Medical Students and Remediation of Error

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THE LANDSCAPE OF MEDICINE IS STREWN WITH LAPSES OF judgment and slips of the knife and pen that mar the orderly lines of scientific practice. The Harvard Medical Practice study found that errors resulting in adverse events occurred in approximately 10% of patients. Occasionally medical errors are identified and discussed at morbidity and mortality meetings. However, many are never publicized and are known only to those directly involved. A medical student who observes a mistake during a surgical procedure is placed in the difficult position of deciding what to do with this information. If the patient inquires about the possibility of a mistake, how should the medical student respond?

Like all medical professionals, the medical student has a duty not to misrepresent or omit unpleasant facts. It can be argued that incomplete disclosure, avoidance of particular questions, or outright falsehood demonstrates a lack of respect to patients as persons. Does this imply that the medical student should disclose all errors to all patients, regardless of the circumstance or consequence? The medical student should appreciate the complexity of the situation and carefully balance the interests of the patients, including respect for patient autonomy and well-being, with the interests of the profession that he or she is aspiring to enter. The latter consideration includes the medical student's role within the medical system and an appreciation of the patient-physician relationship. Ultimately the role of medical student is not to disclose error but to facilitate the therapeutic relationship by conveying patients' concerns to the appropriate persons.

Are All Medical Errors Equal?

An error can be defined generally as “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.” Before the student initiates any response or action, he or she must determine whether they know all the relevant facts surrounding the perceived medical error. Students might feel a genuine uncertainty as to whether an error has actually occurred given their relative lack of experience and expertise. Medical students should also realize that “error” is not synonymous with negligence. For example, for centuries physicians reasonably prescribed bloodletting as means of expelling “bad humours.” These physicians were acting appropriately by the standards of their time and were therefore not negligent, although we now know that the logic of their treatment was flawed. Recognizing this distinction between negligence and error should decrease the tendency of the student reflexively to assign blame or to confront the physician with an attitude of veiled criticism.

Furthermore, not all medical mistakes are similar in type. For example, the medical student may have witnessed a surgical error that resulted from defective equipment. Or perhaps the error reflects a systemic defect in medical organization that allowed an operation to continue with inappropriately low levels of nursing staff, resulting in a crucial delay. Alternatively, the mistake may have been in the surgical technique, such as an inadvertent nick in the bowel causing peritonitis. Finally, and perhaps most commonly, the error may have been the result of several separate factors. Thus, it is evident that not all errors are qualitatively equal. By categorizing errors, physicians and administrators are able to better decide what is the most appropriate response. This might entail reorganization of a medical system that fosters repeated errors or instituting changes on an individual level.

Moreover, not all errors are similar in severity, as measured by the degree of harm that results. An appreciation of the magnitude of error might affect the decision to disclose. For example, informing a patient that their dosage of aspirin had been accidentally halved would serve little purpose unless the half dose of aspirin would have made a clinical difference. Admittedly, assigning some form of objective measurement to subjective expressions of suffering is difficult. Nonetheless, such considerations might play an important part in the decision-making of physicians as they struggle with the issue of disclosing error.

Disclosure and the Patient-Physician Relationship

In contemplating the appropriate response to the patient’s request for information, the medical student should consider the possibility that some disclosures of medical error may be harmful rather than beneficial to patients. It has been argued that there are particular situations in which disclosure of a medical error might cause serious and irreversible harm to the patient. In such situations, physicians can exercise “therapeutic privilege” and choose not to disclose. An example would be a medically unstable patient whose recovery would be jeopardized by an ill-timed disclosure of a medical error. Patients may feel anxious and alarmed upon learning of the mistake: they may lose confidence and faith in the physician’s ability to help them, thereby prolonging their recovery. This doubt and disillusionment may even extend to the medical profession as a whole, and so hamper any subsequent attempts to provide appropriate medical care. However, recent literature suggests that therapeutic privilege should be used rarely and in emergent situations, followed by a commitment to reassess disclosure when the patient is more stable. Physicians should also be prepared to explain their decision not to disclose.

