup>429</sup> Woods and Brucker, *Healing Words*, 13.

Woods's fifth set ties together the competitive nature of the training and the "command and control" view of the world.<sup>430</sup> Woods states that this emphasis on winning, control, and being right "can also lead doctors to challenge anyone who disagrees with them, creating an atmosphere of distrust."<sup>431</sup>

The sixth of the seven sets deals with the nature of feedback physicians-in-training receive.<sup>432</sup> The belittling and abuse considered a normal part of the process can lead to defensiveness; any criticism may be understood as an attack rather than an opportunity to learn or improve.<sup>433</sup> Maintaining a sense of power, control, self-worth, and superiority may lead to using deception as a defense mechanism.

Finally, the seventh set of beliefs-behaviors involves physicians' trained-in narrowness of focus.<sup>434</sup> The technical aspects of the work and the social and psychological dampening associated with the medical culture work to create barriers between physicians and others.<sup>435</sup> Social discomfort that occurs due to inadequate social strategies can result in the use of deception as a balm. The physician may assert that the deception is for others' benefit, when it is actually for the purpose of avoiding others'

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<sup>430</sup> Woods and Brucker, *Healing Words*, 13.

<sup>431</sup> Woods and Brucker, *Healing Words*, 13.

<sup>432</sup> Woods and Brucker, *Healing Words*, 14.

<sup>433</sup> Woods and Brucker, *Healing Words*, 14.

<sup>434</sup> Woods and Brucker, *Healing Words*, 14.

<sup>435</sup> Woods and Brucker, *Healing Words*, 14.

emotions or the physician's own emotions, avoiding unpleasant communication, or avoiding consequences that the physician perceives as punitive or shame-inducing.

## **Psychological**

The life of a physician is stressful. Medical training, through its demands for dedication, delayed gratification, long hours, emotional stamina, and ability to cope with uncertainty, sets physicians up to hide their feelings, deny their fallibility, and identify strongly with their profession. In "The Painful Truth: Physicians Are Not Invincible," Mary N. Miller and K. Ramsey McGowen explore the stressors that can lead physicians to engage in self-destructive behavior.<sup>436</sup> They contend that the culture of medicine encourages and reinforces psychological development in unhealthy directions. They claim: "The culture of medicine is one in which perfectionism and "workaholic standards" rule the day. . . . The process of medical education may enhance development of defense mechanisms that make it difficult to ask for help."<sup>437</sup> They go on to say that "[a] macho mentality pervades medicine," and

[t]his macho mentality may . . . play a role in the increased rates of psychosocial distress within medicine's ranks. Doctors are commonly expected to be strong and support others, but many doctors believe that it is not acceptable to reveal their own weaknesses and vulnerabilities to others.<sup>438</sup>

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<sup>436</sup> Merry N. Miller and K. Ramsey McGowen, "The Painful Truth: Physicians Are Not Invincible," *Southern Medical Journal* 3, no. 10 (October 2000): 966-73.

<sup>437</sup> Miller and McGowen, "The Painful Truth," 970.

<sup>438</sup> Miller and McGowen, "The Painful Truth," 970.

In support, the authors make reference to a statement by Abraham Verghese about this mentality: “He describes this attitude within medicine as ‘a silent but terrible collusion to cover up pain, to cover up depression; there is a fear of blushing, a machismo that destroys.’”<sup>439</sup> The authors believe this machismo may be related to “difficulty with trust” and “difficulty with setting appropriate limits” on work demands.<sup>440</sup>

Miller and McGowen find a number of other psychological traits and behaviors connected to being a physician. Among others, they include the following: identifying work with gratification and self-esteem, guilt about perceived personal shortcomings, perfectionism, emotional distancing from others, denial of personal needs, denial of vulnerability or failure, and the need to be critical of others who do not live up to the unrealistic expectations physicians associate with being a dedicated and competent physician.<sup>441</sup>

Miller and McGowen do not mention deception in their article. Nevertheless, the mental processes of physicians that they have described suggest physicians’ reasons for wanting to conceal painful thoughts and experiences from others. Physicians’ sense of self-esteem seems to depend heavily on their perceptions of success in their work.

In *Lies, Lies, Lies*, Charles Ford discusses the regulation of self-esteem. He writes:

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<sup>439</sup> Miller and McGowen, "The Painful Truth," 970.

<sup>440</sup> Miller and McGowen, "The Painful Truth," 970.

<sup>441</sup> Miller and McGowen, "The Painful Truth," 971-2.

[A] sense of self develops from the ability to exchange (and at times manipulate) ideas and feelings of others. One learns to manage the impressions one makes on others and to dissemble emotional responses in order to protect others or oneself from unnecessary pain or embarrassment. The persona that develops shapes how one is viewed by the external world and by oneself. Through selective memories, self-deception, and duplicitous contacts (impression management) with the external world, a person forms a personal myth that enables coping and shields against potential harm.

The regulation of self-esteem is closely related to issues of deception. External events that reflect poorly on a person are altered for the internal world through self-deception, excuses, rationalizations, and even total denial.<sup>442</sup>

Here, Ford is discussing child-development. A certain amount of deception and self-deception is normal and necessary. Many of the same types of processes occur in the development of a professional identity.

It follows that when a physician is confronted with evidence or an accusation that he has somehow failed in living up to the persona, he may attempt to maintain the persona by discounting the evidence, vilifying the accuser, or reshaping interpretations. These attempts to achieve emotional and psychological equilibrium may involve both self-deception and deception of others.

Ford indicates that “truth and deception are not in and of themselves moral or immoral; they are merely forms of communication. It is how they are applied in one’s relationships with others that determines their moral value (Scheibe 1980).”<sup>443</sup> Where

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<sup>442</sup> Ford, *Lies!, Lies!, Lies!*, 275.

<sup>443</sup> Ford, *Lies!, Lies!, Lies!*, 276.

trust is the issue, as in the physician-patient relationship, the physician's attempt to maintain that equilibrium may create serious moral problems. Ford asserts that

trust is not necessarily the belief that one will always be told the truth . . . [it is more] the belief that the trusted person (or organization) will try to avoid inflicting harm. . . . Trust is not destroyed by deceit but rather by loss of confidence that the offending party does not have our interests at heart.<sup>444</sup>

Because medicine is usually considered a moral endeavor in which the physician places the patient's interests ahead of his or her own, any indication that the physician is protecting his or her own interests at the expense of the patient is likely to be interpreted as morally suspect.

Reluctance to admit to a mistake and accept potentially unpleasant consequences is easy to understand. It is normal. Moral development and strength of character are necessary to overcome the desire to think of others' needs and correct wrongs by humbling oneself.

Sometimes one's personal development and natural tendencies are somewhat skewed in the direction of perfectionism and rigidity, styles that make admitting shortcomings especially difficult. These ways of thinking and behaving fit with the ways physicians, as a group, have been described. Ford describes the obsessive-compulsive personality in a way that parallels the characteristics attributed to physicians:

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<sup>444</sup> Ford, *Lies!, Lies!, Lies!*, 282.

Persons with obsessive-compulsive personality features tend toward perfectionism and rigid behavior. They are often preoccupied with money, time, cleanliness, and issues of right and wrong. Because of their preoccupation with small details, they are often unable to grasp the larger context of the situation (the big picture). Their rigidity is also shown by their emotional responses which are constricted and lack warmth or tenderness.<sup>445</sup>

He goes on to say, “Both secrecy and lying to protect secrets have been recognized as part of the obsessive-compulsive psychopathology” and the behavior associated with the obsessive-compulsive personality typically develops in response to rigid, controlling parenting.<sup>446</sup> If Woods is correct, the medical training process instills these very characteristics through rigid, controlling mentoring.<sup>447</sup>

Ford discusses other personality types and the role of deception in maintaining self-esteem, manipulating others, and avoiding unpleasant consequences. However, the obsessive-compulsive personality profile seems to most closely fit with the professional identity of the physician as described by Woods and Miller and McGowen.<sup>448</sup>

John Banja wrote a book that in many respects echoes these authors’ works. He uses different terminology. Nevertheless, his assessment potentially provides insight into what motivates physicians to avoid communicating about difficult subjects. He theorizes that physicians who deceive about medical errors are narcissistic. Banja is not suggesting

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<sup>445</sup> Ford, *Lies!, Lies!, Lies!*, 128.

<sup>446</sup> Ford, *Lies!, Lies!, Lies!*, 128.

<sup>447</sup> Woods and Brucker, *Healing Words*, 12-4.

<sup>448</sup> Ford, *Lies!, Lies!, Lies!*, 103-46.

that the narcissism he claims characterizes physicians is evidence of serious pathology. Instead, he asserts that most physicians are “healthy narcissists.”<sup>449</sup> He says they exhibit “a kind of muted or closeted narcissism whose associated behaviors serve as a form of self-protection when their feelings of adequacy, control or competency are threatened.”<sup>450</sup> He asserts that this healthy version of narcissism is associated with “healthy self-esteem and reasonably good psychological adjustment and can . . . score high on what would otherwise seem prototypical narcissistic traits such as feelings of superiority, authority, perfection, self-absorptions, self-admiration, and even arrogance.”<sup>451</sup> He goes on to state that “these very characteristics can also correlate with the decidedly pathological narcissist whose self-formation admits very poor judgment, emotional exploitation, excessive hostility and envy of others, excessive demand for admiration, and deficient empathy.”<sup>452</sup>

Banja claims narcissism exists on a continuum and that the difference between healthy and unhealthy forms of narcissism is a matter of self-esteem. He bases this assertion on the work of Paul Watson and his colleagues at the University of Tennessee. Watson and colleagues conducted research on college students concerning how they

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<sup>449</sup> Banja, *Medical Errors and Medical Narcissism*, 49.

<sup>450</sup> Banja, *Medical Errors and Medical Narcissism*, 48.

<sup>451</sup> Banja, *Medical Errors and Medical Narcissism*, 49.

<sup>452</sup> Banja, *Medical Errors and Medical Narcissism*, 49, 82.

responded to recognition and rewards, disagreement with others, pride in accomplishments, failure, close relationships, and painful feelings.<sup>453</sup>

Banja does not claim that all physicians exhibit the more unhealthy tendencies. However, he does claim that people with narcissistic tendencies are often attracted to medicine as a career choice and may exhibit unhealthy behaviors when they feel vulnerable. He distinguishes ordinary versions of narcissism from medical narcissism as follows:

While grandiosity, poor self-esteem, excessive demand for admiration, and emotional exploitativeness might be the hallmarks of the classic pathological narcissist, emotional guardedness, lack of empathy, and controlling behaviors are the classic interpersonal characteristics of the medical narcissist.<sup>454</sup>

His view is “whereas the pathological narcissist sees the world as an extension of himself, the medical narcissist understands medicine as a primary conveyance for affirming his worth in the world.”<sup>455</sup>

Like Woods, Banja indicates that medical training encourages behavior that is counterproductive to developing and maintaining trusting relationships. He agrees that

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<sup>453</sup> Banja, *Medical Errors and Medical Narcissism*, 49-50. Banja cites the following: Paul J. Watson, Sherri P. Varnell and Ronald J. Morris, "Self-Reported Narcissism and Perfectionism: An Ego-Psychological Perspective and the Continuum Hypothesis," *Imagination, Cognition and Personality* 19, no. 1 (2000); Paul J. Watson, Ronald J. Morris and Liv Miller, "Narcissism and the Self as Continuum: Correlations with Assertiveness and Hypercompetitiveness," *Imagination, Cognition and Personality* 17, no. 3 (1997-98); Paul J. Watson, Susan E. Hickman and Ronald J. Morris, "Self-Reported Narcissism and Shame: Testing the Defensive Self-Esteem and Continuum Hypotheses," *Personality and Individual Differences* 21, no. 2 (1996).

<sup>454</sup> Banja, *Medical Errors and Medical Narcissism*, 57.

<sup>455</sup> Banja, *Medical Errors and Medical Narcissism*, 57.

the training encourages compulsiveness and perfectionism.<sup>456</sup> The enormous pressures of being forced to endure long hours and to assume “responsibilities whose scope and magnitude far exceed their ability” encourages the physician to have fantasies of omnipotence and the belief that “he or she can handle any situation—indeed that he or she is indestructible.”<sup>457</sup>

In Banja’s view, medical narcissism involves three key personality characteristics, lack of empathy, ideological rigidity, and compulsiveness.<sup>458</sup> These characteristics translate into poor communication skills, emotional detachment, unwillingness to admit weakness or mistakes, inability to identify with anyone who is unlike himself, a self-image strongly associated with work, and a need to be the hero of every story.<sup>459</sup>

Given these characteristics, one can understand that a medical error is likely to be viewed by the unhealthy medical narcissist as evidence of bad character and other inadequacies for which the offending party should and will be shamed and punished, instead of an unfortunate incident that requires problem-solving skills to remedy.

These psychological elements of the physician’s development and personality can motivate physicians to deceive patients and others about medical errors. Addressing the issues surrounding disclosure, reparations, and changes in the ways organizations deal

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<sup>456</sup> Banja, *Medical Errors and Medical Narcissism*, 66-7.

<sup>457</sup> Banja, *Medical Errors and Medical Narcissism*, 66.

<sup>458</sup> Banja, *Medical Errors and Medical Narcissism*, 68-80.

<sup>459</sup> Banja, *Medical Errors and Medical Narcissism*, 68-80.

with medical errors will require taking physicians' psychological needs into account. This will be difficult. The need for psychological support and compassion for failings is likely to be viewed by physicians as weakness.

The work of some of these authors comes across as shrill at times. Nevertheless, their messages explain how preparations to become a physician and life as a physician may make disclosure difficult or painful. Lack of personal skills and lack of emotional support could easily make a good person choose avoidance and secretiveness over the threatening possibilities connected with truthful disclosure.

## **Political**

Physicians have made use of political clout to protect their interests since the country's beginnings. At first, allopathic physicians were not organized sufficiently to obtain many advantages. However, according to DeVille they were able to use the courts to seek payment; practitioners of other healing arts were not permitted to do so.<sup>460</sup>

After a period in which there were only two states that had licensure laws, allopathic physicians organized, set professional standards, and forced out competition, their political influence grew.<sup>461</sup> They were able to convince states to pass licensing laws and to limit entry to the field. Their claim of a scientific basis for their work assisted in increasing their political power and authority. They used their political power to

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<sup>460</sup> De Ville, *Medical Malpractice in Nineteenth-Century America*, 85-6.

<sup>461</sup> De Ville, *Medical Malpractice in Nineteenth-Century America*, 86, 171.

medicalize certain services that previously had been carried out by others (e.g., midwifery).<sup>462</sup> They were able to obtain limits on who could gain access to and administer a wide variety of medicines and treatments. Laws made certain actions crimes if they were carried out by anyone who lacked the proper medical credentials. A perhaps most important to the current issues physicians face, they were able to limit external controls over their work.

Secrecy and deception have been important instruments for obtaining and maintaining political clout and for limiting the influence of outsiders on the shape of the profession. Of course, the medical profession holds no monopoly over secrecy and deception in the realm of political endeavors. They are among the most common strategies for obtaining benefits and avoiding losses. Other strategies include “Look over there;” “We’re the victims, not the other guys;” “What they don’t know won’t hurt them (us);” “We are good; they are evil;” and “Only we possess the truth.” There are several others. To some extent they all involve deception, self-deception, or ambiguity. In addition, the strategies need not be conscious. An inability to see from others’ perspectives is part of what makes people passionate about their own views.

## ANALYSIS

The messages of Hyman and Silver and Banja may seem shrill. Nevertheless, they present views that are in many respects confirmed by other sources from within and

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<sup>462</sup> See, for example, Judy Barrett Litoff, “An Enduring Tradition: American Midwives in the Twentieth Century,” in *Readings in American Health Care: Current Issues in Socio-Historical Perspective*, ed. William G. Rothstein (Madison: The University of Wisconsin Press, 1995), 225-6.

outside medicine. Physicians as a group tend to share certain perceptions and to behave in particular ways that set them apart from the general public. Those perceptions and behaviors are strongly connected with their identities as physicians and grow out of the extensive process of acculturation that physicians undergo as part of their education and training. Emotional reactions to perceived threats, especially of malpractice lawsuits and personal losses, result in defensive postures that conflict with professional duties and societal expectations.

Physicians have exaggerated fears about being sued for medical malpractice, as noted above. Research does not support their assertions that most malpractice lawsuits are without merit, are motivated by greed, and lead to excessive awards. Furthermore, as Hyman and Silver point out, if physicians' fears were based in reality and malpractice lawsuits were commonplace, physicians as a group would be motivated to do something to reduce the incidence of negligence instead of relying on concealment, deception, and efforts to reduce the amounts of the awards.

Deception in medicine is a pattern with a long history, a pattern that is encouraged by its success in influencing others and in avoiding negative consequences. There is power in deception that allows the physician to sustain an air of authority and the illusion of infallibility. It is a corrupting influence that alters the deceiver by making deception easier, more comfortable, and more desirable for use in a variety of situations. It is part of the hidden curriculum, the unwritten rules of practicing medicine learned from attending physicians during the education and training processes.

Learning to deceive as part of the acculturation into medicine is not necessarily a conscious process. The practice of medicine is not always conscious. Information is pushed at students and residents so quickly that those who have experienced the process have likened it to trying to drink from a fire hose. Biochemistry, anatomy, physiology, pharmacology, disease processes, protocols, rules of thumb, and intuition are part of many, if not most, decisions made by physicians. They rely on learned facts, logic, probabilities, direct observations, tests, patients' stories, attendings' stories, and past experience for guidance in making decisions about diagnoses and next steps. The acculturation process makes much of these processes second nature. They come to seem like common sense, what anyone would do under the circumstances without a thought, automatic, like many aspects of driving a car.

Physicians, like any other normal people, develop biases, preferences, and habits concerning problem-solving and decision-making. They make assumptions based on what they know, believe, want, fear, and find comfortable or familiar. When deception becomes a familiar, successful tool for addressing unpleasant situations, it is likely to be used repeatedly, sometimes without thought about its ethical implications or the potential fallout if the deception is discovered. When physicians deceive about medical error or other matters, it may not seem like deception at all. Physicians must often shape messages for patients, emphasizing some things, leaving out some details, and translating medical language so that the patient will grasp what the physician perceives will fit the situation and the patient's particular needs. How simple it must seem to avoid saying

words like *mistake* or *error*, to smooth over details that seem unnecessarily disturbing or threatening, to avoid saying something that may potentially lead to confrontation or hostility.

