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Truth-telling and error in the clinical setting

Patricia Mary O'Rourke

A thesis
in
The Department
of
Religion

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Abstract

Truth-telling and error in the clinical setting

Patricia Mary O'Rourke, M.A.

This thesis applies the principle of veracity to the accidents and errors that can harm hospital patients. It integrates theological and philosophical works on truth-telling with literature on the sociology and philosophy of medicine, risk management, organizational behavior and the law.

Although, historically, even the strictest theologians and philosophers have viewed lies to the sick and dying as a possible exception to the general imperative to tell the truth, changes in the way the ill are perceived and cared for has rendered this paternalistic stance outdated. Once a patient is seen as an autonomous person with a right to all information about his or her care, the doctor's duty to give information necessary for informed consent may be extended to include an obligation to give the patient or surviving relative information about mistakes that may have inconvenienced, injured or even killed the patient.

The subject of disclosing incidents to patients raises many issues for hospital managers, physicians, risk managers and lawyers. This thesis examines the ways in which physicians define error, the ways in which error may be prevented and the legal and moral aspects of requiring physicians, and those who observe them, to tell the truth about their mistakes.

The thesis concludes with interviews with eight physicians exploring their attitude to these issues and inquiring of them how they live out the obligation to be truthful in their day-to-day practice. The final chapter emphasizes the importance of clear and candid communication as an important component of patient care and as a protection for doctors, patients and institutions.

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Introduction

The granddaughter of a patient who had fallen in a hospital's emergency room phoned a local newspaper to complain that the hospital staff had refused to speak to her about an incident in which her grandmother had been injured. The newspaper printed the story the following day. It briefly stated that the patient had fallen from a stretcher after being placed on a bedpan. The patient had broken her arm and bruised her face. The granddaugher was quoted as saying that the doctors and nurses refused to speak to her about the state of her grandmother's health until many hours after the incident occurred. " ' Ce n'est qu'après leur avoir dit qu'un journaliste de *La Presse* avait été saisi de l'affaire, que les choses ont commencé à bouger ' a déclaré la pauvre femme" (Gervais, 1990, March 18,p.A3) Finally, the granddaughter told this newspaper that she took the complaint to the hospital ombudsman not only to see whether or not the staff had been guilty of negligence but also to complain about the way in which she had been kept in ignorance about her grandmother's condition (Gervais, p.A3).

The type of incident described here is common in all hospitals, particularly when staff have no reason to believe that an elderly patient will fall and so neither restrain the patient nor keep a person by the bedside to stand guard. What clearly angered this relative was what appeared to be a refusal on the part of staff to talk to her about the incident. Patients and their relatives are rightly upset when something goes wrong in medical or hospital care. Silence about mistakes, as I will argue in this thesis, compounds the damage.

In 1849, Dr. Worthington Hooker, a physician in Connecticut, stated that physicians must be truthful and avoid deception because "...the good, which may be done by deception in a *few* cases, is almost as nothing,compared with the evil which it does in *many* cases... " (cited in Beauchamp &

McCullough,1984, p.11).

Veracity, as a principle or duty in the care of patients, is seen by some to be "an independent principle ranking with beneficence, nonmaleficence, and justice"(Warnock, cited in Beauchamp & Childress, 1989, p. 308). Others see it as being "derived from the principles of respect for autonomy, fidelity, or utility (Beauchamp & Childress, p. 308). Beauchamp and Childress state that "the obligation of veracity is part of the respect we owe to others" (Beauchamp & Childress, p. 308). Respect for others is commonly articulated in biomedical ethics through the rule of "respect for autonomy" which demands informed consent from a patient. Consent is an act of autonomy only if informed. It therefore relies on "truthful communication" (Beauchamp & Childress, 1989, p. 308).

Ethicist Sissela Bok, in ***Lying: Moral Choice in Public and Private Life*** (1978, p. 32), argues that the "principle of veracity", although "not necessarily a principle that overrides all others", nor sufficient by itself (Bok, 1978, p. 32), is important in that "trust in some degree of veracity functions as a *foundation* of relations among human beings... "(Bok, 1978, p. 33). Bok describes three types of trust that I would apply to patients: that staff will treat them fairly, have their best interests at heart, and do no harm. If the patient cannot trust the word of the professional, he or she will have difficulty believing in the professional's fairness, compassionate interest and good intentions (Bok, 1978, p. 33).

This thesis presents a particular application of the principle of veracity applied to patient care. It is focused on the accidents and errors that occur on wards, in operating theatres, clinics and laboratories and inquires of physicians how they choose a particular course of action when faced with the decision to tell, or not to tell, a patient or relative that a mistake has been made.

The eight chapters that follow range across literature in the sociology and philosophy of medicine, major works of philosophers and theologians on the topic of veracity and self-deception, works on risk management and organizational behavior, legal opinions and, finally, the opinions of a small group of Montreal area physicians. Cases derived from the author's own experience as a hospital patient representative are disguised to preserve confidentiality or they are drawn from the literature.

The thesis grew out of the author's work on the Clinical Ethics Committee of the Royal Victoria Hospital where she has worked since 1980. She is one of the authors of guidelines written to help hospital staff disclose incidents to patients. Called ***Guidelines For the Disclosure of Incidents to Patients and/ Or Their Families***, they have been in use in that institution since they were approved by the Board in June 1989. Some of the ideas and opinions in this thesis have been presented by the author at the annual conference of the Canadian Society of Bioethics (November 22, 1988) and reported in ***The Globe and Mail*** (Lipovenko,1988, November 28, p.A 4), ***The Gazette***, (Dunn, 1988,November 29, p.A3), ***The Medical Post***. (Rich,1989, January 10, p.42) and ***The Canadian Medical Association Journal*** (Peterkin, 1990, pp. 984-985). She and a colleague presented arguments in favour of honest disclosure of mistakes at a risk management conference (April 27,1990) sponsored by Marsh & McLennan, one of Canada's largest hospital insurance brokers. The topic of disclosing incidents to patients was also incorporated into the course on ethics and jurisprudence given to students in the McGill Faculty of Medicine.

As the chapters that follow will make plain, mistakes are unavoidable in any milieu. But in the medical setting, mistakes are greatly feared not only because of the legal risks but, more importantly, because human lives are at stake. Furthermore, these are human lives placed trustingly in the

hands of fallible men and women who are often viewed as gods, shamans or nurturing parents. Much of the popular literature on medical mistakes focuses on the mendacity of physicians, the incompetence of hospital bureaucracies, and the tendency of the medical profession to prevaricate, obfuscate and otherwise mystify the person who falls victim to medical error. While medicine is a profession like law or accountancy, it alone cloaks its practitioners in a mantle of god-like wisdom and power. The men and women who practice medicine may not perceive themselves as gods or even as parents, but the sick, who in their personal lives may be equally powerful and professional, often return in illness to that childlike state in which they hope that the all-wise and all-loving parent can restore them to peace and wholeness. And doctors may all too readily assume a parental role, even when the patient is a medical colleague or superior (Katz, 1984, pp. ix-x).

In recent years society has shifted from this paternalistic view of the physician to a focus on the patient as consumer. Because of the inherent inequality between the doctor who knows and the patient who is often too sick to question, attention must be paid to mechanisms that create a more equal balance of power. Patients are a vulnerable population and fear to speak up. Physicians who err may fear to speak because they do not wish to distress their patients. The opportunities for dishonesty and self-deception thus abound. It is a tribute to many physicians that they do not succumb. A further reason for the emphasis on telling patients the truth is the fact that patients are more easily able to discover medical mistakes because they can read their own charts or because the number of people caring for them makes inadvertent or malicious disclosure of error more likely. This is not a moral argument for truth-telling, but it is certainly a compelling one.

Each of the following chapters examines a particular aspect of truth and

error in the clinical setting. Chapter one introduces the general topic and looks at the basic issues of truth, lying and deception in the medical setting, the types of errors that can occur and the issue of self-deception. It concludes with an examination of the changes in society and the practice of medicine that call into question the historical practice of not troubling patients with information. Chapter two looks more deeply at truth versus truthfulness, lying, intentional deception and incomplete disclosure and presents an historical overview of the moral and philosophical approaches to truth-telling. Chapter three looks more closely at medical errors, how they are perceived by the public, the limitations of medicine and the internal and external control of the medical profession. It briefly discusses how the law views error and concludes with a risk-management approach to medical error, analyzing the system itself to see how errors can be prevented. Chapter four looks at medical error from the inside, asking how physicians define error and looking at how the profession regulates itself and creates its own moral code. This chapter draws heavily on the work of Charles Bosk, a medical sociologist. Chapter five moves naturally to the topic of whistleblowing both as a moral act or a breach of an internal norm. Whistleblowing is more likely whenever errors are not disclosed. This chapter looks at systems which can encourage individuals to raise questions and ring alarms in a responsible manner. Chapter six looks at that most draconian of external controls — the law. This chapter draws heavily on an article by Joan Vogel and Richard Delgado (1980), two legal experts who argue persusively that only legal sanctions can force physicians, and those who observe them, to disclose their mistakes. Although the law has a symbolic function in reminding a society of what it values, I believe that legal sanctions are of limited utility and suggest organizational incentives instead.

Chapter seven recounts the responses of eight physicians to the issue of truth telling. I presented these physicians with four hypothetical situations

in which a mistake had occurred during the course of a patient's hospitalization. Two of these scenarios are drawn from the literature and discussed in Chapters one and two of this thesis. Two were composed as simulated situations for teaching purposes. The scenarios depict situations from the mild — a mistake is made with no serious effect — up to the serious — a mistake which causes a death. The response to disclosing mistakes with no serious effect may indicate either that a physician is obsessive and scrupulous or simply extremely honest. I will leave it up to the reader to decide which.

Because all situations are hypothetical, only hypothetical morality has been tested. The real situation, with all its pain, threat to professional status and risk of exposure, is a much finer test of the genuine ethical stance of doctors. Finally, it is to be noted that although this is not a formal research study because the sample size is too small, each doctor was approached only after the proposal had been approved by his or her institution's ethics committee and/or director of professional services. This mini-study was performed to see if some of the ideas presented in the body of the thesis were corroborated by people in medical practice. Their reflections are supplemented by the author's own experience as a hospital troubleshooter who not only resolves patient complaints but has spent the past almost twelve years intimately involved in research ethics and patient care committees in a large teaching hospital.

I wish especially to thank Gordon Crelinsten, M.D., chairman of the Clinical Ethics Committee of the Royal Victoria Hospital, who inspired and encouraged me to make the disclosure of incidents to patients my special project, and the members of that committee, as well as all the senior medical,nursing and administrative staff of the hospital who have been enthusiastic in their promotion of my efforts to explore the concept of disclosing incidents to patients. The opinions expressed, as well as the way

in which I have presented and interpreted the various authors, are, of course my own.

Chapter one
The tangled web

Introduction

This chapter will look at the basic issues of truth, lying and deception in the medical setting, the types of errors that challenge the physician who wants to be honest and the issue of self-deception. The acts contrary to the virtue of veracity can be divided into three categories: (a) lying or intentional deception, (b) lack of full disclosure, which includes keeping secrets and confidences, and (c) failure to communicate in a way which helps the listener to fully understand. Under the last category, we can place mental reservations which will be discussed more completely in Chapter two.

In the latter part of this chapter I will look at the changes in society and the practice of medicine which have made crucial a closer examination of the practice of lies, deception and incomplete disclosure in the medical setting. As we shall see, the cloak of secrecy, under which physicians could hide mistakes as well as unfortunate diagnoses, is sorely tattered. Just as society has lost those values which united all in a common goal, so too has the medical profession lost its sense of itself as a priestly caste and as the keeper of the keys to hidden knowledge. Anyone who takes the trouble can obtain all the information she needs to challenge a physician because medical knowledge is so highly specialized that no one physician knows all of it.

Physicians' attitudes towards deception

In an assessment of physician's attitudes towards deception in medicine, a team of researchers sent a questionnaire to 407 practicing physicians asking them to respond to ethical problems potentially resolvable by deception (Novack, Detering, Arnold, Forrow, Ladinsky, Pezzullo, 1989). The majority who responded (52%) saw no problem in

misrepresenting a screening test as a diagnostic test to secure an insurance payment to the patient or to allow the wife of a patient with gonorrhea to be misled about her husband's diagnosis. One third indicated that they would give incomplete information or mislead the patient's family if a mistake had caused a patient's death (Novack, et al., 1989, p. 2980).

The researchers presented the physicians with the following case:

> An 80-year-old man with severe hypertension comes into the hospital with confusion, papilledema and a blood pressure of 250/150 mm Hg (hypertensive crisis). Having decided to start him on diazoxide, you administer a vial labeled with the usual dose of 100 mg. Shortly thereafter, the patient's blood pressure drops and despite resuscitative efforts, he dies. In reviewing his medications, you find that the vial actually contained 1000 mg of a "100mg/cc" solution You are thus sure you accidentally administered a fatal dose. (Novack, et al., 1989, p.2982).

The researchers asked:

> When informing the family about the patient's death, you would (choose one):
>
> a. Emphasize that the patient was very sick but despite your best efforts, he died.
>
> b.Emphasize the patient was very sick and required strong medication. As an unfortunate, but known risk of the medication, his blood pressure dropped too low and he died.
>
> c. Say you inadvertently gave him too much medication over too short a time, which given his serious condition probably caused his death.
>
> d.Other (please explain). (Novack, et al., 1989, pp. 2982-2983).

The physicians were asked:

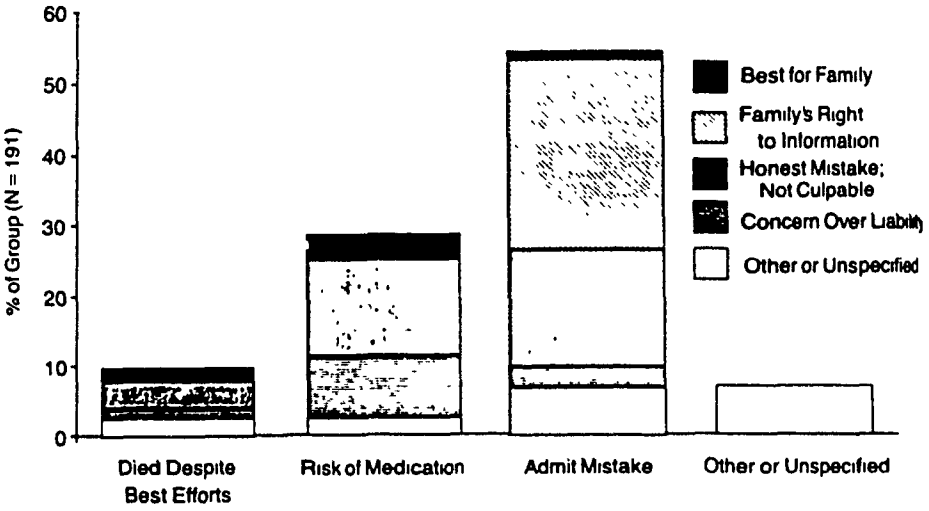
> In choosing your answer, on what did you base your decision? (choose one, or rank order)
>
> a. What was best for the family.
>
> b. The family's right to full information

c. Your belief that you made an honest mistake and are not culpable

d. Your concern about legal/ professional liability.

e. Other (please explain). (Novack, et al., 1989, p.2983).

The results are shown in the table reproduced below. (Novack, et al., p. 2982).



The researchers asked physicians to describe their basic principles about the use of deception to benefit their patients. Forty-four percent of 109 physicians explicitly wrote about the importance of truthfulness. Thirteen percent of 109 said that physicians should never deceive. Eighty-seven percent of 109 pointed out that it was reasonable to deceive under some rare circumstances. A typical comment was "I try to take everything on a case by case basis and to tailor my actions to the people and the situation I confront....The only basic policy is first do no harm. Honesty is *usually* the best policy" (Novack, et al., 1989, p.2983). Thirty-seven percent of 109 physicians spoke of their principles with the majority saying that honesty was generally important but that shaping the truth is occasionally necessary. Thirty-one of sixty respondents who did not answer a question asking for factors considered when justifying a decision to deceive said they never used deception with patients (Novack, et al., p.2983).

In response to the case described, concealment of a medical error, the researchers discovered that physicians over fifty years of age were less likely to tell the family of their mistake (Novack, et al.,1989, p. 2983). The researchers say that their study suggests "that physicians may commonly engage in self-deception, which may facilitate other forms of deception.... Even the twenty-five percent of physicians who said they 'never' use deception chose deceptive answers to our case examples" (Novack, et al. p. 2984). One said that, if he made a medication error, as described, he would " 'emphasize that the patient was very sick but despite your best efforts, he died.' " His justification? " ' Narrowly phrased, this *is* the *truth* isn't it —the "best efforts" of your practice were *your best* —stupid— but "the best" for you !' " (Novack, et al. p. 2984). The survey further suggested that some physicians would consider deceiving to benefit themselves. In the case of the medication error, more than a third of physicians said they would provide incomplete or misleading information on those unfortunate occasions when such mistakes led to a patient's death. Many argued from the principle of beneficence — that the family would be hurt by knowledge of the mistake. It is quite obvious, however, that such deception benefits the physician (Novack, et al., p. 2984). Denial and self-deception are most likely to occur when the physician has a strong need to appear moral and above reproach and so reduce the dissonance between his self-perception and his act (see Fingarette,1969, p. 140). However, a letter in response to this article (Baker, Dersch, Strosberg, Fein, Ponemon, 1989, p.2233) suggested that physicians who "would rather incriminate themselves" than deceive patients or their surviving relatives were adhering to a moral standard which should qualify them for sainthood!

Physicians who decided to deceive generally took a consequentialist stance, appealing to "the good consequences produced and the bad consequences avoided" (Novack, et al., 1989, p. 2984). This is consistent with the findings of a review by Vanderpool and Weiss of ethical positions taken by writers

on truth-telling and cancer (cited in Novack, et al.,1989, p. 2984). Physician-respondents to Novack's survey indicated that they would deceive to protect the welfare of their patients. The most commonly stated justification was that "benefits outweigh the costs" and that it was more important to protect a patient's confidences. "Only after these patient-centred justifications [were used]" did physicians turn to alternative reasons: concern for risk to others, and, less frequently mentioned, "moral convictions about deception, concern for legal ramifications, and obligation to society" (Novack, et al., pp. 2984- 2985).

All respondents to Novack's survey were described as dedicated and thoughtful and all indicated a respect for truth-telling. Their opinions reflected Howard Brody's remarks about truth telling:

> We cannot agree with criteria that elevate the truth as a fundamental moral value for its own sake, independent of the effect that the truth will have on the individual....The fundamental value at issue is that of respect for persons. Truth is valuable because in the vast majority of cases, respect for truth is a way of demonstrating respect for persons; but in rare instances respect for persons might demand that the truth be given a lower priority compared to other considerations. (Brody, cited in Novack,et al., 1989, p.2985).

Can truth be given a lower priority, and what do we mean by truth? Novack and his colleagues asked if it is ever ethical to deceive and, if some deception is moral, where we should draw the line. Novack suggested that a better understanding of deception should help physicians articulate the principles behind their actions (Novack,et al.,1989,p.2985). Beauchamp and Childress state that one of the arguments for deception is that no health-care provider can know the "whole truth" and even if he could, patients would not understand. They state that this argument cannot be "allowed to undermine the obligation of veracity.... The 'whole truth'," they

say,"is a useful concept only in the way infinity is useful in mathematics. Disclosing the whole truth is an ideal against which health-care professionals can measure their performance. But it can only be approximated, never reached..." (Beauchamp & Childress, 1989, p.313). These authors view the obligation of truthful disclosure as requiring the professional to "disclose as fully as possible what a reasonable patient would want to know and what particular patients want to know" (Beauchamp & Childress, p.313).

Arguments for truthfulness

We will turn now to the arguments for truthfulness with patients. In 1973, the American Hospital Association published a Bill of Rights for Patients in which it said "The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can reasonably expected to understand." The next right affirmed is "the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment..." (AHA, 1973,cited in Annas, 1975, p. 26). A statement like this is now enshrined in the rights documents of thousands of hospitals across North America.

Most people understand truth-telling in the clinical setting to refer either to the information required by a patient to give informed consent to treatment or to truthful disclosure by the doctor to the patient of a fatal disease or imminent death. Little has been written on telling patients the details of mistakes that may have injured them or disclosing to families errors which have caused the death of loved ones.

Disclosing incidents to patients is considered by the author to be part of the general duty to give patients information about their care. Guidelines developed by the author and published in 1989 by the Board of the Royal

Victoria Hospital, make this principle clear. (See the Appendix for guidelines). Disclosing incidents to patients falls under the general rubric of informed consent because, although disclosure of incidents refers to information given after treatment is performed, it can be argued that it is part of the general duty of physicians and other health care professionals to give not only the information needed for informed consent but information about care in general and about incidents that may have adversely affected medical care (Robertson, 1987, p. 218). Gerald Robertson argues that the duty to disclose medical mistakes "has much in common with the doctrine of informed consent, in that both stem from the patient's interest in self-determination" (Robertson, p. 218), which is an appeal to the principle of autonomy. "The patient ' has a right to determine what shall be done with his own body ' " he says, citing the case of ***Schloendorff v. Society of New York Hospital*** in 1914, and he goes on to say that the patient, "equally,... should have a right to know what has in fact been done" (Robertson, p.218).

Although one may argue that the patient's right to information is independent of any subsequent action she may take, the patient's interest in self-determination could include the right to know of mistakes which have affected her care so that she can change doctors or hospitals, issue formal complaints or sue if a clear opportunity of compensation for injury is possible. The legal aspect of this argument is discussed in Chapter six .

Truthfulness to patients and the concept of the patient as autonomous is a fairly recent emphasis in medical care. Traditional codes emphasize protecting the patient from harsh truths about fatal illness. In fact, according to Beauchamp & Childress "codes of medical ethics generally ignore rules of veracity" (Beauchamp & Childress,1989, p. 307). The ***Hippocratic Oath***, the ***Declaration of Geneva*** of the World Medical Association and the ***Principles of Medical Ethics*** of the American

Medical Association (in effect from 1957 to 1980) do not impose an obligation of veracity. The 1980 revision of the AMA's ***Principles of Medical Ethics*** held that the physician "should 'deal honestly with patients and colleagues' " (Beauchamp & Childress, p.307). The ***Code of Medical Ethics*** of the College of Physicians and Surgeons of the Province of Quebec is more specific. Item number 14 states: "Unless there are some justifiable reasons, the physician must not conceal a serious or fatal diagnosis from a patient requesting its disclosure and he must not divulge it to the patients' family if the patient forbids him to do so" (Béard, ed.,1971, p. 8). Between 1961 and 1979, physicians in North America showed a significantly greater interest in being truthful with their patients about a diagnosis of cancer (Vanderpool & Weiss, 1987, p. 502). Oken's 1961 study (cited in Vanderpool & Weiss, p. 502) indicated that almost 90 percent of physicians tended to withhold information to maintain hope. By 1979, Novack, et al. (Novack, Plumer, Smith, et al., 1979, cited in Vanderpool & Weiss, p. 502) found 97 percent of physicians making a complete about face, preferring to reveal the diagnosis.

But the fear of harming the patient by disclosing too much has been pervasive in much of medical thinking. Thomas Percival's ***Medical Ethics*** (1802) states:

> To a patient...who makes enquiries, which, if faithfully answered, might prove fatal to him, it would be a gross and unfeeling wrong to reveal the truth. His right to it is suspended...because, its beneficial nature being reversed, it would be deeply injurious to him, to his family and to the public. (Percival, 1802, cited in Jonsen, Siegler, & Winslade,1982, p.72).

It was partly in response to Percival that Hooker, quoted in my introductory chapter, made his assertion that deception undermined confidence in the veracity of physicians. Although he conceded the need sometimes to conceal facts that could hurt, he insisted that no deception be

used (cited in Reiser, 1987, pp.167-168).

One of the tensions which lies at the heart of discussions concerning the disclosure of incidents to patients is the tension between the principle of beneficence and the principle of autonomy. Those who argue for honesty with patients usually appeal to the principle of autonomy. Those who believe that disclosure of unpalatable or painful truths to patients may harm usually appeal to the principle of beneficence (Beauchamp &McCullough, 1984, pp. 14-15). Beauchamp and McCullough argue that truth telling is an example of an issue which "involves reference to both beneficence and respect for autonomy" (Beauchamp & McCullough, p. 15).

The principle of beneficence addresses the issue of providing benefit and avoiding harm. The principle of respect for autonomy, in the clinical setting, regards the mentally competent patient as self governing (Beauchamp & McCullough, 1984, p.15). To respect autonomy may well be a beneficent act but there are rare situations when this is not so.

Types of mistakes

At this point, let us look at what is involved in telling a patient that something has gone wrong in his or her care. The article by Gerald Robertson spoke only of physician's mistakes. However, mishaps in patient care can involve nurses, technicians or physiotherapists. Hospital equipment or procedures may be implicated. Mistakes can range from the trivial — such as medications delivered at the wrong time, or forgotten, with possible discomfort to the patient but no harmful effect — all the way up to outright injury. Many incidents fall in the middle range. A blood sample may be lost, necessitating a repeat test, for example. Many believe that these sorts of incidents need not be explained to the patient. In other cases, it may be difficult to pinpoint the precise cause of an injury. Let us say, for example, that a patient sustains a burn during recovery from

surgery. The burn may or may not have been caused by equipment malfunction. Sometimes it is difficult to assess the cause of damage and the person responsible, if any. Another example: a woman notices a bruise on the head of her elderly father that she did not see the day before. She also notices that he is more confused. Did the patient fall out of bed or was he the victim of abuse committed by a frustrated aide? Is the confusion part of the natural course of the illness or is it the result of injury? After investigation one may be able to offer only a likely or tentative explanation and some would argue that in the absence of proof, no real explanation can be given.

Patients and families often bring to hospital administrators or ombudsmen complaints about the sorts of incidents just described. They suspect wrong-doing by observing or experiencing negative results or side-effects of treatment, and they demand answers. Some, for example, will claim that an injection has caused long-term weakness in a limb or that a post-operative infection is the result of improper technique. The patient's view of the matter and the staff's may differ. Some medical interventions have predictable side effects of which the patient was not informed or may not be aware.

It is important to note here that patients sometimes imagine that something untoward has occurred because procedures and their side effects have been insufficiently explained. In other cases, doctors or nurses are unsure about the causes of an outcome and so do not discuss anything with the patient.

Avoiding the patient, however, is not the best policy as it frequently arouses suspicion and fear. As Jay Katz repeatedly points out in his book ***The Silent World of Doctor and Patient*** (1984), what patients want is communication and conversation. Avoidance and evasion frequently lead to

suspicion of wrongdoing even when wrongdoing is absent.

Communication and conversation — physicians, patients and medical error

To speak of absolute truth when disclosing incidents to patients may on many occasions be reaching for the impossible. Sissela Bok (1978,p.13) argues that it is truthfulness that is required when full truth is out of reach. The concept of truth itself is of importance in philosophy Raanan Gillon says in his article **Telling the truth and medical ethics** (1985). What is important for the doctor or nurse, however, is intention. Does the doctor try to find out what the patient would wish to know and does she intend to try to give information believed to be true or at least admit uncertainty (Gillon, 1985, p.1557). As Beauchamp and Childress (1989, p.313) say, the whole truth "can only be approximated, never reached." I will discuss this preoccupation with the epistemological approach to truth more fully in the next chapter.