On the other hand, truthful disclosure can promote patient well-being. Patients have a right to receive information about their medical condition. Disclosure of such information, including medical errors, can strengthen the bonds of trust between physician and patient. Patients might better understand
Medical students must understand that extreme caution is fundamental to a medical professional’s interactions with patients. An understanding of established legal precedents is fundamental. The consideration of medical error raises the issue of legal liability. Medical professionals are often reluctant to disclose the errors of their colleagues because of a sense of collegiality and identification. For example, medical students may feel that as part of an effective medical team, they have some duty to shield the attending physician from patient or public criticism. Additionally, medical students may be reluctant to disclose the errors of their colleagues—especially those of their superiors—because they are junior staff-persons in a hierarchical system. Despite these understandable attitudes, an overriding professional obligation is to ensure that medicine is practiced in a safe and competent manner.

However, the professional conduct of the apprenticing medical student should not involve the direct disclosure of errors to patients. The medical student has an obligation to recognize and respect the attending physician’s ultimate responsibility for the care of his or her patients. This responsibility includes explaining any errors or complications that might result from the physician’s care. Therefore, it is the attending physician and not the medical student who must determine whether a particular patient is, or is not, to be informed of a medical error.

Medical Error and Legal Vulnerability

The consideration of medical error raises the issue of legal liability. An understanding of established legal precedents is fundamental to a medical professional’s interactions with patients. Medical students must understand that extreme caution is required in discussions with patients about any detailed aspects of a therapeutic intervention. Students must realize that they are not qualified to enter into any technical discussions that can later be held legally against the health professionals involved. This does not mean that the student should ignore the patient’s concerns. In fact, several studies have demonstrated that it is the poor quality of communication surrounding an adverse event rather than the adverse event itself that motivates patients to take legal action. By acknowledging the patient’s desire for additional information and by taking steps to pass along this request and any related concerns to the responsible physician, the student will avoid incurring legal liability by either omission or commission.

Closing the Ranks: Whose Interests Are Being Served?

A recent Canadian court case concluded that nursing staff did not have a legal obligation to tell a patient of a surgeon’s error. Disclosure of an error that resulted in substantial adverse effects to the patient was viewed by the court as a specific duty of care owed by the surgeon to the patient. This finding can be extended to the role of the medical student. By understanding his or her role—as a facilitator between patients and their physicians—the student succeeds in upholding her responsibilities to both patients and the medical profession.

REFERENCES


2002 John Conley Ethics Essay Contest for Medical Students

Often the cultural and moral sensibilities of a patient come into conflict with those of the physician. Participants in the 2002 John Conley Medical Ethics Essay Contest are asked to consider the following case.

“You are a surgeon trained in urogential reconstruction. An 18-year-old female patient comes to you because she is returning to her home village in an African nation. She reports, and you believe, that upon return to her home, she will be obligated to undergo female circumcision. In her homeland, the procedure involves removal of the clitoris and part of the labia majora, and suturing of the vaginal opening, which leaves a small opening for menstruation. These procedures are typically performed in an unsterile field without anesthesia. Because she is concerned about pain and the risk of infection, she requests that you perform the procedure under sterile conditions before she returns home. Regardless of where it is performed, this form of female circumcision results in a permanent decrease in genital sensation, and causes bleeding during intercourse, with accompanying risk of infection. What are some ethical issues to consider as you decide whether to perform the surgery?”

Entries must be postmarked by February 1, 2002, and sent to Conley Essay Contest, c/o MSJAMA, 515 N State St, Chicago, IL 60610. The author(s) of the best essay(s) will be awarded $5000 or a portion thereof. More information about the contest is available online at www.msjama.org.

The judges for the 2001 John Conley Ethics Contest were Linda Emanuel, MD, Northwestern University School of Medicine; Thomas Duffy, MD, Yale University School of Medicine; and Norman Fost, MD, MPH, University of Wisconsin School of Medicine.

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