*Crucial Conversations* is a book that discusses how easy it is for anyone to respond to an uncomfortable situation with silence or emotion-driven communication that invites an unwanted negative reaction.<sup>463</sup> It also discusses how to communicate honestly, clearly, and safely about sensitive matters. One of the book's main points is that everyone at one time or another either avoids unpleasant communication altogether or attempts to address the situation in a manner that they believe (often erroneously) will provide the emotional satisfaction they seek without considering how best to achieve an amicable and mutually beneficial result. Hostility, resentment, bewilderment, and distrust are common responses from others when communication is poor.

The following extract from *Crucial Conversations* describes how successful companies achieve consistently excellent results:

*Solve pressing problems.* The best companies in almost any critical area are the ones that have developed the skills for dealing effectively with conversations that relate to that specific topic. For example:

- *Safety.* When someone violates a procedure or otherwise acts in an unsafe way, the first person to see the problem, regardless of his or her position, steps up and holds a crucial conversation.
- *Productivity.* If an employee underperforms, fails to live up to a promise, doesn't carry his or her fair share, or simply isn't

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<sup>463</sup> Kerry Patterson, Joseph Grenny, Ron McMillan and Al Switzler, *Crucial Conversations: Tools for Talking When Stakes Are High* (New York: McGraw-Hill, 2002).

productive enough, the affected parties address the problem immediately.

- *Diversity*. When someone feels offended, threatened, insulted, or harassed, he or she skillfully and comfortably, discusses the issue with the offending party.
- *Quality*. In companies where quality rules, people discuss problems face-to-face when they first come up.
- *Every other hot topic*. Companies that are best-in-class in innovation, teamwork, change management, or any other area that calls for human interaction are best-in-class in holding the relevant crucial conversations.<sup>464</sup>

Of course, physicians are not companies. Nevertheless, these messages can be extended to the medical profession, but it will not be easy to do for a number of reasons.

Instead of encouraging the kind of openness and honesty described above, the culture of medicine has contributed greatly to silencing others, keeping opinions about the quality of physicians' work quiet, avoiding threats to the hierarchy through fear, hiding problems, and obstructing change in roles and relationships. An underlying assumption in the medical profession's approaches to solving the problems of patient safety, rising health-care costs, access to care, quality of care, and relationships with patients and other health-care providers is that the medical profession is fine, or would be fine if others (lawyers, patients, insurers, and other providers) would change.

Naturally, when a person or a group possesses power and status, there is strong motivation for that person or group to try to preserve its special position by using the resources at hand. Information is a resource, as are group cohesion, political clout,

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<sup>464</sup> Patterson, Grenny, McMillan and Switzler, *Crucial Conversations*, 11.

money, secrecy, and deception. Preventing patients from learning about the medical errors that caused their injuries could be characterized as a form of self-defense or self-preservation, albeit a form that undermines the goals of medicine, helping, healing, caring, and curing.

The reason that physicians tend to avoid truthful disclosure about medical errors is not necessarily that physicians are self-involved, unfeeling, miserly people. Instead, they are acculturated to live without adequate emotional support, healthy communication skills, reasonable beliefs about the abilities and capacities of others, realistic ways of assessing and coping with conflict, and sufficient abilities to accept their own human frailties and medicine's delusions of scientific grandeur. In addition, they exist in a larger culture that has unrealistic expectations about what medicine has to offer and what physicians can and should be able to do.

If the culture of medicine can train these ideas, social structures, and ways of living into people, it must be possible to train in healthier, more adaptive alternatives. The next chapter will address some of the issues that must be addressed to overcome the barriers to truthful disclosure of medical errors.

## **Chapter 5: Possible Remedies**

A number of remedies have been proposed for addressing the medical error-patient safety-malpractice crisis. Among them are caps on malpractice damages, the systems approach, enterprise liability, apology legislation, and no-fault insurance. Each proposed solution leans in favor of the medical profession by offering financial protections for the erring physicians.

I lump the problems together as a single crisis, because they are different ways of perceiving the same set of issues. Power, money, the culture of medicine, deception and deceptive non-disclosure, and lack of reporting are common to all of these perspectives. Patients sometimes have bad outcomes, some preventable, some not. Health-care professionals sometimes make mistakes, some due to negligence, some not. Some injured patients or their families file medical malpractice claims, most do not. Because information is withheld or the limited information provided is suspect, the patients or their families who file claims often do so to find out what really happened. Some of them drop their claims when it becomes clear there was no negligence, the malpractice insurer decides to settle, or the costs and frustrations of moving forward with the claims become unbearable. Others who remain unconvinced there was no wrongdoing or who are angered by the health-care professionals' lack of willingness to be honest, to show compassion, or to accept an appropriate degree of responsibility move forward with litigation. Litigation represents a power struggle between health-care providers and

patients, a battleground for deciding who will bear the costs of the patient's misfortune, and a challenge to the culture of medicine.

Until recently, each adverse event was seen in the practice setting as an isolated incident attributed to the either uncontrollable factors or to the failing of a single individual.<sup>465</sup> Therefore, no attempt was made to see the event as a management problem. If the problem was considered beyond control, there was nothing to be done about it. If the problem was with an individual, it might be overlooked for a long time because of self-deception or the conspiracy of silence. If the error could not be ignored, the individual who was connected with the error(s) might be treated as a pariah. If the problem was with gaps in policies and procedures or lack of adequate communication channels and feedback loops, there was no recognition that a problem existed. Neither physicians nor administrators made serious attempts to identify patterns of missteps or the conditions that contributed to their development. Patients have been subjected to unsafe conditions and practices, and the cycle has repeated itself. The cycle continues for the most part, but awareness has grown.

Malpractice insurers who poorly predicted the costs of payouts raised premiums to be able to correct for being overly optimistic.<sup>466</sup> Claiming that the problem was more litigation, insurers blamed the increases on frivolous lawsuits and greedy lawyers.<sup>467</sup>

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<sup>465</sup> See, for example, Kohn, Corrigan and Donaldson, eds., *To Err Is Human*, 5.

<sup>466</sup> Baker, *The Medical Malpractice Myth*, 66.

<sup>467</sup> Boehm, "Debunking Medical Malpractice Myths," 358.

When analyses of closed claims indicated that little has changed in terms the ratio of claims to physicians, insurers altered their story.<sup>468</sup> They argued that the payouts were much higher than in the past.<sup>469</sup> Although there is some truth to this assertion, health-care inflation explains away a substantial portion of the increase.<sup>470</sup> Payouts are higher, because injuries are more severe, new and costly technologies have become the standard of care, and people, including those who suffer from medical injuries, are living longer due to technological advances.<sup>471</sup> The real reason that malpractice insurers were forced to increase premiums substantially is that they had not corrected premiums that were too low for too long, and the economy took an unanticipated downturn.<sup>472</sup> The realization that profitability, even business survival was threatened led to the need to demand disturbingly higher rates.

Nevertheless, the physicians who encountered these increases in their insurance premiums blame the patients who sue for medical malpractice for rising health-care costs and physicians' anxiety about malpractice litigation.<sup>473</sup> Physicians claim it is their anxiety that causes them to withhold or distort information. They fear loss of income and loss of respect from colleagues and others.

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<sup>468</sup> Baker, *The Medical Malpractice Myth*, 10, 37.

<sup>469</sup> Baker, *The Medical Malpractice Myth*, 1.

<sup>470</sup> Baker, *The Medical Malpractice Myth*, 37.

<sup>471</sup> Baker, *The Medical Malpractice Myth*, 72, 4-5.

<sup>472</sup> Baker, *The Medical Malpractice Myth*, 45-67.

<sup>473</sup> Baker, *The Medical Malpractice Myth*, 13, 7.

By isolating medical errors from medical malpractice insurance issues, medical malpractice litigation, and patient safety, and by blaming increasing health-care costs on imagined undeserving recipients of windfalls, medicine has failed to see the need to address the underlying problems from within. The issues that must be addressed if meaningful change is to occur are complex; a single, simplistic solution will not be enough. There are multiple barriers to change. Central to many of them is the way physicians have been trained to think, believe, and perceive.

In the remainder of this chapter I will discuss the merits and failings of these popular solutions and suggest alternative measures I believe will contribute to alleviating some of the many problems associated with medical errors.

## **LEGISLATIVE SOLUTIONS**

A number of the proposals for fixing what is broken with medicine are in the form of laws and regulations. Most deal with liability. The assumption seems to be that all that ails the medical profession will be made better by reducing the probability or impact of malpractice litigation. Costs will decrease, physicians will report, weak lawsuits will be discouraged, patient safety will improve, and the medical profession will regain some of its lost power and status.

A brief examination of a few of the major proposal will reveal that legislation whether limits on liability can fulfill the promise of solving the problems.

## Tort Reform

Damage caps have been adopted in several states with the goal of stabilizing or reducing malpractice insurance costs. They are what many think of first when they hear the term *tort reform*. Physicians argue that this type of tort reform is necessary to keep qualified people from leaving the profession or moving out of the state to one with more favorable malpractice insurance rates.<sup>474</sup>

The basic idea behind these caps is that the large damages for pain and suffering awarded to plaintiffs who prevail in malpractice litigation are unfair and excessive and should not be allowed.<sup>475</sup> Accompanying this idea is the claim that most malpractice lawsuits are baseless, without merit, and driven by attorneys and patients who abuse the legal system for ill-gotten gain.<sup>476</sup> The rare plaintiff who is the victim of medical negligence will be awarded the value of his loss of income and actual expenses and a limited amount for non-economic losses. Anything more is considered needlessly damaging to the physician's career and to the medical profession in general. Also

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<sup>474</sup> Baker, *The Medical Malpractice Myth*, 1.

<sup>475</sup> Baker, *The Medical Malpractice Myth*, 1; Bryan A. Liang, "Clinical Assessment of Malpractice Case Scenarios in an Anesthesiology Department," *Journal of Clinical Anesthesiology* 11, no. 4 (June 1999): 267-73.

<sup>476</sup> Baker, *The Medical Malpractice Myth*, 1; Liang, "Clinical Assessment of Malpractice Case Scenarios in an Anesthesiology Department," 270-2.

accompanying advocacy in favor of caps is the notion that, by creating disincentives for suing doctors, health-care costs will be contained.<sup>477</sup>

These claims about the benefits of damage caps continue despite evidence to the contrary. In states that have adopted damage caps, health-care costs continue to rise.<sup>478</sup> It is true that some such states have experienced lower numbers of medical malpractice lawsuits and modestly lower medical malpractice insurance premiums in some areas.<sup>479</sup> However, patients are not paying less for their care.<sup>480</sup>

Boehm indicates that the patients with the most grievous injuries are the ones most likely to be harmed by damage caps.<sup>481</sup> Because these patients are most likely to be either very young or very old, their economic damages from loss of income may be small. Their ongoing health-care costs are likely to be high, and if the cost of health care continues its upward trend, they will increase substantially as time passes. Without a large award for pain and suffering, these patients injured through medical negligence will not receive enough money to cover their medical expenses not to mention their living

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<sup>477</sup> Baker, *The Medical Malpractice Myth*, 13, 154.

<sup>478</sup> Bryan A. Liang and LiLan Ren, "Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems to Improve Quality and Safety in Healthcare," *American Journal of Law & Medicine* 30 (2004): 501-40.

<sup>479</sup> Liang and Ren, "Medical Liability Insurance and Damage Caps," 506-8.

<sup>480</sup> Liang and Ren, "Medical Liability Insurance and Damage Caps," 504-21.

<sup>481</sup> Boehm, "Debunking Medical Malpractice Myths," 360.

expenses.<sup>482</sup> Without litigation, they might receive nothing. The tort system's goal of restoring the injured party to the pre-injury state or its dollar equivalent is frustrated by damage caps. Law professor Mark Hall elaborates:

One prominent reform measure is to cap non-compensatory damages at a level such as \$250,000. This appears to blunt the retributive element of tort law and to undermine the goal of corrective justice to restore patients fully to their pre-injured position—even in the most severe cases where justice places the greatest demands. Viewed normatively, then, a damages cap is difficult to defend.<sup>483</sup>

Research that initially set out to demonstrate that there were more instances of medical malpractice litigation than there were instances of medical negligence found the opposite. The IOM report cites study after study showing that medical negligence occurs at least 7 times more often than patients injured by medical negligence file a lawsuit.<sup>484</sup> Assertions that most lawsuits are frivolous are in error.<sup>485</sup> Attorneys do not take on

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<sup>482</sup> Baker, *The Medical Malpractice Myth*, 110.

<sup>483</sup> Hall, "Can You Trust a Doctor You Can't Sue?," 310.

<sup>484</sup> The IOM Report cites the Brennan, Leape et. al Harvard Medical Practice Study, the Andrews study of a Chicago hospital, and a wide variety of studies on medication errors. See Appendix C of the IOM Report.

<sup>485</sup> A study conducted through the combined efforts of physicians, lawyers, and others examined a random sample of closed claims from 5 malpractice insurance companies. They found the following: "Sixty-three percent of the injuries were judged to be the result of error. Most claims involving injuries due to error received compensation (653 of 889 [73 percent]). Most claims that did not involve errors (370 of 515 [72 percent]) or injuries (31 of 37 [84 percent]) did not. Overall, 73 percent (1054 of 1441) of all claims for which determinations of merit were made had outcomes concordant with their merit. Discordant outcomes in the remaining 27 percent of the claims consisted of three types: payment in the absence of documented injury (6 of 1441 [0.4 percent of all claims]), payment in the absence of error (10 percent), and no payment in the presence of error (16 percent). Thus, nonpayment of claims with merit occurred more frequently than did payment of claims that were not associated with errors or injury. Studdert, Mello, Gawande, Gandhi, Kachalia, Yoon, Puopolo and Brennan, "Claims, Errors, and Compensation," 2024-33.

medical malpractice cases that do not appear to have merit. The costs for the attorneys are too high.

First, frivolous lawsuits, lawsuits that are intended to harass or that are not based on a real question of facts, can lead to disciplinary actions against the attorney.<sup>486</sup> The attorney may be fined and lose her license as a result. Second, malpractice litigation is a costly endeavor. Plaintiff's attorneys typically work on a contingency basis.<sup>487</sup> That is, they gamble on the case by using their own resources to finance expert opinions, the discovery process, and various other expenses related to the case. If the client prevails in the lawsuit, the attorney takes a substantial percentage of the award. However, if their client does not prevail, the attorney loses the gamble and goes unpaid.<sup>488</sup> There is no incentive to accept a client unless the case has promise of making the investment worthwhile.

Sometimes, the claim that most malpractice lawsuits are frivolous is based on the fact that physicians prevail most of the time.<sup>489</sup> Prevailing in a lawsuit does not make the original claim frivolous. A jury's determination that an injury was not due to medical negligence is not automatic; evidence must be presented and the jury must decide based

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<sup>486</sup> Boehm, "Debunking Medical Malpractice Myths," 359.

<sup>487</sup> Boehm, "Debunking Medical Malpractice Myths," 359.

<sup>488</sup> Baker, *The Medical Malpractice Myth*, 110.

<sup>489</sup> Boehm, "Debunking Medical Malpractice Myths," 358-9. One admittedly old (1980s) study cited by Baker indicates that plaintiffs lost medical malpractice cases 70 percent of the time. Baker, *The Medical Malpractice Myth*, 74.

on the testimony of experts and the law. Neither does an unexpectedly high award to the plaintiff make a lawsuit frivolous. Truly frivolous lawsuits are baseless, unsupported by facts, lacking in legal justification, and/or filed in bad faith. There is no real question for the court to decide.

Baker explains the purpose of lawsuits and the advantages they offer:

A lawsuit is the opposite of taking matters into your own hands and blowing up a building. Lawsuits channel the very human but very dangerous desire for revenge into a quest for justice. Lawsuits make people work through the system, not against it. Lawsuits take place in the open. Lawsuits provide procedural protections for everyone involved.<sup>490</sup>

Of course, lawsuits do not always have fair outcomes. Usually, both the physician and the patient walk away feeling cheated regardless of who wins. Lawsuits are, as Woods describes, like duels.<sup>491</sup> (This is true of all lawsuits, not just medical malpractice lawsuits.) They are adversarial attempts to settle disagreements that offer no real hope of reconciliation between the parties. The attorneys representing the disputants and the judge orchestrate the fight. Some attorneys are better at hitting their target than their opponents. However, it is also the case that some are given more and better ammunition.

As Baker notes, “[m]alpractice lawsuits ask doctors and hospitals to take responsibility for their mistakes, not just to prevent future mistakes or compensate the

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<sup>490</sup> Baker, *The Medical Malpractice Myth*, 112.

<sup>491</sup> Woods and Brucker, *Healing Words*, 25.

patient, but also because taking responsibility is the morally proper thing to do.”<sup>492</sup>

Nevertheless, litigation is a poor way to solve problems. It should be the last resort instead of the first or only alternative.

Banja mentions other types of tort reform that have been proposed in addition to damage caps in attempts of deal with the so-called malpractice crisis. They include:

1. Doing away with joint and several liability;
2. Additional requirement for an expert witness to qualify;
3. Caps on punitive damages;
4. Counting any contribution the patient made to the negligence that led to injury against any compensation awarded; and
5. Placing limits on the amounts attorneys can receive from litigating.<sup>493</sup>

These additional measures do nothing to encourage fulfillment of the physician’s ethical obligations to honestly disclose, and when appropriate, apologize and make amends to the patient. Instead, they make it more difficult for the patient injured by medical negligence to receive appropriate compensation.

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<sup>492</sup> Baker, *The Medical Malpractice Myth*, 113.

<sup>493</sup> Banja, *Medical Errors and Medical Narcissism*, 121-2. Most of these measures seem clear. However, two of the points may need explanation. Joint and several liability means that all of the defendants are liable for the full amount of any award to the plaintiff until the full amount of the award is paid. If one of the parties refuses or is unable to pay, the others must make up that party’s share of the award. In effect, the defendants can apply pressure to one another to pay their share. Without joint and several liability, the injured party may never receive the full award.