Honesty, according to Sissela Bok, matters more to patients than almost anything else. To be given false information or no information about important choices is to be " rendered powerless" (Bok, 1978, pp. xvi-xvii). If, furthermore, a patient later learns from another source that something went wrong during his hospital stay, his sense of injury and loss can be acute.

What do medical staff do in those situations where they judge that disclosure to a patient will harm him or her. Although respecting the autonomy of a patient may also honour the principle of beneficence in that the patient is given the power to decide how to act by receiving relevant information, the principle of beneficence does not alone carry an obligation of truth-telling. A much quoted article, written in 1935 by Lawrence Henderson, states that "...Far older than the precept,'the truth, the whole

truth, and nothing but the truth,' is another that originates within our profession....So far as possible, do no harm. You can do harm by the process that is quaintly called telling the truth. You can do harm by lying...But try to do as little harm as possible" (Henderson, 1935, cited in Bok, 1978, pp. 12-13).

Naturally one would expect professionals to weigh risks and benefits when determining whether, when and how to approach a patient when something untoward has happened. There may be cases in which a patient is injured but there is no clear evidence of malpractice, nor corrective procedure available. If the patient has sustained a loss, but is unaware of the fact, he might suffer greatly if he were told, especially if he could do nothing. In such a case, ought one to tell?

Sissela Bok suggests that a decision to conceal information from a patient must be seen to be unusual and the burden of proof for withholding information must rest on those who advocate it (Bok, 1978, p.252). Benevolent and altruistic motives for withholding information must carefully be examined. They may well, as Bok points out, be mixed with the fear of repercussions (Bok, 1978, p. 223). She suggests that one should ask whether the patient, if he were later to learn from another source that information was kept from him for his own good, would see the act as benevolent or deceptive (Bok, 1978, p. 227). The decision to disclose or not to disclose should be patient-centred.

Benevolent and altruistic motives for withholding information are, in fact, most vulnerable to charges of self-deception, the subject to which we will now turn.

Self-Deception

The concept of self-deception is fraught with difficulties. The essence of

self-deception might seem to be a total inability to know that one is self-deceived. To make a moral assessment of our own acts we have to grant that we know what we are doing and that we are responsible for our choices (Fingarette, 1969, p.1). But if we suffer from self-deception, are we not invincibly ignorant, and therefore not culpable. As we all know, there are those who lie sincerely, believing their own lies, even when they know they are lies (Fingarette, p. 5). The issue of self-deception touches the very heart of truth. If we ourselves can be deceived that what is not so, is so, how can we chart a firm course in reality? An examination of self-deception can seem to lead us meandering through a field of dreams and shadows.

Fingarette, in ***Self-Deception*** (1969), tries to steer such a firm course and attempts to ask how and why we deceive ourselves, what it is to be in self-deception, and what the signs of self-deception are (Fingarette,1969, p. 7). Fingarette calls the move into self-deception retrogressive and the movement out of it a journey to personal integrity (Fingarette, p.9).

The crucial element in self-deception, Fingarette says, is purposefulness. "If our subject *persuades* himself to believe contrary to the evidence *in order to evade*, somehow, the unpleasant truth to which he has already seen that the evidence points, then and only then is he clearly a self-deceiver" (Fingarette,1969, p. 28).

Normally, we assume a person moves into self-deception because he has a motive, such as attempting to avoid mental conflict or anguish. Even without a motive, Fingarette says, we would describe a person as self-deceived if the person " persuaded himself to believe what in his heart he knows is not so" (Fingarette, 1969, p. 28). But whatever the motive, or even if there is no motive at all, Fingarette says, self-deception contains within it "a certain purposefulness" (Fingarette, p.29).

Fingarette says that many authors try to resolve the paradox that a person can hold two incompatible beliefs at the same time. He states that what they all fail to see is that the paradox of self-deception lies in the element of intentional ignorance rather than the oddness of simultaneous and contradictory thought (Fingarette,1969, p.29). Fingarette makes a further point: " that belief in the face of contrary evidence is not a necessary condition of self-deception." Many people, after all, jump to conclusions because of prejudice or unclear thinking (Fingarette, pp.29-30).

How does a person become conscious? Psychoanalysts would say that full consciousness comes about through a process of psychotherapy in which a person describes to another what he remembers, what he does and what he is experiencing (see Fingarette,1969, p. 45). Fingarette sees becoming conscious as the exercise of the skill of speaking out what one does or feels (Fingarette, pp. 38-39). "Consciousness," he says, is "the exercise of the [learned] skill of 'spelling-out' some feature of the world as we are engaged in it" (Fingarette, p. 39). His thesis is that the features of a person's "engagement in the world" are not usually spelled-out by the individual. Most of us are not usually " explicitly conscious of our engagements in the world " (Fingarette, p. 41). If we are, then we spell it out. Even when we do spell-out, we are usually selective about what we say (Fingarette, pp. 41-42). For example, as I write this on a computer, I am not aware of the steps involved between brain and hand in touch-typing. To exercise the skill of spelling-out means that I will also analyze the situation to see whether I should spell it out (Fingarette, p. 42).

In self-deception the individual has a reason not to spell-out, avoids becoming "explicitly conscious" and avoids becoming "explicitly conscious" that he is avoiding it (Fingarette,1969, p.43). People who meditate and those who have been psychoanalyzed frequently claim that they have achieved consciousness through a very specific technique of spelling-out

(Fingarette, pp.44-45). Vipassana meditation, for example, uses a system of awareness of breath or of the pressure of clothing on the arm whereas for most people, breathing or fabric on flesh is largely unconscious.

The person who is self-deceived is one who " *persistently* avoids spelling-out some feature of his engagement in the world" (Fingarette,1969, p.47). Sometimes he cannot admit the truth to himself but, sometimes, those with him sense that he could if only he tried (Fingarette, p. 47). This is what the theologians call culpable ignorance.

A doctor who has made an error which has injured a patient may have great difficulty spelling-out, even to herself, the magnitude of her act of omission. As we will see in Chapter four, technical errors can be seen as learning experiences and errors of judgement may be ascribed to some problem caused by the patient such as age or medical or social condition (Bosk,1979, p. 138). Physicians reduce cognitive dissonance by repressing the memory of arguments which would have led them to follow another course of action (Illich, 1976, p. 256). To adopt a "*policy* of not spelling-out" in such a situation is to hide the seriousness of one's error from oneself (Fingarette,1969, p. 49). It is most likely that in such a situation, the patient may receive no explanation of an error or may be told "everything's going to be fine. You're recovering nicely" but not told, for example, that his high fever is the result of a hospital-caused infection. It is at this point that the physician will appear evasive because anything which could lead to the spelling-out of information about the now-hidden mistake will scrupulously be avoided (Fingarette, p. 49). The physician may justify this by saying that " the patient is doing so well now. Why spoil it by raising questions which might upset him" (my quotes). If a physician tries to create a "cover-story" he will have to fill in gaps to render the story " internally consistent" (Fingarette, pp. 50-51) and matching the facts of which the patient may be aware. If new inconsistencies should arise, the physician

will have to become even more ingenious. It is at this point that he will seem insincere (Fingarette, pp.50-51) but he himself may come to believe his elaborate rationalizations. He may have restructured the situation in such a way that he takes seriously what he explains to himself. Actions and speech will then conform to this "defective version" of events (Fingarette,p. 54).

Fingarette concludes his section on spelling-out with the statement that

> ...the self-deceiver is one whose life situation is such that, on the basis of his tacit assessment of his situation, he finds there is overriding reason for adopting a policy of not spelling-out some engagement of his in the world....when the issue is raised, he does not, cannot, express the matter explicitly at all....He tells us nothing but what he tells himself....It is because he tells us what he tells himself, a distinctive mark of sincerity, that we do say," He is sincere; he believes his denials.... "
> (Fingarette, 1969, pp. 62-63)

We then conclude, watching the self-deceiver's purposefulness and apparent sincerity, that he both believes and yet disbelieves. We see the discrepancy between the way the "individual really is engaged in the world and the story he tells himself..." and thus have before us "the complex but common form of self-deception in which we are interested" (Fingarette, 1969,p. 63).

Ultimately, Fingarette says, we are confused when faced with self-deception, because we tend to use the language of knowing and believing when speaking of consciousness. But it is spelling-out, which is a skill of consciousness, which characterizes consciousness (Fingarette,1969, pp.63- 64). Furthermore, the self-deceiver refuses to avow his engagement in the world (Fingarette, p. 67). To avow is to declare oneself to the world and to establish one's identity. "...a person may avow or acknowledge *as his* an action, a feeling, an emotion, a perception, a belief, an attitude, a concern, an aim, a reason" (Fingarette, p.70). If one self-deceives by

disavowing one detaches oneself from one's act. "To spell-out,...is to exercise a peculiar authority, an authority intimately associated with one's existence as a particular person" (Fingarette, p. 72). One thus affirms one's identity (Fingarette, p.73). The person who disavows isolates himself from all that is avowed, denies responsibility and seems unable to spell-out (Fingarette, pp.73-74). It is important to note here that, as Hauerwas, Bondi & Burrell say in ***Truthfulness and Tragedy*** (1977) "To bring certain things to consciousness requires the moral stamina to endure the pain that such explicit knowledge cannot help but bring" (Hauerwas, Bondi & Burrell, 1977, p. 85). It is the conscientious surgeon who is more likely to be tempted to self-deception because he is the most concerned with personal integrity (Fingarette, p. 140). The cynic is far less vulnerable (Hauerwas,Bondi & Burrell, 1977, p. 87). She who self-deceives lacks courage, not moral integrity (Hauerwas, Bondi & Burrell, 1977, p. 87).

A mistake in the medical setting, Marcia Millman says, is a challenge to the "faith in science... and rationality" that medicine attempts to inspire (Millman,1976, p. 117). Hence, she says, doctors tend to re-define the cause of their mistakes and blame their patients (Millman, p.201). She describes such self-deceptive manoeuvres as " rationalizations, justifications and emotional demonstrations" (Millman, p. 201).

Most people take a certain level of self-deception for granted (Bok, 1983, p.60). Although it has frequently been viewed as evidence of mental unhealth or moral weakness one author argues that it is highly normal. Shelley E. Taylor, a psychologist who has conducted scientific studies of self-deception, offers in her book ***Positive Illusions*** (1989) persuasive examples that "...normal human thought and perception is marked not by accuracy but by positive self-enhancing illusions about the self, the world, and the future....these illusions are not merely characteristic of human thought; they appear actually to be adaptive, promoting rather than

undermining good mental health" (Taylor,1989, p.7). Throughout her book, she argues that "In many ways, the healthy mind is a self-deceptive one..." (Taylor, p. xi). It would seem, as T.S. Eliot said in his poem Burnt Norton, that "...Human kind/Cannot bear very much reality"(Eliot, 1935, line 42-43. Mack, Dean & Frost [Eds.], 1961).

As we shall see in Chapter four, physicians have their own systematic way of dealing with the fear and guilt that making a mistake can inspire. Marcia Millman says (1976, p.91) "there are built-in professional protections for the doctor against having to recognize and take responsibility for mistakes made on patients. These defenses against acknowledging mistakes reside in the very heart of medical work, philosophy and organization. Furthermore, every aspect of medical work is shaped by this group collusion to ignore and justify errors." Sissela Bok (1983,p.60) describes self-deception as a secret from oneself. It frequently points to "harmful ignorance" and for that reason invites the concern of all those who care about harm to others and responsibility (Bok, 1983, p.64). Self-deception may sometimes be harmless but not in the case of a mistake which has injured a patient. Explaining away mistakes deprives the patient of knowledge and recourse to remedy and satisfaction. My thesis in all the chapters that follow is that it is important to recognize errors in the medical setting, understand how they may be prevented, speak honestly about them to patients and create systems in medical institutions that make it relatively easy for physicians, nurses, health-care workers and hospital administrators to be honest when individuals or the institution itself has injured someone. Errors, after all, are a fact of life. Institutions which pretend to be error-free will probably be faced at some point with an angry patient or a righteously incensed reporter demanding a full explanation of an incompletely hidden error. This is because social changes have rendered it very difficult to hide mistakes and misdeeds.

Social changes

The present concern with the patient's right to information is a result of a variety of social changes. From the mid-1960's to 1970's in the United States, government-mandated committees were established to regulate the process of informing human subjects of research experiments (Grundner, 1986, pp. 6-7). In 1973, as mentioned before, the American Hospital Association issued a Patient's Bill of Rights. Our newspapers, magazines and televisions bring us news almost daily about new medical techniques and cures. The patient, once seen only as a grateful recipient of medical care, has become an active consumer of medical products. Furthermore, medicine itself is more complex and technological. Gone are the days when the trusted family doctor could fix you up in his (or, occasionally, her) office. What was once a personal contract between patient and physician has become a contract with an institutional team which provides a broad spectrum of services. Even the most intimate details told to a physician are often shared with nurses, social workers and chaplains (Pellegrino, 1987, p.53) and entered into the permanent patient record. In fact, up to 100 health professionals and administrative staff may see the record of a patient admitted for a short stay — all for legitimate reasons. These include housestaff, health-care students, secretaries, chart reviewers (Siegler,1982, in Mappes & Zembaty, 1986,p.159). For all these reasons, secrecy, were it even desirable in some cases, is virtually impossible. The patient interacts with many people and large institutions are not short of individuals who delight in pointing out that someone else (usually a member of another professional group) might have "goofed". Even when a doctor decides for what seem to be perfectly good reasons to withhold or delay giving information to a patient, other staff members might disagree. It is my experience that patients are usually aware that something has gone wrong simply from the expressions on care-givers' faces or from a series of confused and contradictory statements.

The chance of being found out is hardly an ethical reason for disclosing incidents to patients. But truth-telling is important for pragmatic as well as moral reasons. Although it would be cynical and unfair to claim that medical staff tell the truth only to protect themselves from lawsuits and loss of reputation, it is significant that the concept of disclosing incidents to patients — a philosophy once greeted with horror by medical malpractice lawyers and insurance companies — is now cautiously welcomed in legal circles. The author and a colleague made a presentation (April 1990) on this subject to doctors, lawyers, administrators and insurance professionals at a risk management conference sponsored by Marsh & McLennan, Canada's largest medical insurance broker. Arguments similar to the ones used in this thesis were well-received. Disclosure of incidents to patients was generally viewed as an effective form of risk management with the potential for decreasing litigation. Even in 1979 American teaching hospitals developed risk management teams who detected malpractice, approached the patient, were honest and open and offered restitution (Vogel and Delgado, 1980, note 167 p. 84). Vogel and Delgado saw this practice as a way of reducing, not increasing, lawsuits.

An interesting and related question is the extent to which societal pressures shape moral action. Do we become more moral in act, and subsequently in attitude, because of external demands? More than twenty years ago, the author wrote publicity for two chemical companies and watched with interest as government regulations forced chemical companies first to pay lip-service to caring for the environment and then slowly to move towards the more costly task of actually changing their practices. Hospitals and doctors, like chemical companies, changed because of complaints from consumers and government regulations. If withholding information actually increases the potential for a lawsuit, then veracity, or some semblance of it, will be viewed as expedient. This is a utilitarian argument that impresses where moral suasion fails.

Conclusion

Alasdair MacIntyre in ***After Virtue*** (1984) advances the idea that the language of morality is in a serious state of disorder and that what the modern world possesses "are the fragments of a conceptual scheme, parts which now lack those contexts from which their significance derived" (MacIntyre, 1984, pp. 2, 10-11). We use the language of Aquinas and Kant (when we speak of the virtues, or the duty to respect autonomy) but our society has lost its understanding of morality (MacIntyre, p.2). We wrench the thoughts of the theologians and moral philosophers of the past from the context of their cultures and milieus (MacIntyre, p.11) and, to a greater and greater degree, speak "*as if* emotivism were true", because "emotivism has become embodied in our culture" (MacIntyre, p. 22). What we once called morality, MacIntyre says, has largely disappeared (MacIntyre, p.22). Emotivism, which " is the doctrine that all evaluative judgments and more specifically all moral judgments are *nothing but* expressions of preference, ...attitude or feeling, insofar as they are moral or evaluative in character" marks our society and creates interminable moral disagreements (MacIntyre pp.11-12). Our culture is emotivist and, although we may explicity use the language of the past, our implicit stance is the relativism of emotivism (MacIntyre, p.22). Moral thought has become what MacIntyre calls a conceptual *mélange* (MacIntyre, p.252) and the only way we can extricate ourselves from a babel of competing moralities is to use our moral arguments to come to more refined disagreements rather than achieving consensus (MacIntyre, pp. 252-253).

Let us turn, therefore, to the various moral arguments advanced against lying and deception to see if we can achieve some refined disagreements about how truth can be handled in the clinical setting.

Chapter two
Truth-telling and deception: the moral argument

Introduction

An elderly man was dying. The nurse asked the wife to come immediately, but he died before she got to the bedside. Other members of the family were at the bedside when he died. Remembering that the wife was almost blind, the nurse suggested to the family that they all let the woman believe that her husband was still alive. The family agreed. When the wife entered the room, the nurse brought her to the bedside. " She lifted her husband's still-warm hand to her lips and said ' Darling, I'm here with you.' " The nurse said to the wife " I think he waited for you to come " and then, a few minutes later, told the wife that her husband had stopped breathing. This deathbed scene lasted for ten minutes. Afterwards the wife said to the nurse "I'm so glad George waited for me " (Schmelzer & Anema, 1988, p.110).

The nurse who engineered this apparently touching scene said that he "couldn't regret the lie that had given Mrs Laning a chance for fewer regrets in the lonely months of grief ahead " (Schmelzer & Anema, 1988, p. 110). Many medical people, including the authors who cite him, would view this deception as inexcusable paternalism.

Although this thesis addresses the issue of truth-telling about medical mistakes, much of the literature on veracity in the medical setting focuses on the ostensibly " kind " untruth, told to protect the patient from shock or despair. Even Augustine, who thought all lies to be wrong, wavered when considering the plight of the ill.

In this chapter I will look at truth versus truthfulness, lying, intentional deception and incomplete disclosure, and finish with an

historical overview of the moral and philosophical approaches to truth-telling.

I will conclude with this brief historical survey because it reveals the roots of two approaches to lying: that all lies are wrong, versus the view that lies which do good either are good, not culpable or not lies at all. Both approaches have a very long history. What has been dominant throughout the more than 1500 years since Augustine has been the view that the sick and dying are a special category of person to whom lies or deception might be a kindness. Even Augustine, who thought all lies to be wrong, felt tempted to this position. It is only in very recent years that we have come to view the patient as an autonomous person with the right to information so as to exercise the right of self-determination. To call a doctor paternalistic is, nowadays, pejorative.

Truth and truthfulness

Given the universality of human lying, it is startling to discover that the question has received so little attention. Every philosopher has grappled with the exalted concept of truth. In contrast, says Bok, deception and lying has received little attention. She points out that no reference to lying or deception can be found in the index to the eight-volume ***Encyclopedia of Philosophy*** (Bok, 1978,pp. xix-xx). My own research, which included a computer search in the Bioethics data bank of the Kennedy Institute of Ethics, Georgetown University, for articles over the last ten years on truth-telling, lying and deception about medical mistakes, brought to light very little on the subject, in spite of the more recent focus on the obligation of the physician to disclose to patients. Yet lying and deception are no less common in the medical field than in any other area of human endeavour. This is not to say that physicians are dishonest. It is a great error to automatically assume misbehavior on the part of the powerful on "the unthinking conviction that those with power

are evil and those without power, good" (Joan Cassell, 1981, p.166). Cassell points out that field workers in the human sciences tend, when "studying up" to see themselves as the natural allies of the exploited (Cassell, p.166). In the medical setting, it is patients who are viewed as vulnerable to exploitation.

An exalted preoccupation with truth, Bok says, can lead to a reluctance to grapple with deception (Bok,1978 pp.5-9). The question of what truth is, and whether or not it can be attained, has preoccupied many philosophers and theologians. As noted in the introduction, throughout history two extreme positions have been taken which make nonsense of any moral imperative to be truthful. Radical sceptics held that nothing can be known at all and that, therefore, nothing could " be said to be honourable or dishonourable" (Bok, 1978, p. 9). They argued that the epistemological should have priority over the ethical because "it is useless to be overly concerned with truthfulness...so long as we cannot know whether human beings are capable of knowing and conveying the truth in the first place" (Bok, 1978, p.9). Religious fanatics, attempting to impose the "absolute " truth on others, can justify lies to further their aims and tell untruths to promote a "higher" truth (Bok,1978, p.7). Both groups, Bok says, ignore the distinctions between truthfulness and falsehood in a quest for certainty (Bok,1978, p.10). The agnostic will either despair or accept a view of the world in which absolute truth is a chimera. Those who find ambiguity difficult or intolerable will cling to a system which claims to provide an answer to all the imponderables of the universe.

The desire to place "epistemological certainty ahead of ethical analysis" can, in Bok's view, harm moral choice (Bok, 1978, p. 10). If one doubts the reliability of all knowledge then one may give lesser importance to the moral aspects of how people treat one another (Bok,1978, p.10). This over-rational denial helps the thinker avoid the moral claims and demands

of truth. Epistemological uncertainty is what undoubtedly led Lawrence Henderson to say that "since telling the truth is impossible, there can be no sharp distinction between what is true and what is false" (cited in Bok,1978, p.12). Raanon Gillon (1985, p.1557) says that to argue that the "'whole truth' is usually a mirage," creates a difficulty which has nothing to do with the issues of truthfulness and deceit. Gillon suggests that "those with residual doubts should, as Sissela Bok suggests, imagine what their response would be to a used car dealer who used such arguments to justify his deceit" (Gillon, p.1557). Bok says that the "misuse of scepticism by those who wish to justify their lies " creates the "fallacious argument.... that since we can never know the truth or falsity of anything anyway, it does not matter whether or not we lie when we have a good reason for doing so" (Bok,1978,p.12). Those who question whether or not the whole truth is attainable should ask themselves if they can put such concerns aside in their everyday lives (Bok, 1978, p.10). For example, if Eastern Airlines tells them that the plane will fly to Boston at 7:20, they will probably assume this to be true. And, in their human relationships, they will quite naturally trust the word of some more than others (Bok, 1978, p. 10).

Such an argument, as Bok points out, is the same one used by researchers and, I might add, many physicians, who claim that a patient's informed consent is meaningless because genuinely informed consent is unattainable (Bok, 1978, p.13).

As we can see, in any discussion of truth-telling in the clinical setting, it is of supreme importance to make a sharp distinction " between the moral issue of truth telling...on one hand and the epistemological, logical, and semantic problems that beset the concept of truth itself" (Gillon, 1985, p.1557). What is crucial, Gillon says, is the doctor's intentions: "does he intend to discover what the patient would wish to know and does he intend

to try to meet such wishes " even when the facts given may upset the patient (Gillon, p.1557).

Intention belongs to the realm of mora' theology and applied ethics. Because applied ethics, according to Bok, has not seemed interesting to many moral philosophers, practical moral choice, especially in the case of lies, has been neglected (Bok, 1978, p.ll). Further on in this chapter we will look at the the Fathers of the Church and the theologians to see how theoretical knowledge about truth can be translated into right action. Before we do this, however, we will look at lying and deception.

Lying and deception

In her book ***Lying: Moral Choice in Public and Private Life*** (1978), Sissela Bok defines as a lie any stated message which is intentionally deceptive. She places lying in the larger category of deception, which includes speech, gesture, disguise,action, inaction or silence which attempts to make another believe what we ourselves do not believe. Lying is a deceptive statement (Bok 1978,p.l4).

Intentional deception, according to Bok, includes not only speech, but actions, gestures or omissions. When deciding whether or not to disclose the truth to patients, a doctor may lie or he may act deceptively by withholding information. He may act deceptively simply by being reassuring. Kind words and a gentle manner, though essential to a good bedside manner, may cloak the painful admission that something has gone wrong. A reassuring tone of voice, for example, may lead the patient to believe that the situation is more hopeful than it is. The doctor, in admitting a mistake, may neglect to impart to that information the full weight of the seriousness of his error. "Don't worry Mrs X. Even though we did remove your ovaries (instead of just the uterus, a less radical procedure), you might have gotten cancer there anyway."

Joseph Ellin (1981) makes a clear distinction between lying and deception. Deception, he says, is not as bad as lying (in Mappes & Zembaty, eds.1986, p. 84). Ellin argues that physicians have an absolute duty not to lie to patients but do not have even a prima facie duty not to deceive (Ellin, 1981, p.84). Ellin argues that deception,though it may harm, is different from lying. Intentional deception which is not a lie involves words or actions from which one may assume that the person who is the object of this exercise will draw a false conclusion. He says that even Kant (in his lecture ***Ethical Duties Towards Others: Truthfulness***) said "I can make believe, make a demonstration from which others will draw the conclusion I want, though they have no right to expect that my action will express my real mind. In that case, I have not lied to them....I may, for instance, wish people to think that I am off on a journey, and so I pack my luggage" (Kant, cited in Ellin, p.85). According to Ellin, if a person is deceived without a lie, he is somewhat to blame because he has not investigated a situation or has jumped to conclusions (Ellin, p. 85). Furthermore, the person who deceives has merely given the person to whom he speaks material to draw inaccurate conclusions. This does not directly harm a person's right to have true beliefs. Finally, Ellin believes that deception is not as serious as lying because it does not violate the social contract in the same way that lying does. The liar is always perceived to be less trustworthy than the deceiver (Ellin, p.86).

If we look at truth-telling as an ideal, not lying becomes a basic obligation. Intentional deception may be construed as lying but circumstances exist in which not fully disclosing information could be placed in the category of deception of which Ellin speaks.

Ellin describes two situations in which he thinks doctors might deceive their patients: when a course of treatment which a doctor feels can benefit a patient cannot be undertaken unless the patient is deceived or when a

patient's physical or mental health would be injured unless information is at least temporarily withheld (Ellin, 1981, p.83). He states that most authors say that patients should not be deceived unless something more important than truth is at stake. This is a utilitarian argument in which the patient's health might be given a higher value than the patient's right to truth. Others take the view that the duty of veracity is absolute. In common with many authors, Ellin feels that it would not be realistic to adopt a position so rigorous that one is obliged to "inflict avoidable anguish on someone already sick" as hope may promote healing (Ellin, p.84). He notes, however, that physicians who weigh the principle of veracity in this way are easily tempted to deceive or to conceal information when they want to use placebos, induce patients to give up dangerous habits or trust the medical team (Ellin, p. 84). Ellin states that the problem facing the physician who wishes to approach an ethical dilemma involving truth-telling by determining if the end is sufficiently important to justify an exception to the principle of veracity is deciding "what counts as a sufficiently important end" (Ellin, p.84). Thus we are faced with a dilemma which states either that veracity is an absolute duty, which is probably unworkable, or we say that it is prima facie only (Ellin, p.84), which could lead to abuse. Lying to generate confidence in a medical team is, in my view, exactly the sort of abuse which naturally follows from balancing means and ends to determine whether the principle of veracity can safely be violated.

Ellin's solution to this dilemma is his distinction between lying and deception and his definition of the relationship between doctor and patient as fiduciary. The duty not to lie, he says, is absolute; there is no duty to avoid deception. "Deception....is not even wrong prima facie, but is simply one tool the doctor may employ to achieve the ends of medicine" (Ellin, 1981, p.84). Ellin believes that the two principles, one forbidding lying and the other allowing deception, may be defended by viewing the

doctor-patient relationship as fiduciary (Ellin, p.84).