Caps on punitive damages may invite egregious behavior. Typically, punitive damages are applied to deter defendants from future offensive behavior. As implied by the name, the damages are supposed to be high enough to be threatening or painful so that the defendants may face financial ruin if they persist in their wrongdoing. In addition, in states where damage caps already exist, savvy juries who find for the plaintiff may apply punitive damages to make certain that the plaintiff actually obtains enough compensation to cover all of his or her appropriate medical, legal, and life expenses.

## **The Systems Approach**

As mentioned in the Chapter 1, the systems approach is lauded as the panacea to patient safety. It entails removing the stigma and fear associated with errors and creating reporting and feedback mechanisms for correcting gaps in communication, management flaws, troublesome policies and procedures, data management, and a variety of other ailments of health-care systems. The basic premise of the systems approach is that errors are usually the result of a series of problems within the system rather than the failings of an individual. By changing the negative ways that the institutions react to errors, health-care workers will be more willing to communicate about mishaps so that patterns can be identified and preventive measures can be developed and implemented. Protecting reports of errors from discovery by litigious patients will help the errant health-care workers feel at ease about sharing their unfortunate missteps with the administrators and agencies who are in the position to institute safety measures. The administrators and agencies will study the information and develop ways to avert future medical errors.

The approach is valuable in that it offers a model for change that has been proven effective in another industry. It offers a way of measuring quality, efficiency, and effectiveness within a health care facility. It also offers opportunities to identify better ways to accomplish goals throughout medicine. By collecting and analyzing data on adverse events and errors, the health-care industry can apply scientific methods to areas of medicine that have long been only matters of speculation and conjecture.

There are several ways that the systems approach could be used to reduce errors. Automation is one of the most easily recognized ways. Electronic order entry that only allows certain options would prevent many errors that commonly result from miscommunications. Handwriting would be less of an issue if all information is typed. Calculations can be made automatically. Prompts can remind the physician to specify the timing of medications and the method of administration. Warnings can be built into software to alert physicians of potential drug interactions or the patient allergies or sensitivities. Pop-ups can remind of tasks that have not been carried out.

Through analyses of error reports, administrators may be able to identify patterns of behavior that are risky, work areas that are poorly designed, equipment that is not functioning properly, common misinterpretations of forms or policies, or times of day when particular mistakes are likely to happen. Resources can be reorganized for greater efficiency and effectiveness, training can be implemented to improve awareness of opportunities for errors, or queuing and scheduling may be changed to minimize risks. Feedback loops, assumptions testing, facilities planning, team-building, and fail-safe/redundancy development can all grow out of the systems approach.

The downsides of the systems approach involve physician skepticism about the systems nature of errors, ethical obligations to patients, potential erosion of medicine as a profession, financial issues, and compliance. Lucian Leape and Donald Berwick examined the impact of the IOM report five years after its publication. They found that

despite the widely disseminated message from the IOM that systems failures cause most injuries, most individuals still believe that the major cause of bad care is bad physicians, and that if miscreant physicians were removed everything would be alright. Some have claimed that the emphasis on systems, and particularly not blaming individuals will weaken accountability for physician performance.<sup>494</sup>

Compliance may be one of the greatest obstacles to implementing the systems approach.

Change is difficult for anyone. It is likely to be most difficult for people who consider themselves independent experts and who fear they have a great deal to lose by changing.

Leape and Berwick assert that change requires ways of interacting with others that

“professionals easily perceive as threats to their authority and autonomy.”<sup>495</sup> They

indicate that the reasons physicians have not taken a more active role in implementing the

systems approach “are to be found in the culture of medicine, a culture that is deeply

rooted, both by custom and by training in high standards of autonomous individual

performance.”<sup>496</sup> Many of these concerns have already been discussed to some extent in

this document.

Woods adds support to some of these concerns as follows:

Many physicians are skeptical that a similar system [to that used to deal with errors in the aviation industry] could work in medicine. They fear individuals who make medical errors would be singled out and somehow punished, despite the fact that the ASRS [Aviation Safety Reporting System] has successfully overcome all issues of confidentiality, anonymity, and retaliatory discipline in its own system.

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<sup>494</sup> Leape and Berwick, "Five Years after *to Err Is Human*," 2384.

<sup>495</sup> Leape and Berwick, "Five Years after *to Err Is Human*," 2387.

<sup>496</sup> Leape and Berwick, "Five Years after *to Err Is Human*," 2387.

And they argue—probably correctly—that physicians would resist being singled out for additional training designed to prevent future errors. (Pilots routinely receive training about new policies and procedures designed to enhance safety when weaknesses in the system are revealed.)<sup>497</sup>

Furthermore, the culture of medicine is likely to be a barrier to any approach that threatens physicians' sense of autonomy and power.

Fear is not the only contributor to the skepticism. Distaste for interference from outsiders and for limitations on their discretion is likely to emerge in response to the process. Leape and Berwick observe that

many physicians greeted the horrendous mortality data published by the IOM with disbelief and concern that the information would undermine public trust. The normal human resistance to change was amplified by fears of loss of autonomy, antipathy toward attempts by others outside the profession to improve practice, and skepticism about the new concept that systems failures are the underlying cause of most human errors. An understandable fear of malpractice liability inhibits willingness to discuss, or even admit, errors.<sup>498</sup>

Leape and Berwick lament that third-party payers also impede progress in implementing change by refusing to cover “new practices that reduce errors,” but “often [unwittingly] subsidize unsafe care.”<sup>499</sup>

An additional obstacle may come from opponents who are not part of the health-care community. There is something distasteful about anyone, much less anyone who calls himself a professional, making the claim that “I’m just a little cog in a big machine.”

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<sup>497</sup> Woods and Brucker, *Healing Words*, 59.

<sup>498</sup> Leape and Berwick, “Five Years after *to Err Is Human*,” 2387.

<sup>499</sup> Leape and Berwick, “Five Years after *to Err Is Human*,” 2388.

It sounds a bit too much like “I was just following orders.” As appealing as pointing to the system as the main source of errors may seem—especially to physicians who live in constant fear of medical malpractice lawsuits—doing so invites denial of responsibility for one’s own actions.

Perhaps one of the reasons that the systems approach has not yet brought about dramatic changes in medicine is that, on some level, physicians recognize that the approach provides a different kind of threat to their status and authority. Instead of being leaders, they are potentially helpless pawns at the mercy of decisions made by clerks or administrators. They grasp the apparent contradiction that to err may be human, but according to the IOM something other than humans are responsible for the errors. Concern about being thought of as technicians who practice *cookie cutter medicine* or *cookbook medicine* may also serve to slow the process.

Montgomery offers a convincing argument that physicians should not fear losing their importance as healers. She builds her case on the idea that physicians practice *phronesis*, practical reasoning that involves a kind of understanding and interpretation that cannot be reduced to protocols and policies and procedures.<sup>500</sup> Physicians do far more than collect data and spew facts; they offer human contact, shape reality for the patient, calm fears, and guide people through some of their most frightening times. Nevertheless, the danger remains that physicians may lose status due to their perceived status as victims of circumstance.

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<sup>500</sup> Montgomery, *How Doctors Think*, 34-9.

## Enterprise Liability

Enterprise liability is a possible remedy for the systems-based errors and subsequent disclosure issues. Enterprise liability makes the hospital or health-care organization bear a greater proportion of the malpractice insurance and liability burden.

According to Baker,

There are two reasons to think that the burden of paying medical malpractice insurance premiums falls too heavily on at least some doctors. First, doctors have to pay a larger share of malpractice insurance premiums than their share of health-care revenues. Doctors bear most of the costs of medical liability despite the fact that they receive less than 15 percent of the health-care revenues. . . .

Second, doctors in high-risk specialties and high-risk locations pay large premiums that may be out of proportion to their ability to prevent medical injuries. Preventable mistakes are to some degree inevitable in complicated, high-risk medical systems. It is fair to compensate the injured patient. And we want to provide an incentive for the doctor to be careful. But the mistake really results from the health-care system, of which the doctor is only a part.<sup>501</sup>

Although the physician might pay into an insurance pool for the institution to maintain privileges, he or she would not be subject to individual liability in the event of a negligent iatrogenic injury.<sup>502</sup> Because the organization would bear a greater financial risk, it would have incentive to learn about and correct systems problems, weed out health-care professionals whose performance invites complaints, encourage teamwork,

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<sup>501</sup> Baker, *The Medical Malpractice Myth*, 64.

<sup>502</sup> Banja, *Medical Errors and Medical Narcissism*, 125.

and standardize disclosure processes so that patients receive consistent and helpful information.

The patient who believes he or she is the victim of culpable medical error would still have to prove medical malpractice, but the organization would be accountable in ways that it is not at present. One major advantage of this approach is that managed care organizations would have greater responsibility to patients, relieving some of the pressures on physicians to hold down costs.

Because most people with health insurance, including managed care programs, are subject to ERISA restrictions concerning complaints about denied care, some change in the law may be necessary to enforce compensation for certain types of errors.<sup>503</sup> Law professor Stacey Tovino writes: “ERISA permits patients to sue for reimbursement of the costs associated with denied benefits, ERISA does not permit damages for any resulting injuries or death.”<sup>504</sup>

Banja notes that there are troublesome disadvantages to enterprise liability. First, physicians often work with a number of organizations. Paying into a variety of managed care organizations and hospitals might be unmanageable.<sup>505</sup> Second, the organizations are

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<sup>503</sup> ERISA is the Employee Retirement Income Security Act of 1974. For an example of the conflicts associated with HMOs and ERISA, see *Pegram v. Herdrich*, 530 U.S. 211 (2000).

<sup>504</sup> Stacey A. Tovino, "ERISA Preempts Wrongful Denial of Benefits Action Involving "Pure Eligibility Decisions"," University of Houston Health Law and Policy Institute, <http://www.law.uh.edu/healthlaw/perspectives/HealthPolicy/070404revisederisa.pdf> (accessed January 13, 2007).

<sup>505</sup> Banja, *Medical Errors and Medical Narcissism*, 127.

likely to resist out of fear; the costs of enterprise liability are unknown.<sup>506</sup> Some of these organizations have enjoyed protections from vulnerability; enterprise liability could bring about major changes in these organizations' bottom lines.<sup>507</sup> They would have to re-think how they do business.

### **No-Fault Insurance**

No-fault insurance is another solutions proposed by some who believe that malpractice litigation and malpractice insurance rates retard efforts toward improving patient safety.<sup>508</sup> The reasoning behind this approach is the same as for other methods of reducing fears about lawsuits; reduce the likelihood of being sued and physicians will be forthcoming with information about errors.

No-fault insurance would operate something like worker's compensation.<sup>509</sup> The harmed patient would have to demonstrate a sufficient degree of injury to qualify for payment. The amount of payment would be calculated by determining actual medical expenses and lost income and in accord with standardized allowances for disability and pain and suffering. The physician would not suffer consequences unless he or she engaged in egregious or intentional harmful behavior.

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<sup>506</sup> Banja, *Medical Errors and Medical Narcissism*, 127.

<sup>507</sup> Banja, *Medical Errors and Medical Narcissism*, 127.

<sup>508</sup> Studdert and Brennan, "No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention," 217-23.

<sup>509</sup> Banja, *Medical Errors and Medical Narcissism*, 128.

Banja discusses the advantages and disadvantages of this alternative to medical malpractice litigation. The advantages he finds with this approach include avoiding costly and emotionally draining litigation, faster access to compensation for the injured patient, lower malpractice insurance costs, and greater likelihood of compensation for the injured patient.<sup>510</sup> There is a certain appeal to a system that makes compensation available for most of the patients who are injured through medical error. Even those whose injuries are not devastating would have a chance to recoup some of their losses. Furthermore, the extent of iatrogenic injuries could be measured more easily through analysis of the claims for compensation that are filed.

However, he does not necessarily favor the no-fault approach. The disadvantages he identifies are substantial. They are as follows:

1. There may be little incentive to improve health care, because payouts are limited and have little or no effect on the physician's insurance rate. In fact, physicians might pay less attention to safety due to the relative lack of consequences for the physician.
2. There is no real indication that physicians would be more likely to disclose errors under a no-fault program.
3. There are a number of unknowns about the costs associated with a no-fault approach, in part, because so many injured patients have not been compensated in the past. They would likely be higher, if everyone who suffers a disabling injury

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<sup>510</sup> Banja, *Medical Errors and Medical Narcissism*, 128.

receives compensation. As it stands, only a small percentage of known injured patients receive compensation.

4. The no fault system might unfairly enhance the physician's power over the patient by reducing the physician's accountability.<sup>511</sup>

To Banja's list, I will add that the worker's compensation system is subject to a variety of abuses. Injured workers sometimes try to defraud the system to gain benefits beyond those warranted,<sup>512</sup> and the parties against whom claims are made sometimes try to avoid meeting their obligations to the injured workers. There is no reason to believe there would not be parallels in a no-fault insurance approach to medical errors.

Furthermore, patient trust may suffer. As Hall notes, no-fault compensation systems

dispense with any attempt to assess blame for medical injuries; therefore, they might be expected to mollify physicians but at the same time deny patients the vindication they sometimes seek from the tort system. Moreover, they minimize the "voice" that, according to the procedural justice studies, litigants seek from adversarial proceedings—namely the sense that their claim has been heard and fairly considered.<sup>513</sup>

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<sup>511</sup> Banja, *Medical Errors and Medical Narcissism*, 130.

<sup>512</sup> See, for example, James D. Capozzi and Rosamond Rhodes, "Lying for the Patient's Good," *Journal of Bone & Joint Surgery* 86-A, no. 1 (2004): 187.

<sup>513</sup> Hall, "Can You Trust a Doctor You Can't Sue?," 311.

David Studdert and Troyen Brennan propose a combination of no-fault liability and enterprise liability.<sup>514</sup> They discuss the combination as an answer to what they see as inevitable conflict between the systems approach and tort system. The systems approach aims at processes and mechanisms instead of people; the tort system aims at people. Reporting of errors to identify inadequate processes and mechanisms could result in identifying people. People who do not want to be identified as the cause of an error are unlikely to report. Offers to keep reporting confidential are opposed by patient advocates; patients want to know when their injury is due to medical error. Therefore, there is no easy way to achieve a compromise between the systems approach and the medical malpractice approach to error.

They claim that the no-fault-enterprise liability combination would meet all of the needs of a workable system. To their way of thinking, a workable system must

1. Prevent future errors and compensate injured parties when errors occur;
2. Provide financial incentives to bring about improvements;
3. Deal with incompetent or otherwise dangerous physicians in a way that will prevent future harms;
4. Compensate in a way that encourages a healthy, honest physician-patient relationship; and

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<sup>514</sup> David M. Studdert and Troyen A. Brennan, "Toward a Workable Model Of "No-Fault" Compensation for Medical Injury in the United States," *American Journal of Law and Medicine* 27, no. 2-3 (2001): 231.

5. Compensate equitably, quickly, and predictably.<sup>515</sup>

Studdert and Brennan indicate that other countries have versions of this approach and have used them successfully for decades. Those countries have kept costs down by setting a *disability threshold* that is met by being hospitalized for a certain number of days or by being unable to work for a certain number of days.<sup>516</sup>

This approach is not without its drawbacks. Implementing it is problematic for many of the same reasons as the separate schemes. Nevertheless, the authors suggest that a state-wide program would ease some of the administrative burden and would improve cost effectiveness.<sup>517</sup>

The focus of these models appears to be on economic issues and on diverting attention from the responsibility of individuals to the injured patient. Patients want to know what happened and they want an apology from one or more individuals who breached their trust. There is nothing in the tort law, the systems approach, enterprise liability, no-fault liability, or any combination of these that provides the injured patient with the sense that anyone cares in a personal way. It is possible that apology laws were passed to address this part of the injured patient's or patient's family's needs.

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<sup>515</sup> Studdert and Brennan, "Toward a Workable Model of No-Fault Compensation," 231.

<sup>516</sup> Studdert and Brennan, "Toward a Workable Model of No-Fault Compensation," 231.

<sup>517</sup> Studdert and Brennan, "Toward a Workable Model of No-Fault Compensation," 231.

## Apology Laws

According to the National Conference of State Legislatures website, as of December 2005, nineteen states have adopted laws that prohibit the use of a physician's expressions of sympathy, benevolence, or regret as evidence of liability or guilt.<sup>518</sup> The laws vary concerning the kinds of statements that are covered. Most concern only physicians' expressions of caring and concern. However, a few use the word *apology* in the statute.<sup>519</sup>

On the positive side, these laws encourage physicians to attempt to show patients that they feel compassion for the patient and the patient's family without inviting them to use words of kindness and support as weapons in court. Before these laws were passed, physicians were reluctant to express any sense of grief or sorrow about the patient's outcome for fear that a lawsuit would automatically follow; courts often viewed expressions of sympathy, regret, or apology as admissions of failure to meet the standard of care.

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<sup>518</sup> Committee on Law & Criminal Justice National Conference of State Legislators, "Medical Malpractice Tort Reform: 2005 Enacted Legislation in the States," <http://www.ncsl.org/standcomm/sclaw/medmalreform05.htm> (accessed January 2, 2007); Committee on Law & Criminal Justice National Conference of State Legislators, "Medical Malpractice Tort Reform: 2006 Enacted Legislation in the States," <http://www.ncsl.org/standcomm/sclaw/medmalreform06.htm> (accessed January 2, 2007).

<sup>519</sup> National Conference of State Legislators, "N.C.S.L."; National Conference of State Legislators, "Medical Malpractice Tort Reform: 2006 Enacted Legislation in the States.". Some statutes go so far as to cover admissions of liability.

Banja notes that apology laws likely make enforcement of cooperation clauses in malpractice insurance policies difficult.<sup>520</sup> “Many jurisdictions require insurers pleading an insured’s breach of the cooperation clause to show not only that the clause was violated, but that the violation prejudiced or negatively affected the insurer’s ability to process the injured party’s claim or to defend its insured in court.”<sup>521</sup> Because the statements made by the physician outside the courtroom cannot be used in evidence, they are probably “nonprejudicial to the insurer.”<sup>522</sup>

The laws mentioned above are, in part, the result of recognition that apologies help to heal some of the damage caused by medical errors, including damage to the health-care bottom line. The main example of a success story to which many point is the Veteran’s Affairs Medical Center in Lexington, Kentucky. This facility put in place a policy of full disclosure, apology, and compensation for patients injured by error. Berlinger notes that “far from encouraging lawsuits, the practice of disclosing mistakes, apologizing, and offering fair compensation according to Kraman and Hamm, [creators

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<sup>520</sup> Banja, "Does Disclosure of Medical Error Violate the Medical Malpractice Insurance Cooperation Clause?."

<sup>521</sup> Banja, "Does Disclosure of Medical Error Violate the Medical Malpractice Insurance Cooperation Clause?."

<sup>522</sup> Banja, "Does Disclosure of Medical Error Violate the Medical Malpractice Insurance Cooperation Clause?."

of the Lexington model], “diminishes the anger and desire for revenge that often motivate patients’ litigation.”<sup>523</sup>

Apology laws may be abused by physicians who want to relieve their consciences, yet want to avoid paying the consequences of their inappropriate or inadequate care. They may offer words that seem on some level to show compassion, yet do so in a way that avoids any responsibility, and sometimes any real emotional support for the patient or patient’s family.

Not all *apologies* are equal. Some consider the following to be apologies:

1. “I am sorry you had a complication.”
2. “I regret that your outcome was not all that we hoped for.”
3. “I wish things had turned out differently.”
4. “I’m sorry you are unhappy (or angry, or upset).”

These are not true apologies. They may be sincere expressions of sympathy or regret (or may fall insultingly short of expressing sincere concern), but they lack important elements of a true apology.

According to Woods, Robbennolt, Berlinger, and others, genuine apologies have four components.<sup>524</sup> Woods refers to them as the four R’s: “recognition, regret,

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<sup>523</sup>Berlinger, *After Harm*, 70. quoting from Steve S. Kraman and Ginny M. Hamm, “Risk Management: Extreme Honesty May Be the Best Policy,” *Annals of Internal Medicine* 131, no. 12 (1999): 963-7.

<sup>524</sup>Woods and Brucker, *Healing Words*, 40; Jennifer K. Robbennolt, “Apologies and Legal Settlement: An Empirical Examination,” *Michigan Law Review* 102 (December 2003): 468-9; Berlinger, *After Harm*, 61.

responsibility, and remedy.”<sup>525</sup> Berlinger describes *apology*, as follows: “the actions that acknowledge harm, responsibility, and regret, and *repentance*, the actions that materially restore the injured person to health, that repair the relational breach, and that safeguard against future injuries.”<sup>526</sup>

Although *remedy* and *repentance* seem to cover the same ground, Lazare borrows from Harvard Divinity School’s Harvey Cox to say that repentance also has four components, one of which is not clearly included in many other definitions of apology.<sup>527</sup> They are remorse, resolution, restitution, and restoration. *Remorse* is “an acknowledgment of the harm done together with being genuinely sorry for such deeds.”<sup>528</sup> *Resolution* is the “determination not to repeat the offending behaviors.”<sup>529</sup> *Restitution* is “taking modest steps toward restoring what has been damaged.”<sup>530</sup> Finally, *restoration* is “full integration back into the human community.”<sup>531</sup> This last step places an obligation on others as much as on the erring party. After repenting, the erring party must come to accept himself, overcome feelings that distance him from others, and come

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<sup>525</sup> Woods and Brucker, *Healing Words*, 40.

<sup>526</sup> Berlinger, *After Harm*, 61.

<sup>527</sup> Aaron Lazare, *On Apology* (New York: Oxford University Press, 2005), 230; Harvey Cox, “The Roots of Repentance: Some Thoughts on Forgiveness for a Nation in the Midst of Apologies,” *Religion and Values in Public Life* 5, no. 4 (Summer 1975).

<sup>528</sup> Lazare, *On Apology*, 230.

<sup>529</sup> Lazare, *On Apology*, 230.

<sup>530</sup> Lazare, *On Apology*, 230.

<sup>531</sup> Lazare, *On Apology*, 230.

away from the error humbled, but capable of fulfilling his role in society. Others must recognize that the erring party is worthy of returning to his social group, because he has paid the price to restore himself as a member of the group. Without repentance or remedy, an apology is just words.

These just-words versions of apologies appear to have elements of the apology form, but lack the intent and purpose of true apologies. These false apologies are referred to by psychiatrist Aaron Lazare as *pseudo-apologies* or *failed apologies*.<sup>532</sup> These so-called apologies are conditional, imply that no real offense was committed, downplay the importance of the offense, or otherwise express an attempt to evade responsibility. The following are examples:

1. Conditional: “I’m sorry if I did something to offend you.”
2. Denial: “I’m sorry you interpreted it that way.”
3. Minimization: “I have a drinking problem, and sometimes I do things others do not appreciate. I have entered rehab.” Or, “I’m sorry, I had no idea that it would upset anyone.”

Another pseudo-apology takes the form of a true apology, and admits to an offense of sorts but shows no willingness to make reparations or changes.<sup>533</sup> Lazare uses as an example a hotel undergoing renovations. A written statement attached to an area undergoing construction might say something like: “We are making improvements. We

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<sup>532</sup> Lazare, *On Apology*, 75-106.

<sup>533</sup> Lazare, *On Apology*, 26.

apologize for the inconvenience.” The hotel’s management may want patrons to make allowances for any mess, blights on the hotel’s appearance, detours, or limits on services, but the apology is not a true apology; it is a request for indulgence, not an expression of remorse. The hotel would not change its plans regardless of how its patrons felt about the inconveniences created by the renovations.

Other pseudo- or failed-apologies include impersonal or wrongly directed apologies.<sup>534</sup> “I’m sorry, I’m sorry, I’m sorry,” without more translates into, “Please do not hurt me,” and has little to do with acknowledging an offense.<sup>535</sup> The statement “I’m sorry a mistake was made,” accepts no responsibility and can suggest that the speaker is implying that another or some unknown entity, possibly even the message’s recipient brought about the offense. Another wrongly directed apology offers humbling words to a less threatening party who is not the aggrieved party. A physician may apologize to his spouse and his colleagues about an error, but never mention the error to the patient. Yet another wrongly directed apology involves the negation of the expression of apology. Its form is, “I’m sorry, but . . .” The *but* part of the apology signals the speaker’s attempt to justify his actions or to turn the harmed party into the offender. Sometimes the *but* is implied. For example, “I’m sorry, but you were in my way”, or “I’m sorry; I was busy.”

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<sup>534</sup> Lazare, *On Apology*, 101-2.

<sup>535</sup> Lazare, *On Apology*, 86.

Yet another type of pseudo- or failed apology involves apologizing for the wrong offense.<sup>536</sup> Lazare relates the story of a man who apologizes to his wife for causing the emotional pain that led to the end of their marriage, but notes that his extramarital affairs, the discovery of which led to the wife's distress, are not a serious matter. In a sense, the philandering husband used his apology to blame his wife for reacting in a manner that he considered unreasonable.

These pseudo- or failed apologies often exacerbate the harms created by the offenses and serve to destroy trust and credibility. As Lazare notes,

[T]he offender is trying to reap the benefits of apologizing without having actually earned them. People who offer a pseudo-apology are unwilling to take the steps necessary for a genuine apology; that is, they do not acknowledge the offense adequately, or express genuine remorse, or offer appropriate reparations, including a commitment to make changes in the future.<sup>537</sup>

#### **ALTERNATIVE APPROACHES**

After reviewing others' thoughts on how to alleviate medicine's ills, I have arrived at a few thoughts of my own. Although they are underdeveloped at this point, they can serve as proposals for addressing some of the symptoms.

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<sup>536</sup> Lazare, *On Apology*, 102-5.

<sup>537</sup> Lazare, *On Apology*, 9.

## **Change Legislation**

A state-operated medical malpractice insurance program that places a substantial portion of the burden for malpractice insurance on the hospitals and other health-care institutions is a possible solution to some of the difficulties with patient safety, rising malpractice insurance costs, patient compensation, the standard of care, consistent definitions for medical errors, and reporting. The state, as the legitimating body for the profession, has some responsibility for the medical profession's viability, integrity, quality, accessibility, and service to the public. The medical profession has failed in its role in this respect. Therefore, the state's interests should be asserted.

To some extent, this has already happened. A least one state has passed legislation to institute mandatory reporting of errors.

Although physicians may object to potential intrusions from the state and malpractice insurers will no doubt object to the threat of lost income, it may be time for all to recognize that the public often bears the burdens of losses through paying for social programs that support people who become disabled, loss of contributors to the taxes, loss of talented workers who can no longer work or who must devote their time to caring for injured loved ones, loss of skilled practitioners because they prefer a more encouraging insurance climate, more indigent care at emergency rooms, and a number of other hidden costs connected to uncompensated injuries caused by medical errors.

In addition to considering a different approach to medical malpractice insurance, perhaps it is time to give more thought to a universal health care system.

## Change Perceptions

If power and fear of its loss is central to physicians' concerns about disclosure, the way to encourage honesty and transparency, and to restore medicine to the status of a profession is to find a way to give physicians power. This will require some behavioral changes on the parts of physicians, and it will also require some appealing framing.

Framing, the concept developed by sociologist Erving Goffman and popularized through the works of linguist George Lakoff and his public battle with Steven Pinker, involves shaping thinking and experience through the use of rhetoric and metaphors.<sup>538</sup> Framing is unavoidable; the language and metaphors one uses imply how one should understand a viewpoint, and what one values and wishes for others to perceive and value. Some of Lakoff's work discusses political uses of language to shape preferences.<sup>539</sup> One example is the change of terms used to discuss taxation of wealth transferred to heirs when a person with substantial assets dies. The political party in power changed the terminology of the tax from fairly neutral, *estate tax*, to something unappealing, *death tax*, to promote its distaste for the policy. Changes in language can also promote positive perceptions.

If one doubts the effectiveness of framing in making changes in medicine, he need only look to the experience with the notorious Tuskegee Syphilis Study. The study that

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<sup>538</sup> See, for example, Steven Pinker, "Review of George Lakoff's 'Whose Freedom?'" *The New Republic*, September 30, 2006; Erving Goffman, *Frame Analysis* (New York: Harper & Row, 1974).

<sup>539</sup> See, for example, George Lakoff, *Don't Think Elephant!: Know Your Values and Frame the Debate* (np: Chelsea Green Publishing, 2006).

was conducted without informed consent and that prevented the subjects, a group of African-American men, from learning their diagnosis and receiving effective treatment for syphilis, went on for decades without effective criticism about its methods or concerns about its ethics.<sup>540</sup>

(Apparently, there was an assumption in medical research that deceiving human research subjects and intentionally causing them harm was socially justifiable. Rothman relates the story of Henry Beecher's famous 1966 exposé of researchers' use of uninformed, vulnerable people as human subjects for risky experiments.<sup>541</sup> The ethics of the numerous studies of this kind went on unquestioned until Beecher made his concerns public. Rothman explains that the researchers' worked under war-time utilitarian assumptions, despite the fact that the war ended long before most of the studies began. They operated under the belief that their duty was to advancing knowledge for the greater good of society, not to protect the health and interests of individuals who participated in the protocols.<sup>542</sup>)

Attitudes changed when the media framed the Tuskegee study as racially discriminatory and emphasized its similarities to Nazi experiments.<sup>543</sup> At the time, racism

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<sup>540</sup> See generally, James H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment* (New York: Free Press, 1981 & 1993).

<sup>541</sup> Rothman, *Strangers at the Bedside*, 72-84; Henry K. Beecher, "Ethics and Clinical Research," *New England Journal of Medicine* 274 (1966): 1354-60.

<sup>542</sup> Rothman, *Strangers at the Bedside*, 79-82.

<sup>543</sup> Jones, *Bad Blood*.

and civil rights were highly charged political issues. Public outrage resulted from the news. Informed consent became a minimum requirement for ethical biomedical research.

As odd as it might seem, the concept of informed consent, originally a protection for patients, was later reframed to be thought of as a protection for physicians. Many physicians and members of the general public believe that informed consent involves nothing more than obtaining signed documents from the patient that the physician can produce if accused of carrying out a medical procedure without the patient's permission. As they understand it, informed consent is *not* a matter of ethics, intended to protect the interests of the patient, nor is it a process. Instead, it is thought of as a legal precaution for the physician, like a contract or a waiver. In his book *Do We Still Need Doctors?*, physician John Lantos's discussion of informed consent provides an example:

Informed consent is like the disclaimer on the back of a ski-lift ticket: "Surgery is a dangerous sport." If we tell patients about bad outcomes and they consent, then they are responsible, not us. Rather than a way of sharing power, truth-telling and the process of seeking consent has become a way of evading accountability.<sup>544</sup>

It is not clear how this reframing came about. What is important to this discussion is that thinking changed as a result of reframing.

As mentioned in Chapter 2, one of the ways culture is transmitted is through language and metaphors. Changing some of the terms used, emphasizing the positive side of truthful disclosure, and focusing on the strength of character and moral superiority associated with honest and full disclosure of medical errors could provide a step toward

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<sup>544</sup> Lantos, *Do We Still Need Doctors?*, 89-90.

recognizing disclosure as a source of power. At the same time, language and metaphors would have to be used to indicate that refusal to honestly disclose errors reflects weakness, irresponsibility, and moral failure.

The effectiveness of this process would require widespread use of the language changes in education and in the media. It would take time and persistence for the perceptions to become part of the professional and public mental landscape. Furthermore, it would require some sort of reinforcement in the form of a reward or reduction in loss that is carefully balanced against the need to make appropriate reparations to injured patients and their families.

If physicians came to understand honesty as strength, communication as a medical skill, and legitimate authority and leadership as abilities to influence and inspire in positive ways, they would gain back some of the sense of power lost to regulation and innovations in health-care financing. They would find benefits in demonstrating the compassion many currently feel the need to dampen. Perhaps most important, they would restore the public's faith that the medical profession is devoted to helping patients rather than to promoting injustices.

### **Change Attitudes**

It seems plausible that something has been lost as medicine has become more scientific, technically sophisticated, and business-oriented. It may be possible for physicians to find some of the power they need through a different kind of character-building than is usually part of medical training.

## ***Reverence***

Paul Woodruff's book, *Reverence: Renewing a Forgotten Virtue*, may prove instructive for these purposes.<sup>545</sup> He defines reverence as follows: "Reverence, as a virtue, is primarily a capacity for having certain feelings at the right time in the right way."<sup>546</sup> He goes on to say that "virtue is the source of feelings that prompt us to behave well. Virtue ethics takes feelings seriously because feelings affect our lives more deeply than beliefs do."<sup>547</sup>

It is reverence, the capacity to feel awe toward things beyond human control, that physicians may need to develop. Woodruff explains:

Reverence begins with a deep understanding of human limitations; from this grows the capacity to be in awe of whatever we believe lies outside of our control. . . . The capacity for awe, as it grows, brings with it the capacity for respecting fellow human beings, flaws and all. This in turn fosters the ability to be ashamed when we show moral flaws exceeding the normal human allotment.<sup>548</sup>

Woodruff claims that feeling ashamed is not always a bad thing. As is implied from his discussion of reverence and virtue, shame must be the appropriate feeling for the situation. When it is the proper feeling, shame is instructive and serves to "push us to live

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<sup>545</sup> Paul Woodruff, *Reverence: Renewing a Forgotten Virtue* (New York: Oxford University Press, 2002).

<sup>546</sup> Woodruff, *Reverence*, 49.

<sup>547</sup> Woodruff, *Reverence*, 6.

<sup>548</sup> Woodruff, *Reverence*, 3.

better and be better people.”<sup>549</sup> It does not grow out of hubris; instead it comes from “feeling respect for something larger than yourself.”<sup>550</sup> That something larger is not the exceptional ability to achieve beyond what most human beings achieve. It is the capacity to recognize one’s own humanity and one’s opportunity to make a difference in the lives of others.

When physicians learn to distance themselves from patients to achieve objectivity, to avoid sharing their patients pain, and to maintain focus on the science of repairing the body, they sometimes forget that they are ordinary humans living in a world that is made up of other humans, some of who need physicians’ humanity as much as they need pills or surgeries. Without the capacity to feel the appropriate feelings at the appropriate times, physicians can lose touch with what it means to be good people.

### ***Professionalism***

As the medical profession has lost power and prestige, some who have entered the field have lost sight of the humanity of medicine. Fixing the body alone has become for many physicians their only occupation. They do not understand their professional duties to include fulfilling the roles of teacher, advisor, and confidant.

To counteract the gulf that has grown between physicians and patients, medical education programs are attempting to develop curricula that will instill values and teach skills to create a balance between the scientific-technical aspects of treating diseases and

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<sup>549</sup> Woodruff, *Reverence*, 73.

<sup>550</sup> Woodruff, *Reverence*, 72.

injuries and the interpersonal-relational aspects of dealing with people, especially when they are experiencing stress and vulnerability.

The term associated with this movement toward balance is called *professionalism*. Central to professionalism are three key elements: respectful, honest communication with others; accountability; and willingness to change to accommodate new and better ways to meet the honorable goals of medicine. These three themes are interconnected.

Although ethical guidelines for physicians emphasize honesty with patients, a subtle ambivalence remains about communicating about medical error. The following statement in the Medical Professionalism Charter backed by the ABIM Foundation, the ACP Foundation, and the European Federation of Internal Medicine:

Commitment to honesty with patients. Physicians *must* [my emphasis] ensure that patients are completely and honestly informed before the patient has consented to treatment and after treatment has occurred. . . . Physicians *should* [my emphasis] also acknowledge that in health care, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients *should be* [my emphasis] informed promptly because failure to do so compromises patient and societal trust.<sup>551</sup>

One could interpret the *shoulds* to be less important than the *must*. Clearly the *shoulds* do not indicate that the associated behavior is mandatory. In addition, the meaning of the second *should* is unclear. It could emphasize the promptness of mandatory disclosure of the error. It could mean that it is advisable to reveal the error, but

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<sup>551</sup> ACP Foundation & European Federation of Internal Medicine ABIM Foundation, "Medical Professionalism in the New Millenium: A Physician Charter," ABIM Foundation, [http://www.abimfoundation.org/professionalism/pdf\\_charter/ABIM\\_Charter\\_Ins.pdf](http://www.abimfoundation.org/professionalism/pdf_charter/ABIM_Charter_Ins.pdf) (accessed February 13, 2007).

not mandatory. The statement about disclosing the error to the patient is written in the passive voice, suggesting that someone other than the physician may have the responsibility to decide whether or not the error to the patient. An alternative interpretation is that the patient has the responsibility to find out what happened when he experiences a medical injury.