The concept of the fiduciary relationship is based on the idea that the fiduciary has a legal responsibility for a beneficiary and that the "fiduciary's responsibilities are limited to the specific goals of the relationship" (Ellin,1981, p. 87). To view the physician as one with a fiduciary responsibility for his patient is to hold him responsible only for those aspects of the patient which define the relationship. The patient's morals, finances, living conditions, or family conflicts have no part of the fiduciary concept of the doctor-patient relationship because they fall outside the interests which define the relationship (Ellin,p.87). According to Ellin, the relationship is similar to that which one may have with a lawyer:

> I do not expect my lawyer to take responsibility for my emotional stability, the strength of my marriage, how I use my leisure time, etc., though of course these other interests of mine might be affected by my legal condition. Where my legal interests conflict with some of my other interests, it is up to me, not my lawyer, to make the necessary choices. Those who expect their lawyer or doctor to look after a broad range of their interests, perhaps even their total welfare, obviously do not have a a fiduciary conception of the professional relationship; they think of the professional as priest, friend or some similarly broad model. (Ellin,1981, p.87).

Ellin concludes, "Since a patient's interest in not being deceived is a moral interest and not a health interest, the doctor-patient relationship, construed as fiduciary, does not even prima facie exclude deception" (Ellin,1981, p.87).

According to Ellin, some would say that this argument seems to remove from doctors the obligation not to lie when they fear a patient's health might be injured (Ellin,1981, p.87). There is a difference, however, between the relationship between doctor and patient and "the obligations which make the relationship possible. In a fiduciary relationship, the only obligation *of* the relationship is to do whatever is necessary to further the

goals by which the relationship is defined" (Ellin, p.88). But no relationship would be possible were it not for respect for other obligations. Therefore, "obligations which make the relationship possible override in cases of conflict, obligations *of* the relationship" (Ellin, p. 88). The obligation not to lie is what makes the relationship possible. In other words, lying destroys the doctor-patient relationship if one conceives it as fiduciary because it is fiduciary relationships which most depend on trust. The fiduciary, therefore, cannot lie, even to protect health. (Ellin, p.88). According to Ellin, "lying is more destructive to trust than deception because lying is a greater violation of the social contract. The liar by his false speech violates the very promise that he makes in speaking, the promise to speak the truth" (Ellin, p.88).

Ellin's argument seems to offer much to the physician seeking rationalizations for evasiveness. By defining as fiduciary the doctor-patient relationship, it seems to offer a model that avoids paternalism. But, in fact, it is highly paternalistic and weighted in favour of the physician. As Mark Sheldon (1982, p.652) points out, Ellin's argument is very similar to that of Henderson's (see Chapter one of this thesis) in that both view the healing process as more important than the truth. A physician who has made a mistake could find ample justification, using this model, to "protect" her patient from information she feels would reduce the trust so necessary to a fiduciary relationship. As Kant (1963, p. 227) said "...a *falsiloquium* can be a *mendacium* — a lie — especially when it contravenes the right of an individual." Although untruths of this sort are not necessarily lies, they are if the other party in the relationship, in this case, the patient, has been led to expect that the doctor will reveal all information pertinent to his medical care (see Kant, 1963, p. 228).

Breaches of any obligation to tell patients about medical mistakes are far more likely to involve deceptive omission rather than bold-faced lies. A

patient, approached by a suitably contrite doctor, may find himself enveloped in comforting words and kind smiles. He may hesitate to probe too deeply or ask hard questions. The doctor has, in this encounter, ample opportunity to engage in evasion, mental reservation, white lies, excuses or justifications rather than simply to come out with the unvarnished truth. This may be justified by saying that a crisis situation demands deception, or that colleagues must be protected, or, the most common reason of all, that a sick person must not be harmed by unpleasant truths. As Bok points out, whenever the opportunity for deception occurs in a profession with high rewards and is found in a situation in which there is little time to consider alternatives, the door is opened to the development of deceptive practices (Bok,1978, pp. 128-129). A physician, faced with the reality of a mistake which could be kept secret from a patient, might intentionally deceive (lie) or not disclose relevant information. An example of the latter is given by Marcia Millman in ***The Unkindest Cut*** (1976) whom Ellin cites, pointing out that the doctor's bad faith in this case renders the deception the moral equivalent to a lie (Ellin,1981, p. 84).

Millman describes the experience of a young biochemist who appears to have been bulldozed into having a liver biopsy (Millman,1976, pp. 138-139). After several days of finding the doctors seemingly reluctant to inform her of the test results (Millman, pp.140-142), she was finally told: "Don't worry, the biopsy didn't show anything wrong with your liver " (Millman, p. 142). With considerable difficulty, the patient was able to obtain her chart (Millman, pp. 142-144) only to discover that the biopsy report said "No analysis, Specimen Insufficient for Diagnosis" (Millman, p. 144). It seems that the physician had not inserted the needle properly and therefore missed getting an adequate sample. The housestaff and other physician covering for her doctor allowed this patient to believe for two days that she was dying of an intrinsic liver disease rather than let her know of the mistake (Millman, p. 144). Perhaps the physicians felt justified in not

disclosing relevant information because the patient is most unlikely to have asked "Did you get enough of my liver to make a diagnosis?" This is a type of error that might easily be kept secret. It was the staff's evasiveness that lead to her deep suspicion. In this sense, secret-keeping, as Ellin pointed out when speaking of evasiveness (Ellin,1981, p.84), can turn into lying if questions are asked and not answered.

Millman (1976, p. 144) says that bending the truth or speaking in a misleading way is common when doctors speak to patients. For example, she says, a chief of surgery said that when a surgeon removes a normal appendix he might answer a question about it by saying "That appendix was red, all right." And the family of a patient who died because the cardiac surgeons were clumsy might be told: "We did our best but her heart was so weak and far gone that she just couldn't make it through the operation" (Millman, p. 144) As Sissela Bok says in ***Secrets*** (1983) "...lying and secrecy...intertwine and overlap. Lies are part of the arsenal used to guard and to invade secrecy; and secrecy allows lies to go undiscovered and to build up" (Bok, 1983, p. xv).

Since most human beings speak and communicate with others, probably all of us have, at one time or another, told a lie. We may have lied to make a child happy (Santa Claus will come down the chimney, so lay out milk and cookies for him); to protect the confidence of another (No. Mrs X is not my client); to protect ourselves (My husband will be home in five minutes so please leave); to preserve another's feelings (that dress is a nice colour but [unstated] it looks horrible on you). We also keep secrets, which is not necessarily deceptive because secrecy is not necessarily wrong in the way that lying is. As Bok says "... every lie stands in need of justification, all secrets do not"(1983,p.xv). "There is," as Kant says, "...such a thing as prudent reserve..." (Kant, 1963, p. 225).

Most religions prohibit lying. They rarely do so without admitting of exceptions. The fourth of the five Buddhist precepts asks followers not to tell lies, but certain lies are not regarded as sins. Jewish texts likewise prohibit lying. Some lies, especially those which will preserve the peace of a family, are viewed as exceptions (Bok,1978,pp.47-48).

This is Sissela Bok's position. There are, she says, some circumstances which warrant a lie. The first reason would be the lie to protect innocent lives. But, she says, we must not take lightly the "profound concern" of the "absolutist theologians and philosophers" for the lie's *sequelae*: harm to trust, to one's own integrity, and the long-range effects on human society (Bok, 1978,pp.48-49).

People in the modern world, even when they have no particular religious beliefs, find lying repugnant. Common sense tells us that we cannot function in society if we cannot trust the words of another. If anything, our modern secular state is obsessive in its search for truth. We are greeted daily by exposés in the newspapers of dishonesty on the part of governments, the Church, the medical profession. In this post-enlightenment age, the rights of the common man or woman are so well-protected and defended that government officials, bishops and hospital directors need to be scrupulously careful that those for whom they are responsible adhere to high ethical standards in their professional lives. One pragmatic reason for this sudden explosion of "truth " is the near impossibility, in an age of rapid communication, of keeping malfeasance secret. Another is a social empowering of individuals that helps them to speak out and to be taken seriously. Government officials and bishops in Newfoundland were able to keep child abuse secret for years until the victims spoke, under court protection, and the evidence against the perpetrators mounted. In 1991 a council of the College of Physicians and Surgeons of Ontario released the report of an independent task force they

had commissioned to study sexual abuse in the medical profession. An astounding (and some say exaggerated) finding of this task force was that ten percent of physicians are guilty of at least some type of sexual misconduct with patients (Mickleburgh, 1991, May 28,pp. A1, A3A; May 29, p.A3) The Act Respecting Access to Information (Québec) makes available to reporters documents which disclose the way in which public funds are spent. Finally, as mentioned elsewhere, Quebec patients have access to their charts. The only way to deal with this explosion of information is to disclose the truth before one is found out. This may well be the reason that the College of Physicians and Surgeons of Ontario opened its council meetings to the public and redesigned its complaint procedures to be more accessible to unhappy patients (Mickleburgh, 1991, April 2, p. A1).

In answer to the question I raised at the end of chapter one, it would seem that society does become more moral because legislation and rapid electronic communication enforce morality. In the absence of universally shared beliefs, the law becomes the guardian of society's morals (See MacIntyre, 1984, p.253) as well as various professional groups.

Historical perspective

Christ demanded of his disciples simple and upright speech (Mt.5:33-34). St. Peter saw the lie as directed against the Holy Spirit and tells us the cautionary tale of Ananias and Sapphira who were punished not for hiding the money they gained from selling land but because they lied about it (Acts 5:1-11). Ancient Hellenic Christian tradition combined Greek philosophy and Holy Scripture. Except for Aristotle and Sophocles, no other representative of Greek philosophy condemns the lie as always wrong. The Hebrew Scriptures recount the lies of patriarchs without condemning them. Consequently early Christianity hesitated before the question of the morality of lying. The Fathers of the Church, Origen, Chrysostom, Hilary

and Cassian are obscure on the subject. Appealing to the example of the biblical patriarchs, (Abraham, Gen 12: 11-13; Isaac, Gen 26: 7-11; Jacob, Gen 27:[6] 8-27 [Häring, 1979, p.45]) they tried to justify at least the use of the officious (helpful) lie if it would help another (Häring, 1966a, p.561). The notion that falsehood is at times justifiable has a history that reaches far back into antiquity even though it was nearly eliminated by Augustine.

Augustine (died 430)

One way to solve the problem of lying is to forbid all lies. The most famous proponent of this position is Augustine who claimed that God forbids all lies and that speech with the intention to deceive subverted the purpose of human speech (Bok,1978 p. 35). Even he had difficulty with his definition of a lie. The paternalistic lie told by the nurse at the beginning of this chapter could well have found support from Augustine who said that he could not resist when faced with a patient who is so ill that his strength might not last if told of the death of his son. Augustine said that he was moved "more powerfully than wisely" by arguments that those who tell the truth to the sick are guilty of killing them (Augustine, 1952a, pp.171-172).

But one lie often leads to another. Augustine pointed out that a lie to help a dying man might lead to a tissue of lies (Augustine, 1952a, p. 172). This same argument is used by Schmelzer and Anema in finding the nurse's lie unacceptable. The woman's relationship with her family might be damaged were she to know that they deceived her. The family will have to carry the knowledge of their deception for the rest of the deceived woman's life (Schmelzer & Anema, 1988, p.112). The same holds true when concealing from a patient that an error has been made. To conceal an error, chart notes would have to be written in an oblique manner and other members of the treating team would need to agree to secrecy. A family might collude in a " kind " deception; a team of professionals and auxiliary staff is highly unlikely to do so. This is an example of secret-keeping which can easily turn

into lying.

Augustine, while deeming all lies wrong, set up an eightfold distinction among lies, describing some as more abhorrent than others. Here is his typology:

1. the deadly lie uttered in the teaching of religion
2. the lie which injures someone unjustly, which helps no one and harms someone
3. the lie that is beneficial to one but harms another
4. the lie told solely for the pleasure of doing so
5. the lie which is told out of a desire to please others in conversation

6, 7 and 8 refer to lies which do no harm and benefit someone (Augustine, 1952b, pp. 86-87).

I would argue that many lies in the medical setting fall under Augustine's category number three as they may be beneficial to the physician but harmful to the patient, or they may be presumed to be told to spare the patient but hurt the physician who is then trapped in a succession of lies.

Bok states that Augustine's thinking on lying had great impact on subsequent thinkers (Bok, 1978, p. 35). Jerome, in his commentary on Galatians, had "justified the officious lie in serious situations," but was later "won over to Augustine's point of view" (Häring,1966a, p.562). Even the Bible had seemed to give examples of lying which made it difficult to object to all lies. Although Augustine continued to maintain that God forbade all lies (Bok,1978, p.35), his contribution to later theological interpretations was to distinguish among lies according to their intention and whether or not they resulted in harm (Bok,1978, p.36).

By saying that all lies were sinful, Augustine created a doctrine that was difficult to live with and led to mechanisms that softened the

prohibition or let a few lies slip in. As Bok says, three different paths were taken: some lies could be pardoned; some deceptive statements were claimed not to be falsehoods but misinterpretations by the listener (what Ellin [Ellin,1981 p. 85] calls justifiable deception). Finally, some claimed "that certain falsehoods do not *count* as lies" (Bok, 1978, p.36).

Aquinas (died 1274)

Aquinas built upon Augustine's eightfold typology, going from the most serious lies to the most pardonable. He distinguished between three kinds of lies: " the officious, or helpful, lies; the jocose lies,told in jest; and the mischievous, or malicious, lies, told to harm someone" (Bok, 1978, p. 36). Aquinas agreed with Augustine that all lies are sins but stated that only malicious lies are mortal sins (Bok,1978, p.36). Such distinctions were not unimportant in a society that had developed the Sacrament of Penance to the stage where the Church's pardoning function could mean, in the perception of the individual penitent, the difference between dying in a state of grace or being condemned to eternal damnation, were the lie not forgiven (Bok, 1978, p. 36). Between the eleventh and fourteenth centuries, arguments were developed to demand that the sinner confess to a priest. By Aquinas' time, not only confession to a priest was demanded, but absolution by a priest, a practice which was not part of the custom or teaching of the early Church (McBrien, 1981, pp.779-780). This change of emphasis required more refined distinctions between sins. It is to Aquinas that Roman Catholics chiefly owe the distinction between mortal and venial sins. The penitentials of the early Middle Ages had already made use of Augustine's distinctions (Bok, 1978, pp. 36 & note 5,p. 314). The more refined development of the Church's thinking on lying led to other paths around Augustine's strict prohibition. One path assumed that certain statements that were intentionally deceptive were not, in fact, lies and could be used in good conscience (Bok,1978, p.37). Aquinas contributed to this development by distinguishing between an intention to utter a

falsehood and an intention to deceive. He claimed that only the intention to say what is false forms the essential notion of a lie (Aquinas cited in Bok,note 6, pp.314-315). Thus we have the famous mental reservation.

History of the Mental Reservation

One of the doctors who responded to the survey by Novack, cited in Chapter one, said that he never used deception with patients yet at the same time said that, if a man died because of a physician's mistake, he would "emphasize that the patient was very sick but despite your best efforts, he died....Narrowly phrased, this *is* the *truth* isn't it — the ' best efforts' of your practice were *your best* — stupid — but ' the best' for you" (Novack, et al., 1989, p.2984)!

This is a good example of the mental reservation in action. It has a long, and somewhat tarnished, history. According to Bok, the concept of the mental reservation is derived from Augustine's definition of lying as "having one thing in one's heart and uttering another" (Bok, 1978,p.37). However this definition removed the speaker's intention to deceive from the definition (Bok,1978, p. 37). This, according to the proponents of mental reservation, allowed for the following: "If you say something misleading to another and merely add a qualification to it in your mind so as to make it true, you cannot be responsible for the 'misinterpretation' made by the listener" (Bok,1978, p.37). This is somewhat like Kant packing his bags for a journey with no intention of actually going anywhere (Kant, cited in Ellin,1981, p.85). There were those who argued that mental reservations were to be reserved for a cause which is just and only when the deceived person had at least an opportunity to guess at the truth behind the words (Bok, 1978,p.37). Kant said that the mental reservation is a form of dissimulation. He thought this form of equivocation was acceptable to silence someone trying to force us to tell a truth we must conceal. But he did not accept it when it took a deceptive form. Though the Jesuits called

these deceptions *peccatilla* (peccadilloes) Kant quite forcibly said "... a lie is a lie, and is in itself intrinsically base" (Kant, 1963, p. 229).

Suffice it to say that clever people could always quickly concoct a mental reservation to suit their purposes. The doctrine had, and continues to have, its opponents. However, in times of religious persecution, mental reservations which disclaimed outward speech or acts probably saved many lives (Bok,1978, p.38). Helmut Thielicke speaks of the enemy who has no right to truth when he suggests that white lies are justified when, for example, facing the gestapo (Thielicke,1966, p. 531). Mental reservations were commonly used in court proceedings by those who swore an oath but feared God's punishment if they uttered a falsehood (Bok, 1978, p.38).

John Henry Newman, in ***Apologia Pro Vita Sua***, (1864) said that almost all Catholic and Protestant authors agreed that certain kinds of verbal misleadings are not sins if there is a sufficiently good reason to mislead (Newman,1864, p. 299). He quotes Concina as saying that mental reservations are lies, and Caramuel, who described them as unnecessary if sincere and pestilent if destructive (Newman, 1864,pp.306-307).

The mental reservation is still with us. Many official oaths contain a clause to omit it. Some still suggest its use. ***Medical Ethics*** (McFadden, 1967, cited in Bok, 1978, p.39) suggests that medical people should deceive patients with mental reservations if such an act seems appropriate, when, for example, a seriously ill patient inquires about his health. Häring places this act in the broader context of intention by saying that a doctor may legitimately withhold the truth if he feels it necessary but must do so as part of an intention to later reveal more. In other words, he seems to be saying, truthful disclosure may be a gradual process with information timed appropriately. In this view, an initial concealment is not dishonest as long as there is the intention to later speak the truth (Häring, 1979, p. 48). In

some situations, mental reservations are clearly lies, apparently justified by the speaker. In others, a mental reservation may be a statement that is truthful in the context of a larger, moral reality but still an overt lie because the intention is to deceive. From Augustine all the way to Joseph Ellin, a fundamental assumption about the sick is made which I believe to be questionable — the assumption that bad news will retard healing or kill the patient. The mental reservation was a way to deal with the idea that falsehood can be justifiable. The old proverb " you lie like a doctor " (*mentiris ut medicus*) was not meant to imply that all doctors lie but that doctors knew how to lie for the good of the person lied to (Newman,1864, p.317). I believe one has to question the paternalism inherent in this view. The mental reservation might be justifiable to delay a truth until the patient is in a better state to receive fuller information. A traffic accident victim whose only child is critically injured might initially be told "we're doing all we can" with no further elaboration. Staff might be justified in being temporarily evasive (Ellin,1981,p.89). But a seriously ill person who inquires about her health has a right to information, albeit sensitively communicated. It is, in my opinion, a gross injustice and a serious moral violation to take away from a patient her right to her own death by filtering information and keeping the patient in a narcotic slumber, unless the patient has specifically asked that she not be told the full truth. Even if an intentionally false statement is not a lie, it may not be justified. The only justifiable deception, in my view, is one that is patient centred.

Hugo Grotius (died 1645)

One of the most powerful proponents of the view that not all intentionally false statements ought to count as lies was Hugo Grotius, a lawyer and Protestant theologian (Bok, 1978, p. 39). Grotius also felt it was acceptable to lie to those who wish to be deceived, but, again, he seems to assume that the very ill would automatically wish to be lied to (Grotius, cited in Bok,1978, p. 283). Häring says that since Grotius' time, Protestant

thinkers have accepted the distinction between the unjust lie, which withholds a truth to which the other has a right, and " consciously false" speech which keeps the truth from the person who has no right to it (Häring, 1979, p. 47).

Grotius argued that a falsehood is a lie only if it is in conflict with the rights of the person spoken to. Essentially, he seemed to be saying, error has no rights. Someone attempting to rob or kill me has no right to information. To lie to someone attempting to injure me is acceptable because honest speech is grounded in the right of liberty of judgement. If the person to whom I speak has evil intentions, then he has lost the right to my honest speech (Bok, 1978, p.39). This argument, that a lie in self-defense is acceptable, has been invoked by some to argue that they may lie to avoid harm (Bok,1978, p.83). A doctor could conceivably use this argument to avoid disclosing an error so as to avoid a lawsuit, loss of income or loss of professional license. Grotius also felt that a lie to someone who wishes to be deceived is acceptable. He saw no wrong in comforting a sick friend by telling him something which was not true (cited in Bok,1978, p. 283). Here again, we have justification for lying to the sick and dying on the grounds that they would wish to be lied to.

Some modern theologians

Lutheran theologians Dietrich Bonhoeffer (executed 1945) and Helmut Thielicke, one a victim and the other a survivor of the Nazis, both elaborate on the justification for lies to those who wish to injure or deprive one of liberty. " Speaking the truth," Thielicke says, "cannot be separated from the situation in which the speaking" takes place (Thielicke, 1966, pp. 530-531). Thus, he says, to "deceive an interrogation officer [in a] totalitarian state" is not just to dispute with him the truth of a particular fact but to resist an attempt on all that one values (Thielicke, p. 531). " As one who wills the

system of truth, I am fighting for my life against this representative of the system of untruth" (Thielicke, p.531). Thielicke says that one cannot "demand of those to whom truth is sacred that they should 'honor' it," when that means that they are participating in a charade of untruth created by their opponents (Thielicke, p. 532).

In much the same vein, Bonhoeffer said:

> There is a truth which is of Satan. Its essence is that under the semblance of truth it denies everything that is real. It lives upon hatred of the real and of the world which is created and loved by God. It pretends to be executing the judgement of God upon the fall of the real. God's truth judges created things out of love, and Satan's truth judges them out of envy and hatred. God's truth has become flesh in the world and is alive in the real, but Satan's truth is the death of all reality. (Bonhoeffer, 1955,p.366).

Bonhoeffer strongly disagreed with the definition from Catholic moral theology of "the lie as a conscious discrepancy between thought and speech" (Bonhoeffer, 1955, p. 368). "The essential character of the lie," Bonhoeffer said," is to be found at a far deeper level than in the discrepancy between thought and speech" (Bonhoeffer, p. 369):

> Jesus calls Satan' the father of the lie' (John 8:44). The lie is primarily the denial of God as He has evidenced Himself to the world....The lie is a contradiction of the word of God, which God has spoken in Christ, and upon which creation is founded. Consequently the lie is the denial, the negation and the conscious and deliberate destruction of the reality which is created by God and which consists in God, no matter whether this purpose is achieved by speech or by silence. The assigned purpose of our words, in unity with the word of God, is to express the real, as it exists in God; and the assigned purpose of our silence is to signify the limit which is imposed upon our words by the real as it exists in God. (Bonhoeffer,1955,pp. 369-370).

As Häring says, "words have their meaning only within the context" (Häring, 1979, p.48). When Nazi state employees asked nurses for the number of children with certain types of genetic diseases, he says, the nurses answered truthfully if they said "none" because the real question was "how many children do you have for the gas chambers?" (Häring, p. 48).

Philosophical approaches to lying

Utilitarianism and Consequentialism

The utilitarians and their precursors did not accept the belief that God has ruled out all lies. Unlike the theologians, these philosophers said that what ought to be done was not right because of divine fiat but right because "it brought about the greatest balance of good over evil." In this view, it is the consequences of the act that render it justifiable (Bok,1978, p.51). Utilitarians stress the difference in gravity between lies but do not need to use concepts like the mental reservation or the white lie to stress this difference. Their methods are much closer to those people actually use when faced with ethical problems, particularly in the medical setting. Lies intended to cover up a serious mistake are viewed by most as much more serious, because of the damaging consequences, than the lie to the patient which says "this will make you feel better " when the physician is not at all sure that it will. But in Bok's view, the more complex the act, the more unsatisfactory the utilitarian position turns out to be because it is difficult to compare the consequences convincingly (Bok, 1978, p.52).

The other problem posed by utilitarianism is that it seems to rob lying of its essential wrongness. A lie and the truth that achieve the same ends may appear to be of equal value (Bok,1978,p.53). If a liar evaluates a lie by weighing risky against beneficial consequences, he or she may think that his process of ethical deliberation is grounded in utilitarian principles. But this is a misuse of utilitarianism. "...even strict utilitarians might be willing to grant the premise that in making moral choices, we should allow

an initial presumption against lies" (Bok, 1978,p.53).

Utilitarianism is a popular philosophy in medical circles. When a physician considers proposing a particular course of treatment, he or she may weigh the risks versus the benefits to arrive at a decision. A person suffering from mild headaches would be wise to try various remedies or non-invasive diagnostic procedures before undergoing, for example, a lumbar puncture to withdraw spinal fluid for diagnosis. When patients are presented with treatment options, the doctrine of informed consent requires that risks and benefits be clearly explained.

When this type of calculation is applied to the concept of disclosing medical mistakes to patients, the dangers of delusion on the part of the person doing the explaining are very real. A physician might draw on the historical caveat against telling harsh truths to the sick and decide that telling a patient about a mistake would be a grievous shock and, therefore, a great risk with no benefit. The more devious might argue that the risk to his or her own professional reputation outweighs any putative benefit to a patient. The physician might consider the risk of a lawsuit, loss of income and even loss of license as jeopardizing the well-being of his family and depriving future patients of his ministrations. This might appear to be a risk outweighing any benefit to his patient. The opportunities for self-deception are great when an individual is faced with admitting a mistake which is personally damaging.

For these reasons, utilitarianism seems an inadequate ethical method to use when determining whether or not the truth should be told. I would agree with Augustine and Kant that all lies are wrong, including lies of omission, and call for exceptions in only the rarest of circumstances. Kant's views (Immanuel Kant, died 1804) are the strongest we have against lying. Unlike Aquinas and even Augustine, he does not accept the generous

motive or the threat to life as an excuse to lie. "Truthfulness in statements which cannot be avoided is the formal duty of an individual to everyone, however great may be the disadvantage accruing to himself or to another" (Kant, cited in Bok,1978, p.40). This brings us to the ethical system which contrasts most strongly with utilitarianism — the deontological ethical stance.

Deontology

Deontologists argue from principles rather than weighing risks, benefits and consequences. Immanuel Kant avoided the subtleties of Aquinas and Grotius (Bok,1978, p.39-40). His absolutist position eliminated any attempt to distinguish between lies. Kant viewed the lie, even when it hurts no one, as always harming human society " for it vitiates the source of law " (cited in Bok,1978, p.40) and renders the dignity of the human being worthless (Bok, 1978, p.40). He completely dismissed the idea, propounded by Grotius and later by Thielicke and Bonhoeffer "that we owe the duty of speaking the truth only to those who have a right to the truth.... Truthfulness is a duty which no circumstances can abrogate" (Bok, 1978, p. 41). He maintained that "a conflict of duties and obligations is inconceivable" (Kant, cited in Bok, 1978, p. 41). If one does one's duty, he says, one will discover that there were no conflicting obligations (Bok,1978, p.41).

More than "intuition" or "common sense" about the necessity to tell the truth motivated Augustine and Aquinas. Evidence to show that lies must be ruled out is, as Sissela Bok says, "almost always of a religious nature" and is based on religious revelations or documents (Bok,1978, pp. 44-45). Even Kant was profoundly influenced by his beliefs though he claimed that his moral principles were independent of his faith. He acknowledged that "the highest good " cannot be possible without some assumption as to the existence of God (Kant, cited in Bok, 1978, p. 46). His views on lying are vehement and consistent with his deeply pious religious background

(Bok,1978, p.45-46). He sounds very like Augustine when he says:

> the man who communicates his thoughts to someone in words which yet (intentionally) contain the contrary of what he thinks on the subject has a purpose directly opposed to the natural purposiveness of the power of communicating one's thoughts and therefore renounces his personality and makes himself a mere deceptive appearance of man, not man himself (***Doctrine of virtue***, cited in Bok,1978, footnote,pp.45-46).

This is almost identical to Augustine's (Bok, 1978,footnote, pp. 45-46) :

> Now it is evident that speech was given to man, not that men might therewith deceive one another, but that one man might make known his thoughts to another. To use speech,then, for the purpose of deception, and not for its appointed end, is a sin. ***The Enchiridion***, cited in Bok, 1978,p.34).

Ethical and Religious Systems: a summary

Individuals have always tried to produce systems that would render moral choice easy. But genuine moral dilemmas are, of their very nature, difficult. In the medical setting, they often involve choosing between a good and a better action. As Bok (1978,p. 57) says, we rarely have difficulty deciding whether or not torture is wrong. We might wonder if it is really necessary to tell a sick and depressed patient that the medication we gave them was the wrong one, especially if this medication error caused no real harm. Augustine would probably puzzle over the same question.

All structures devised to render moral choice easier can be seductive in their clarity and design. They provide certainty, make sense of the world and human relationships and give us a firm structure in which to lead a life of integrity (Bok,1978,p.56). Those who find ambiguity difficult or intolerable will cling to them.

It is not uncommon for medical students, faced with the uncertainties of their profession and their role in it, to grasp eagerly at any simple recipe-book approach to the most serious moral dilemmas. " Is it written down somewhere what to say and do if a person you are able to treat refuses your help?" they plead. An *apologie sécurisante* is always comforting, because it narrows choice to those courses of action approved by religious, legal or other authority. Moral philosophers, according to Fergus Kerr (Kerr,1991, 25 May, p.644), will search for the rules in which their school of ethics is grounded; Roman Catholics, Jews and Muslims will look to religious law to make the right decision. If one follows Aquinas one will see the foundations of ethics in the virtues. "The question is not, 'What is the right thing to do?' but rather, 'What kind of person do I want to be?' " (Kerr, p. 644). The second part of Aquinas' ***Summa*** replaced morality based on an explanation of law with a theology based on Aristotle's description of the virtues. It is virtue, says Fergus Kerr in this review of the ***Summa***, that helps "human beings to flourish" (Kerr, p. 644).

In the hospital setting, a plurality of beliefs and values will necessarily lead to a variety of approaches to truth-telling. Fragments of the old traditions of religion and ethics will be found alongside the modern concepts of rights (MacIntyre,1984, p. 252). To what body of religious law or ethics can a doctor appeal when asking whether she should tell her patient the truth about a medical error?

There are those who argue that patients do not necessarily wish to be told the truth (Gillon, 1985,p.1557). Doctors are often faced with the situation in which the patient simply says: "Just look after me, doctor, and don't tell me anything." Younger doctors, educated firmly to believe in the patient's autonomy, say they have difficulty with this. This difficulty is compounded in hospitals populated with patients from many different cultures. It must not be forgotten that the concept of the patient as

autonomous is not only recent, but Western. F.J. Ingelfinger (1978, p.669) takes issue with Bok's argument that patients want the truth. He says that she relies on the problems presented by patients with or without cancer, which, until recently, was a diagnosis often withheld from patients. " The average doctor, however, spends far more time in tending the well, the worried and those with self-limited disorders than in trying to alleviate those with terminal and fatal illness" (Ingelfinger, 1978, p. 669). Mark Sheldon discusses the views Ellin put forth in **Lying and Deception: The Solution to a Dilemma in Medical Ethics** (1981) and suggests that the deception allowed by Ellin and Henderson works because patients feel subtly coerced not to ask questions but passively to submit so as to receive care. Just because a patient doesn't ask questions, he says, doesn't mean she doesn't want information (Sheldon, 1982, p. 654).

Bok states, and I agree, that "many lies to those who are very ill,... are taken by the liars themselves as understood and accepted by all involved, whereas those thus lied to have agreed to nothing of the sort " (1978, p.93). It is paternalism to assume that a patient would wish to be lied to or to be spoken to evasively. "It is rare that children, friends, or spouses will have consented in advance to being deceived for their own good" (Bok, 1978, p.226). The issue, Bok says, is one of consent. The argument for implied consent holds that those deceived for a noble purpose will later be grateful (1978, p.226). An analogous argument has been used to justify treating patients against their will. To circumvent the requirement for consent, some physicians say "If those who are now being deceived for what is truly their own good were completely rational, sane, adult, or healthy, they would consent to what is being done for them " (Bok,1978, p.226). Even J.S. Mill, the great promoter of liberty, thought that the decisions of the weak could be overridden for their own good (Bok, 1978, p.230).

As we saw in the historical overview of truth-telling, protection of the weak

stands out as the most notable exception to religious and philosophical objections to lying. Underlying the idea that the sick should be protected from painful truths is an assumption by those in power that their deceits are benign (Bok, 1978, p. 176). Doctors, the Church, governments " ...have seen themselves as high-minded and well-bred— whether by birth or by training — and as superior to those they deceive. Some have gone so far as to claim that those who govern have a *right* to lie. The powerful tell lies believing that they have greater than ordinary understanding of what is at stake; very often, they regard their dupes as having inadequate judgment, or as likely to respond in the wrong way to truthful information" (Bok,1978, p.177).

Many who govern, Bok says, frequently feel that some situations are too painful or difficult for ordinary people to cope with. For these reasons, governments withhold information about natural disasters, bishops withhold information about clergy who pose a danger to others and doctors say they will not bother patients with " all the picky details about risks or harm " (my quotes but see Bok,1978, p.177). As Bok points out (1978,p.240) this "...paternalistic assumption of superiority... also...risks turning to contempt. "

From the perspective of the deceived, arguments that we do not need to know "all the picky little details " do not persuade. Perhaps more authoritarian cultures led people to trust those in power. Ours is a culture of deep mistrust in once-powerful professions.

All of us in this mistrustful society are faced with a dilemma because all of us need, at one time or another, to have recourse to someone who can help and heal us when we are physically ill, psychologically distraught, or spiritually weary. As Alasdair MacIntyre points out in ***After Virtue*** (1984) we can no longer rely upon commonly held values. What we possess are

fragments of a moral scheme wrenched from the context in which those philosophies were created (MacIntyre, 1984, p.2). Serious moral choice can be agonizing, particularly in our period of history when there seem to be few signposts. We may find that when we need to make difficult moral choices systems of religion or philosophy give little help. As Bok says, many claim that such systems were never meant for everyday decision-making. " Yet it is natural to *try* to use them at those times when we are most bewildered, when it seems that in obeying one moral principle we are transgressing another" (Bok,1978,p.56). As Bok says, there is no evidence that any system or principle can lead to a clear answer because "...adherents of every moral system...have been found on every conceivable side of the difficult moral issues that have divided mankind " (Bok,1978, pp.56-57). And even if we adhere to one system, it is quite possible that the person with whom we are communicating is following another. The notion of choice, so valued in our culture, creates dilemmas about which principles we should choose (MacIntyre, 1984, p.43). Various codes embody the virtue of truthfulness and provide occasions for exceptions to that rule (MacIntyre, 1984, p. 193). As MacIntyre says (MacIntyre,p.193), all these codes will embody the same virtue but the codes will vary as societies vary. However, he says, practices (of truthfulness) do not "flourish in societies in which the virtues were not valued" (MacIntyre, 1984, p.193). North American doctors, valuing autonomy, may tell the truth as an application of that value. In Asia, or even Europe, doctors, wishing to protect patients from pain, may not tell the truth out of beneficent motives. But if the virtues themselves are not valued, if competing authorities are appealed to, then only legal, institutional and professional authority becomes compelling (see MacIntyre,p.193, 253).

The theologians and philosophers discussed in this chapter spoke from the context of a particular understanding of human nature. That understanding presupposed the existence of God. Our society, as MacIntyre

says, cannot achieve moral consensus. It can only find a way to negotiate between competing systems. The law performs this function (MacIntyre,1984,pp. 252-253).

Conclusion

"God's truth judges created things out of love," Bonhoeffer said (Bonhoeffer, 1955,p.366). Although it may contradict popular opinion, which relishes sordid stories of medical mendacity, many physicians and health-care professionals are both truthful and caring. The physician who genuinely cares about her patients will probably agonize when faced with telling a patient or, worse, a patient's surviving relatives, about a serious or fatal error. I have met such physicians. As those who design courses in ethics know, no course can teach ethical behavior. All theories can do is help the beleaguered physician find a way of approaching a dilemma. The fundamentally truthful person seems instinctively to know how to show care and concern for a patient while at the same time telling the truth. Such individuals may not always disclose all information. Some incidents — like the fact that the priest was called to the bedside but got there minutes after the patient died — are probably best kept secret out of kindness. "The assigned purpose of our words...", as Bonhoeffer says,"... is to express the real..." (Bonhoeffer, 1955 pp. 369-370). Bonhoeffer saw the real as rooted in God. Adherents of natural law theology would say that the law is written on people's hearts (Romans 2: 14-16) and that, therefore, the naturally good person, whether he or she believes in God or not, is also a naturally truthful person. Physicians who spend more time worrying about malpractice suits than caring about their patients are perhaps more likely to lie, deceive, dissemble,or evade when faced with telling a patient the truth about a mistake. The caring physician is probably the truthful physician who is able to place the various components of what must be communicated to the patient in the larger reality of which Bonhoeffer speaks when he says:

Every utterance or word lives and has its home in a particular environment. The word in the family is different from the word in business or in public. The word which has come to life in the warmth of personal relationship is frozen to death in the cold air of public existence. The word of command, which has its habitat in public service, would sever the bonds of mutual confidence if it were spoken in the family. Each word must have its own place and keep to it... (Bonhoeffer, 1955. p.367).

Chapter three

The operation was a success but the patient died— How errors are defined and explained

Introduction

The patient engages a doctor or enters a modern hospital at his own risk. If he or she does not ask the important question "does the benefit of this consultation or treatment exceed the risks of invasive diagnostic tests, medication or surgery, then he has placed his life and health at the disposal of a person or an institution which can harm him. Ivan Illich (1976) says that the number of accidents reported in hospitals is higher than the number reported in all but two industries: mining and high-rise construction (Illich, 1976, p. 40) and "that one out of every five patients admitted to a typical research hospital acquires an iatrogenic disease" (Illich, p. 41). Although many of these hospital- or doctor-induced diseases are trivial, he says that one in thirty lead to death. Half of these complications result from treatment with drugs; one in ten from diagnostic interventions (Illich, p. 41). According to Illich, the "pain, dysfunction, disability and anguish" resulting from medical interventions rival those resulting from injury caused by traffic and work accidents and even the injuries of war. He sees the impact of medicine as a rapidly spreading epidemic (Illich, p. 35). He cites high levels of diagnostic error (Illich, p. 101) and aggressive diagnostic tests (cardiac catheterization) as examples of medical interventions which can kill (Illich, p. 102). Add to this injuries inflicted by malfunctioning equipment and nosocomial infections and the reasonably healthy person is well-advised to stay clear of medical institutions unless absolutely necessary.

In fairness to the profession, many doctors weary of patients who arrive in their offices seeking medical solutions to emotional and spiritual problems. Those truly dedicated to the full meaning of informed consent

will outline all risks and the alternatives to treatment which may well be no treatment at all. If doctors are perceived as all-powerful parent figures, or priest/shamans who mediate the grace of healing, it is partly so because people, in their search for gods, priests and parents, have invested medicine with a power it cannot possess.

This chapter will look at the issue of medical error, the public perception of medical error, the limitations of medicine, and internal and external control of the medical profession. It will discuss how the law views error, present various definitions of what error is in the medical setting and analyze the system itself to see how errors can be prevented. This chapter provides a background for the chapters to follow on how physicians view their mistakes (Chapter four); whistle-blowing as a method of social control (Chapter five), and the law as an agent of external control (Chapter six).

The public perception of medicine

Since the authority-questioning consumer movement of the 1960's and 1970's a definite shift in the public perception of medicine has taken place. Medicine has also, as noted earlier, been transformed from a personal contract between physician and patient to a relationship with an institution. Errors which in the past might have been ascribed to a fault on the part of the doctor can now " be rationalized into the occasional breakdown of equipment" or the carelessness of those who tend or operate the machinery. "In a complex technological hospital negligence becomes 'random human error' or 'system breakdown' " (Illich,1976, p.39) and incompetence can be blamed on government agencies or hospital administrators who will not give doctors adequate tools to do the job. There is merit to this complaint and governments in state-funded health care systems may be open to lawsuits.

Consumer protection movements, according to Illich (1976, pp.238-239) only reinforce the collusion between the giver of medical care and the recipient. He feels they can contribute only if they "move beyond the control of quality" and management of risk into the defence of the individual's freedom to take or leave the services offered by medicine. The attempt to impose lay control on medicine Illich views as ineffective (Illich, p.246). He says that the "medical clergy" can be controlled only if the law is used to restrict and remove the medical monopoly on deciding who is sick and how each person is to be treated (Illich, p. 251). He sees organized medicine as a "grotesque priesthood" which has "become a law unto itself" (Illich, p.249). Medicine, he says, is on the borderline of science and the professions, and has come to play a role reserved to ministers of religion, "using scientific principles as its theology"(Illich, p. 254). Medicine, in his view, is focused less on healing the curable than it is with the salvation of human beings from the onslaughts of illness, impairment and even death (Illich,1976, p.254). I would add, that with the decline of belief in the doctrines of organized religion, many, in the words of David Howes (lecture, 1986) have traded eternity for longevity and so turn to the high priests of medicine for a this-worldly salvation .

Given Illich's views, it is hardly surprising that he thinks that doctors should not be licensed by their own professional group but should be evaluated by informed clients (Illich, 1976, p.257). What he calls for is nothing less than the deprofessionalization of medicine and "the unmasking of the myth" that technical progress requires science to solve human problems (Illich, p. 258)

Limits to medicine

David F Horrobin in ***Medical Hubris — a reply to Ivan Illich***, (1977?) agrees with Illich that "the medical establishment has become a major threat to health" (Illich, cited in Horrobin, p.1) but he argues that

medical hubris ("the sin of appropriating the prerogatives of the gods" [Horrobin, p. 6]) is not entirely misplaced. If God exists, he says, then he has asked people to take responsibility for organizing their own health care system. If God does not exist, then humans are solely responsible. "We... have no alternative to acting in ways which should be the prerogative of heaven" (Horrobin, p. 7). The danger is that we may not fully appreciate what we are doing (Horrobin, p.7). Far from being guilty of the charge of attempting to take on the attributes of the gods, Horrobin argues that medicine's

> ...current problems are consequences of the accumulating weight of small decisions made by small men and women with small concerns. Such people have been totally unaware of the huge consequences of what they have been doing. The image which best fits is not of a phalanx of Promethean heroes setting out to conquer the world: it is one of an army of peasants who by their small and immediate day to day concerns seriously damage the potential of a whole land. The medical profession has made great decisions without realising it. As was said of Britain, medicine has acquired its empire almost in a fit of absentmindedness. Having acquired it, it has no idea what to do with it. (Horrobin,1977?, p.23).

I agree, with Horrobin, that Illich's analysis is brilliant but frequently overstated (Horrobin,1977?,pp. 7, 36). To give but two examples, his description of cardiac catheterization as a type of medical intervention that can kill (Illich,1976, p.102) tends to nullify his case by hyperbole (Horrobin, p.36). Cardiac catheterization is never used as a routine screening process, which Illich admits (Illich, p. 102). It is almost always performed on those already ill with heart disease and its goal is to define the nature of that illness (Horrobin, pp. 36-37). Horrobin says that the death rates from cardiac catheterization are about 1 in 1000, not 1 in 50 as Illich claims, occur in those already ill enough to require surgical intervention and is an important "preliminary to cardiac surgery" if the surgeon is to know exactly what she should do when faced with the patient

in the operating theatre (Horrobin, p.37). Certainly patients can be harmed by unnecessary drugs, operations and diagnostic tests but it is equally true that many treatment side effects "attributed to the debit side by a polemicist are known and calculated risks taken by doctors often in consultation with their patients " (Horrobin, p.19).

Treatments which are designed to cure have risks which cannot be dissociated from very real benefits such as twenty more years of a useful life. (Horrobin,1977?, p.19). Nowhere, in my opinion, is Illich's argument weaker than when he points to kidney dialysis as a method of " dying in exquisite torture" (Illich, 1976, p.113). Before long-term hemodialysis was made possible in 1960 the often young person who succumbed to renal failure would rapidly die within weeks (Horrobin, p.43). Although the early days of dialysis were marked by scarcity which necessitated allocating this resource by using social as well as medical criteria (Fox & Swazey, 1974, pp. 220, 222, 240-279) there is no question that kidney dialysis, though time-consuming for the patient, has made it possible for young fathers and mothers to live to see their children grow, aspiring students to win degrees and contribute usefully to society and, in fact, has probably, like kidney and heart transplants, contributed to the general happiness of individuals and society. It is difficult to argue that such technological benefits are examples of medical hubris. Although science and technology can hardly solve all human problems, victims of kidney and heart failure, severed limbs, or life-threatening but potentially curable infections are usually grateful for the advances in technology and scientific medicine that have given them twenty, thirty or more years of a happy and productive life. Science has given them the power to contribute to their families and society their own unique gifts.

A physician who does not understand the natural limits of medicine was the physician the Greeks accused of hubris (Jecker, 1991, p. 5). Nancy Jecker

says that many of our problems in defining limits stems from a shift from a Hippocratic to a Baconian view of medicine (Jecker, p. 5). A work attributed to Hippocrates states that one must "refuse to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless" (Hippocrates, cited in Jecker, p. 5). The scientific revolution of the seventeenth century led to the the view that the goal of science was to conquer nature.

> In contrast to Hippocratic medicine, Baconian science was a tool for plundering, rather than a means of revering, nature. In Bacon's words, the applications of science do not"merely exert a gentle guidance over nature's course; they have the power to conquer and subdue her." Defending the interrogation of nature by the scientific method, Bacon compared it to the interrogation of witches. He argued that witch trials were above reproach because they ferreted out truth, and "Neither ought a man to make a scruple of entering and penetrating into those holes and corners [of nature], when the inquisition of truth is his whole object." (Bacon, cited in Jecker, 1991, p.6)

Much of Bacon's imagery, Jecker notes, views nature as a female to be controlled and tortured (Merchant, cited in Jecker,1991, note 8, p.8). It is little wonder that an informal coalition of special-interest groups — feminists, environmentalists, new age movement followers and alternative medical practitioners — either attack or avoid modern scientific medicine as an expression of patriarchal domination. "The goal of bending nature to one's will, which is integral to modern science, became a goal of scientific medicine as well" (Jecker, p. 6).

Physicians working in the modern scientific tradition thus came to see medicine as limitless, a belief that joined hands with the eighteenth century's belief in scientific progress. Condorcet, an eighteenth-century mathematician and philosopher, believed that improvement in medicine would mean the end to all disease to the point that only unusual accidents

would cause death (Condorcet, cited in Jecker 1991, p. 6). This may well be the secret belief and hope of many young and aspiring physicians and researchers. Yet almost three centuries after the scientific revolution, diseases with no cure abound. AIDS is only the most recent challenge to medical hubris. It is misplaced faith in science that is often behind medically useless rescue operations. "Like the grand purpose religion imparted to the religious life, the modern idea of scientific progress 'represented the secularization of an attitude, initially religious, which looks to a fine fulfillment in some future, far-off event' " (Butterfield, cited in Jecker, 1991, p.7).

Will we find a way out of our dilemma by turning medicine and science over to the control of the public? Or would we be better served by allowing medicine itself to examine the values it has inherited? I believe that no control is possible until both doctors and specialists in religion, anthropology, ethics, and history, to name but some helpful specialties, collaborate to create a medicine that is scientifically grounded but which respects the values inherent in the Hippocratic tradition.

The control of medicine

Illich's view, that doctors should be evaluated by informed clients (Illich, 1976, p.257), is viewed by Horrobin as an incorrect assumption that medicine is a monolith (Horrobin,1977?, p. 52). Illich cannot see the medical profession as capable of reforming itself (Horrobin, p.21). Horrobin agrees that change is required but believes that "to return medical care ' to the people' by removing controls and allowing lay individuals to supply and to accept medical care freely would lead to total disaster" (Horrobin, p. 22).

Many authors believe that medicine requires external controls for the protection of potential and actual medical victims. It is difficult to imagine a state-funded system without external controls since the state, by paying

the bills, is as much a consumer as the actual patients. I would suggest that it is impertinent to assume that doctors have no genuine moral interest in maintaining high standards. Fear of punishment may motivate some people to practice their profession with care. Many physicians, however, are drawn to the profession out of a desire to use their gifts and skills to serve people. Physicians do, in fact, have a well-developed system for monitoring and maintaining medical standards as we shall see in an analysis of the way two surgical services handled failure in Charles Bosk's ***Forgive and Remember: Managing Medical Failure*** (1979).

Whether or not this system is sufficient, relying as it does on internal controls, is open to question. Chapter six will look at arguments that patients are better protected with a system of external sanctions. Before examining how patients who become victims might be protected from further damage, however, let us look at definitions of error in the health care setting.

Error defined

When the Royal Victoria Hospital was drawing up its guidelines on the disclosure of incidents to patients, the first question asked was "what is the definition of an incident, and who is involved in determining that an incident has happened?"

The word itself simply refers to something that is apt to occur. It is mild in tone but the realities it cloaks can be immensely serious. It refers to what risk managers usually call "adverse outcomes" and what ordinary people call injury or death. It is only institutions that refer to incidents, events and adverse patient occurrences. Patients and non-involved staff refer to screw-ups, goofs, disasters and horror-shows. When the veil is lifted from the innocent-sounding word, we are looking at mistakes that can hurt, maim or kill.

Hospitals define incidents as any event which occurs outside the routine of patient care. "Event", like "incident" is an all-purpose descriptor for anything from a missed medication to an operating room mistake that causes injury or death. Incidents are variously described as any occurrence which deviates from normal policies and procedures and which may or may not have an adverse outcome. The Canadian Medical Protective Association, in its medico-legal handbook, does not define an incident but talks of "a serious or unexpected mishap [which] has occurred in the course of treatment" as "an early warning sign", presumably of a potential lawsuit (Evans, 1990, p.6).

How are errors understood? "How", in the words of Charles Bosk, "does the surgeon cope with the knowledge that his clumsiness, forgetfulness, or tardiness contributed to" the death or suffering of another (Bosk, 1979, p.4)? Failure is inevitable in human life and incidents, as noted earlier, are events which are apt to occur. All human groups, says Bosk, have ways of making failure a normal and accountable aspect of life (Bosk, 1979, p. 4). We can account for it by saying it is God's will. We can blame it on a scapegoat, as crop failure and the plague were blamed on witches in earlier times. We can investigate failure scientifically and point to specific causes. Marcia Millman in ***The Unkindest Cut*** (1976) says that doctors, to protect themselves against feelings of extraordinary responsibility for people they have damaged "employ several collective rationales for distancing themselves from the outcomes of their mistakes" (Millman, 1976, p.91). She says that physicians neutralize medical mistakes by ignoring them, justifying them or trying to make them appear unimportant. These are built-in protections that she says are defenses against acknowledging mistakes (Millman, p. 91).

Bosk (1979, pp.22-23) states that defining error has not been perceived as a problem in studies of social control in medicine. Some studies have

assumed that defining an error in the medical context is a straightforward exercise of applying standard criterion. Some people think that it is easy to recognize an error. An event either has the characteristics of an error and can be defined as such, or it does not. Much literature on medical error views it not as a problem of definition but as a problem of deciding whether or not the error should be punished (Bosk, p. 23), and how. Millman says that the definition of a medical error is one controlled by the medical profession. "What would probably be viewed as a mistake by the patient may not be interpreted as a mistake by the physician, and the doctor usually has the power to control the identification of mistakes" (Millman, 1976, p.91). Within the profession, she says, what is seen as success and failure has little to do with the "concerns of the particular patient" (Millman, pp. 91-92).

The problems surrounding the definition of error in the medical setting can be explained by the fact that medicine is not an exact science. It is a profession which draws on great skill in judging the appropriate treatment for a particular condition. It is rare for a physician to be able to say " ' This patient has *x* and we must do *y* ' " (Bosk,1979, p. 23). Even when the nature of the condition is certain, the treatment will vary according to severity of disease or trauma, the age of the patient, the skill of the physician and the treatments available (Bosk, p. 23). Furthermore, leading experts may disagree on the treatment of choice. In ***The Silent World of Doctor and Patient*** (1984) Jay Katz tells the story of a young woman with breast cancer whose physician decided, until he revealed alternatives to his patient, to treat her with a total mastectomy. That was the usual treatment at that time but the physician knew that other physicians in his own institution thought that removal of the tumour alone, with radiation therapy, was equally effective (Katz, 1984, pp. 90-99). With the explosion of new technologies and new treatments, it is not always clear what is appropriate treatment. Leading experts may swear by one procedure or

another and both, in a sense, may be right. The patient, therefore, is in many cases given various choices and the end result may well depend on the good judgement of the patient as well as the doctor.

As Bosk says, "not all diagnoses and treatments that later experience proves wrong are mistakes" (Bosk, 1979, pp. 23-24). If the patient with the breast tumour had a recurrence of cancer because she opted for the less radical procedure, few would say the surgeon had made an error if his action was one any reasonable doctor would have taken. Furthermore, surgical interventions may fail for reasons that have nothing to do with the competence of the surgeon. The patient's disease may render the best efforts of the surgeon in vain. A patient who delays getting treatment or does not cooperate with treatment may be the agent of the failure of the treatment performed on him. Important sources of failure are errors on the part of support staff and equipment malfunctions (Bosk, 1979, pp. 67-70). Medications given at the wrong dose, at the wrong time, or not at all; failure of nurses to monitor closely a post-operative patient for hemorrhage; test results which are delayed or lost; the failure of technicians to check the safety of equipment — all account for surgical failures even when the surgery itself was successful. Hence the grim joke that the operation was a success but the patient died. Nursing errors and support and technical staff errors, as well as problems with equipment safety, are difficulties in different chains of command but are crucial to a successful surgical outcome.

It is extremely important, in understanding how social controls operate in the medical profession, to understand how physicians decide "between what was a reasonable treatment option that subsequent events proved wrong" and what is an indefensible act which we could define as an error (Bosk,1979, p.24). Sociologists, Bosk claims, have been quick to produce facile explanations for the ways in which error is treated, but negligent in

explaining what errors are. To the physician, error is "an 'essentially contested' concept" (Gallie, cited in Bosk, p.24). As Bosk says, any study of error in medicine must pay attention to "the phenomenological nature of error as a category of social life" (Bosk, p. 32). The law, however, views error in more concrete terms.