A sentence that follows the statement above is also written in the passive voice. It specifically mentions medical mistakes and the importance of reporting and analyzing them for the purpose of improving care and *appropriately* compensating injured patients (whatever *appropriately* means).

If professionalism is to succeed, something will have to be done to improve even this kind of communication. The statement's authors have gone to considerable trouble to be vague about accountability, honest communication, and achieving change.

### ***Respectful Communication***

Respectful communication is sometimes a serious problem for physicians. Time constraints, fatigue, the medical hierarchy, tradition, and other factors can cause physicians to deal with others, especially those of lesser status (medical students, interns, residents, allied health professionals, nurses, and patients) in ways that are condescending, thoughtless, or rude. Interrupting, discounting concerns, attempting to humiliate, insinuating another's incompetence with they question of disagree, showing impatience, making crude remarks, exhibiting a lack of warmth, using techno-speak with the uninitiated, lying, deceiving, coercing, intimidating, and other forms of causing

another to feel unimportant or lacking in worth are all forms of disrespectful communication.

Sometimes, disrespectful communication can threaten the health of a patient. In Beverly Jones's book chapter "Nurses and the "Code of Silence,"" the author provides an example:

Questioning a prescriber often leads to a disrespectful, aggressive response from the prescriber. Avoiding the prescriber's wrath out of fear of being treated as incompetent leads some nurses and pharmacists to quietly accept the prescription as written even when it is known to fall outside of practice guidelines.<sup>552</sup>

Intimidation combined with lack of compliance with guidelines could lead to an avoidable error. Respectful communication is a prerequisite for professionalism.

## **Change Behaviors**

### ***Truthful Disclosure***

One way to give power back to physicians is to encourage them to recognize the skills they learned as children and to do their best to live up to their own expectations of being generous, caring people who have devoted their lives to reducing patients' suffering and doing what is in patients' best interests.<sup>553</sup>

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<sup>552</sup> Jones, "Nurses and The "Code of Silence", " 93-4.

<sup>553</sup> In *All I Really Need to Know I Learned in Kindergarten*, Robert Fulghum reminds of basic rules for getting along. Three of those rules are especially applicable to medical errors: (1) "Play fair;" (2) "Clean up your own messes;" and (3) "Say you're sorry when you hurt somebody." Robert L. Fulghum, *All I Really Need to Know I Learned in Kindergarten* (New York: Random House, 2003), 4.

When it comes to adverse events and errors, truthful disclosure is in the patient's best interests. Patients and, if appropriate, their families want to know, need to know, and deserve to know what is happening with their bodies and with their health care to the extent that the physician knows. Furthermore, they need to know as soon as possible in language they can understand and in terms that are tactful and sympathetic to the patient's unfortunate situation.

Truthful disclosure is a process, not an event. In many respects revealing information about the bad outcome is like conveying a frightening diagnosis. It is bad news. Like other bad news, it is easily misunderstood, misremembered, and misinterpreted. In some respects it is like obtaining informed consent, the ideal version and not merely the version that meets the minimum legal requirements. It is a dialogue initiated by the physician that allows for questions and feedback. It requires active listening and observation of reactions. It requires patience.

The news must be conveyed with sensitivity and care, explained using visual aids, if possible, while allowing expressions of emotions. The news should be accompanied by reassurances that steps will be taken to closely evaluate the situation and by the physician's expressions of personal sorrow about the outcome. Where the bad outcome is clearly the result of error, the physician must do more. He or she must live up to his own desire to make things right, rather than giving in to fears. Failure to do so amounts to another medical error.

Conveying the known facts is an essential minimum. The known facts include what happened, how it happened (if known), why it happened (if known), and what impact it will have on the patient's recovery and future.

Like physicians, patients need to feel respected and worthy of attention. Although physicians may feel they have almost no relationship with the patients due to time limitations, large patient loads, and the need to operate on an emotional economy to cope with stress, physicians represent an important source of emotional support for patients. A patient must place his trust in the physician in order to accept physicians' assessment of his health and agree to and cooperate in fulfilling a treatment plan. Patients expect *care* in return for that trust.

If one were to think of the responsibility to disclose errors in philosophical terms, the arguments in favor of informed consent often transfer. One of the most well-known approaches to bioethics issues such as informed consent is *principlism*. Beauchamp and Childress are the champions of this way of understanding the physician's duties to the patient.<sup>554</sup>

*Principlism* is made up of four basic concepts or principles, *autonomy*, *beneficence*, *nonmaleficence*, and *justice*. *Autonomy* refers to the patient's right to make choices about his or her own health care. *Beneficence* means acting in the best interests of the patient. *Nonmaleficence* means avoiding unnecessary or non-therapeutic harm to the patient. *Justice* means fairness. These abstract terms can be and have been interpreted in a

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<sup>554</sup> Beauchamp and Childress, *Principles*.

number of ways. Despite the vagueness of these terms, they have relevance to the discussion of medical error disclosure.

Beneficence, an important goal of medicine, involves reducing suffering and contributing to healing. Although it is sometimes necessary to harm in order to restore health, the harm is only an unfortunate and temporary means to a praise-worthy end. The physician's duty of beneficence does not change when a physician makes an error. Although truthful disclosure of the error may be painful to the patient and the patient's family, the disclosure can help to heal the painful suspicions and anxieties about what will happen next and why.

When the patient needs further treatment to correct the effects of the error, or even when the only effect of the error is a prolonged stay in the hospital, the physician needs to tell the patient about what happened in order to be acting in the patient's best medical interests. Failure to do so can cause the patient to feel anxious, frustrated, abandoned, suspicious and angry.

William Winslade's experience with surgery for prostate cancer provides an example.<sup>555</sup> Winslade, though not a physician, is a professor at a medical school and an ethics consultant for a hospital.<sup>556</sup> He underwent the surgery expecting a hospital stay of

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<sup>555</sup> William J. Winslade, working paper, *Surgical Complications as Perceived by the Patient*, (Galveston, Tex.: University of Texas Medical Branch, 2006).

<sup>556</sup> Winslade, "Surgical Complications," 1.

a few days followed by a rapid recovery.<sup>557</sup> He agreed to submit to a robotic procedure after his highly regarded urologist, who claimed substantial experience with the technique, indicated that only tiny incisions would be necessary as opposed to a much larger one.<sup>558</sup>

Unfortunately, the surgery and the recovery did not go well. Needles lost in his body during the procedure extended Winslade's time in the operating room.<sup>559</sup> After the surgery, fluid leaked from a tube in his side instead of flowing through a Foley catheter to a collection bag.<sup>560</sup> Something was clearly wrong, but nobody was quite certain what to do about it. Without mentioning travel plans before the surgery the highly regarded urologist left town and was not available to deal with the complication.<sup>561</sup> Winslade spent thirteen days in the hospital, missed a month of work, and experienced considerable turmoil from a series of confusing and disappointing events during his stay.<sup>562</sup>

Throughout the telling of his story, Winslade emphasized his feelings of abandonment and frustration and his suspicion of a cover-up.<sup>563</sup> He did heal without any additional surgery, but he experienced losses that might have been devastating to

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<sup>557</sup> Winslade, "Surgical Complications," 1, 5.

<sup>558</sup> Winslade, "Surgical Complications," 2.

<sup>559</sup> Winslade, "Surgical Complications," 3, 8.

<sup>560</sup> Winslade, "Surgical Complications," 4.

<sup>561</sup> Winslade, "Surgical Complications," 4.

<sup>562</sup> Winslade, "Surgical Complications," 7.

<sup>563</sup> Winslade, "Surgical Complications," 5-8.

someone with fewer resources and social support. He did not receive an explanation or an apology. The only thing the urologist offered was that such a complication had never happened to *him* before, as if he were the one who experienced the discomfort of the delayed recovery.<sup>564</sup>

Winslade indicated that an apology would have gone a long way to ease his feelings of abandonment and resentment about his physician's apparent lack of concern about the quality of care his patient received.<sup>565</sup>

The harm that Winslade experienced from his experience went far beyond the physical. The physicians involved in his care failed in the area of nonmaleficence. The anger, frustration, and abandonment patients and their families feel when communication is poor and truthful disclosure is lacking is a harm that can rise to the level of a medical error. Furthermore, when additional or prolonged treatment is necessary as the result of a failed plan, the patient's autonomy is compromised. She cannot exercise her right to decide what is in her own best interests, such as changing facilities, changing physicians, or finding guidance and support for addressing the fallout from the error.

The issue of justice arises in instances of medical error. It is perhaps the greatest concern of people in the medical profession. Although the principle of justice usually involves the fair distribution of health-care goods and services, the term takes on a different meaning in the context of a medical error. It has the more common meaning of

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<sup>564</sup> Winslade, "Surgical Complications," 6.

<sup>565</sup> Winslade, "Surgical Complications," 8.

righting wrongs, achieving fairness, and restoring societal balance and order. It is this meaning that brings about opposition to the tort system, which has been called a mechanism for redistributing wealth from physicians to patients, instead of one for correcting the effects of negligence. It is for that reason, at least in part, that physicians think of compensating patients injured through medical errors as punishment.

It is not punishment. It is asking the party that carelessly inflicted harm to make up for the harmed person's loss. It is not unlike replacing or paying for a lost or damaged item that one borrowed or otherwise had in his possession. It is not unlike paying for the damage to another's car that was caused by one's own negligent driving.

Perhaps physicians who are required to compensate injured patients feel they are being punished because they are wedded to the idea that they have already paid their dues by sacrificing to become physicians. Or, perhaps they experience shock and bewilderment about being sued for errors when so many are overlooked and go uncompensated. Like the speeding driver who is ticketed when others are not and when he is accustomed to speeding without being caught, the erring physician may feel indignant that the system that is intended to protect and deter is not being used to deal with those who are *really* a threat to society.

The major point of this discussion is that patients expect care. When they do not receive what they believe they should receive in terms of care, they feel that physicians have failed to fulfill their duties.

As mentioned in Chapter 1, White discusses this concept of *care* in his book *Attention*.<sup>566</sup> He points out that *care* can have several meanings. Physicians *care* for patients or provide medical *care*. Lack of *care* can mean indifference about the outcome, or it can mean carrying out an action inattentively so that the outcome is not what was desired or expected. If a physician does not *care* about the patient, he or she may still provide adequate medical attention, yet feel no personal connection to the patient as an individual. However, if the physician does not *care* what happens to the patient, the physician is indifferent to the patient's needs or wellbeing and may provide inadequate health services. To do something with care can mean giving close attention to executing the action. *Careless* action can be executed with close attention, but without regard to the consequences, or without awareness that the plan one is executing is the wrong one.

Patients often expect several kinds of attention associated with the term *care*. Physicians may have much narrower ideas about the kinds of *care* they should provide. Their training generally does not provide preparation for addressing patient's emotional needs. When a physician fails to meet the patient's expectations of *care*, the patient is likely to interpret the physician's behavior as unsatisfactory.

According to Woods and others, one of the main reasons a patient sues a physician is that the angry patient feels the physician did not care.<sup>567</sup> Poor communication

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<sup>566</sup> White, *Attention*, 75-8.

<sup>567</sup> See, for example, Woods and Brucker, *Healing Words*, 9; Buckman and Kason, *How to Break Bad News*, 9, 27-8.

leads patients and their families to feel anger, distress, and a desire for revenge.<sup>568</sup> Woods notes that the culture of medicine encourages physicians to exhibit emotional detachment and to deny performance that is anything less than perfection. The physician's demeanor and denial of fallibility add to the patient's perception that the physician's does not care. Meeting the profession's expectations is sometimes not enough for members of the general public to feel that the physician has provided adequate care. Few are willing to define a physician as one who tinkers with a bundle of body bits.

Woods relates his own experience of being accused of medical malpractice to illustrate the differences in physicians' and patients' perceptions. One of his patients sued for an inadvertent slip of an instrument. Woods was conducting a laparoscopic procedure. When the mishap occurred, a larger incision was required to gain access to the damaged area and another specialist was brought in to make the repairs. The patient's recovery was delayed a few days.

The patient's grievance was not that the surgery and recovery did not go as well as expected, but rather that she felt Woods had failed to demonstrate the appropriate degree of interest or concern about the unfortunate series of events. Woods relates his patient's response to the question of why she sued as follows: "I sued because he acted

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<sup>568</sup> Buckman and Kason, *How to Break Bad News*, 9. "The frequency of litigation varies from country to country, but there are two common factors in all parts of the world: (1) litigation is becoming more, not less frequent and (2) the most common cause of litigation is failure of communication rather than true medical negligence."

like what happened to me was no big deal. One time when I saw him in the office after it happened, he actually put his feet up on the desk while we talked. He just didn't care."<sup>569</sup>

Woods, acting with detachment as he had been trained, was perceived as apathetic, cold, distant, and superior, in a word, arrogant.<sup>570</sup> His arrogance mirrored that of other physicians in similar situations.<sup>571</sup> When he heard his patient's reasoning, he was outraged. His first response was: "How could she do this when I had saved her life?"<sup>572</sup> He had responded in accord with what he called the physician's trained-in "denial and defend" approach to unfavorable outcomes. That approach is to "think, It was clearly unavoidable—an act of God for which I could not possibly be at fault. Why should I apologize?"<sup>573</sup>

After a period of reflection, Woods concluded that the "denial and defend" approach was not good medicine. Both physicians and patients need expressions of compassion and apologies when things go awry. "In the wake of a bad outcome, saying

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<sup>569</sup> Woods and Brucker, *Healing Words*, 9.

<sup>570</sup> Woods and Brucker, *Healing Words*, 10-8, 20.

<sup>571</sup> Albert W. Wu, "Handling Hospital Errors: Is Disclosure the Best Defense?," *Annals of Internal Medicine* 131, no. 12 (December 21, 1999): 970.

<sup>572</sup> Woods and Brucker, *Healing Words*, 8.

<sup>573</sup> Woods and Brucker, *Healing Words*, 11-2.

I'm sorry could be as helpful for the patient's—and the physician's—psychic healing process as antibiotics are for curing an infections.”<sup>574</sup>

Attitudes about apologies are changing somewhat as new evidence becomes available. Studies show that patients want and expect apologies when something goes wrong.<sup>575</sup> Perhaps more important, studies indicate that apologies may reduce the likelihood of malpractice litigation and lead to smaller amounts of compensation paid to injured patients.<sup>576</sup> That has been the experience of the Veterans Affairs medical center in Lexington, Kentucky.<sup>577</sup> The center instituted a policy of full disclosure, apology, and compensation for injured patients. The result was a greater number of claims for compensation, but lower total payouts and litigation costs.

Apologies should not be attempts to manipulate just to avoid litigation and compensating patients. That is not to say that there can never be an apology that is made

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<sup>574</sup> Woods and Brucker, *Healing Words*, 3.

<sup>575</sup> See, for example, Kathleen M. Mazor, Steven R. Simon, R. A. Yood, B. C. Martinson, M. J. Gunter, G. W. Reed and Jerry H. Gurwitz, "Health Plan Members' Views on Forgiving Medical Errors," *American Journal of Managed Care* 11, no. 1 (2005): 49-52; Mazor, Simon and Gurwitz, "Communicating with Patients": 1690-07; Thomas H. Gallagher, Amy D. Waterman, Alison G. Ebers, Victoria J. Fraser and Wendy Levinson, "Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors," *Journal of the American Medical Association* 289, no. 8 (February 26, 2003): 1001-7; C. Hobgood, C. R. Peck, B. Gilbert, K. Chappell and B. Zou, "Medical Errors-What and When: What Do Patients Want to Know?," *Academic Emergency Medicine* 9, no. 11 (November 2002): 1156-61; M. Hingorani, T. Wong and G. Vafidis, "Patients' and Doctors' Attitudes to Amount of Information Given after Unintended Injury During Treatment: Cross Sectional, Questionnaire Survey," *British Medical Journal* 318, no. 7184 (1999): 1640-1; A. B. Witman, D. M. Park and S. B. Hardin, "How Do Patients Want Physicians to Handle Mistakes? A Survey of Internal Medicine Patients in an Academic Setting," *Archives of Internal Medicine* 156, no. 22 (1996): 2565-9.

<sup>576</sup> Wu, "Handling Hospital Errors," 970-2.

<sup>577</sup> Kraman and Hamm, "Risk Management," 963-7.

for reasons other than a desire to appease the injured party. Lazare claims that some apologies can be effective whether genuine or not. “Apologies genuine or not, can be effective (or regarded as successful) when the offender is humiliated and the offended has their dignity restored.”<sup>578</sup> To illustrate, he relates the story of a famous military leader who had slapped two ill soldiers whose ailments were not apparent and accused them of cowardice; then, bragged about his behavior. The country’s president ordered the military leader to apologize to the soldiers he slapped, as well as an entire military division. The military leader complied with the president’s demand and accepted what he considered humiliation so he could stay in good graces with the president and not because he felt remorse for slapping the soldiers. The soldiers’ dignity was restored despite the insincerity of the apology. Although this story may have limited applications in medicine, sincere apologies should be the norm.

The timing and delivery of error disclosure and apology are vital to their success. Waiting too long can diminish the value of the communication. The harmed party may have developed such anger and suspicion that nothing but revenge will provide any satisfaction. If the communication is delayed, he or she may believe that only pressure from another source brought about the disclosure or that the disclosure and expression of regret or apology are intended to cover up something worse than the immediately known circumstances.

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<sup>578</sup> Lazare, *On Apology*, 225.

Recall that a true apology has four elements: recognition or acknowledgement of the offense; a sincere expression of regret or remorse; acceptance of responsibility, and if appropriate, acceptance of accountability; and a remedy or reparations. The true apology requires that the erring party *recognize* that an error has occurred.<sup>579</sup> As discussed at length in another chapter, this is not always a simple matter. Sometimes an investigation will be necessary to determine whether or not a bad outcome is due to error. The physician will not want to encourage the patient to assume an error occurred, if it is not relatively clear. Nevertheless, disclosure of what is known and an explanation of next steps to be taken along with a sincere expression of concern are in order. If the bad outcome was determined to be due to error, further investigation may be necessary to determine whether the error was preventable and/or of the culpable variety.