How the law views error

Not all errors are actionable. The legal profession says that "a cause of action refers to the set of facts or alleged faults which if established gives rise to the claim for damages" (Evans,1990, p. 11). Although the general public uses the term malpractice freely, "malpractice is not a well-defined legal term" and "does not serve to define the true nature of the cause of action against the physician " (Evans, p.11). The Canadian Medical Protective Association (CMPA) handbook, written by Kenneth Evans, says that "untoward results may occur in medical procedures even when the highest possible degree of skill and care have been applied" (Evans, p. 15). Since "the law does not demand perfection," the physician must ask him or herself what standards of care apply so as to avoid accusations of negligence (Evans, p.15).

Medical interventions (or non-interventions when some form of action is required) which lead to litigation and judgement against a physician may include assault and battery (often non-emergency surgery without adequate consent or operations on the wrong patient, limb or organ); false imprisonment, which accounts for actions brought against psychiatrists; defamation, which usually applies to breaches of confidentiality which shame the patient; breach of contract, in which the surgery does not achieve the guaranteed result; lack of informed consent (a significant risk may have been omitted or alternatives not suggested) and negligence (Evans, 1990, pp. 11-13).

Claims of negligence account for the majority of legal actions brought against physicians. These suits involve "an allegation that the defendant doctor did not exercise a reasonable and acceptable standard of care, competence and skill... and as a result the patient suffered harm or injury" (Evans,1990, p. 13).

Negligence extends not only to positive acts but to actions which the physician should have taken, but did not. Most claims for negligence are made because of alleged acts of omission (Evans,1990, p. 15).

A successful legal claim for negligence must have four basic elements: "a duty of care owed towards the patient"; "a breach of that duty of care"; harm or injury suffered by the patient; harm or injury which is "directly related or caused by the breach of the duty of care" (Evans, 1990, p. 15). In other words, once a doctor agrees to treat a patient, he or she is obliged to care for the patient "as the situation requires and the circumstances reasonably permit," exercising "reasonable care, skill and judgement" according to "current and accepted standards of practice" (Evans, pp. 15-16). He or she need not be perfect but must exercise the degree of care and skill that could reasonably be expected of a doctor with a similar standard of training. The patient must prove that she has suffered harm or injury if she wishes to establish that her doctor was negligent as mistakes with no adverse result are not actionable. The patient must be able to establish causality, demonstrating that the harm or injury complained of is caused by the alleged breach of duty (Evans, pp. 16-18).

A typology of errors

As we saw in the last section, not all errors are grounds for a lawsuit. But distinctions between types of error are important so that they may be avoided in future. It may be of little comfort to the injured patient, but to the person responsible for preventing risk and disclosing incidents, it does

matter how one type of error is distinguished from another. Patients should feel confident that the hospital and its staff are doing all that they can to prevent mistakes. Nonetheless, certain things can go wrong. A preliminary scale of errors might read as follows:

A. Errors determined by factors which could not have been foreseen

Mistakes in this category are a matter of regret but not necessarily of guilt, either felt or real.

1. characteristics inherent in a procedure and its match with a particular patient. In retrospect it may later be seen that the patient was not a suitable candidate for a procedure. Some of the "exogenous sources of failure" described by Bosk: complications because of the patient's disease, "procrastination or noncooperation" (Bosk, 1979, pp.67-69) may be included in this category.
2. unforeseen factors — a city-wide black out and a balky emergency power generator, for example.
3. full information not available to medical staff.

B. Preventable error

1.poor judgement. A3 might belong here if surgeons operated before reading all completed test results. Failures or errors that result from poor judgement can occur when one set of rules or procedures rather than another was chosen and followed. In retrospect, the choice of these procedures appears to have been mistaken. However, an honest error of judgement is not a breach of a physician's duty (Evans, 1990, p. 17).
2. not considering the possibility of something going wrong.
3. carelessness, mistakes,slips,oversights. A3 might belong here if information were missing from the chart.
4. technical errors which may be failures due to the limitations of machines because they are worn out; individuals because of finite knowledge, exhaustion or lack of energy, and slips of the hand; of teams because of poor

communication or inadequate staffing. The types of errors made by nursing and support staff which Bosk describes would be listed here. They include forgotten medications, intravenous fluids not replaced or administered too slowly or quickly, wounds not kept clean (Bosk, 1979, pp. 69-70).

5.malfunctioning equipment. This includes computerized test results being printed out incorrectly; failures of pumps, ventilators (Bosk, p. 70), and imaging machines.

6. failures that result from not following guidelines or protocols, whether procedural or legal. These errors may result either from human negligence — not paying sufficient attention, as in the nursing errors listed above — or from intentional violation. How and why these errors occur does make a difference. Doctors who do not thoroughly investigate a patient's medical history and course of treatment in hospital may prescribe a medication that can harm. Doctors who comply only with the minimum legal requirements of informed consent may, by tone of voice, haste, lack of clear speech, deprive their patients of information and expose them to risks they would not have chosen to take.

C. Culpable error

1. malicious errors. Although it is probably extremely rare for a physician to deliberately injure a patient, one reads from time to time of deranged doctors causing injury, support staff sabotaging equipment or doctors and nurses deliberately withholding essential information from other team members which leads to mistakes.

2. errors caused by substance addiction.

3. errors caused by disobeying instructions; not answering pages.

Prevention of error

Patients can sustain serious harm even though the medical staff exercised good judgement and skill. Conversely, they may suffer no injury even though they receive a medication overdose. Some people would suggest that

patients not be told of incidents that cause no harm, even though staff have been negligent. Furthermore, some physicians feel that if they are guiltless, they are under no obligation to discuss an incident with a patient. Unlikely as this may seem in the face of some event personally unpleasant to the patient, it may not be uncommon. Patients who sustain mild, but uncomfortable or inconvenient injuries caused by the clumsiness of medical students, may find that their request for an explanation and apology is brushed off with "This is a teaching hospital and these things happen".

Errors and mishaps are likely to occur in all organizational settings because of technical problems, operator mistakes, negligence and the limits to the capacity of human beings to respond quickly and well. If these mishaps are to be minimized in their consequences and not frequently repeated, then it is essential that those involved acknowledge the mistakes. Truth telling, in the sense both of not lying and disclosing fully, and coherent communication, are essential if those responsible for the care of patients are to act and react responsibly. The problem arises if one wishes to keep such reporting internal to the team or service caring for the patient and not tell either the institution, through incident reports, or affected clients. When the institution or its patients are not accurately and adequately informed of mistakes, mishaps and incidents are more likely to recur and their consequences will be more severe and extensive.

Risk analysis

One way of looking at mistakes or accidents in the medical setting is to define them with the help of two constructs — complexity of organizational decision-making and coupling of events and decisions (Perrow, 1984, p.62). Perrow's contribution to the analysis of risk, as he himself says in ***Normal Accidents*** , is that he focuses on systems rather than on those who operate them whereas most people explain mistakes by pointing to the errors made by individuals, poor design of equipment, carelessness about safety,

inexperienced staff, outdated equipment or systems that are unwieldy, underfunded or badly managed (Perrow, p. 63). Perrow believes that something far more basic makes systems fail. It is not the problems that are widespread and common to all systems, but characteristics of the systems themselves that explain accidents and incidents (Perrow, p.63).

Although ***Normal Accidents*** refers to such high risk industries as nuclear power plants and the marine and airline industries, his analysis is applicable to many aspects of the medical setting. First of all, he distinguishes between accidents, which he describes as events which so damage a system that future output is disrupted and incidents, which are comparatively more minor events that may cause temporary disruption (Perrow, 1984, pp. 64-65). Accidents are as rare in the hospital setting as they are in the nuclear industry. Incidents are more common (Perrow, p.71). An accident, in the hospital setting, might be a leak of noxious fumes that injures patients, or an outbreak of a virulent disease because of poor infection control.

Perrow maintains that although most systems place operator error high on the list of reasons for accidents, accidents are frequently caused by an operator confronted with the "unexpected and usually mysterious interactions among failures...." Another important point he makes is that "great events have small beginnings" (Perrow, 1984, p. 9). Those who reconstruct catastrophes often find their causes to be trivial (Perrow, p. 9). The explanation is to be found in these two concepts — complexity and coupling (Perrow, p. 62).

Complexity

Linear interactions are defined by Perrow as those that take place in an expected sequence and complex interactions those that occur in an unplanned or unexpected sequence. Strictly speaking, Perrow says, it is

not the systems themselves that are linear or complex but only the interactions (Perrow, 1984, p.78). Linear systems exist in all settings. Frequently, they include separate stages of production in separate settings (Perrow, p.86). The operating theatre, the recovery room and the ward are an example of a linear setting. The operating room is run by specialists, found in the complex system, the recovery room is staffed by specialists as well as the generalists, found in the linear system. The ward is staffed mainly by generalists. Nurses, unless highly-specialized, can replace each other, and are thus part of the linear system. The lone cardiac transplant surgeon has no replacement and is part of the complex system (Perrow, pp. 86-87). Surgeons, like nuclear physicists, have highly specialized skills that do not " bridge the wide range of possible interactions; [it is] generalists, [found in the linear system], rather than specialists, [who] are perhaps more likely to see unexpected connections and cope with them " (Perrow, p. 87). It is not solely the surgeon's task to ensure that the patient is adequately prepared for surgery. It is most likely that various members of the nursing and support staff have ensured that the patient is prepared and that all the equipment and staff needed are present .

Systems most prone to accidents are those with complex as well as linear interactions and those that are tightly coupled (Perrow, 1984, pp.72,75). Linear interactions (a leads to b and c naturally follows) are predominant in all systems. But even the most linear of activities can be derailed by baffling interactions that were not designed into the system (Perrow, p. 72). These unplanned or baffling sequences render the system complex (Perrow, p.73). An invisible laboratory worker, unhappy with her job, may accidentally switch labels on test tubes, labelling patient a with the illness of patient b. The linear system of sending samples to laboratories whose staff in turn return results to the floor relies on the fact that blood and tissue samples will be correctly marked, analyzed and the results properly identified. The baffling factor here is the temporarily non-functioning

human being. Nuclear and spaceship accidents have been caused by similar types of human frailty. Similarly, transport workers may lose tissue samples and record room clerks misfile chart information or the charts themselves. Or a nurse may neglect to chart significant changes in a patient's health status which the nurse on the next shift may need to know.

Coupling

Perrow looks at what engineers speak of as tight and loose coupling. Tight coupling means that there is no slack between two items. Loosely coupled systems have a great deal of "give" between, for example, "official programs and actual behavior" (Perrow, 1984, p. 90). In a hospital, many clinical procedures — for example cardiac catheterization — are tightly coupled. Lack of attention or equipment failure could be hazardous in such an invasive intervention. An out-patient geriatric clinic is most likely to be loosely coupled. The hospital may have some sort of official program to enhance the lives of the elderly but administrative ennui at the clinic level (for example, booking twenty patients for the same hour, physician lateness, nurses paying more attention to charting than to interacting with patients) may render null any lofty goals of providing humane care. Incidents in this setting are unlikely since this is a loosely coupled system with ambiguous or variable performance standards (see Perrow, pp. 90-91). and a clientele who may even enjoy waiting in the clinic, viewing it as a social outing. Loosely coupled systems are not necessarily disorganized but they are structured to allow for individual and idiosyncratic expression (Perrow, p. 92).

In tightly coupled systems, time is important (Perrow, 1984, p.93). A heart transplant is probably one of the most tightly coupled systems there is. The young man who dies from a gunshot wound in the head in Sherbrooke, Quebec must have his heart removed quickly and transported by air to the patient waiting in the hospital in Montreal. The surgical team in the

Montreal hospital will move quickly to prepare the recipient, probably bumping off the surgical waiting list other patients whose surgical needs are less urgent. In a tightly coupled system, back-up systems must be in place and well thought out in advance. A "crash cart" (which holds emergency resuscitation supplies) stands in readiness in specific areas of the hospital, for example. In a loosely coupled system, expedient buffers and last-minute substitutions can be used (Perrow, pp. 94-95). An emergency department that runs out of a particular type of dressing for superficial wounds can usually find a substitute. There is no substitute for items commonly found on a crash cart. A tightly coupled system brooks no delays in processing, has "only one method to achieve [its] goal", cannot easily substitute supplies, equipment or staff, designs in buffers and any substitute supplies, equipment or staff. The loosely coupled system allows for delays, can switch the sequence of various actions, use alternative methods, will not be in serious trouble if staff or supplies are not always available, can make use of "fortuitously available" substitutions, and buffers (Perrow, p. 96).

It is fairly obvious that certain systems are so loosely coupled that if something goes wrong, there is plenty of time for recovery. Perrow uses universities and post-offices as examples. The university is an example of a system of complex and loosely coupled interactions whereas the post-office functions in a linear, loosely coupled manner. But system accidents simply do not occur in either of these settings. Hospitals, like universities, are complex settings which house linear and both tightly and loosely coupled systems. Administrative offices, while important to the management of risk and resources, are loosely coupled in that their members can usually substitute one for the other and they can recover easily from upsets (Perrow, 1984, pp. 98-99) .

The operating theatre is a good example of a tightly coupled complex

system functioning within a linear setting , and, as such, a system most prone to mistakes (Perrow, 1984, pp. 72-73, 75). It involves doctors, nurses, anesthetists, equipment, and supplies from other systems such as anesthetic gas or electricity (linear). A few of these doctors will be irreplaceable (complex). Events include not only the actual surgical procedure but the patient's post-operative course in the recovery room and on the floor (linear and tightly coupled). Each individual practitioner may do his very best but in this system there are a number of occasions in which there is no slack between two actions (tightly coupled) and the patient's well-being may be in jeopardy if events or individuals out of sight of the operating theatre (linear) do not function as they should. In the operating theatre, emergency power must be available in case of electrical black-outs. What happens if the emergency generator kicks in five minutes after a power failure? As Perrow says, linear systems have the environment as a source of complex interactions because what happens outside the controlled area affects the parts or units of the system, constituting a common source of failure (Perrow, p. 75). Certain types of equipment may malfunction and no substitute is possible (tightly coupled). Even if all goes well in the operating theatre and recovery room, the patient may be moved too quickly back to the ward because of pressure for recovery room beds. The post-operative patient, returned to the ward, still requires monitoring. Nurses may look for evidence (pulse, respiration) that assures them that the patient is stable and miss the unexpected (blood seeping through a dressing on a wound) because they have not been instructed to look for an unexpected, baffling interaction (Perrow, p.72). Many of these actions are what Perrow calls trivial events in nontrivial systems (Perrow, p.43). They can be responsible for great tragedies

Conclusion

As a method of analyzing systems that present a potential for risk, Perrow's analysis is helpful. It takes the focus off individual wrong-doing

and shares the blame, so to speak. The cause of many accidents is to be found in the complexity of systems in which, in many cases, each person's failure is trivial by itself. Failures which are trivial in themselves, even when backup systems exist, become serious when they interact with other failures. An interaction of many failures explains many accidents (Perrow, 1984, pp. 7-8). In the next chapter, we will look at the ways in which physicians attribute blame and control error. Their focus is individualistic. Perrow's focus is on corporate responsibility. Physicians do not exist separately from the hospitals in which they practice. The complexity and tight coupling of systems within the hospital, wedded to a loosely coupled administrative structure, probably accounts for a great many patient-related incidents. Each complex system within the structure is linked to a linear system. By viewing physicians as one element in a complex interweaving system of interactions, it might be possible to so arrange hospital services as to reduce errors. Attention to the job satisfaction and skills of the often forgotten workers — laboratory technicians, transport workers and others whose behind the scenes labours are so crucial to efficient functioning — would probably go a long way towards reducing risk to patients. In my experience, many mistakes have their source in misfiled medical reports, tissue samples that mysteriously disappear or blood tests that somehow don't get analyzed. Furthermore, the tightly-coupled system needs open communication. As we have seen, each individual practitioner may do her best, but the system itself can harm. Communication between doctors and nurses, and doctors and patients is essential. Physicians may see themselves as the centre of the medical enterprise but, as we saw at the beginning of this chapter, the time-honoured relationship between doctor and patient has been replaced with the relationship between patient and institution. No discussion of medical error would be complete without attention to the frailties to which these institutions are vulnerable.

Chapter four
Physicians look at their mistakes

Introduction

The patient's surgery was uneventful. In the recovery room, he blinked his eyes and had a subdued conversation with a nurse. Up on the ward, all seemed well. Before the end of the night shift, the nurse made his rounds and discovered the patient hemorrhaging. The patient was rushed to the Intensive Care Unit and died.

What went wrong?

When a medical procedure has an unexpected outcome, staff move rapidly first to save the patient; only later do they go through the agonizing process of self-examination. In a large teaching hospital, the sequel to such an event would be an intense experience of soul-searching. Meetings would take place with the patient's family. All the staff involved, both doctors and nurses, would go over the entire course of the patient's hospitalization. Insurance companies and lawyers would be contacted. The risk manager and hospital ombudsman would be informed. Even when the error is one person's alone — the surgeon's for example -- others are implicated. The surgeon is responsible for all housestaff under his jurisdiction. Questions will be asked. Was the surgery performed by the resident, insufficiently supervised by the staff surgeon? Did nurses pay sufficient attention to the patient? Were they and the doctors alert to what seemed unusual or did they just look for what was expected? Was the staff doctor contacted quickly enough when a problem was detected? Were there any problems with hospital equipment? With ward staffing? As the last chapter made clear, surgical interventions may fail for reasons that have nothing to do with the competence of the surgeon.

Bosk's study of the surgical training program of "Pacific Hospital" is

particularly instructive in its analysis of how physicians define error. The very title, ***Forgive and Remember*** (1979), is significant in its deliberate variation of the colloquial phrase "to forgive and forget". As we shall see, the surgeons and housestaff among whom Bosk spent eighteen months as a participant-observer, were more than conscious of the possibility of error and devised their own ways of detecting, categorizing and sanctioning mistakes. Some were forgiven, some not, but all were remembered as instructive examples of what to do or avoid in future.

Durkheim, Bosk says,suggested that "each occupational group had its own unique morality" (Bosk, 1979 p. 13). Bosk's study (Bosk, p. 13) bears this out. Bosk asks how surgeons "recognize, define, punish, and/or neutralize failure" (Bosk,p. 16). He states that social control "is the criterion variable that distinguishes one sociological perspective on the professions from another" (Bosk, p.17). In American sociology, the term social control has two distinct meanings: the capacity of the individual or group to "regulate itself on its own initiative" or the "coercive means" a community uses to discipline its members (Janowitz, cited in Bosk, p.18). The doctors Bosk studied regulated their own behavior in a systematic way and had a highly structured system in which certain breaches of the code resulted in expulsion from the ranks of this prestigious teaching hospital. The medical profession has always fought vigorously when its claims to self-regulation have been questioned or attacked. But it has not always made clear what this self-regulation imposes (Bosk, p. 27). To outsiders, doctors can appear to be a cabal of self-serving individuals, quick to close ranks at the slightest suspicion of wrong-doing. What Bosk does is to look at the ways in which physicians discover and define errors and punish those who make them. He analyzes their behavior patterns to determine what they call an error, and what they do not; looks at how they decide the seriousness of a mistake "independent of its effect on a patient", and presents the rules doctors follow for defining an error in the clinical setting (Bosk, p. 27). These rules, he

says, "help form a hierarchical, but very limited authority system which has very concrete implications for the quality of care we all receive" (Bosk, p. 27).

Four types of social control

Bosk presents four types of social control: **informal-internal**,which includes the day-to-day ways in which group members keep one another aware of their working responsibilities. This is the decision changed because of a conversation about a case made over a cup of coffee; **formal-internal**, which includes case conferences, mortality and morbidity rounds; **informal-external** control, which includes random monitoring by outside agents. Chart audits performed by an administrative body outside the department would fall under this category. For example, the registrar-in-chief might check charts at random to see if they are properly completed. The last form of social control is the **formal-external** (Bosk, 1979, pp. 18-19). Hospital accreditation is a method of external control of the functioning of a hospital by a body of outside experts and has been a method used in Canada since 1959. England has no such system. Government audits of individual doctors (by reviewing medicare billing slips), or investigation of complaints by government ombudsmen fall into the category of formal-external control.

The hospital risk management committee is one form of control which combines several of these modalities. The committees are usually composed of doctors, lawyers, nurses, representatives of the patient and the hospital board and one or two people from the outside community. These committees, which are relatively new on the hospital scene, are an attempt to prevent serious medical, nursing and institutional failures by requiring all employees who witness incidents to document and submit them to their department heads. These incident reports are screened by senior staff and, if deemed serious enough, are submitted to the committee. Errors and

omissions that come to light through other means — complaints brought to the hospital ombudsman,for example — also make their way to this committee. The random quality of these submissions — not every case is known or, if known, is not reported all the way up to the committee — renders this mechanism an informal system. The committee's membership is external as well as internal, and its function is to make recommendations which will help medical, nursing and administrative staff improve patient care. Decisions are not meant to be punitive or binding but in certain situations, committee members may demand action thus rendering this system one of informal/formal-internal/external control.

According to sociologists of medicine (Barber et al., 1973; Crane, 1975; Freidson, 1975; Gray 1975, cited in Bosk, 1979, p.21) the medical profession "does not have a well-articulated system of formal controls" and therefore, in the absence of these formal controls, "regulatory responsibility must be removed from the profession or at least structurally formalized." (Bosk, p.21) The rationale for this argument is "that the only effective social control is coercive or formal..." (Bosk, p. 21). This is the opinion of Vogel and Delgado (1980) who argue that legally forcing the disclosure of mistakes to patients is more potent than any moral inducement (Vogel & Delgado, 1980, p. 87) and that it is urgent to do so to protect the patient (Vogel & Delgado, 1980, pp.52-54), who is an unequal partner in the medical enterprise. I will discuss this view in Chapter six. Illich argues that even lay control is frequently ineffective (Illich, 1976, pp. 238-239) as lay people must rely on the medical profession's definitions of illness and decisions as to who requires treatment (Kennedy, 1983, pp. 1-2).

Bosk believes, on the basis of his fieldwork, that people adhere to the norms of their society or profession either by controlling themselves as individuals or bowing to the pressure of the group (Bosk, 1979, p. 21). "Control...is built into the system," he says "through socialization, work routines and normal

relations with colleagues" (Bosk, p. 21). This does not remove the value of formal controls, he says, but it puts into perspective the model of control which says that if there are no formal external controls, then"no social controls exist at all" (Bosk, p. 21). He states that, though the medical profession imposes few coercive or external controls, and few formal controls operate, this does not mean that controls are absent. What, in other words, does the medical profession mean when it says that it controls itself? "Is it claiming that its individual members each regulate him/herself so well that any additional controls are unnecessary" (Bosk, p. 22)? In his conclusion, Bosk views medicine as a system which "celebrates individual conscience as a control" but ignores "corporate responsibility" (Bosk, p. 188). Physicians who commit moral breaches are expelled, but often to a less prestigious sector of the medical community (Bosk, pp. 169, 179). He believes that controls are effective only to the degree that "a corporate moral sense is cultivated equal to the individual moral sense" (Bosk, p. 188). However Millman says that her study of a private, university-affiliated hospital indicates that chiefs at that hospital felt that they should keep incompetent doctors on staff as a protection. In a teaching hospital, residents and other staff would always be there to make sure that patients were not injured. In institutions or private offices with no surveillance, they might inflict their poor work on these hapless victims of unmonitored medical care (Millman, 1976, p. 130).

It is well-known that medicine, as a profession, resists external control. Physicians objected when universal medicare was introduced into Canada in 1968. They objected in Ontario when the government attempted to restrain double-billing. They objected in Quebec when the government attempted to tell new graduates where they could practice and they managed, in 1991, to delay massive reforms to the Quebec health care system proposed under Bill 120. According to Millman, doctors are protected from being challenged because they have, in our society, both

power and privilege, and their work is seen as more valuable (Millman, 1976, p. 13). Consequently, the general public perceives the medical profession to be extremely powerful, and sees, in the words of George Bernard Shaw "all professions ...[as] conspiracies against the laity" (***The Doctor's Dilemma*** [1906], Act 1, cited in Bosk, p. 189).

This fear of external control includes a view that the hospital itself is external to the practice of medicine. The handbook on legal liability published by the Canadian Medical Protective Association (CMPA) argues that hospitals should not be liable for the negligence of all physicians practicing in them (Evans, 1990, pp. 24-25). Doctors, after all, are not hospital employees. The CMPA, which is an organization run by doctors whose opinions, presumably, are fairly represented in this booklet, dislikes what it feels is a trend towards greater control by hospital administration over medical procedures, leading to the possibility that more risky procedures would be eliminated by an administration fearful of lawsuits (Evans, p. 25). "There would be great temptation to assess the range of services or procedures made available to patients with an eye towards cost analysis and not on the basis of health needs and the exercise of medical judgement. Any move in this direction would, in the end, result in a decrease in the quality of care being made available to patients" (Evans, p. 25). This is the usual response of doctors to external control. It is the profession which determines what illness is, how it should be diagnosed and treated, who should have access and who should not. As Ian Kennedy points out in ***The Unmasking of Medicine*** (1983), illness itself is not a self-evident category but is defined by the medical profession (Kennedy, 1983, pp. 5-6). Homosexuality was, for example, defined as illness by the American Psychiatric Association until 1974 (Kennedy, p. 1). Barren women were defined as ill in the last century (Kennedy, p. 3) and can choose to be defined as ill now, with the advent of birth technologies. Menopause is simply a stage of life in many cultures and to many women.

Gynecologists and pharmaceutical companies might view it as an estrogen-deficiency disease (also see Turner,1984, chapter 9).

It is all too easy to assume that doctors resist external control for nefarious and self-serving reasons. People "commonly believe that physicians maintain a conspiracy of silence, protecting incompetent colleagues by shielding their mistakes from the lay public" (Bosk,1979, p. 191). Bosk does not see conspiracies of silence as intrinsically evil but only as harmful when they permit physicians to function with the knowledge that their mistakes may go unattributed and unreported (Bosk, p. 191). The real problem, Bosk says, exists for medicine when silence about betraying colleagues and juniors is elevated as a value higher than the corresponding lesson that the professional is responsible for correcting his own errors (Bosk, p.191). In fact, it is notable that anger directed at the power of physicians is usually directed towards them as a corporate body. And it most frequently is physicians as a corporate body, not as individuals, who resist control. Bosk argues that, to understand what often looks like a professional "stranglehold on the market", we must look at the "cognitive frameworks" of the profession itself to see how the surgeon "constructs his world" (Bosk, p. 189). If sociologists resist using their own definitions of right and wrong when studying lower-class deviance, then they have an obligation to impose on themselves the same standards when studying people of high status (Bosk, p. 189). Understanding the "physician's phenomenal world" will help in understanding the nature of error from the physician's perspective (Bosk, p. 189).

Error from the physician's perspective

Errors, according to Bosk, fall into four categories. First there is the body of theoretical knowledge where mistakes can be made either in judgement or in the application of techniques. This creates the category of the **technical error** and the **judgemental error** (Bosk, 1979, p. 168). Then there is the

area of **normative** and **quasi-normative errors**. These are mistakes made in the interpretation of the code of conduct or moral norms on which professional practice is based (Bosk, p. 68). Bosk concludes that technical mistakes, whatever their source, are not treated in the same way as normative errors. "Technical errors are always subordinated to... normative errors" (Bosk, p. 32) because a good man or woman can always make a mistake but a breach of the moral code of the profession puts the person of the doctor on the line (Bosk, pp.51, 60-61). The literature on the professions leads us to assume that "impersonal evaluations of techniques... have priority over personal judgments" of moral worth but, in fact, the opposite is true (Bosk, p. 169). The physician's "last line of defense" when a serious mistake has been made is that he has done "everything possible", which is a moral, not a technical defense. It is a claim that he has acted ethically and in good faith (Bosk, p. 170). Furthermore, the moral claim that everything possible was done is a guarantee of the intention to give "high-quality technical care". "...it is proper moral performance alone that substantiates a claim to proper technical performance when events mock such a claim. It is not the patient dying but the patient dying when the doctor on call fails to answer his pages that makes it impossible to sustain a case of acting in the client's interest" (Bosk, p.171). Moral error "undercuts all the presumptions on which the professional-client relationship is based" (Bosk, pp. 169-171). As we will see, some types of mistakes are classified as excusable; others as unforgiveable. Since medical diagnosis and decision-making is surrounded with uncertainty, it is probably easier to neutralize errors attributable to the body of theoretical knowledge than those in breach of a code of conduct (Bosk, p.26). There may well be mistakes from which physicians cannot recover (Bosk, p. 26) but these mistakes are likely to be normative errors which breach a moral code (Bosk,pp.174- 175).

Let us look in detail at Bosk's taxonomy of errors.

Technical errors

In technical error, the surgeon performs her "role conscientiously but [her] skills fall short of what the task requires" (Bosk, 1979, p. 37). Everyone makes technical errors, but they are expected to be rare. Sometimes, surgery fails because of imperfect technique (Bosk, p. 37). The surgical intern and resident, for example, has to learn how to tie knots (Bosk, p. 37). It is possible for a suture to give way if improperly placed or tied, leading to hemorrhage and death. Clumsiness in the performance of invasive tests, such as a sigmoidoscopy, which is an examination of the colon and large intestine, can lead to accidental punctures which necessitate reparative surgery. The staff doctor is responsible for making sure that residents and interns make as few mistakes as possible. If a resident nicks the aorta when he opens a patient's abdomen, he has done something incompetently. But the mistake is not unforgiveable. It is a mistake that anyone at this stage of training may make and it is the attending's job to minimize such mistakes (Bosk, p. 38). In this way, attending surgeons claim that they can forgive even serious lapses of technique (Bosk, p. 37). Such errors are an occasion for passing on the "tricks of the trade" to those learning (Bosk, p. 38).

Two conditions must be met to allow an error to be defined as technical: the error must be quickly "noticed, reported and treated" (Bosk, 1979, p. 38). This indicates that the housestaff member intended to do a good job and allows the problem to be corrected before any serious consequences ensue (Bosk, p. 38). It establishes the error as not typical of the person who made it but a momentary lapse due to inexperience (Bosk, p.39). If the same error were reported after a delay, attending staff would suspect a normative as well as a technical error. Quick reporting of mistakes by housestaff to the attending indicates conscientiousness and care for the patient. "It pays tribute to the norms of clinical responsibility" (Bosk, p. 38). Slow reporting of technical error leads attending staff to wonder if the houseofficer is

not guilty of a moral lapse (Bosk, p. 38). The virtue of conscientiousness is the key to how a technical error is judged because it is critical to establishing the doctor's trustworthiness (Beauchamp & Childress, 1989, pp.385-386).

The second condition that must be met to allow an error to be described as technical is that mistakes must not be made frequently, otherwise the person who makes one cannot claim that it is a rare lapse in an otherwise impeccable record of performance. Frequent failure leads attending staff to doubt a subordinate's intentions (Bosk,1979, p. 39). The virtue of conscientiousness, according to Beauchamp and Childress, has "motivational and procedural components. The conscientious person is motivated to perform right actions and follows procedures to discern those actions" (Beauchamp & Childress, 1989, p. 386). The conscientious doctor tries to determine that what he intends to do is correct and he is motivated to do the right thing "because it is right" (Beauchamp & Childress, p.386). A resident may make a mistake. That is forgiveable. But if he is slow to report it to his superiors and acts evasively with the patient about the mistake, or if he makes many mistakes, then he is guilty of more than technical error; he has committed a normative error.

As Bosk says, the costs of technical failure are rarely insignificant. The patient always pays (Bosk, 1979, p. 39) in discomfort, pain and sometimes death and the hospital pays through increased costs. An accidentally punctured bowel, for example, would require reparative surgery and a longer stay in hospital. Thus another patient is deprived of a bed and the injured patient has suffered unnecessarily from pain and, perhaps, lost income from work due to an over-extended convalescence.

Housestaff worry much more about failing to learn from mistakes, although they are undoubtedly remorseful about causing suffering to patients. When

they are novices, interns and junior residents are frightened of making errors that will have disastrous effects on patients. As they learn that everyone makes mistakes, and that mistakes can be managed, they exchange that fear for a fear of making the same mistakes again "and not learning from their experience" (Bosk, 1979, p. 40). Technical errors can be transferred into positive experiences, at least for the neophyte doctor. One way in which doctors reduce cognitive dissonance is to point to the benefit future and as yet unknown patients will derive from the lesson learned from the error (Bosk, p. 41). As Illich points out, an individual physician in a particular case may still remember his obligation to his patient, "but only a high level of tolerance for cognitive dissonance" allows him to perform "divergent roles" (Illich, 1976, p.256) — in this case, as healer and student.

Benefit to future patients may be a comforting thought for novice doctors. It is not, however, an explanation that satisfies patients. Most patients in a teaching hospital accept that the young have to learn. They expect, however, that the attending surgeon will be present throughout surgery and prevent mistakes from happening. In fact, many patients nowadays ask whether their chosen surgeon will be present throughout the operation. If something goes wrong, they demand to know who actually performed the procedure. Because operating room reports, which are frequently read by patients, list everyone present by name, individuals are accountable. Patients in teaching hospitals expect a better standard of care than in a non-teaching hospital. They do not like to be practiced on for the benefit of nameless patients in the future. This is a tension inherent in the teaching hospital system. Teaching hospitals are usually more up-to-date and apply stringent standards so that young doctors will learn to diagnose and perform procedures at a sophisticated level. But because so many procedures are performed by students, a certain number of technical errors are bound to occur. Bosk points out that neither attendings nor housestaff view technical error in a cavalier fashion, and every attempt is made to

keep such errors small. As a long-term, abstract, concept, technical error can be acceptable; concrete evidence of technical error is never accepted cheerfully (Bosk,1979, p. 41).

Judgemental errors

Judgemental errors occur when the incorrect treatment is chosen and are rare for subordinates who have few discretionary powers when treatment decisions are made. The most serious judgemental errors are made by attendings (Bosk, 1979, p.45).

"Judgement is not always [or necessarily] incorrect in any absolute sense; the surgeon, given the clinical evidence available at the time, may have chosen" what seemed reasonable at the time. The result — injury or death — then forces the surgeon to ask whether he ought to have chosen an alternative course of action (Bosk, 1979, p. 45). It is significant to note that it is the results, not the reasoning behind a particular course of action, which decide whether judgement is correct (Bosk, p.45). The old joke "the operation was a success but the patient died" illustrates what happens when principles enunciated in textbooks are not adapted to meet the immediate situation (Bosk, p. 46). Illich says that after a "patient has been damaged or has died, the physician will try to freeze the decision that led to this result by reducing cognitive dissonance" and repressing arguments which favoured the unchosen alternative (Illich, 1976, note 90, p.256). If a treatment that textbooks, experience and statistics say should be effective fails, physicians tend to focus more on the patient and less on procedure. The patient's age and social standing are referred to, often reflecting the surgeon's biases. "They speak of 'this poor, unfortunate teenage boy,' or 'this courageous mother of five,' or 'this unpleasant, unattractive alcoholic' " (Bosk, pp. 137-138). Millman's view is less benign: "...in their tendency to blame patient-victims for medical errors, physicians demonstrate just how far their actual behavior may stray from their claims about being client

service-oriented rather than self-interested" (Millman, 1976, pp. 201-202). She recounts the story of a fifty-year old woman who died in the emergency room of an undiagnosed perforated duodenal ulcer. At the mortality and morbidity conference, the presenting doctors stated that they thought she smelled of alcohol (Millman, pp. 107-108). In this manner, presumed defects in the patient can be used to somehow gloss over serious mistakes.

The two most common judgemental errors made by attendings are either overestimating the need for treatment or underestimating (Bosk, 1979, p. 46). Surgery may be overly heroic or may not be done at all when the situation warrants a surgical intervention. An elderly patient with advanced metastatic cancer would clearly not be a suitable candidate for a heart transplant. However, surgery to alleviate pain (palliative surgery) might be indicated. Oncologists might be tempted to heroics — toxic chemotherapy on a dying patient for example. Some would say that antibiotics for pneumonia in the dying is heroic. Decisions to operate call into play all the moral/ethical debates about the value of life versus the value of a good death. And surgeons, as Bosk points out, (Bosk, pp.131-132) are notoriously impatient with philosophical discourse. They do not like to "debate questions without answers" because their entire professional formation is focused on decisive action (Bosk, pp.131-132). Bosk says that if subordinates disagree with the judgement of an attending, there is little they can do other than engage in polite questioning (Bosk, pp. 47-48). In my experience, very junior housestaff frequently worry about whether or not an attending's decision not to act on a moribund patient is euthanasia. Nurses might view an attending's decision to act as engaging in "heroics". Where strong disagreement exists, many forces may mobilize to oppose the attending. Nurses and housestaff might telephone the hospital ombudsman, risk manager, ethicist, ethics committee or lawyer in cases when they feel strongly that heroic treatment injured the patient. Injury, here, is broadly defined to include psychological and spiritual harm.

Or an individual resident might strongly resist the attending's decision to write a do-not-resuscitate order on a patient and, when the patient suffers a cardiac arrest, act to save the patient.

A second judgemental error "is the failure to establish a clear-cut plan of action for chronic problems" (Bosk, 1979, p. 48). In some patients, problems other than the one for which they were admitted make surgery impossible (Bosk, p. 48). Such people tend to be known, disparagingly, as "bed blocks". They are neither discharged nor aggressively treated (Bosk, p. 48). Such patients may undergo many intensive diagnostic tests even when they will not treated extensively. These are the patients who are too sick to undergo surgery. Because they present theoretical or psychosocial problems, they tend to frustrate surgeons to the point that the surgeon loses interest (Bosk, p. 48) and begs the social worker to find a convalescent hospital or other placement for the patient.

Housestaff may claim that they are responsible for serious errors of judgement (for example ordering medications that may cause serious harm) but they do not have the ultimate responsibility for such decisions and are therefore not held accountable (Bosk,1979, pp. 49-50). Attending staff are protected by their professional accomplishments from being accused of defective judgement. Their individual failures are balanced against success in the practice of their profession or in their research. Because they have often operated on cases that others have rejected as too difficult, they are viewed with admiration. Death, caused by a judgemental error in a situation already fraught with difficulties, is accepted as "an uncomfortable fact of life" (Bosk,p.50). An attending who makes no errors has probably taken no risks. This is not a compliment in a profession which views too much caution as more culpable than taking too many risks. Certain hospitals are known for heroic surgery in risky situations and, in such cases, judgemental error is expected and not severely judged. Surgeons

courageous enough to take on these cases contribute to the image of the surgeon as the lone hero, grappling with death and calling back to life those trapped in its jaws (Bosk, pp. 50-51). If doctors are more afraid of death than the average person, as Jay Katz, citing a study by Feifel, says, (Katz, 1984, p.219), then the "gunslinger" surgeon, though he attracts opprobrium, also attracts the most admiration (Bosk, p. 51). Some will say he plays God. Patients who are rescued from death will see him as the agent of their salvation.

Normative errors

"A normative error," as we saw before, "occurs when a surgeon has, in the eyes of others, failed to discharge his role obligations conscientiously. Technical and judgemental errors are errors in a role; normative errors signal error in assuming a role" (Bosk, 1979, p. 51). If a houseofficer's behavior breaches what is expected of her in her professional role, then a normative error has occurred. The commission of a normative error means that the individual who perpetrates it is no longer seen as "a just and reasonably prudent individual.... Sociologically, normative errors challenge tacit background assumptions about how reality in a scene is constructed" (Bosk, p. 51).

The rule that covers all behavior in the clinical setting is "no surprises." As we saw in the importance given to reporting technical errors promptly, attendings expect housestaff to tell them about any change, no matter how small, that affects the status of the service (Bosk, 1979, p. 51) or the patient.

Surgical services are arranged so that certain cases are reserved for junior staff and others for senior. "Give me a call" from attending to housestaff, or from resident to intern, is no mere conversational politeness. It implies that the subordinate is responsible for seeking help in situations beyond his

level of competence (Bosk, 1979, pp.43-44). "An important part of the subordinate's training is learning to discriminate between situations which he can and cannot handle" (Bosk,p.44). Housestaff learn procedures, Bosk says, the way "children learn to ride bicycles. An unseen hand supports their efforts.... [and]... is withdrawn by stages..." (Bosk, pp. 44-45). Problems occur when this level of supervision is not experienced by housestaff who then feel abandoned. Medical students complain that some residents and attendings are notorious for complaining when called at home about a problem and some of the senior staff most deeply resented are those who verbally abuse the student in front of others for "wasting my time. Can't you figure this out for yourself." Needless to say, a senior with this attitude will encourage housestaff to act on their own when the situation is beyond their competence. It is these situations which contribute to serious errors. The norms described by Bosk— that technical errors are accepted at certain stages of training as long as they are quickly reported, are momentary lapses and teach the student to avoid the error in the future — will not be operative in a situation in which the attending staff person abandons his or her responsibility to offer a helping hand. The attending here has committed a normative error.

It is in this area that the houseofficer's judgement is crucial. He or she does not want to appear unable to handle the simplest situation. He or she also does not want to risk an explosion from the attending or risk the patient's life should he assess the situation incorrectly. Bosk says that he never observed superordinates reacting negatively to subordinates who called them for what later became unnecessary reasons. "When in doubt, call" is the operative principle. However, housestaff feel there is a cost in calling. Many wish to learn how to handle situations on their own (Bosk, 1979, p.53).

A member of housestaff who springs a surprise on the attending violates

the principle of truthful disclosure. Bosk says that it implies that the member of housestaff is "lazy, negligent, or dishonest" (Bosk, 1979, p. 53). An attending may be surprised when he later learns something about a patient that the resident or intern knew all along, or when he discovers something that his resident or intern missed and was expected to know (Bosk, p. 53).

"Normative breaches are breaches of the etiquette governing the role relations between attending surgeons and housestaff" (Bosk, 1979, p.55). When making a decision, any physician is expected to treat situations as they come up or to make sure that they are dealt with before he goes on to something else. "An attending who is surprised assumes that his housestaff have not been dispensing proper clinical care. Had they been, housestaff would have informed him of changes in clinical status" (Bosk, 1979, p.55). A typical surprise for the attending in underfunded Quebec hospitals is to discover that an over-zealous chief resident, without informing the attending, has cleared beds of patients he deems no longer in need of care. On medical wards, chief residents have considerable, but not final, authority. The attending, who may be unknown to the patient, is, however, the person legally responsible for the patient and he does not like to re-admit from the Emergency room a patient discharged by his resident.

Two other types of surprises are treated as normative errors. If housestaff cannot get on with the nursing team, this, according to Bosk, is treated by attendings as a normative error as it violates the expectation that personality conflicts will not contaminate clinical care (Bosk, 1979, p. 55). Housestaff may complain that nurses call them too frequently for what they deem to be insufficient reasons, or that they do not monitor the patient. In one case, cited by Bosk, the housestaff complained that the nurses called every fifteen minutes for something they should have looked after themselves. The attending told the student that it was the student's job to

answer these calls and he was upset that the student was arguing with staff. This attending expected professional behavior from the houseofficer because "you're a professional, you are better educated, better trained, and supposedly more mature than the staff" (Bosk, pp. 55- 56). I am not sure if this is a view generally held by attendings nowadays. Nurses, certainly, consider themselves professionals and many are university graduates with more maturity and experience than the interns.

Failure to maintain good working relationships indicates that the subordinate lacks management skills. He may be blamed for placing his own needs above those of the patient. The subordinate who quarrels with nurses may, when he advances further up the hierarchy, start complaining about the interns or residents under him. The subordinate is expected to be committed and to take responsibility no matter what the behavior of those below him in the hierarchy (Bosk, p. 56).

A second, and related, normative failure is the inability to work well with patients and their families (Bosk, 1979, p. 56). Housestaff spend more time than attendings with patients and families, obtaining the patient's consent, explaining clearly the pre-operative and post-operative care needed and, in general, answering the questions and dealing with the anxieties presented by the patient and his or her relatives. If the intern or resident fails at these tasks, he is viewed as unable to control the normal problems of his work and creates extra work for the staffman (Bosk, pp. 56-57). Though "technical and judgemental errors also create extra work,...[this] is seen as an inevitable part of surgery" (Bosk, p. 57). Extra work created because the young doctor cannot communicate clearly or work harmoniously with others is viewed as unnecessary (Bosk,p. 57).

Thus, an enormous burden of responsibility falls on the shoulders of young men and women not only to be as technically good as they can be but to

excel in human relations skills. I maintain that this area is a rich source of patient complaints. The system, in fact, demands of people in their middle to late twenties to be able to communicate effectively with the sick, dying, elderly, and distraught, both on a technical and an emotional level. Frequently, patients perceive these young people as inadequate to the task and demand to see the "real" doctor. Medical schools require that those admitted be proficient in scientific subjects; probably less attention is paid to interpersonal skills. Perhaps it is hoped that the students will pick up "people" skills along the way. Courses in communicating with patients would be helpful but are not given. The issue of communicating with patients often arises in seminars on ethics. One medical student, for example, thought that obtaining informed consent necessitated an explanation of the proposed surgery right out of the textbook. Medical students are often far removed, by education and social class, from the lives of many of their patients. Furthermore, because of their youth, inexperience and uncertainty, they may be more more inclined to engage in black and white thinking and are often more judgemental than those older. This often compounds the problem. Young doctors can be censorious, making interior judgements about patients who drink, smoke or are obese. They may treat older patients coldly. They may fail to see that the patient has less control over his or her lifestyle than they imagine. They may be ignorant of the fact that the patient cannot comply with a treatment plan because she cannot afford the prescribed medication or that his life is not worthwhile without the Saturday night beer and poker party or that her living conditions are so impoverished that she cannot go home because her building has no easy access in winter or she cannot pay the heating bills.

"Although normative errors are committed by both subordinates and superordinates, only those of housestaff are criticized and punished" (Bosk, 1979, p.57). It is easy for housestaff to make normative errors because "they are subject to so many cross-cutting systems of relevance that it is

often impossible for them to bracket all systems of relevance, keep unfolding action under control, and avoid unnecessary problems for attendings" (Bosk, p. 57). Housestaff work extraordinarily long hours and they are still studying the problems they are treating (Bosk, p. 57). They say that often, when examining a patient under the watchful eye of an attending, they are so afraid of making a mistake that they forget to introduce themselves or behave in a humane fashion, that they say things over the patient's head that they know alarm the patient. Sometimes they are asked to do things they consider unethical, such as practicing certain types of physical exams on unconscious patients, but hesitate to speak up for fear of the attending's disapproval. A chief resident is often responsible for coordinating the treatment of as many as thirty-five patients making sure that tests are ordered and patients and family informed (Bosk, p. 57). Attendings, however, have gone through the same system and view with disgust housestaff demands for shorter hours and more pay. Housestaff are expected to pay their dues in this time-honoured system of apprenticeship. The "basic doctor-patient dyad" is the core system of relevance and, in the view of the attending, "no other system of relevance", for example, the need for sleep, "is allowed ascendency". A normative error indicates "that the houseofficer placed some other concern above patient care" (Bosk, p. 57).

In this system, normative errors are judged more harshly, even though they do not always result in direct harm to the patient. Technical and judgemental errors always involve discomfort or harm to the patient yet are interpreted as evidence of housestaff commitment if housestaff learn from their mistakes. "Normative performance is seen as an indicator of honesty and responsibility" (Bosk, 1979, p. 60). As one surgeon quoted by Bosk said: you "could teach a gorilla to operate in six months, but I can't teach honesty and responsibility. It's the people who have these qualities who make outstanding surgeons " (Bosk, p.60). Errors in technique and judgement say something about training. Normative error reflects on the individual

(Bosk, p.60).

Bosk says that "... an attending is not publicly blamed for normative errors because there is no one to accuse him of such moral lapses" (Bosk,1979, p. 58). However, I find that this is not completely true. Attendings may fail in communicating well with or demonstrating empathy towards patients and their families which, in my experience, causes the greatest unhappiness and the largest number of complaints. They can also create extra work by not working well with nurses and other staff. They are not usually irresponsible, but they can be dishonest, hiding errors and demanding that those under them remain loyally silent. However, patients are quick to discern a poor attitude and readily discover supposedly hidden mistakes. They are also aware that they have recourse to governmental or institutional ombudsmen and/or professional corporations if they feel they have been injured or treated badly. Hospital administrators and even the media are available immediately to patients who feel a wrong has been done. All these groups and individuals stand above the attending to enforce the rule of "no surprises" in spite of what Bosk says (Bosk, p. 58). Complaints will result in an immediate investigation in which the senior doctor may well be accused. However, I believe that Bosk is essentially correct in saying that they are not publicly blamed. Unless a complaint goes to the media or the courts, attendings' infractions of normative standards will probably be known only among a small group of people and would normally be whispered about. I have observed a strong tendency on the part of hospital staff **not** to speak too openly about physician misconduct. As Millman noted , the power, prestige and special skills of physicians (Millman, 1976, p. 13) are such that most people are aware that criticism could be construed as libellous and defamatory because physicians are perceived to have more to lose than others.

In the past, a patient might have had a personal relationship with the

physician treating her and would have been reluctant to complain or even to question. Trust in the doctor acted to reduce dissonance in the patient. If mistakes occurred, such a patient might say: "How could my doctor do such a thing?" or "It couldn't possibly be his fault." In a modern teaching hospital, many patients enter the system without having any on-going relationship with a physician. Rather, they may have been cared for by different doctors in different clinics. Many feel themselves to be consumers in the same way that members of the public, using the services of two or three different banks, feel free to switch allegiances when dissatisfied. Such patients feel no guilt or lack of loyalty in complaining or blowing the whistle. They demand truth.

The expectation underlying intolerance of normative error is the expectation of truth-telling. The budding doctor is trained not to cover up (Bosk, 1979, p. 61). One of Bosk's attending doctors is quoted as saying: "Now in this business, it takes a lot of self-confidence, a lot of maturity, to admit errors.... All mistakes have costs attached to them. Now a certain amount are inevitable. But it is the obligation of everyone involved in patient care to minimize mistakes. The way to do that is by full and total disclosure" (Bosk, pp. 60-61). "A normative error breaches this system of full and open disclosure" (Bosk, p. 61). "The most technically incompetent can be trained" to do something, but the "morally bankrupt represent a threat" (Bosk, p. 61).

Not disclosing mistakes to superiors or patients does not, of course, imply that the physician is necessarily morally bankrupt. Minimum, as well as ideal, standards exist for disclosing incidents to patients and to superiors. There is an enormous difference between making a mistake and covering it up by not entering it in the chart or ripping out pages of the chart and making a mistake and noting it but attempting to blame others. One can see disclosing mistakes along a continuum from dishonestly hiding the

mistake, not disclosing it, disclosing it while trying to avoid personal responsibility, disclosing it but blaming others, disclosing it but blaming others as well as oneself, and openly and honestly admitting the mistake and apologizing to the patient. The morally bankrupt are those, in my opinion, who lie, cover up and destroy evidence. The ideal is disclosing the mistake and admitting one's own part in it not only to one's superior but to the patient. At a minimum, the resident should admit the mistake to his superior without assigning blame to others.

The last category of error is the quasi-normative.

Quasi-normative errors

Quasi-normative errors are specific to particular attending staff and are peculiar to each individual. Each attending has a certain way of doing things and the subordinate who does not honour this mocks the authority under which she works. By disobeying rules, she claims that her judgement is equal to her superior's (Bosk, 1979, p. 61). The resident, mentioned earlier, who ignores the attending's do-not-resuscitate order, has mocked the judgement of one who is presumed to know better. He may be performing a brave and highly moral act, but he is unlikely to be viewed positively by the staffman. Housestaff who exercise independent judgement appear insubordinate and untrustworthy and are viewed as capable of normative error (Bosk, p. 63). A normative breach involves a breach in the standards of clinical care and a breach of "the etiquette governing role relations among attendings and housestaff" (Bosk, p. 64). A quasi-normative error is one in which clinical care may be correct "and the general etiquette of role relations may even be followed" (Bosk, p. 64). The fault, in quasi-normative error, lies in pride (Bosk, p. 64). Quasi-normative errors create tension. The demands of attendings may seem to be whims (Bosk, p. 65), but they are to be heeded (Bosk, p. 66). Subordinates who make many quasi-normative errors, especially if they make them on more

than one service, or blatantly, place their future in the profession at risk (Bosk, p. 67).

Conclusion

"The control of techniques... [is a] less conspicuous part" of the teaching hospital ethos than control of moral behavior (Bosk,1979, p. 173). Surgeons may criticize the outcome of a particular intervention but they will admit that they do not know what they would have done, had they been faced with the same case (Bosk, p. 173). It is not "that technical performance is unimportant[,]....[but] that normative, that is, moral, standards are the organizing principle" of the profession (Bosk, p. 172). In this way, doctors can view the occasional error in technique benignly, even when it results in the injury or death of a patient. This "defends them psychologically, socially and legally against charges of exploiting a client's helplessness; and assures the client that his best interests are cared for" (Bosk, p. 172). This is not an answer which would satisfy an injured patient but it points up the reality that "the statistical limit which separates acceptable from unacceptable technical performance has never been firmly established" (Bosk, p. 172). Bosk asks how many wound infections indicate that a surgeon is incompetent? How many undiseased organs are sacrificed before a surgeon's honesty and integrity are questioned? Yet only one moral breach can bar a physician from the hospital, or even the profession, forever (Bosk, p. 172). Technical failure may be due to the "inherent limits to medical knowledge; ...the inability of any one physician... to master [all that is known about medical science and] the difficulty in deciding... between the limits of the science and the limits of the person" (Bosk, Fox cited in Bosk, p. 174). I would add to this the limits of available technology. Technical failure has its source in these uncertainties and so physicians learn early "to suspend judgement about the failure of others" so as to cope with their own uncertainty. Physicians, therefore, act in good faith (Bosk, p. 174)). By acting in good faith, they are presumed to judge and act with

diligence (Bosk, p. 175) according to the standards of any reasonable doctor at their level of training. Culpable error always joins moral to technical failure (Bosk, p. 177). The doctor who performs surgery and then is unavailable when the patient's post-operative recovery reveals problems has committed a normative or moral breach. The mistake alone may invite a lawsuit. The mistake, wedded to an uncaring and irresponsible attitude, will invite not only a lawsuit but the contempt of colleagues. The mistake alone is not sufficient to do this. In fact, colleagues may be extremely sympathetic to the physician who has made an honest mistake. It is for this reason that the number of technical errors that occur in medical practice exceeds the number of disciplinary actions taken by hospital boards (Bosk, p. 177) or the corporation of physicians.

Moral competence thus acts as the organizing principle of how the medical community governs itself (Bosk, 1979, p.172). Forgiveness and punishment are the ways in which "group membership" and the "boundaries of the professional group" are established (Bosk, p. 178). Forgiveness of technical errors operates as a deterrent, encouraging the subordinate to be more careful in future. More importantly, when the specialist in training sees that when he makes a mistake he is forgiven, then he has no reason to conceal mistakes (Bosk, p. 178). Forgiveness encourages the junior doctor to seek help and removes the shame he may feel for not always knowing what to do (Bosk, p. 178).