The recognition to which Woods refers is not always the need to provide a full apology. Sometimes, it is recognition of a need to offer words of regret or commiseration preliminary to knowing that a full apology is in order. He suggests that the cues about how to interact with the patient or patient's family are available in the encounter. He suggests that the physician must pay attention to his or her own feelings and evidence of tension in verbal and non-verbal communication.<sup>580</sup>

Note that Woods is suggesting that physicians need to pay attention to matters beyond those needed to accurately diagnose and treat. He is urging that the physician

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<sup>579</sup> Woods and Brucker, *Healing Words*, 40.

<sup>580</sup> Woods and Brucker, *Healing Words*, 45.

demonstrate the same courtesies expected in other types of social encounters, instead of one-upmanship. He implies that developing the habit will improve physician-patient relationships, in general.

Regret or remorse is the second step in the four-step process of apology. If it is clear that an error led to the patient's injury, negligent or not, the treating physician and the erring health-care professional (if they are not the same) should tell the patient or the patient's family that they are sorry for the error that caused the patient's injury. The erring party should use words similar to "I am sorry I made an error that caused your injury." In addition, they should explain what happened, why it happened, and how it happened to the extent it is known. The non-erring physician who is present is there to take the next step.

Responsibility and/or accountability make up the third step in the apology process. If it is not clear what happened to cause the patient's injury or why or how the injury came about, it is the physician's responsibility to find out, to make the information available to the injured patient, and to facilitate any further care that is necessary. This should take place regardless of whether the patient's injury was the result of error. However, if the injury was the result of error and anything can be done to prevent similar problems, the physician has the responsibility to initiate whatever change is necessary and to inform the patient or patient's family of the steps taken to initiate change.

The remedy step in Woods's four-step apology responds to three questions first posed by Gallagher and colleagues in "Patients' and Physicians' Attitudes Regarding Disclosure of Medical Errors:"

1. "What is being done to correct the problem that I now have?"
2. "How will this affect my health in the short term and the long term?"
3. "Am I going to be responsible for the cost of this error or complication?"<sup>581</sup>

In an ideal world, patients would be provided with information on investigations into complications and errors as part of their informed consent process. The process would allow input from the injured patient and would generate a written summary that would be open to scrutiny. This would reduce concerns about cover-ups and collusion to avoid compensation. In addition, it would possibly make patients aware that health-care professionals are human and make mistakes, thus, reducing unrealistic expectations of perfection. Furthermore, in the event of a bad outcome, patients may be better prepared for what will follow.

Some physicians will argue that it is not they who provide the barriers to truthful disclosure, but rather it is their lawyers who discourage it. In their article "To Tell or Not to Tell: Disclosing Medical Error," William J. Winslade and E. Bernadette McKinney discuss why erring physicians should honestly disclose errors and apologize and why

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<sup>581</sup> Thomas H. Gallagher, Amy D. Waterman, Alison G. Ebers, Victoria J. Fraser and Wendy Levinson, "Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors," *Journal of the American Medical Association* 289, no. 8 (February 26, 2003): 101-7; Woods and Brucker, *Healing Words*, 44.

their lawyers should encourage them to do so.<sup>582</sup> The AMA and various specialty organizations include in their codes of ethics that honest, full disclosure is appropriate. The AMA's statement of ethics on the matter appears below:

It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. 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. Only through full disclosure is a patient able to make informed decisions regarding future medical care. Ethical responsibility includes informing patients of changes in their diagnoses resulting from retrospective review of test results or any other information. This obligation holds even though the patient's medical treatment or therapeutic options may not be altered by the new information. Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient.<sup>583</sup>

The ethics statements do not say the physician should only honestly disclose when it is comfortable, convenient, or likely to be well-received. Unfortunately, as noted above in the Chapter 1 discussion of the research by Gallagher and colleagues, that is the way many physicians have interpreted their responsibility to patients.<sup>584</sup>

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<sup>582</sup> William J. Winslade and E. Bernadette McKinney, "To Tell or Not to Tell: Disclosing Medical Error," *Journal of Law, Medicine & Ethics* 34, no. 4 (Winter 2006): 813-6.

<sup>583</sup> Council on Ethical and Judicial Affairs AMA, "Patient Information, Section 8.12," American Medical Association, <http://www.ama-assn.org> (accessed August 4, 2006).

<sup>584</sup> See Gallagher, Waterman, Garbutt, Kapp, Chan, Dunagan, Fraser and Levinson, "U.S. and Canadian Physicians' Attitudes," 1607-8.

## **Change Contexts**

### ***Mediation***

Mediation, also known as guided negotiation, may be helpful in facilitating open and clear communication between patients who believe their poor outcomes may be due to error and physicians and other health-care professionals are concerned about the possibility of an explosive situation. The goal would be to create a safe environment in which both sides feel they can speak freely; none of the proceedings would be available for use in a lawsuit. Prior to engaging in the mediation, the parties would listen to an explanation of the mediation process and sign an agreement stating that they will not raise their voices, will not act in an aggressive manner, and will not attempt to use any part of the proceedings for litigation.

I am not suggesting that mediation be used in place of an ethics consultation. Some responses to a situation are clearly wrong. Mediation to negotiate an unethical agreement or dispute settlement would not be an improvement over tort litigation.

There are different types of mediation. However, there is one particular type I believe will be useful in communicating about errors and arriving at a reasonable way to work toward reinforcing or repairing the relationship between the health-care provider(s) and the patient or patient's family. It is one that makes use of a disinterested third party trained in the process who sets rules for a face-to-face meeting between the parties, gives each side an uninterrupted opportunity to express their concerns and beliefs about what has taken place, checks for understanding of the points the individual speaking at a given

time has made, and allows each side an uninterrupted turn to question or rebut the other side's statements. At the end of these steps, the parties would be asked to consider the other party's understanding of the situation and, if necessary to work together to find common ground. If the parties are able to do so, they will work out a binding agreement about what they need to do to resolve any of their differences and sign it.

This process is relatively fast and simple, low in cost compared to litigation, and allows the parties to find a way to minimize damage to the relationship and fulfill the needs of both parties. There is one more important advantage; if reparations are necessary after the communication between the parties has been facilitated, the mediation process allows an injured party to ask for reparations that have nothing to do with money.

This process would not preclude fulfilling reporting requirements. If the patient or patient's family believe that the patient's injury is due to medical negligence and do not wish to enter into an agreement with the health-care provider(s), they would have the option of pursuing litigation.

Many times, the injured parties who want to sue have no concept of the other party's point of view. Sometimes, once they gain information that was not previously available to them, they realize that they have misunderstood or misinterpreted the situation. If fault is clear, they often want actions that will restore their dignity as much or more than they want restitution.<sup>585</sup> Wu elaborates:

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<sup>585</sup> I speak from my own experience as a mediator. I have directed mediations that restored relationships simply by providing a controlled forum for an exchange of information in which both sides have equal rights and power to express their thoughts. I have seen angry opponents walk into a mediation

Why do patients sue? Bad outcomes and errors in care are obvious factors, but some of the available evidence implicates deficient communication. One attorney explained it to me this way:

In over 25 years of representing both physicians and patients, it became apparent that a large percentage of patient dissatisfaction was generated by physician attitude and denial, rather than the negligence itself. In fact, my experience has been that close to half of malpractice cases could have been avoided through disclosure or apology but instead were relegated to litigation. What the majority of patients really wanted was simply an honest explanation of what happened, and if appropriate, an apology. Unfortunately, when they were not only offered neither but were rejected as well, they felt doubly wronged and then sought legal counsel.<sup>586</sup>

## **Change Beliefs**

### ***Emotional Support for Erring Health-Care Providers***

The culture of medicine's emphasis on independence and physician autonomy has an unintended side effect. It encourages physicians to keep their emotions to themselves in order to avoid the appearance of weakness or inadequacy. The problem with this stance is that physicians, like other human beings, need support in times of stress. Errors are stressful. The fear that physicians experience concerning loss of status among peers provides them with little in the way of opportunities to grieve their personal losses and forgive themselves for human frailties.

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room each believing that they are in the right and walk out with a different perspective on what happened, how it happened, and why it happened. I have assisted tense disputants in finding a way to resolve their fears and anger through a cooperative effort and walk out with smiles on their faces.

<sup>586</sup> Wu, "Handling Hospital Errors," 970.

Daniel Ofri writes about the perils of working in the medical profession and the need for emotional support. Although she is not specifically referring to medical error, one can gain insight into the stress physicians face from her statement:

Ours is a dangerous profession, I've often thought. There is the constant assault of physical and emotional challenges of taking care of patients that is layered upon the already difficult task of conducting our own lives. It is no wonder that so many of us become overwhelmed at times and need some intensive care. For every Dr. Sitkin [a physician who committed suicide] who eventually declares his pain to the world, there are probably fifty others who suffer silently, for who the anguish burns slowly and excruciatingly. The medical profession has little room or patience for hearing about this. These feelings often get expressed as bitter, abusive personalities, or drug and alcohol addictions.

The cliché says that doctors make the worst patients, that they are the last to seek treatment. We are always trying to help our patients get beyond their denial, but it seems that we use it most for ourselves. Is that the Faustian bargain we make when we enter the profession. I don't want to believe that is true, but for some it is apparently so.<sup>587</sup>

Seeking self-forgiveness should not replace seeking forgiveness from the injured patient and his family. However, it is an important step in regaining a sense of competence and appreciation for the work to which he has devoted so much. Talking to a person who is a trained listener, who is not judgmental and who understands the extraordinary pressures associated with the health-care environment would probably be ideal.

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<sup>587</sup> Ofri, *Singular Intimacies*, 221.

Unfortunately, seeking out a counselor or psychiatrist is seen by many, not just physicians, as a weakness.<sup>588</sup> The culture of medicine discourages the appearance or admission of weakness. Therefore, this is another area of the culture that will need to change. Knowing one's vulnerabilities and limits is a sign of strength. Physicians are supposed to know their professional limits and consult others who are more skilled in a particular area of expertise. The same should be recognized as necessary and appropriate when it comes to addressing their own emotional needs.

## **Change Acculturation**

### ***Medical Education***

Medical education is a necessary step in bringing about changes in the culture of medicine. The medical education cannot begin with a group of students; it must begin with the people who serve as the teachers, mentors, and role models for the students. If the hidden curriculum is the source of information for students and trainees about the way medicine really works, those who teach them how medicine really works must practice what they preach. Students and residents must be given the opportunity to have the kind of mentoring, guidance, and role models that will help them to address the needs of their patients, their own needs, and the needs of the organization(s) they work within to be able to cope successfully with the pressures and stresses of practicing medicine, while remaining true to their ideals.

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<sup>588</sup> See generally Erin Prather, "Ultimate Failure: Some Physicians Find the Life They Can't Save Is Their Own," *Texas Medicine* 101, no. 5 (May 2005): 30-8.

## *Leadership*

Providing the kind of leadership that physicians-in-training need will be more difficult than encouraging students and residents to “Do what I say; not what I do.” As Woodruff says, “[y]ou cannot bring up your children to be principled or brave and also expect them to cave in to your authority. In matters of character, strength leads to strength, and one lapse leads to another.”<sup>589</sup> Physicians who are entrenched in the culture of medicine will have to act consciously, thinking carefully about what they are doing and saying, why they are taking the actions they take, and how their behaviors may be perceived and understood by their students and trainees.

Note the parallels between Woodruff’s discussion of leadership in the military and certain aspects of the culture of medicine and its traditions:

Leadership training thirty years ago included a strong injunction never to admit that you are wrong when you are in a position of authority. An officer, we were told, is never lost, never ill informed, never without resources to complete a mission. “Can do, sir! Was the refrain of an officer in those days.” We were taught, in other words, to deceive those above us and below in a systematic way, as if a mask of deceit were essential to good leadership. It isn’t. True, soldiers will not follow an officer who is clueless or who leads them into disaster, But in a healthy unit, soldiers can respect an officer who makes unfair decisions, if they recognize in him or her a common commitment to fairness, and they can respect a reverent leader who makes an occasional mistake. They will actually respect their officers all the more if they do not catch them hiding their mistakes or blaming them on other people. A reverent leader need not pretend to be godlike; the ideals are godlike enough.<sup>590</sup>

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<sup>589</sup> Woodruff, *Reverence*, 25.

<sup>590</sup> Woodruff, *Reverence*, 202.

The physicians who teach the future physicians will have to recognize that they are leaders who are expected to lead by good example, not by following the same well-worn path that their predecessors followed.

In addition to changing the ways mentors interact with their charges other changes will have to take place. Administrators, medical organizations leaders, legislators and others with influence will have to support the new approach with words, actions, and resources.

Unfortunately, there is little evidence that the resources will be there to facilitate change. Evidence for this can position can be found in Leape and Berwick's article: "[u]nfortunately, in 2004 after only 3 years of support, federal funding for patient safety research through AHRQ [Agency for Healthcare Research and Quality] became almost entirely earmarked toward studies of information technology."<sup>591</sup> This suggests that there is little enthusiasm for trying to change attitudes; instead, automation is expected to make all the difference. These parties will also have to act as reverent, respectful leaders.

A number of remedies have been proposed for addressing the medical error-patient safety-malpractice crisis. Among them are caps on malpractice damages, the systems approach, enterprise liability, apology legislation, and no-fault insurance. Each proposed solution leans in favor of the medical profession by offering financial protections for the erring physicians.

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<sup>591</sup> Leape and Berwick, "Five Years after *to Err Is Human*," 2385.

## **Chapter 6: Summary and Conclusions**

### **SUMMARY**

The research on the incidence of medical errors has brought to light the need for a number of changes in the health-care industry, not the least of which is agreement about what is and is not a medical error, and what should be done about it once a medical error has been identified.

I have reviewed several definitions of medical error, showing that there is considerable ambiguity in the term. The definition that is most often used in articles that favor the systems approach is overly vague and brief. Other definitions offer insights into the types of errors that occur in medicine, the situations in which they occur, and the reasons people err. Unfortunately, the variety and number of definitions provide little guidance for one who is trying to distinguish an error from a non-error. Before attempts are made to classify and explain errors, it seems necessary to have some method for identifying them. Sometimes errors are obvious to even the uninitiated observer. However, the less-than-obvious errors are the ones that are most likely to lend themselves to deception and self-deception. It is this ambiguity that has allowed the medical profession to maintain a degree of independence and flexibility that has not always served patients well.

The culture of medicine underlies many of the attitudes, beliefs, and strategies physicians have been known to use in dealing with medical errors. Although the term

culture of medicine is one that has been incautiously used, there is a core of meaning or meanings that make it a valuable tool. I have presented five ways of understanding the concept of culture, showing that each one can be applied to medicine to reveal something about what sets physicians as a group apart from the larger society. Whether one thinks of culture in terms of language and meaning, traditions and symbols, values and beliefs, norms and social roles, or knowledge and tools, medicine proves to be distinct from other endeavors. The people who enter the culture of medicine are changed into members of a group that experiences the world differently than outsiders. Their acculturation processes often model behaviors that can create turmoil and stress unnecessarily. The defense mechanisms physicians draw on for dealing with their discomfort have been part of the ways of physicians for centuries.

It is widely known that physicians have withheld important information from their patients, bent the truth to encourage compliance, and even lied to avoid unpleasant interactions with patients and their families. Apparently, without asking, most physicians came to the conclusion that patients were too ignorant, too emotional, or too fragile to make decisions about their health care needs or to cope with news about cancer or impending death.<sup>592</sup> With time came change and evidence that patients were no longer willing to accept without question physicians' assessments of patient's abilities and health-care needs. Scandals revealed that the professionals who were supposed to have

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<sup>592</sup> For more information about truth-telling and cancer, see Gary B. Weiss and Harold Y. Vanderpool, *Ethics and Cancer: An Annotated Bibliography* (Galveston, Tex.: University of Texas Medical Branch, 1984).

patients' best interests at heart were sometimes abusing their power and avoiding their responsibilities.

Recently, more evidence has come to light that the profession that seems devoted to perfection and science has failed to live up to its own ideals or to support its own complaints about the litigiousness of patients. The shocking information revealed through conservative research projects indicates that physicians have not demonstrated the honesty and integrity that the public expects. Physicians have concealed their errors from patients and colleagues in order to avoid being blamed for what they have done. As a result, patients injured through negligence have carried the burdens of their losses alone. The erring physician may have benefited from the additional care that the patient needed to recover from the mistake. Meanwhile, the concealed error which others might have learned to avoid has remained hidden.

There are a number of reasons that physicians hide their errors. Their education and training, their colleagues, and their position in the larger society create pressures that may be difficult for the outsider to grasp. They believe and act as they do in accord with what they perceive as reality, a reality formed through a special socialization process.

Priorities and fears shape the ways physician perceive medical error. Some understand the issues surrounding medical error as financial in nature. Some translate the issues into a struggle for power. Some focus on the quality of care, accountability, integrity, or professionalism in general. All recognize in one way or another that medical errors pose a threat to individual physicians and to the profession as a whole.

Those who focus on the financial concern themselves with avoiding high malpractice premiums, avoiding malpractice litigation and the associated losses, limiting exposure to liability through legal protections, and directing attention away from individual responsibility and accountability by advocating insurance innovations and administrative improvements in health-care organizations.

Those who focus on power complain of threats to physician autonomy and discretion. They express concerns about being thought of as technicians instead of independent professionals whose judgment is valued. They complain that the people who would regulate and evaluate their work want to deny the value of their experience and knowledge and do away with the parts of medical training that are necessary to develop the dedication and stamina to treat patients in all kinds of situations under any circumstances. They claim that physicians develop extraordinary abilities to think and act in the patient's best interests in the face of great uncertainty, extreme stress, and fatigue. They imply that because of their dedication and personal sacrifices, most errors, including negligent errors that are not due to incompetence, substance induced impairment, or reckless or intentional acts should have no consequences for physicians. Furthermore, regulation of the profession is the profession's business; outsiders cannot possibly understand. Therefore, physicians should not have to live in constant fear of malpractice litigation and punitive actions on the part of hospitals and insurers.

Attempts to limit physicians' power and discretion have been met with attempts to limit outsiders' influence through legislation, studies intended to demonstrate the truth of

physicians' beliefs, and propaganda to refute inconvenient revelations about medicine. In spite of these attempts, physicians have lost considerable power to non-physicians.

Those who focus on the various qualities that fall under medical education's formulation of professionalism seek to educate to build character, encourage the ability to see issues from others' perspectives, promote healthier relationships, and recognize in themselves and others the need for social and emotion support, especially in times of extraordinary stress.

Each viewpoint has its merits. Each must be addressed in some way to deal with the crisis in medicine, however it is perceived.