Forgiveness is a ritual that protects the boundaries of the group. Bosk describes the "hair-shirt" ritual in which a physician who has made a mistake criticizes himself, confesses and seeks forgiveness (Bosk,1979, p. 178). In "donning the hair shirt" the senior attending turns the Mortality and Morbidity Conference into a public confessional (Bosk, p. 137). This action, in which the attending scrupulously reports all operative misadventures, indicates to housestaff that the "attending applies to his

own work the same standards" set for subordinates and proves that the attending is ready to"sacrifice face" to conform to the highest professional ideals. He demonstrates, by admitting fault, that his "integrity and motives are beyond question" and that his highest value is "improvement in patient care" (Bosk, p. 146). The surgeon who "dons the hair shirt" shows, according to Bosk, his "charity, humanity, and the scope of his wisdom" and adds to his professional self the qualities required of a healer: "humility, gentleness, wisdom, and a certain wry acceptance of the universe that allows him to accept the limits of human activity" (Bosk, p. 144). He expresses guilt, but it does not consume him (Bosk, p. 144). By donning the hair shirt, "surgeons excuse their mistakes by admitting them" (Bosk, p. 145). It is also an act of chivalry. Those who avoid what is perceived as public embarrassment and refuse to concede failure are viewed with disdain (Bosk, p. 145). An attending says "it's a case of insecurity leading to weakness and weakness leading to dishonesty.... They lose all credibility and professional respect" (Bosk, p. 146). Those who refuse to wear the hair shirt when called for "undermine their own authority with colleagues and subordinates" (Bosk,p.146). In the "hair-shirt" ritual, the attending also assumes total responsibility for his cases. He maintains silence about the errors of subordinates, promoting solidarity within the service, while at the same time openly taking responsibility for the mistakes of his subordinates (Bosk, p. 191).

The "hair shirt" ritual is an ancient form of public exorcism. Mortality and Morbidity rounds are a secular form of the monastic chapter of faults (Bosk, 1979, p. 178). By admitting mistakes and receiving forgiveness, the individual maintains membership in the group (Bosk, pp. 178-179). Only those who resolutely refuse to admit error and are therefore invincibly culpable will be expelled (Bosk, p. 179). On the day-to-day activity of the ward, confession is encouraged. " The houseofficer confesses to his attending," just as "the attending confesses to the entire collegium, which is

his superordinate. Both humble themselves and in turn both are forgiven and embraced" (Bosk, p. 179). He who confesses and is forgiven is bound to the group who pledge him to do better in the future. The very act of confession is "proof that an individual adheres" to the values of the group (Bosk, p. 179) and is proof of moral worth. The confession itself is punishment. "Therefore, forgiveness serves to limit self-criticism and prevent an individual from being immobilized by guilt" which would have highly deleterious effects on her sense of self-mastery and therefore on her practice of medicine (Bosk, p. 179).

Hiding one's faults, by contrast, is a moral error which is subject to severe punishment. The guilty one is shamed and placed cutside the boundaries of the group. He must then show that "his lapse was only temporary and not representative of his work....Those who cannot demonstrate this... are excommunicated" (Bosk, 1979, p. 179). In most cases, this means that the resident may be excluded from the prestigious teaching hospital (Bosk, p. 179). He may well continue to practice, but not in his chosen specialty, or in his specialty but in an inferior hospital. Attendings who refuse to wear the hair shirt may, eventually, lose their university appointments and be banished from the teaching hospital system.

Chapter five
Whistleblowing

Introduction

To be placed outside the boundaries of the group, as we saw in the last chapter, is a form of banishment exercised against those physicians who breach the moral norms of their profession. These moral norms strongly emphasize prompt and honest disclosure to one's peers and superiors about mistakes and require harmonious relationships with colleagues and members of related professions. This chapter will examine whether similar rites of exclusion are used against the whistleblower. Is whistleblowing a moral act that is viewed, within the medical system, as a breach of an internal norm? Should whistleblowing be condoned or enforced so as to protect unwitting victims of medical malpractice? Can organizations develop systems which encourage and reward those who raise questions responsibly and punish those who do so with malicious intent?

The whistleblower is the person who sounds an alarm about a danger that he or she believes threatens members of the public. But, as most whistleblowers know, or will certainly learn if they make what is private public, revealing secrets can lead to serious risk for the person blowing the whistle (Bok, 1983, p.211).

As Bok says, a secret, once learned, cannot be unlearned (Bok,1983, p.33). The nurse who witnesses a doctor make a mistake and then hide it, or the physician-scientist who believes that a common medical procedure is dangerous, possess information that may weigh on their consciences. Do they tell, and to whom? Do they confront directly or leak the information? If they speak out, what sort of dangers do they face?

Every human group has its secrets and the boundaries of the group are marked by what sort of information is given to outsiders, and what is

not (Bok, 1983, pp. 39-40). Bok refers to the *"esoteric rationale "*, (her italics,1983, p.39) by which people make sacred certain activities shared by the group. These secrets can also keep at bay any inquiry into the closed system "through the incentives it offers people to remain in a childish relationship to secrecy and power" (Bok,1983, p. 40).

Whistleblowers may act from the highest of moral principles, but they can be treated as psychiatrically unfit, difficult to get along with, alarmists, or lacking in judgement (Beardshaw, 1981, p.3; Bok,1983, p.212). It is sometimes many years before they are vindicated, and they will be vindicated only if they have done their homework.

Whistleblowing includes three elements: dissent, breach of loyalty and accusation (Bok,1983, pp. 214-215). Like all dissent, it drags into the public arena "a disagreement with an authority", casting light on abuse, alerting people in a wider circle and naming names. The whistleblower also " blows the whistle on his own team", placing concern for public interest against concern for colleagues, or members or clients of his own institution (Bok,1983 p. 214). The whistleblower may single out a particular person or group (Bok,1983, p.215) . Because of these three elements, dissent, breach of loyalty and accusation, the tension between whether to reveal or to conceal can be acute (Bok,1983 p. 216). Betrayal has its price and the person who blows the whistle will most certainly be seen by those within the hierarchy as a betrayer (Bok,1983,p. 215).

Whistleblowing is a dangerous activity. Individuals can be accused falsely, reputations unfairly destroyed and trust within a working group or an institution undermined. Institutions do not function well with a high "level of internal prying and mutual suspicion" (Bok, 1983, p.213). Furthermore, as Bok points out, " ...it is a fact that the disappointed, the incompetent, the malicious, and the paranoid all too often make groundless accusations "

(Bok,1983, p. 213). "If the hospital environment became one where health professionals watched one another, informed on one another, the long-range repercussions, even for patients, might be undesirable" (Bok,1978, p. 165).

However, there is a price to be paid for a type of misplaced loyalty which allows physicians, nurses and other hospital staff to turn a blind eye to mistakes, misdeeds and questionable practices. Doctors and nurses have a clear professional mandate to protect those in their care and, by extension, all other patients. To know the truth, but to ensure that no one else does, may deprive patients of the protection which is rightfully theirs. Stifling dissent within an institution may create conditions in which abuse of patients can flourish and continue (Beardshaw, 1981, pp. 3-5).

Whistleblowing as a breach of an internal norm

It is commonly believed that without formal, external controls and sanctions, individual physicians will not police themselves. Bosk, in ***Forgive and Remember*** points out that " We commonly believe that physicians maintain a conspiracy of silence, protecting incompetent colleagues by shielding their mistakes from the lay public" (Bosk,1979, p.191). His book makes clear that the public confessional of Mortality and Morbidity rounds both conceals as well as reveals. When an attending physician engages in the "hair shirt" ritual, he appears to be revealing all. But he is silent about the errors of subordinates. Were he to betray their confidences, he would destroy the solidarity of the team. This type of ritual presents two lessons: " 'we don't tell tales' as well as 'we openly admit our mistakes and strive to correct them' " (Bosk, p. 191). In this way, the model of professional responsibility communicated is one of individual, not corporate responsibility (Bosk, p.191).

"At present " Bosk says " a physician's conscience is not only his guide but

the patient's only protection. The patient deserves the protection of not only the individual's but also the collectivity's conscience "(Bosk,1979, p. 192). Bosk calls for medicine to promote change and create stronger accounting mechanisms (Bosk, p. 192). When mechanisms that promote public accountability do not exist, the likelihood that individuals will " blow the whistle" increases. Institutional inducements to tell the truth should therefore reduce the more extreme dangers of whistleblowing.

When negligence and abuse are concealed, those who work within the group may experience strong tensions and face up to "questions of loyalty, conscience, and truthfulness, and personal concerns about careers and peace of mind" (Bok,1983, p.211). Professionals whose consciences make it difficult for them to ignore wrongdoing are also faced with the conflicting demands of professional codes which require both loyalty to colleagues and a corresponding duty to the public (Bok,1983, p.211). For example, the Canadian Medical Association's ***Code of ethics*** (1990, articles 27, 29) says: "An ethical Physician [27]:... will report to the appropriate professional body any conduct by a colleague which might be generally considered as being unbecoming to the profession;" but, 29: "will avoid impugning the reputation of any colleague." The ***Code of ethics*** of the Canadian Nurses Association (1985) is more forthright: "It is unethical for a nurse to participate in efforts to deceive or mislead clients regarding the cause of their injury." However it recognizes that "The nurse who attempts to protect clients threatened by incompetent or unethical conduct may be placed in a difficult position" and it points out that colleagues and professional associations must support nurses who fulfill their ethical obligations. It also recommends institutional mechanisms for reporting incidents or incompetent care (CNA, 1985, pp. 26-27).

The prestige given to the profession of medicine may account for the general reluctance of one physician to speak openly about the mistakes of a

colleague (Bosk, 1979, p. 21; Millman, 1976, p. 13; and see Vogel & Delgado, 1980, pp. 60, 85). Not only physicians, but all those involved in the medical field, are socialized into silence (see Bosk, p.191; Vogel & Delgado, p. 85). This silence is not necessarily a result of fear of reprisals. Although physicians who testify against other physicians risk being boycotted (Vogel & Delgado, 1980, p. 60), many remain silent out of sympathy and a fear that they, too, could make a similar mistake (Vogel & Delgado, note 45, pp. 59-60). Silence is a way of coping with uncertainty (Bosk, pp. 173-174). As Sissela Bok says, doctors are reluctant to reveal the incompetence of a colleague. Some, when they are asked to divulge the truth, choose to lie. She asks whether the duty of secrecy can be stretched to justify a lie (Bok, 1978, p. 156).

Vogel and Delgado (1980) describe a case in which a doctor knew that a colleague had failed to make a correct diagnosis which necessitated an emergency operation to save the life of a child. The parents were told "that the child developed the condition while in hospital. 'What I'd told them was the truth, sort of.... [T]here was no sense in suggesting that Joe [the other doctor] had missed the diagnosis. It wouldn't do the family any good and would only hurt Joe. I knew he'd protect me if the roles were reversed....' " (Nolen, cited in Vogel and Delgado,1980, note 45, pp. 59-60).

Bosk's analysis clearly demonstrates that the theory of social control that regulates physician's behavior may work on the individual level, but is less effective in giving the profession a sense of corporate responsibility (Bosk,1979, p.183). Joan Cassel (1981) interviewed ten surgeons, six of whom practiced at university teaching hospitals, about Bosk's findings. She says she received ambivalent responses to the question " Do you think doctors have responsibility for the actions of their colleagues and of the profession, and should they " (Cassell,1981 p. 165)? Although one claimed not to be his brother's keeper it was apparent that simply reading Bosk's

book changed the attitudes of some. Those surgeons responsible for others as chiefs of service accepted responsibility for those under them. One noted that, though in the past he would not tell a less prestigious hospital of the lapses of a dismissed member of housestaff, he would now. Another noted that he, too, had changed his attitudes and had started to speak up about what he considered to be inadequate surgical skill.

Fear of lawsuits from those who are sanctioned can effectively prevent physicians from blowing the whistle on a colleague. For this reason, Vogel and Delgado argue that the courts should give serious attention to enforcing on physicians the duty to disclose the malpractice of colleagues because the current method of self-policing is inadequate and does not help the victims (Vogel and Delgado,1980, pp. 58-59, 94). They view as inadequate the sanctions that exist against doctors guilty of malpractice. Professional sanctions, they say, usually take the form of refusal to refer patients, refusal to collaborate or refusal of access to hospital beds or operating theatres (Vogel and Delgado, p.59). None of these sanctions exclude the doctor from the profession but merely push him or her outside the camp of the elite (Vogel and Delgado, p. 59). Unless the incompetent physician gains notoriety because of media exposure, it is unlikely that potential patients would be aware of his incompetence.

I believe that legally requiring doctors to report their colleagues is an extreme and authoritarian measure of control that should be appealed to only once other, more workable systems have been put in place and used. Vogel and Delgado believe that effective teamwork would not be impaired by the wariness that might exist under a system that legally forces one physician to report another (Vogel & Delgado,1980, p.85). I am not so sure that this is true. Wariness about malpractice suits clearly affects the way doctors practice medicine and probably accounts for many unnecessary tests. Why should the threat of legally enforced punitive measures for not

reporting the malpractice of others be any different? As we saw in Bosk's analysis of controls of physician behavior, physicians often do not blow the whistle on each other because they are aware of their own fragility (Bosk, 1979, pp. 21, 174). Would a legally mandated requirement to report others lead doctors to refuse to participate in risky procedures, rendering the whole team more timid? Doctors should be cautious but an excess of timidity will probably not benefit the patient as situations exist in which heroic acts are decisive in returning the patient to health.

I believe that more effective methods can be instituted to promote disclosure of incidents. In the next section I will discuss methods that, because they can be embedded in the hospital culture, are more likely to achieve the desired result of protecting patients and might even lead to long-range change in the way individual physicians conduct their practices.

Whistleblowing Systems as an internal norm

Whistleblowing is often an extreme act by someone with no other method of getting the truth out. It can be avoided by putting in place internal systems of checks and balances. Systems which encourage internal criticism and review provide an outlet for those who think they see malpractice or other acts which imperil patients but aren't sure what to do about it. They provide a mechanism for patients or clients to route complaints for evaluation and enable them to report to the highest level of the system. "They allow for criticism with much less need for heroism; give a way to deflect the crank or the witch-hunter *before* his message gains publicity, ...make it easier to distinguish between urgent alarms and long-range worries;... " (Bok,1983, p.226).

"Contrary to a belief that a lack of complaints is evidence of management skill, an organization without complaints is probably an organization that does not listen.... A mature and sophisticated organizational culture

constantly identifies and attempts to correct problems" James Ziegenfuss, Jr. says in ***Organizational Troubleshooters: Resolving Problems with Customers and Employees*** (1988, p.38). Organizations which hire official troubleshooters ensure that they have within their walls an early warning system which allows deficiencies to be exposed in time for corrective action to be taken (Ziegenfuss, p.95). The official troubleshooter who works in a complex organization staffed by highly specialized professionals is able to minimize the sort of problems found in such institutions by communicating across the professional groups and acting as a "complexity reducer" (Ziegenfuss, p.166). This "shuttle diplomat" (Ziegenfuss, p.25) is able to communicate between highly specialized areas and people and, if necessary, send information quickly up to top management who may be unaware of impending danger (Waters & Chant, 1982, p. 63).

As the public demands more accountability from its institutions, the managers of institutions are frequently unable to reassure the public. Though they are speaking of corporations, Waters and Chant in **Internal Control of Managerial Integrity: Beyond Accounting Systems** (1982) could well be speaking of hospitals when they point to the abundance of stories in the media about illegal and unethical practices (Waters & Chant, 1982, p. 60) and the fact that their disclosure is a surprise to senior managers (Waters & Chant, p. 63). Cynics may believe that such practices are encouraged by those responsible for organizations and demand external control as a means of ensuring moral probity (Waters & Chant, p. 61). What they may not realize is that those responsible may not even know of wrongdoing (Waters & Chant, p. 63). Waters and Chant say that most managers usually rely on internal systems of accountability (Waters & Chant, p. 61) which, in the hospital system, would include chart audits, mortality and morbidity rounds, tissue review committees, and so on. Unfortunately, these methods of internal control can fail because errors

that occur in hospitals are not only caused by physicians but are the result of practices which are mistakenly viewed as for the good of the institution (Waters & Chant, p. 62). A department may, for example, attempt to cut budgets by re-using hospital supplies that the manufacturer recommends for one-time use only. This is not an inherently dangerous practice, but it should only be carried out after rigorous safety checks.

More effective systems of control are those which ensure that every employee within the institution feels free to raise questions when he or she sees practices which she feels to be unethical or thinks might endanger patients (Waters & Chant,1982, p. 62) and those which involve official troubleshooters who act as a potent symbol that the corporate culture is one which is committed to listening and solving problems (Ziegenfuss,1988, p.157).

The issue of corporate culture is important because attention to internal systems of control may more effectively prevent serious problems and avoid coercive, bureaucratic and often lengthy governmental or legal sanctions. Waters and Chant speak of "control climate", which means the general attitude members of an institution have about administrative or medical integrity. In other words, do employees feel that it is important to speak up when they see something they fear is dangerous or unethical (Waters & Chant, 1982, p. 63)?

Systems of internal control

Waters and Chant suggest various ways in which institutions can create mechanisms to help employees raise questions about possible wrongdoing. They list the following:

1.unambiguous statements that demand compliance with ethical standards (Waters & Chant,1982, p.63) can be issued. In hospitals, senior administration could require all employees to read and sign a code of ethics

(see Waters & Chant, p. 64). This would be in addition to the codes of ethics governing the various professional groups and would address the reality that in a hospital possibly 3,000 employees are governed by no professional code but are well placed to see and judge behavior that falls short of acceptable standards.

2. specific methods for employees to raise questions (Waters & Chant, p.64). Ombudsmen provide a specific channel through which complaints can be treated confidentially, investigated discreetly and dealt with diplomatically. In hospitals with ombudsmen, it is not at all unusual for that person to learn of unethical practices from the ward clerk, the pharmacy student or the pastoral visitor. Good ombudsmen will quietly follow up such rumours of wrong-doing learned in the course of their jobs.

3. managers could include in their annual goals and objectives a statement of the methods they will use to ensure that illegal and unethical acts do not occur (Waters & Chant, p.64).

4. the in-house lawyer could circulate written presentations or interpretations of existing legislation that governs the practice of the institution (Waters & Chant, p. 64).

5. task forces could be created made up of representatives of different parts of the institution to review policies and procedures and ensure that they comply with current ethical and legal standards (Waters & Chant, p. 64).

6. each department could hold sessions in which selected employees would brainstorm about the sort of illegal or unethical practices to which their department might be vulnerable (Waters & Chant, p. 64).

7. orientation sessions given to new employees would encourage them to

question suspected illegal and unethical practices and would tell them what concrete steps to take should they notice anything untoward (Waters & Chant, p. 65). From my own experience presenting patients' rights to new employees, I have discovered that new employees are quick to talk about practices which seem dubious and anxious to know what to do about them.

What all these methods have in common is a raising of consciousness within the organization of the importance of high ethical standards and a concomitant expectation that each person within the institution will take responsibility if she should see an illegal or unethical act (Waters & Chant,1982, p. 65). Although employees may sometimes be unclear about whether or not what they see is unethical, such a corporate culture encourages questions and reduces the common fear of reprisals for questioning institutional conduct. Fear of reprisals can be modified if senior administration openly demands ethical behavior and supplies employees with concrete channels through which to communicate their concerns (Waters & Chant, p. 65).

Internal controls show managerial commitment to excellence. Institutional managers and medical chiefs who wait for government regulations to control their behavior may find that not only are illegal and unethical activities not eliminated but that a reactive approach inspires intrusive and coercive government legislation (Waters & Chant,1982, p. 65).

While methods of internal control are effective if engaged in honestly, some institutions attempt to appear au courant and avoid government intrusion by creating policies and positions that create the illusion of openness. As Sissela Bok notes, such mechanisms as review boards, ombudsmen, patient participation on administrative boards, bills of rights, risk management committees are all helpful as long as they are not window-dressing,

providing the illusion that the administration cares about criticism and mistakes and is willing to take action (Bok, 1983, p. 226). The danger, to which I can personally attest, is that the ombudsman or patient representative employed by the institution will come to feel a part of the institution even if the institution is not consciously co-opting that person. From being a member of the loyal opposition, the institutional ombudsman can become a part of the problem, and the frustrated or exhausted patient will be forced either to submit to a weak explanation of a problem, which will sound like an excuse, or to go to even higher levels, outside the institution (Bok, 1983 , pp. 226- 227).

Government agencies themselves can engage in window-dressing exercises, creating more frustration for the patient. Complaints that might have rung alarm bells can die of sheer inertia as they wind their way from the office of the local M.P., to the Ministry of Health, to a local council and, often, back to the hospital which the patient had found so unresponsive. The patient is often crushed under the weight of many levels of bureaucracy. State run hospital systems are particularly vulnerable to this problem. Quebec citizens are frequently told of their rights but many find that their complaints can take months, or even years, to be heard by the various government bureaus erected to protect and defend those rights. Where does one go to complain about the Protecteur du Citoyen or the Human Rights Commission? How safe can the public feel when a member of a watchdog agency loses his job because he blows the whistle on his own department?

Patients are ostensibly protected by various government agencies, one of which is the Federal Health Protection Branch of Canada and a subdivision, the Bureau of Medical devices. These groups monitor drugs and medical devices to ensure that they do not damage patients. However, as Dr. Pierre Blais found to his cost, it can be dangerous to blow the whistle even when you are a member of a watchdog group. This doctor was fired in

1989 by the Bureau of Medical Devices for making public his concern about the safety of the Meme breast implant after he felt that the Bureau was not listening to him. He concluded that the implant posed a serious risk of cancer by releasing the agent Toluene diamine. Although the breast implant had been on the Bureau's high risk list since 1983, the possible dangers it poses only received widespread publicity in 1991. As Dr. Blais discovered, it can take courage to blow the whistle (Regush, 1991, pp. 9-18; 62-63). Dr. Blais continued to be viewed as an alarmist even after the makers of the implant pulled it from the market in April 1991. Only in August 1991 did Health and Welfare admit that they may have blundered (Kasowski,1991,August 18, p. A3).

The courage to blow the whistle

Tillich, in ***The courage to be*** (1950, cited in Nielsen, 1989, p.123) speaks of the courage required to speak up about unethical behevior. The courage of which he speaks is the courage to follow one's conscience so as to be true to one's being as an individual and one's being as part of an organization (Nielsen, p. 123). The doctor or hospital employee who witnesses the malpractice of another owes a duty to follow her own conscience, which might guide her to do what will protect the patient, and a duty to the profession of medicine and the standards of the institution in which she works, which might make it very difficult for her to collude in hiding malpractice.

What does a doctor or employee do when faced with unethical behavior? Various solutions, proposed by Richard P. Nielsen (1989) include :

1. "secretly blowing the whistle"
2. "quietly blowing the whistle" by telling a person of higher rank
3. "secretly threatening" the wrongdoer that you will tell
4. "secretly threatening" the person in charge that you will blow the whistle outside

5. "publicly threatening" the person in charge that you will blow the whistle
6. sabotaging the attempts of the wrongdoer or manager to implement the unethical behavior
7. "Publicly blowing the whistle within the organization"
8. "quietly refraining from implementing an unethical order/policy"
9. "conscientiously objecting to an unethical policy or refusing to implement it"
10.saying one is uncertain about or refuses to "support a cover-up" if the individual is caught
11."secretly blowing the whistle outside" the organization
12 "publicly blowing the whistle outside the organization"
Nielsen, 1989, pp. 124-125)

As Nielsen points out, each of these methods have limitations (Nielsen, 1989, p. 125). The individual may misjudge the situation because of inadequate information about what is correct procedure or what is ethically or legally acceptable. Relationships can be damaged, especially if it is a subordinate who will appear insubordinate by confronting a more senior or higher level professional. If the individual is wrong, the organization can be hurt (Nielsen, p. 125). Whistleblowing is a use of force which indicates that the only way to change behavior is not by education or example but by the power of public embarrassment (Nielsen, p.126).

Nielsen quotes Tillich in saying that the courage to be part of society is the courage to affirm oneself through involvement with others: "The self affirms itself as participant in the power of a group, of a movement....Self-affirmation within a group includes the courage to accept guilt and its consequences as public guilt, whether one is oneself responsible or whether somebody else is" (Tillich,1950, cited in Nielsen,1989, p. 126). The fact that one is part of a group is, of course,what creates the intense fear and conflict of loyalties inherent in

confronting wrong doing on the part of a colleague or team member. Humans have a natural terror of being placed outside the boundaries of the group.

An ideal way to resolve this conflict would be to inspire a change in the behavior of one's colleague or team, creating what is called a win-win solution by negotiating a resolution (Nielsen,1989, p.127). In a sense, the "hair-shirt ritual" described in the last chapter is just such an exercise. Mistakes are admitted but the attending physician assumes the faults of those beneath him. In a hospital with a strong culture of openness, the physician might go one step further and discuss the issue with the patient or survivor. Or she might meet with the hospital ombudsman to discuss a way of disclosing the incident to the patient or family. Such a response tends to stop in their tracks those who gloatingly threaten to "blow this situation sky high". Organizations that officially encourage openness and reward honesty tend to lead by example and reduce the need for individuals to blow the whistle. Nielsen points out that organizations which discourage nonconformity are most vulnerable to the dangers accompanying a perceived pressure to obey unethical and illegal orders (Nielsen, 1989, p. 128). Nurses used to be obliged to obey physicians unquestioningly. Nurses now no longer "nurse for doctor so-and-so" but function as professionals within their own hierarchy and thus bear responsibility for challenging physicians when necessary. In fact, their code of ethics demands it: "The first consideration of the nurse who suspects incompetence or unethical conduct should be the welfare of present clients or potential harm to future clients" (CNA, 1985, p.26). But, it adds,"Relationships in the health care team should not be disrupted unnecessarily. If a situation can be resolved without peril to present or future clients by direct discussion with the colleague suspected of providing incompetent or unethical care, that should be done" (CNA, p.26). Although this section is headed with the statement that the nurse, as a member of

the health care team, must make sure that the patient is treated competently and ethically (CNA, p. 26), it is not clear whether colleague here means the physician in the health care team or another nurse.

However, these recommendations are consistent with Nielsen's. According to him, the steps an individual should take when he witnesses wrong-doing is first to try moral suasion, helping the other to behave ethically and, only if that does not work, becoming sufficiently courageous to blow the whistle against the other and/or the organization (Nielsen, 1989,p.129). I believe, however, that before one blows the whistle one should gather facts, speak to an impartial third party such as an institutional ombudsman, or discuss the situation, without using identifying information, with someone in the organization who can view the situation impartially. A wise employee might tell the individual that she is going to discuss this with another person. The nursing code of ethics insists that the nurse clarify the facts of the situation when she is deciding which action to take (CNA, 1985,p.26). The type of action most likely to backfire is blowing the whistle publicly, for example, in the media, before seeking to discover whether simpler methods will be more effective.

Whistle-blowing as a legal requirement

Vogel and Delgado argue that a special relationship exists not only between the patient and his doctor but between the patient and the team that treated him. Any member of this team who is aware of an error which affects the patient has, they believe, an obligation to make sure that the patient is informed (Vogel & Delgado, 1980,pp.71-72). In institutions where open relationships exist among members of a team, this might not pose a problem. But any team that includes a physician adamantly opposed to revealing an error may encourage other members to go behind his or her back.