This paper is an attempt to show how a number of issues associated with failure to adequately disclose medical errors are interrelated and grow out of what is commonly called the culture of medicine. The main thrust of this exploration is to show that the culture of medicine will have to undergo meaningful change for physicians to accept responsibility for medical errors, for physicians to treat patients injured through medical error with due respect, and for physicians to improve patient safety.

## **CONCLUSIONS**

The medical profession is in the midst of a crisis. I am not referring to the medical malpractice crisis. The crisis is one of moral authority. Physicians have lost some of their power and prestige. More important, they have lost trust. When abuses by physician-researchers made the news in the early 1970s, the public realized that physicians sometimes had agendas that did not fit with patients' needs and preferences. The more

recent revelations by The Institute of Medicine's about deaths and injuries caused by medical errors have further tarnished the image of the physician.

Physicians and others recognize that something has to change. The problems with informed consent and ethical treatment of patients changed when lawyers, philosophers, and reformers of various types applied pressure from outside the medical profession. They did so because there was no indication that the medical profession would change without external pressure. As awareness of the problems with patient safety and lack of disclosure and reporting grows, a number of authors studying the issues are once again advocating for additional outside pressure to bring about change. Hyman and Silver share this view as do Gallagher and his colleagues. Physicians and hospital are responding to the safety issues by creating new policies and making improvements in information technology. However, there is little evidence that physicians are changing the way they think, a necessary step for restoring the profession's moral authority and patients' trust that they will be treated fairly and with respect in the event of a medical error.

Gallagher and colleagues recognize that for real change to occur there must be true leadership and support for change. Those in influential positions in health-care organizations must be committed to supporting disclosure and reporting in ways that are meaningful. Creating forms and buying new software are not enough to demonstrate commitment.

Buy-in at the top is not enough, either. Physicians place great value on their own autonomy and discretion. The top in medicine is difficult to identify. There is no official

supreme panel of physicians, no pope of doctordom, no president of united physicians. Nevertheless, charismatic leaders, heads of professional and medical service organizations, medical educators, and others who have influence over the shaping of physicians' behavior must share recognition and desire for meaningful change for it to be realized.

External pressure, though necessary for adoption of certain practices and procedures and for bringing thought processes and beliefs to light, is insufficient to cause change in the culture of medicine. Informed consent, the result of external pressure, is often considered by physicians to be an empty exercise, an addition to the bureaucratic part of the business of medicine that fulfills legal requirements, but does not have much effect on how much the patient understands or on medical decision making.<sup>593</sup> Physicians continue to control information and to influence perceptions about what choices patients should make.

The changes necessary for honesty, transparency, and improvements in patient safety must become part of the acculturation process. Currently, much of the acculturation process is unconscious. Physicians learn most about how to be physicians from other physicians. Attitudes, beliefs, approaches to problem-solving, and ways of interacting with colleagues and patients are usually obtained by watching, listening, modeling behavior on that of superiors, and receiving feedback from them.

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<sup>593</sup> Grant H. Morris, "Dissing Disclosure: Just What the Doctor Ordered," *Arizona Law Review* 44 (Summer 2002): 317-43.

The insecurities and fears the professions' members exhibit reflect a sense of victimization and loss of power, power that traditionally has been protected through secrecy, deception, and exclusion. Demands that physicians give up more power to entities outside the profession are likely to be met with resistance. Attempts to impose structures, rules, and processes may be successful on the surface, but unless physicians decide to make them part of the medical culture, the interventions will be undermined or skirted. There are already policies and procedures for reporting for hospitals. However, the numbers of incidents reported bear no resemblance to the findings of researchers cited in the IOM report.<sup>594</sup>

The answer is to recognize physicians' need for empowerment. They need better coping skills, better communication strategies, and better ways of learning about how to avoid errors. They need laws and policies that reduce fears without taking away consequences for misdeeds, ways of compensating patients injured by error that do not

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<sup>594</sup> The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) at first required reporting, then backed down and asked for voluntary reporting. "A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response." <http://www.jointcommission.org/SentinelEvents/> There have been 3811 sentinel events reviewed by the Joint Commission since January 1995 when reporting began. Of these 3811 sentinel events, 501 were due to patient suicide. [http://www.jointcommission.org/NR/rdonlyres/74540565-4D0F-4992-863E-8F9E949E6B56/0/se\\_stats\\_6\\_30\\_06.pdf](http://www.jointcommission.org/NR/rdonlyres/74540565-4D0F-4992-863E-8F9E949E6B56/0/se_stats_6_30_06.pdf)

destroy the careers of good doctors, and renewed commitment to act honorably and compassionately toward patients.

No single solution will address the issues of patient safety, physician responsibility and accountability, patient compensation for iatrogenic injury, and containing health-care costs. The response to these issues must necessarily be complex and multifaceted. Culture change means upsetting conventional wisdom and making unconscious choices conscious.

Conventional wisdom does not always serve us well. As Verlyn Klinkenborg wrote in a *New York Times* column:

Unlike scientists, most of us tend to live easily, almost unknowingly among our assumptions—another word for our ignorance. But the business of science is to formally test assumptions, better known as hypotheses. You can feel the tension between these two ways of knowing in a few lines from the movie “Men in Black” The scene is the Manhattan waterfront. Will Smith is still in shock after his first encounter with aliens. Tommy Lee Jones says to him, “Fifteen hundred years ago everybody knew the earth was the center of the universe. Five hundred years ago, everybody knew the earth was flat. And fifteen minutes ago you knew that people were alone on this planet. Imagine what you’ll know tomorrow.” Obviously, what everybody knows isn’t a very high standard of proof. And things that can be proven—matters of scientific fact—don’t always surface as common knowledge.<sup>595</sup>

Physicians’ version of common knowledge is equally susceptible to careful scrutiny.

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<sup>595</sup> Verlyn Klinkenborg, “On the Recentness of What We Know,” *The New York Times*, August 9, 2006.

## Bibliography

- ABIM Foundation, ACP Foundation & European Federation of Internal Medicine.  
"Medical Professionalism in the New Millenium: A Physician Charter." ABIM Foundation,  
[http://www.abimfoundation.org/professionalism/pdf\\_charter/ABIM\\_Charter\\_I ns.pdf](http://www.abimfoundation.org/professionalism/pdf_charter/ABIM_Charter_I ns.pdf) (accessed February 13, 2007).
- AMA. "Medical Student Section: Medical Student Debt." American Medical Association, <http://www.ama-assn.org/ama/pub/category/5349.html> (accessed February 15, 2007).
- AMA, Council on Ethical and Judicial Affairs. "Patient Information, Section 8.12." American Medical Association, <http://www.ama-assn.org> (accessed August 4, 2006).
- . "Principles of Medical Ethics." <http://www.ama-assn.org/ama/pub/category/2512.html> (accessed January 31, 2007).
- . "Withholding Information from Patients (Therapeutic Privilege)." [http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja\\_recs\\_2a06.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_recs_2a06.pdf) (accessed January 31, 2007).
- Andrews, Lori. "Studying Medical Error in Situ: Implications for Malpractice Law and Policy." *DePaul Law Review* 54 (2005): 357-92.
- Arendt, J.Todd, Judith Owens, Megan Crouch, Jessica Stahl, and Mary A. Carskadon. "Neurobehavioral Performance of Residents after Heavy Night Call vs after Alcohol Ingestion." *Journal of the American Medical Association* 294, no. 9 (2005): 1025-33.

Baker, Tom. *The Medical Malpractice Myth*. Chicago: University of Chicago Press, 2005.

Banja, John D. "Does Disclosure of Medical Error Violate the Medical Malpractice Insurance Cooperation Clause?" Agency for Healthcare Research and Quality, <http://www.ahrq.gov/qual/advances/> (accessed August 4, 2006).

———. *Medical Errors and Medical Narcissism*. Sudbury, Mass.: Jones and Bartlett Publishers, 2005.

Barber, Nick, M. Rawlins, and B. Dean Franklin. "Reducing Prescribing Error: Competence, Control, and Culture." *Quality & Safety in Health Care* 12 Suppl 1 (2003): i29-32.

Beauchamp, Tom L., and James F. Childress. *Principles of Biomedical Ethics*. 5th ed. New York: Oxford University Press, 2001.

Beckman, Howard B., and Richard M. Frankel. "The Effect of Physician Behavior on the Collection of Data." *Annals of Internal Medicine* 101, no. 5 (1984): 692-6.

Beecher, Henry K. "Ethics and Clinical Research." *New England Journal of Medicine* 274 (1966): 1354-60.

Berger, Peter L., and Thomas Luckmann. *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. New York: Anchor Books, 1967.

Berlinger, Nancy. *After Harm: Medical Error and the Ethics of Forgiveness*. Baltimore, Md.: Johns Hopkins University Press, 2005.

Berlinger, Nancy, and Albert W. Wu. "Subtracting Insult from Injury: Addressing Cultural Expectations in the Disclosure of Medical Error." *Journal of Medical Ethics* 31, no. 2 (2005): 106-8.

*Black's Law Dictionary: Definitions of the Terms and Phrases of American and English Jurisprudence, Ancient and Modern*. 6th ed. St. Paul, Minn.: West Publishing, 1990.

Blumhagen, Dan W. "The Doctor's White Coat. The Image of the Physician in Modern America." *Annals of Internal Medicine* 91, no. 1 (1979): 111-6.

Boehm, Geoff. "Debunking Medical Malpractice Myths: Unraveling the False Premises Behind "Tort Reform"." *Yale Journal of Policy & Ethics* 5 (2005): 357-69.

Bok, Sissela. *Lying: Moral Choice in Public and Private Life*. New York: Pantheon Books, 1978.

Boozang, Kathleen M. "The Therapeutic Placebo: The Case for Patient Deception." *Florida Law Review* 54 (2002): 687-746.

Borkan, Jeffrey M., and William L. Miller. "Storytelling in Medicine." In *Patients and Doctors: Life Changing Stories from Primary Care*, edited by Jeffrey Borkan, Shmuel Reis, Dov Steinmetz and Jack H. Medalie, 3-13. Madison, Wisc.: University of Wisconsin Press, 1999.

Bosk, Charles L. *Forgive and Remember: Managing Medical Failure*. 2nd ed. Chicago: University of Chicago Press, 2003.

Branch, William T. "Deconstructing the White Coat." *Annals of Internal Medicine* 129, no. 9 (1998): 740-2.

- Brennan, Troyen A., and Lucian L. Leape. "Adverse Events, Negligence in Hospitalized Patients: Results from the Harvard Medical Practice Study." *Perspectives in Healthcare Risk Management* 11, no. 2 (1991): 2-8.
- Brennan, Troyen A., Lucian L. Leape, N. M. Laird, L. Hebert, A. R. Localio, A. G. Lawthers, J. P. Newhouse, P. C. Weiler, and H. H. Hiatt. "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I. 1991." *Quality & Safety in Health Care* 13, no. 2 (2004): 145-51; discussion 51-2.
- Brody, Howard. *The Healer's Power*. New Haven, Conn.: Yale University Press, 1992.
- . "Reflections." In *Patients and Doctors: Life-Changing Stories from Primary Care*, edited by Jeffrey Borkan, Shmuel Reis, Dov Steinmetz and Jack H. Medalie, 67-72. Madison, Wisc.: University of Wisconsin Press, 1999.
- Buckman, Robert , and Yvonne Kason. *How to Break Bad News: A Guide for Health Care Professionals*. Baltimore, Md.: The Johns Hopkins University Press, 1992.
- Burns, Chester R. "Setting the Stage: Moral Philosophy, Benjamin Rush, and Medical Ethics in the United States before 1846." In *The American Medical Ethics Revolution: How the Ama's Code of Ethics Has Transformed Physicians' Relationships to Patients, Professionals, and Society*, edited by Robert B. Baker, Arthur L. Caplan, Linda L. Emanuel and Stephen R. Latham, 3-16. Baltimore, Md.: Johns Hopkins Press, 1999.
- Burton, Elizabeth C., and Peter N. Nemetz. "Medical Error and Outcomes Measures: Where Have All the Autopsies Gone?" *Medscape General Medicine* 2, no. 2 (2000): E8.

Cabot, Richard C. *Honesty*. New York: The Macmillan Company, 1938.

Calman, Neil S. "No One Needs to Know." *Health Affairs* 20, no. 2 (2001): 243-9.

Campbell, Darell A., and Patricia L. Cornett. "How Stress and Burnout Produce Medical Mistakes." In *Medical Error: What Do We Know? What Do We Do?*, edited by Marilyn M. Rosenthal and Kathleen M. Sutcliffe, 37-57. San Francisco, Calif.: Jossey-Bass, 2002.

*Canterbury v. Spence*, 464 F.2d 772 (1972).

Capozzi, James D., and Rosamond Rhodes. "Lying for the Patient's Good." *Journal of Bone & Joint Surgery* 86-A, no. 1 (2004): 187-8.

Cassedy, James H. *Medicine in America: A Short History*. Baltimore, Md.: Johns Hopkins University Press, 1991.

Clausen, Christopher. "The Culture of Culture." *New Leader* 77, no. 6 (1994): 14-5.

Connor, M., P. R. Ponte, and J. Conway. "Multidisciplinary Approaches to Reducing Error and Risk in a Patient Care Setting." *Critical Care Nursing Clinics of North America* 14, no. 4 (2002): 359-67, viii.

Cox, Harvey. "The Roots of Repentance: Some Thoughts on Forgiveness for a Nation in the Midst of Apologies." *Religion and Values in Public Life* 5, no. 4 (1975).

Cranfill, Linda W. "Approaches for Improving Patient Safety through a Safety Clearinghouse." *Journal for Healthcare Quality* 25, no. 1 (2003): 43-7.

Davis, Neil M., and Michael R. Cohen. *Medication Errors: Causes and Prevention*. Philadelphia, Pa.: George F. Stickley 1983.

De Ville, Kenneth. *Medical Malpractice in Nineteenth-Century America: Origins and Legacy*. New York: New York University Press, 1990.

Deskin, W. C., and R. E. Hoyer. "Another Look at Medical Error." *Journal of Surgical Oncology* 88, no. 3 (2004): 122-9.

Dovey, S. M., and R. L. Phillips. "What Should We Report to Medical Error Reporting Systems?" *Quality & Safety in Health Care* 13, no. 5 (2004): 322-3.

Even-Zohar, Itamar. "Culture as Goods, Culture as Tools." Tel Aviv University, <http://www.tau.ac.il/~itamarez/works/papers/papers/good-tools.pdf#search='Zohar%20tools%20culture'> (accessed January 11,, 2007).

Fadiman, Anne. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. New York: Farrar, Straus and Giroux, 1997. Reprint, 2000.

Fan, Ruiping, and Benfu Li. "Truth Telling in Medicine: The Confucian View." *Journal of Medicine and Philosophy* 29, no. 2 (2004): 179-93.

Fishbein, Morris. *Morris Fishbein, M.D.; an Autobiography*. New York: Doubleday, 1969.

Ford, Charles. *Lies!, Lies!, Lies!: The Psychology of Deceit*. Washington, DC: American Psychiatric Press, 1999.

Fresne, Julie, Matthew Shick, and Raj Sabharwal. "Medical Student Education: Cost, Debt, and Resident Stipend Facts." American Association of Medical Colleges, <http://www.aamc.org/students/financing/debthelp/factcard06.pdf> (accessed February 15, 2007).

Fulghum, Robert L. *All I Really Need to Know I Learned in Kindergarten*. New York: Random House, 2003.

Gallagher, Thomas H., Jane M. Garbutt, Amy D. Waterman, David R. Flum, Eric B. Larson, Brian M. Waterman, W. Claiborne Dunagan, Victoria J. Fraser, and Wendy Levinson. "Choosing Your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients." *Archives of Internal Medicine* 166, no. 15 (2006): 1585-93.

Gallagher, Thomas H., Amy D. Waterman, Alison G. Ebers, Victoria J. Fraser, and Wendy Levinson. "Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors." *Journal of the American Medical Association* 289, no. 8 (2003): 1001-7.

———. "Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors." *Journal of the American Medical Association* 289, no. 8 (2003): 1001-7.

Gallagher, Thomas H., Amy D. Waterman, Jane M. Garbutt, Julie M. Kapp, David K. Chan, W. Claiborne Dunagan, Victoria J. Fraser, and Wendy Levinson. "U.S. and Canadian Physicians' Attitudes and Experiences Regarding Disclosing Errors to Patients." *Archives of Internal Medicine* 166, no. 15 (2006): 1605-11.

Gawande, Atul. *Complications: A Surgeon's Notes on an Imperfect Science*. New York: Picador, 2002.

Geertz, Clifford. "Thick Description: Toward and Interpretive Theory of Culture." In *The Interpretation of Cultures*, 470. New York: Basic Books, 1973.

Goffman, Erving. *Frame Analysis*. New York: Harper & Row, 1974.

Good, Mary-Jo DelVecchio, Cara James, Byron J. Good, and Anne E. Becker. "The Culture of Medicine and Racial, Ethnic, and Class Disparities in Healthcare." *Russell Sage Working Papers* 199 (2002): 594-624.

Grouse, Lawrence D. "The Lie." In *A Piece of My Mind: A Collection of Essays from the Journal of the American Medical Association*, edited by Bruce B. Dan and Roxanne K. Young, 25-7. Los Angeles: Feeling Fine Programs and Alfred A. Knopf, 1988.

Hall, Mark A. "Can You Trust a Doctor You Can't Sue?" *DePaul Law Review* 54 (2005): 303-13.

Hayre, Heta. *The Limits of Medical Paternalism*. London: Routledge, 1991.

Helmreich, Robert L., and A. C. Merritt. *Culture at Work: National, Organizational and Professional Influences*. Aldershot, U.K.: Ashgate, 1998.

Hilfiker, David. *Healing the Wounds*. Omaha, Neb.: Creighton University Press, 1998.

Hingorani, M., T. Wong, and G. Vafidis. "Patients' and Doctors' Attitudes to Amount of Information Given after Unintended Injury During Treatment: Cross Sectional, Questionnaire Survey." *British Medical Journal* 318, no. 7184 (1999): 640-1.

Hobgood, C., C. R. Peck, B. Gilbert, K. Chappell, and B. Zou. "Medical Errors-What and When: What Do Patients Want to Know?" *Academic Emergency Medicine* 9, no. 11 (2002): 1156-61.

- Hoijer, Harry. "The Sapir-Whorf Hypothesis." In *Readings in Anthropology*, edited by Morton H. Fried, 404-17. New York: Thomas Y. Crowell, 1968.
- Hughes, Rhonda G., and Eduardo Ortiz. "Medication Errors: Why They Happen, and How They Can Be Prevented." *Journal of Infusion Nursing* 28 (2005): 14-24.
- Hunter, Kathryn Montgomery. *Doctors' Stories: The Narrative Structure of Medical Knowledge*. Princeton, N.J.: Princeton University Press, 1991.
- Hyman, David A., and Charles Silver. "The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?" *Cornell Law Review* 90 (2005): 893-993.
- Jackson, Jennifer. *Truth, Trust, and Medicine*. New York: Routledge, 2001.
- Jones, Beverly. "Nurses and The "Code of Silence"." In *Medical Error: What Do We Know? What Do We Do?*, edited by Marilyn M. Rosenthal and Kathleen M. Sutcliffe, 84-100. San Francisco, Calif.: Jossey-Bass, 2002.
- Jones, James H. *Bad Blood: The Tuskegee Syphilis Experiment*. New York: Free Press, 1981 & 1993.
- Jones, W.H.S., and E.T. Withington. *Hippocrates*. 4 vols: Loeb Classical Library, 1923-31. Reprint, 1957-1959.
- Jonsen, Albert R., Mark Siegler, and William J. Winslade. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*. 5th ed. New York: McGraw Hill, 2002.

- Joshi, M. S., J. F. Anderson, and S. Marwaha. "A Systems Approach to Improving Error Reporting." *Journal of Healthcare Information Management* 16, no. 1 (2002): 40-5.
- Kagan, Robert, and Romaine Clifton. "Communicating with Patients." *American Journal of Clinical Oncology* 27, no. 6 (2004): 547-9.
- Kapp, Marshall B. "Medical Error Versus Malpractice." *DePaul Journal of Health Care Law* 1 (1997): 751-6.
- Katz, Jay. *The Silent World of Doctor and Patient*. Baltimore, Md.: Johns Hopkins University Press, 2002.
- Kazel, Robert. "Minnesota Insurer Won't Pay Hospital For "Never Events"." *American Medical News*, November 8 2004.
- Keating, Dominic T., Kayser Nayeem, J. J. Gilmartin, and Shaun T. O'Keeffe. "Advance Directives for Truth Disclosure." *Chest* 128, no. 2 (2005): 1037-9.
- Klass, Perri. *A Not Entirely Benign Procedure: Four Years as a Medical Student*. New York: Penguin Books/Plume, 1987.
- Klinkenborg, Verlyn. "On the Recentness of What We Know." *The New York Times*, August 9, 2006.
- Kohn, Linda T., Janet M. Corrigan, and Molla S. Donaldson, eds. *To Err Is Human: Building a Safer Health System*. Washington, D.C.: National Academy Press, 2000.

Konner, Melvin. *Becoming a Doctor: A Journey of Initiation in Medical School*. New York: Penguin Books, 1988.

Koster, Henry. "Harvey." 104 minutes. U.S.A., 1950.

Kraman, Steve S., and Ginny M. Hamm. "Risk Management: Extreme Honesty May Be the Best Policy." *Annals of Internal Medicine* 131, no. 12 (1999): 963-7.

Krause, Joan H. "Medical Error as False Claim." *American Journal of Law & Medicine* 27, no. 2-3 (2001): 181-201.

Krisman-Scott, Mary Ann. "An Historical Analysis of Disclosure of Terminal Status." *Journal of Nursing Scholarship* 32, no. 1 (2000): 47-52.

Krizek, Thomas J. "Surgical Error: Ethical Issues of Adverse Events." *Archives of Surgery* 135, no. 11 (2000): 1359-66.

Kroeber, Alfred L., and Clyde Kluckhohn. *Culture: A Critical Review of Concepts and Definitions*. New York: Random House, 1952.

Lakoff, George. *Don't Think Elephant!: Know Your Values and Frame the Debate*. np: Chelsea Green Publishing, 2006.

Lamont, Elizabeth B., and Nicholas A. Christakis. "Prognostic Disclosure to Patients with Cancer near the End of Life." *Annals of Internal Medicine* 134, no. 12 (2001): 1096-105.

Lantos, John. *Do We Still Need Doctors?* New York: Routledge, 1997.

Lazare, Aaron. *On Apology*. New York: Oxford University Press, 2005.

Leape, Lucian L. "Error in Medicine." *Journal of the American Medical Association* 272, no. 23 (1994): 1851-7.

———. "Error in Medicine." In *Margin of Error: The Ethics of Mistakes in the Practice of Medicine*, edited by Susan B. Rubin and Laurie Zoloth, 95-111. Hagerstown, Md.: University Publishing Group, 2000.

Leape, Lucian L., and Donald M. Berwick. "Five Years After *To Err Is Human*: What Have We Learned?" *Journal of the American Medical Association* 293, no. 19 (2005): 2384-90.

Leape, Lucian L., Troyen A. Brennan, Nan Laird, A. G. Lawthers, A. R. Localio, B. A. Barnes, L. Hebert, J. P. Newhouse, P. C. Weiler, and H. Hiatt. "The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II." *New England Journal of Medicine* 324, no. 6 (1991): 377-84.

Liang, Bryan A. "Clinical Assessment of Malpractice Case Scenarios in an Anesthesiology Department." *Journal of Clinical Anesthesiology* 11, no. 4 (1999): 267-79.

———. "Promoting Patient Safety through Reducing Medical Error: A Paradigm of Cooperation between Patient, Physician, and Attorney." *Southern Illinois University Law Journal* 24 (2000): 541.

———. "The Adverse Event of Unaddressed Medical Error: Identifying and Filling the Holes in the Health-Care and Legal Systems." *Journal of Law, Medicine & Ethics* 29 (2001): 346.

- Liang, Bryan A., and LiLan Ren. "Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare." *American Journal of Law & Medicine* 30 (2004): 501.
- Light, Donald, Jr., and Suzanne Keller. *Sociology*. 2nd ed. New York: Alfred A. Knopf, 1979.
- Litoff, Judy Barrett. "An Enduring Tradition: American Midwives in the Twentieth Century." In *Readings in American Health Care: Current Issues in Socio-Historical Perspective*, edited by William G. Rosthstein, 223-34. Madison: The University of Wisconsin Press, 1995.
- Macdonald, Elisabeth. "An Introduction to Basics." In *Difficult Conversations in Medicine*, edited by Elisabeth Macdonald, 1-4. New York: Oxford University Press, 2004.
- Martin, Mike W. *Self-Deception and Morality*. Lawrence: University Press of Kansas, 1986.
- Marvel, Kim M., Ronald M. Epstein, Kristine Flowers, and Howard B. Beckman. "Soliciting the Patient's Agenda: Have We Improved?" *Journal of the American Medical Association* 281, no. 3 (1999): 283-7.
- Mazor, Kathleen M., Steven R. Simon, and Jerry H. Gurwitz. "Communicating with Patients About Medical Errors: A Review of the Literature." *Archives of Internal Medicine* 164, no. 15 (2004): 1690-7.
- . "Communicating with Patients About Medical Errors: A Review of the Literature." *Archives of Internal Medicine* 164, no. 15 (2004): 1690-7.

Mazor, Kathleen M., Steven R. Simon, R. A. Yood, B. C. Martinson, M. J. Gunter, G. W. Reed, and Jerry H. Gurwitz. "Health Plan Members' Views on Forgiving Medical Errors." *American Journal of Managed Care* 11, no. 1 (2005): 49-52.

*Merriam-Webster's Collegiate Dictionary*. Edited by Frederick C. Mish. 10th ed. Springfield, Mass.: Merriam-Webster, 1993.

Miller, Merry N., and K. Ramsey McGowen. "The Painful Truth: Physicians Are Not Invincible." *Southern Medical Journal* 3, no. 10 (2000): 966-73.

Montgomery, Kathryn. *How Doctors Think: Clinical Judgment and the Practice of Medicine*. New York: Oxford University Press, 2006.

Morreim, E. Haavi. "Redefining Quality by Reassigning Responsibility." *American Journal of Law and Medicine* 20 (1994): 79-104.

———. *Holding Health Care Accountable: Law and the New Medical Marketplace*. New York: Oxford University Press, 2001.

Morris, Grant H. "Dissing Disclosure: Just What the Doctor Ordered." *Arizona Law Review* 44 (2002).

Morrissey, John. "Encyclopedia of Errors. Growing Database of Medication Errors Allows Hospitals to Compare Their Track Records with Facilities Nationwide in a Nonpunitive Setting." *Modern Healthcare* 33, no. 12 (2003): 40.

Myers, Keith. "Medical Errors: Causes, Cures, and Capitalism." *Journal of Law and Health* 16, no. 2 (2001): 255-88.

Natarajan, Anita. "Medical Ethics and Truth Telling in the Case of Androgen Insensitivity Syndrome." *Canadian Medical Association Journal* 154, no. 4 (1996): 568-70.

National Conference of State Legislators, Committee on Law & Criminal Justice. "Medical Malpractice Tort Reform: 2005 Enacted Legislation in the States." <http://www.ncsl.org/standcomm/sclaw/medmalreform05.htm> (accessed January 2, 2007).

———. "Medical Malpractice Tort Reform: 2006 Enacted Legislation in the States." <http://www.ncsl.org/standcomm/sclaw/medmalreform06.htm> (accessed January 2, 2007).

Novack, D. H., B. J. Detering, R. Arnold, L. Forrow, M. Ladinsky, and J. C. Pezzullo. "Physicians' Attitudes toward Using Deception to Resolve Difficult Ethical Problems." *Journal of the American Medical Association* 261, no. 20 (1989): 2980-5.

Ofri, Danielle. *Singular Intimacies: Becoming a Doctor at Bellevue*. Boston, Mass.: Beacon Press, 2003.

Organizations, Joint Commission on Accreditation of Healthcare. "Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury." Joint Commission on Accreditation of Healthcare Organizations, [http://www.jointcommission.org/NR/rdonlyres/167DD821-A395-48FD-87F9-6AB12BCACB0F/0/Medical\\_Liability.pdf](http://www.jointcommission.org/NR/rdonlyres/167DD821-A395-48FD-87F9-6AB12BCACB0F/0/Medical_Liability.pdf) (accessed February 14, 2007).

Patterson, Kerry, Joseph Grenny, Ron McMillan, and Al Switzler. *Crucial Conversations: Tools for Talking When Stakes Are High*. New York: McGraw-Hill, 2002.

Pinker, Steven. "Review of George Lakoff's "Whose Freedom?"" *The New Republic*, September 30, 2006.

"Power (Sociology)."  
[http://en.wikipedia.org/wiki/Power\\_\(sociology\)#Five\\_bases\\_of\\_power](http://en.wikipedia.org/wiki/Power_(sociology)#Five_bases_of_power)  
(accessed November 26, 2006).

Prather, Erin. "Ultimate Failure: Some Physicians Find the Life They Can't Save Is Their Own." *Texas Medicine* 101, no. 5 (2005): 30-8.

Pritt, Bobbi S., Nicolas J. Hardin, Jeffrey A. Richmond, and Steven L. Shapiro. "Death Certification Errors at an Academic Institution." *Archives of Pathology & Laboratory Medicine* 129, no. 11 (2005): 1476-9.

Reason, James T. *Human Error*. Cambridge [England]; New York: Cambridge University Press, 1990.

Reiser, Stanley J. "Words as Scalpels: Transmitting Evidence in the Clinical Dialogue." *Annals of Internal Medicine* 92, no. 6 (1980): 837-42.

Robbennolt, Jennifer K. "Apologies and Legal Settlement: An Empirical Examination." *Michigan Law Review* 102 (2003): 460-515.

Rosenthal, Marilyn M., and Kathleen M. Sutcliffe. "Struggling to Understand, Struggling to Act." In *Medical Error: What Do We Know? What Do We Do?*, edited by Marilyn M. Rosenthal and Kathleen M. Sutcliffe, 237-66. San Francisco, Calif.: Jossey-Bass, 2002.

Rothman, David J. *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making, Social Institutions and Social Change*. New York: Aldine de Gruyter, 2003.

Sage, William M. "Malpractice Liability, Patient Safety, and the Personification of Medical Injury: Opportunities for Academic Medicine." *Academic Medicine* 81, no. 9 (2006): 823-6.

Sharpe, Virginia A. "Taking Responsibility for Medical Mistakes." In *Margin of Error: The Ethics of Mistakes in the Practice of Medicine*, edited by Susan B. Rubin and Laurie Zoloth, 183-92. Hagerstown, Md.: University Publishing Group, 2000.

Shem, Samuel. *House of God*. New York: Dell, 1988.

Sinclair, Simon. *Making Doctors: An Institutional Apprenticeship*. New York: Berg, 1997.

Smith Sehdev, A. E., and G. M. Hutchins. "Problems with Proper Completion and Accuracy of the Cause-of-Death Statement." *Archives of Internal Medicine* 161, no. 2 (2001): 277-84.

Starr, Paul. *The Social Transformation of American Medicine*. n.p.: HarperCollins, 1982.

*Stedman's Concise Medical Dictionary for the Health Professions: Illustrated*. Edited by John Dirckx. 4th ed. Philadelphia, Pa.: Lippincott Williams & Wilkins, 2001.

Stein, Jesse, ed. *The Random House College Dictionary*. rev. ed. New York: Random House, 1975.

Stone, Deborah A. *Policy Paradox: The Art of Political Decision Making*. New York: W.W. Norton, 1997.

Studdert, David M., and Troyen A. Brennan. "No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention." *Journal of the American Medical Association* 286, no. 2 (2001): 217-23.

———. "Toward a Workable Model Of "No-Fault" Compensation for Medical Injury in the United States." *American Journal of Law and Medicine* 27, no. 2-3 (2001): 225-52.

Studdert, David M., Michelle M. Mello, and Troyen A. Brennan. "Medical Malpractice." *New England Journal of Medicine* 350, no. 3 (2004): 283-92.

Studdert, David M., Michelle M. Mello, Atul A. Gawande, Tejal K. Gandhi, Allen Kachalia, Catherine Yoon, Ann Louise Puopolo, and Troyen A. Brennan. "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation." *New England Journal of Medicine* 354, no. 19 (2006): 2024-33.

Thomas, Eric J., and Robert L. Helmreich. "Will Airline Safety Models Work in Medicine?" In *Medical Error: What Do We Know? What Do We Do?*, edited by Marilynn M. Rosenthal and Kathleen M. Sutcliffe, 217-34. San Francisco: Jossey-Bass, 2002.

Tovino, Stacey A. "ERISA Preempts Wrongful Denial of Benefits Action Involving "Pure Eligibility Decisions"." University of Houston Health Law and Policy Institute, <http://www.law.uh.edu/healthlaw/perspectives/HealthPolicy/070404revisederisa.pdf> (accessed January 13, 2007).

Wagner, Tor D., James K. Rilling, Edward E. Smith, Alex Sokolik, Kenneth L. Casey, Richard J. Davidson, Stephen M. Kosslyn, Robert M. Rose, and Jonathan D. Cohen. "Placebo-Induced Changes in fMRI in the Anticipation and Experience of Pain." *Science* 303, no. 20 (2004): 1662-7.

Watson, Paul J., Susan E. Hickman, and Ronald J. Morris. "Self-Reported Narcissism and Shame: Testing the Defensive Self-Esteem and Continuum Hypotheses." *Personality and Individual Differences* 21, no. 2 (1996): 253-9.

Watson, Paul J., Ronald J. Morris, and Liv Miller. "Narcissism and the Self as Continuum: Correlations with Assertiveness and Hypercompetitiveness." *Imagination, Cognition and Personality* 17, no. 3 (1997-98): 249-59.

Watson, Paul J., Sherri P. Varnell, and Ronald J. Morris. "Self-Reported Narcissism and Perfectionism: An Ego-Psychological Perspective and the Continuum Hypothesis." *Imagination, Cognition and Personality* 19, no. 1 (2000): 59-69.

*Webster's New World Dictionary of the American Language*. Edited by David Bernard Guralnik and Joseph H. Friend. Cleveland, Ohio: World Publishing, 1966.

Weiss, Gary B., and Harold Y. Vanderpool. *Ethics and Cancer: An Annotated Bibliography*. Galveston, Tex.: University of Texas Medical Branch, 1984.

Werner, Rachel M., G. Caleb Alexander, Angela Fagerlin, and Peter A. Ubel. "Lying to Insurance Companies: The Desire to Deceive among Physicians and the Public." *American Journal of Bioethics* 4, no. 4 (2004): 53-9.

White, Alan R. *Attention*. Oxford: Basil Blackwell, 1964.

Winslade, William J. "Working Paper, Surgical Complications as Perceived by the Patient." Galveston, Tex.: University of Texas Medical Branch, 2006.

Winslade, William J., and E. Bernadette McKinney. "To Tell or Not to Tell: Disclosing Medical Error." *Journal of Law, Medicine & Ethics* 34, no. 4 (2006): 813-6.

Winterstein, A. G., T. E. Johns, E. I. Rosenberg, R. C. Hatton, R. Gonzalez-Rothi, and P. Kanjanarat. "Nature and Causes of Clinically Significant Medication Errors in a Tertiary Care Hospital." *American Journal of Health-System Pharmacy* 61, no. 18 (2004): 1908-16.

Witman, A. B., D. M. Park, and S. B. Hardin. "How Do Patients Want Physicians to Handle Mistakes? A Survey of Internal Medicine Patients in an Academic Setting." *Archives of Internal Medicine* 156, no. 22 (1996): 2565-9.

Woodruff, Paul. *Reverence: Renewing a Forgotten Virtue*. New York: Oxford University Press, 2002.

Woods, Michael S., and Hilda J. Brucker. *Healing Words: The Power of Apology in Medicine*. Oak Park, Ill.: Doctors in Touch, 2004.

Wu, Albert W. "Handling Hospital Errors: Is Disclosure the Best Defense?" *Annals of Internal Medicine* 131, no. 12 (1999): 970-2.

———. "Medical Error: The Second Victim." *Western Journal of Medicine* 172, no. 6 (2000): 358-9.

X. *Intern*. New York: Harper & Row, 1965.