Vogel and Delgado cite seven factors which they believe support the creation of a duty to disclose malpractice:

1. "forseeability of harm to the victim"
2. "certainty that the victim would suffer injury"
3. a close connection between the conduct of the doctor and the injury of the patient
4. "moral blameworthiness" of the doctor
5. "need for preventing future harm"
6." extent of the burden on the defendant and consequences to the community of imposing such a duty"
7."availability of insurance to cover the cost of the harm"

(Vogel and Delgado,1980, p.72)

The requirement on members of the treatment team to disclose malpractice is fraught with difficulty. The first difficulty is technical — the malpractice may be "evident only to those with specialized training". Senior physicians could argue that a nurse or house officer have insufficient training to accuse a senior doctor of malpractice (Vogel & Delgado,1980, p. 79,note 146, p. 79). Further, many cases exist on a borderline. A duty to require physicians to disclose borderline cases could present enormous enforcement problems (Vogel & Delgado, note 142, p. 78). Vogel and Delgado limit their recommendation to enforce disclosure to cases of clear malpractice which no health care professional could doubt (Vogel and Delgado, note 142, p. 78, pp. 78-79).

Should the the one who committed the injury be the one to disclose or should others do so? Vogel and Delgado say that some people who observe malpractice prefer to confront the physician in person and demand that he or she disclose. This, I believe, is the best way to proceed. Those in the lowest ranks, they suggest, may prefer to "discharge their duties by means of an anonymous letter to the patient" (Vogel and Delgado, note 149, p. 79).

I cannot argue too strongly against anonymous letters to patients and have strong reservations about legally imposed requirements that observers of malpractice disclose. Medicine, as Bosk points out, has a coherent system of internal controls. Medical students and interns who accuse senior physicians behind their backs can expect the same thing as they rise up the hierarchy. Such practices are, in my view, deceptive and could have seriously deleterious effects on the training of physicians, particularly because it will create in them the fear of making any mistake. Vogel and Delgado, in their laudable attempt to protect the patient are arguing for a system of reporting misdeeds that could create a climate in which internal control is replaced by a sort of star chamber system in which accusations are made but those making them, in the case of anonymous letters to patients, are neither accountable nor open to questions. If the legal requirement to disclose is applied only to cases where a physician's practice or act falls well below the norm, then their argument might have merit. However, fear of lawsuits is endemic, even in Canadian hospitals. I am using a slippery slope argument to insist that imposing the duty on observers is dangerous. It presumes that all members of a health care team have accurate observation skills, good judgement, are interested only in the patient and never in themselves, are objective, fair and moral. To demand that observers disclose directly to patients makes possible the most appalling misuse of another sort of power—the power to retaliate or to bring low the high and mighty. A disgruntled nurse or house officer, or a jealous colleague, might relish this legal inducement to cut down to size an arrogant physician. Physicians might then be afraid to take risks. This can work against the patient. An attending obstetric surgeon might, for example, opt for a caesarian section when a vaginal delivery might be preferable and safer. Cardiac catheterization might be done " just in case ". People presenting as poor risks for surgery might be refused treatment that would have a moderate chance of success.

Vogel and Delgado view the requirement to disclose from outside the culture of the medical setting. But as all who work in any large institution know, few institutions are short of individuals who are only too happy to point an accusing finger at colleagues or members of another professional group. Legally to impose the duty to disclose on observers of medical malpractice feeds the more base instincts of those who are jealous or who seek revenge. The possibility of protecting present and future patients must be weighed against the damage imposed on an institutional group. Physicians do not work apart from nurses and although the two groups might be in conflict, an imposed duty on members of a team to disclose may create mistrust so great that a working relationship would be rendered impossible. Nurses who blow the whistle before speaking to the physician not only jeopardize the smooth running of the service on which they work, or for which they are responsible, but might hurt patients by obliquely, or, in the case of a letter, directly, attacking the patients' physicians. However Vogel and Delgado argue that "the trust that currently exists among doctors and between doctors and nurses" protects the incompetent "at the expense of their patients" (Vogel & Delgado, p. 85). They quote Louisell and Williams (Vogel and Delgado, 1980,note 168, p. 84) that "[t]he mind [of the patient] naturally feeds upon uncertainties rooted in a lack of understanding resulting from a less than forthright explanation,..." The additional danger, however, is that an observer may observe incorrectly and may conclude that an error was made where one was not. He or she may be unaware of the non-normative errors referred to by Bosk—idiosyncrasies that are acceptable practice — and create uncertainty for no good reason.

However, some situations of clear malpractice, undisclosed, must somehow be communicated to the patient. Vogel and Delgado's strongest argument for enforcing public disclosure of physician errors relates both to the fact that long delays in discovering malpractice reduce the likelihood of a

successful lawsuit and that the victim may endure further physical harm if not told of an injury which must quickly be corrected (Vogel & Delgado, 1980, p. 58).

Delays in disclosure may mean, in some provinces, that the patient cannot sue because the statute of limitations allows a suit only within a certain number of years from the date of last treatment. Happily for the patient, most provinces now allow the patient to take legal action within a certain number of years from the date he or she discovers the injury. If too many years elapse between the date of injury and the date of trial, however, the patient still suffers harm. Evidence may be missing or destroyed, witnesses may have moved and memories may falter (Vogel and Delgado,1980, p.63). The suit may be won, but years after the patient is in most urgent need of treatment and/or financial compensation.

Further physical harm if an injury is not disclosed is, from a moral point of view, an even more serious reason for enforcing swift disclosure. Vogel and Delgado give the example of a patient who suffered injury to a spinal accessory nerve who only found out about it when it was too late for corrective surgery (Vogel and Delgado,1980, pp.62-63,note 63, p. 63).

Conclusion

Legal enforcement of disclosure has strong symbolic value in that it indicates that society believes that the relationship between patient and doctor should be one of openness and honest communication. Legal and other mechanisms can reduce the need for whistleblowing, with all its attendant risks. However, institutions which make troubleshooters part of their culture and create policies that encourage and reinforce openness protect themselves from excessive outside control and reduce the need for whistleblowing. As Sissela Bok (1983, pp. 228-229) says, if we can reduce "practices of collective secrecy" so as to allow official "channels of public

inquiry" to function, then whistleblowing will be unnecessary. I believe that institutional and governmental ombudsmen are more effective watchdogs and complaint receivers because they can raise the alarm when a situation may prove harmful to an individual or a group of people, and effectively dispose of those complaints inspired by malice, vindictiveness or mental disturbance. Ombudsmen also offer a way for people who are tempted to blow the whistle to let off steam and to assess their plan of action with an objective consultant.

However, the law has its place and it could be said laws which compel disclosure ensure that all hospitals will comply with a minimum requirement to be truthful about the mistakes of those who practice within their walls. We have already noted that the law could compel physicians to disclose malpractice — either their own, or that of others. Those who report malpractice could legally be protected against retaliation or defamation (Vogel and Delgado,1980, note 149, pp. 79-80) or certain types of malpractice might legally be required to be reported (Bok,1983, p.228), thus reducing fear of reprisals, tensions created by conflict of loyalties and encouraging would-be whistleblowers to speak up (Bok, 1983, p. 228). We will turn now to arguments for legal enforcement of disclosure.

Chapter six
External control — the legal argument for truth telling

Introduction

A Montreal doctor recounts the story of a patient who had his gallbladder removed. Two days after the surgery, his skin turned yellow. A subsequent operation restored the patient to perfect health. Now, four years later, the patient wants to know why the second operation was necessary. This physician checked the hospital record to discover that "the surgeon had accidentally tied off the bile duct which drained the liver," causing severe jaundice. The second operation corrected this (McConnell, 1989, p.25).

According to Dr. Todd McConnell, "throughout its evolution, the medical profession has marinated itself in caution and conservatism. We hate to make a mistake. But when we do, we hate to admit it" (McConnell,1989, p.25). This physician goes on to say that "there are probably more minor errors in hospitals today [than there] were thirty years ago..."(McConnell, p. 25). Modern medical practice and scientific advance allow "...more diagnostic and therapeutic interventions," thus increasing the "potential for human and technological misadventure" (McConnell, p. 25). Patients expect more, because more is available. In the face of so much sophisticated technology, it is difficult for the modern physician to say to a patient "I don't know what's wrong with you" (my quotes but see McConnell, p. 25). It is also very difficult for physicians to avoid trying one more thing so as to "let science make intuition seem the fool" (McConnell, p. 25).

> But science has made physicians more accountable even when it leaves them dangling.... The pressures of science and society make the modern physician as accountable as a football referee. There is less room for feeling and intuition in the arena of hard disks and instant replays. Science is no friend to the failing physician. How could anyone in this day and age tie off the common bile duct?... Yet, medical ethicists are telling us to be truthful with patients at a time when failure seems less

and less acceptable " (McConnell,1989, p.25).

The public both trusts and mistrusts medicine. The literature claiming that medicine has grown too powerful and its high priests, the physicians, too self-serving (see Illich, 1976), may note that physicians have power because power has been granted to them. The view of the body as a machine and the cartesian split between body and psyche is well-entrenched in the thinking of Western people (Kennedy, 1983, p. 20).

Books with titles such as ***Woman's body : An Owner's Manual*** (The Diagram Group, 1977) make explicit this technological view of the human body as a machine which needs to be sent for diagnostic tune-ups on a regular basis. We speak of running out of fuel, of re-charging our batteries. Magnetic resonance imaging machines, which reveal more of the the human body than any x-ray; endoscopes which can investigate bladders, bronchi, colons and knee joints, are part of the vast array of technology which can read every tissue, organ and cell of the body. This leads people to trust that somewhere, there is a machine which can read them and tell them why they have this ache or that pain. Much is expected of medicine.

And, as McConnell says (1989, p. 25), much can go wrong. Nothing can equal the fury of the patient betrayed. If one submits one's body in trust to an expert, one expects that expert to restore it to perfect running order. Patients often feel powerless before the arcane knowledge of the modern physician-scientist but they have one tool to make equal the inequality that exists between expert and layman. They have the law, a powerful instrument to bring the powerful to their knees.

Medicine has a long tradition of secrecy. Obscure rituals, arcane language, a hieratic priesthood, have all served to shroud medical acts with the mantle of sacred power. In contrast, denunciation of secrecy is a ritual of

science (Bok,1983, pp. 153-154). Scientists denounce secrecy to conjure away its power (Bok, 1983, p. 153). Modern scientists believe that "free and open communication" is essential to their work, and secret practices are viewed by those outside the scientific community with deep suspicion. Modern scientists speak loudly against secrecy to disavow the gnostic view of science as an ancient and esoteric craft of knowledge, penetrated only by the elect (Bok, 1983, p. 153). The Hippocratic Corpus states "Things however that are holy are revealed only to men who are holy. The profane may not learn them until they have been initiated into the mysteries of science" (Hippocrates, cited in Bok, 1983, p. 154). This is the secret practice of the early alchemists who delved into the deeply hidden mysteries of nature. "To share the secret" would have been to invite "public disapproval" and "destroy the quest" (Bok,1983, p. 154). For modern science, "disclaimers of secrecy" are an attempt to allay the fear that scientists might use knowledge for their own personal profit. Bok suggests that the "public's fear of such abuses of secrecy" is especially strong when applied to medical science (Bok,1983, p. 154).

Secrecy, Bok says, is essential to human life. If no boundaries existed between our innermost thoughts and the outside world, no human relationships would be possible (Bok, 1983, pp. 10-13). Yet a popular view of secrecy holds it to be shameful and often dangerous (Bok, 1983, p.8), especially when allied with great power (Bok, 1983, p.106).

Secrecy is important to protect the confidentiality of patients. An enduring ethical dilemma is that in which the physician knows something about a patient which can endanger others: the barbiturate-addicted airline pilot; the sexually active patient with AIDS; the homicidal psychopath. The Tarasoff case (Vogel & Delgado, 1980, p. 72), in which a psychiatrist failed to inform the victim that his patient intended to kill her, is a benchmark lawsuit in which the right to secrecy was balanced against the right to

public safety. But as Bok points out (1983, p. 131), "the greatest burden of secrecy imposed by confidentiality... is that of the secrets professionals keep to protect themselves..." (Bok, 1983, p. 131). Confidentiality can shield activities that those involved would not wish known (Bok,1983, p.131). By invoking the paternalistic concept of therapeutic privilege, which ostensibly protects patients from harmful information, physicians can extend confidentiality so far as to include secrets that would destroy their own professional reputations. Poor care can be hidden under the rubric of patient confidentiality so that outsiders may never know of negligence, unnecessary surgery or death. As we saw in the case of the elderly man who died of a physician-administered drug overdose, (Chapter one) physicians can bury their secrets. Confidentiality may also be invoked by one professional to protect the reputation and hide the misdeeds of a colleague (Bok, 1983, p. 133). The professional may deceive himself in this way to rationalize his act and to avoid the pain and conflict of whistle-blowing.

Forcing disclosure of mistakes

Joan Vogel and Richard Delgado (1980) suggest that physicians will not tell the truth unless the law forces them to. They laud the patient-consumer movement for dispelling the feelings of vulnerability, dependence and helplessness which many patients suffer and point out that modern patients read their medical records, feel confident in demanding second opinions, and, in general, ask more questions about their treatment than they did in the past (Vogel & Delgado, 1980, pp. 52-53). But, they argue, this is not enough. Physicians must be forced by law to disclose their mistakes (Vogel & Delgado, p. 94).

Patients who are injured seek recompense. Although it seems self-evident that someone who has received an injury which may deprive her of income or incur extra costs would naturally turn to the courts for financial

compensation, the causes of medical malpractice suits lie much deeper. Just as a physician has recourse to a ritual of confession and forgiveness in "donning the hair shirt" and admitting mistakes in the protective circle of medical colleagues, so too does an aggrieved patient have recourse to a ritual — the lawsuit. A lawsuit is a ritual of compensation for injury when other rituals have failed.

The lawsuit is a "culturally transmitted symbolic code" which fulfills the requirements of ritual: it is "stylized", can be "regularly repeated", is, in the courtroom, "dramatically structured", is "authoritatively designated" and is "intrinsically valued" (Bird, 1980, p. 388). Rituals exist to contain strong emotion, (Bird, 1980, p. 391) such as the anger, betrayal, loss, and grief that follows medical injury, in an action sanctioned by society in which the injured person receives public recognition of his injury and accepts a token which goes some way towards assuaging feelings of loss and betrayal. No amount of money can restore a life or a limb, but the injured patient or surviving relative who wins a lawsuit can be satisfied that justice is done and seen to be done. The ritual of initiating a lawsuit is often the first step taken by an injured patient or grieving relative to deal with anger and loss. It has a kenotic aspect in which anger is discharged in ritual form, leaving the person free to get on with his life (see Vogel & Delgado, 1980, note 167, p. 84). Significantly, patients or relatives often launch the suit and then do not pursue it further. When a hospital or doctor receives the initial letter from the law firm, a very clear signal of displeasure has been sent. The letter itself has a ritual quality and may prompt those involved with the patient's care to act immediately to contain the patient's or relative's anger, proposing, perhaps, a meeting with senior medical staff. It is at this point that patients may decide to proceed no further because the reason for the suit is not financial compensation but public recognition and apology.

A popular belief has it that if a doctor wishes to avoid lawsuits, he or she

should make friends with all her patients. The belief reflects the idea that people who feel cared for as human beings rather than treated as machines are also more likely to be able to communicate with their physicians and less likely to seek revenge if the physician makes a mistake. I know of several cases in which serious mistakes, admitted by doctors to their patients, have been accepted with "Oh well. No one is perfect." It is also not unusual for patients to attempt to blame someone else — a nurse or medical student — because "my doctor couldn't possibly have made this error." Patients will often deny that the physician could be wrong, as that would call into question the whole basis of their trust in their doctor, and, perhaps, reflect badly on their judgement when choosing a physician.

When doctors retreat behind a wall of silence (Lipovenko, 1988, p. A.4) patients are apt to have their suspicions aroused. It is humanly very difficult for any of us to admit to mistakes, especially when those mistakes have serious consequences. If the mistake is easily hidden, the temptation is greater. Vogel and Delgado discuss those incidents which have been easily hidden and suggest legal remedies for the patient who is unaware that he or she is the victim of malpractice. They describe many truly hair-raising incidents of medical malpractice that were both unreported and unremedied for long periods of time. For example:

The parents of a three-and-a-half year old boy brought their son to a medical center for treatment of a respiratory illness. "The child was placed in an adult intensive care unit where he was given ten times the normal dosage of a muscle relaxant designed to facilitate breathing. Later, the respirator tube slipped out of the passage leading to the boy's lungs "and he received oxygen in his stomach, rather than in his lungs. "He suffered cardiac arrest" and "permanent brain damage. " Weeks later, the parents overheard one doctor discuss the overdose with another. The fact that the parents had not been told was explained with "they 'had enough on [their] minds already' " (Vogel and Delgado, 1980, p.55)

This is an example of paternalism used as an excuse not to disclose an incident. Did the physician truly believe he was sparing the parent's feelings or was he in fact explaining away and engaging in self-deception?

Vogel and Delgado analyze the problem of undisclosed malpractice with two paradigms:

1. "An unconscious patient is the victim of clear medical malpractice committed by one member of the treatment team, acting alone." For example, the surgeon damages an organ or leaves medical equipment inside the patient's body. The equipment could be something as simple as a sponge, which is not so rare an event as one might imagine. After the surgery the patient feels pain, suffers an infection, or loses the function of some organ. "The doctor explains that this is a common outcome of the surgery" (Vogel & Delgado, 1980, p. 57).

2. The patient dies because of malpractice and the surviving relative is told that "...these things happen. We did our best" (Vogel and Delgado, 1980, p.57).

In both cases, the victims or their survivors "have a primary cause of action... for malpractice and perhaps for misrepresentation." But the victims are left with the impression that they have merely suffered bad luck (Vogel & Delgado,1980, p. 57). Vogel and Delgado argue that the law must impose on the primary physician and all those who observed the malpractice, the obligation to report it (Vogel & Delgado, pp. 71-72). Their primary argument is a consequentialist one. The obligation to disclose, they argue, not only protects the legal rights of those injured but might protect the future patients of the physician who may well repeat the mistake. They suggest that a physician who fails to report the malpractice of another could be liable to future patients injured by this person (Vogel & Delgado, note 113, p. 72). The authors argue that patients should be told

about mistakes and add to their other reasons the deontological argument that physicians must disclose because the Golden Rule supports a duty to disclose (Vogel & Delgado, note 55, p. 61).

Vogel and Delgado claim that the medical profession does not regulate itself effectively and that "the inherent inequality... in the doctor-patient relationship" and, I would add, the institution-patient relationship, demands legal mechanisms to render the balance between the parties more equal (Vogel and Delgado, 1980, p.57). Although physicians do regulate their own behavior, as Bosk points out, a sense of corporate responsibility is lacking in the medical profession. Furthermore, as Bosk illustrated, the system of social control in which attendings protect their subordinates and students by assuming responsibility for errors committed by underlings, militates against an ethic of disclosing the mistakes of others (Bosk, 1979, pp. 141-144).

According to Vogel and Delgado, the medical profession's self-policing is inadequate (Vogel & Delgado, 1980, pp. 55-56) and rarely provides relief to the victims of malpractice. Their strongest argument for speedy disclosure relates to the two facts spoken of in the last chapter. Long delays in discovering malpractice reduce the likelihood of a successful malpractice suit because of the dangers of destroyed evidence, lack of witnesses and failed memories. Some areas have statutes of limitation which may further curb the possibility of redress (Vogel & Delgado, pp. 63, 65-66). Even more serious is harm to the patient.

Why does it take a long time for patients to discover injures? In many cases, the injured person may be a newborn and damage may not be evident until much later. Too much oxygen administered at birth may cause brain damage that may not be obvious for several more years. Vogel and Delgado, in a footnote, describe the patient who received severe burns during

radiation treatment for cancer but did not discover the doctor's negligence until after the statute of limitations in New Jersey had run out (Vogel & Delgado, 1980, note 78, pp.65-66). She had been told that X-ray burns were a normal result of treatment (Vogel & Delgado,note 90, p. 67) and only discovered the real cause of her injury by overhearing other radiologists discussing her case (Vogel & Delgado, note 79, p. 66).

Vogel and Delgado argue that enforced disclosure of incidents would enable victims to learn about malpractice without having to rely on chance (Vogel & Delgado, 1980, p. 66). They argue that the duty to disclose could be described as a fiduciary obligation. Since "one party is dependent on another for information... that only the first [and superior] party possesses".... the superior party has an obligation "to disclose all information relevant to... [his client's] interests,... [which includes] information regarding any loss or injury caused by" the person with the fiduciary obligation (Vogel & Delgado, pp. 66-67). They extend the argument, using the precedent of some commercial cases, to impose the duty on observers. In commercial law, failure to disclose information relative to the interests of the protected party is misrepresentation (Vogel & Delgado, note 84, pp. 66-67, & pp. 66-67). Vogel and Delgado query why physicians should not be held accountable in the same way (Vogel & Delgado, p. 67) although they advance a number of legal reasons why this has not been the case. For example, disclosure of medical malpractice may be seen as a legal, not a medical duty. The courts may have refrained from enforcing disclosure because it is viewed as a non-medical matter which requires the physician to make a legal judgement (Vogel & Delgado, note 91,pp. 67- 68). Including the duty of disclosure in the doctor's duty of due care has difficulties. Care normally refers to diagnosis and treatment of an illness. If the consequences of disclosure of incidents are economic, not physical, then the requirement seems to go beyond the duty of due care. Furthermore, the duty of due care is negative — it is a duty to avoid harm.

To require disclosure is to impose an affirmative duty (Vogel & Delgado, p.69). To impose the duty of disclosure on those who merely observe malpractice could be seen as going far beyond the requirement of accountability for error imposed on the doctor. However, Vogel and Delgado, using a consequentialist argument, feel that strong reasons exist to extend this duty to observers (Vogel & Delgado, p.69). Like Gerald Robertson (1987, pp. 217-218), Vogel and Delgado argue that the reason for the duty to disclose is similar to the reason behind the requirement of informed consent: that without information, the patient cannot make a knowledgeable choice of treatment. Vogel and Delgado argue, as Robertson does, that the "patient's need for information is not confined to the period before treatment" but is required if malpractice occurs so that the patient can choose how to seek remedy for the injury (Vogel & Delgado, pp. 69-70).

If the physician-patient relationship is viewed as a partnership, the "sense of shared enterprise" in which the patient and physician are partners in the goal of healing means that the patient must be advised of all actions taken by the physician (Vogel & Delgado, 1980, pp. 70-71). But the informed consent rationale might be applied only to cases in which the physician is responsible for post-treatment care and personally carries out remedial measures which were not included in the original consent (Vogel & Delgado, note 96, pp. 69-70). It might be held to be non-applicable when a different physician handles subsequent care. Using this argument, the physician need not tell a patient of a mistake made two years earlier by someone else.

Vogel and Delgado, however, seem to indicate otherwise (Vogel & Delgado, 1980, note 96, pp. 69-70), though it is not certain if they think that Dr. A in hospital B should disclose the malpractice, committed five years earlier, of Dr.C in hospital D. A patient is admitted to a hospital under the name of one physician, but she is often treated by many different medical specialists who have differing contractual obligations. In a sense, the patient/plaintiff

is in the custody of several people, each of whom owe a duty of care. Vogel and Delgado argue that even if one person injured the patient, the duty to disclose falls on all those who have the care of the patient: nondisclosure could be seen as neglect. They argue that "permitting the duty to rest on the malpracticing physician" creates the greatest risk of non-disclosure as she has the "greatest incentive not to disclose." They argue that all members of the treating team should be subject to the duty to disclose so as more fully to protect the patient (Vogel & Delgado,p. 71). Furthermore, a hospital which, for example, knowingly allows an incompetent surgeon to operate is responsible because a hospital has a duty to supervise. It could, therefore, be concluded that all members of the team are required to disclose (Vogel & Delgado, p. 74). They base their argument on *Ybarra v Spangard* in which a patient who had surgery for appendicitis suffered severe injuries to his shoulder and right arm. "The court permitted the use of *res ipsa loquitur* against all members of the treatment team because the plaintiff" could not, on his own, discover the individual responsible (Vogel & Delgado, p. 71).

Some have "argued that a doctor's failure to disclose is not blameworthy because non-disclosure is the norm in the medical profession, and what is 'normal' cannot be immoral" (Vogel & Delgado, 1980, note 115, p. 73). This begs the question and is a false argument connecting unrelated concepts. Physicians set their own standards for treatment (Vogel & Delgado, note 115, p. 73) but they cannot set their own standards on legal matters (see Vogel & Delgado, note 91, pp. 67-68).

Other arguments in favour of legal enforcement of disclosure are: the duty not to impede rescue which ensures that the administrator or physician who tells another not to disclose could be accused of impeding rescue (Vogel & Delgado, 1980, p.75). If doctors, nurses, and administrators give the patient the impression that a procedure or operation went well, when it did not, they are guilty of misrepresentation (Vogel & Delgado, pp. 75-76).

Objections to legal enforcement of the duty to disclose

Objections to the proposed duty to disclose are several: the duty to disclose destroys trust between patient and physician or patient and institution; it would erode trust within and among professional groups; it is ineffective; it would "encourage false reporting"; it would increase medical costs; it would discourage doctors from specializing (Vogel & Delgado,1980, p. 83 and see pp.83-92).

Vogel and Delgado argue that an increase in malpractice suits might erode trust but "blind trust" does not deserve legal protection (Vogel & Delgado, 1980, p. 83). Others argue that trust might be damaged because of the "symbolic effect" of adopting such a rule (Vogel & Delgado, p. 84). Vogel and Delgado argue, quite fairly, that for many people, the trust has already been eroded if they or their friends and relatives have had unfortunate encounters with the medical profession. The existence of a duty to disclose should enhance, not weaken trust (Vogel & Delgado, p. 84). The duty should reduce the need for patients to engage in a surreptitious seeking of second opinions or filing lawsuits in a desperate attempt simply to obtain information (Vogel & Delgado, p.84). As Vogel and Delgado emphasize, as a society, we have demanded that politicians and corporations disclose financial conflict of interest and punish severely those who hide their misdeeds (Vogel & Delgado, p. 84). As to the argument that it is ineffective, Vogel and Delgado say that physicians usually find legal controls compelling, that even one person coming forward would protect the patient (Vogel & Delgado, p.86), and that it would work in the same way that the doctrine of informed consent has in changing practice (Vogel & Delgado, pp.86-87).They dismiss the fear of false reporting by indicating that he who does could be sued for defamation (Vogel & Delgado, p. 91). As for discouraging doctors from specializing, those who are discouraged should probably be discouraged (Vogel & Delgado, p. 92).

As I stated earlier, anger and a feeling of betrayal lie behind many malpractice suits (Vogel & Delgado, 1980, note 167, p. 84). In hospitals committed to openness, patients are less likely to turn to the law to pry out answers. Hospitals with patients' committees, ombudsmen, risk managers and risk management committees are able more often to rapidly identify malpractice or perceived malpractice and to disclose facts openly to patients and families. If cause for action exists, patients are free to take it, but openness can drain off some of the explosive anger and hurt experienced by patients who are kept in the dark. A clear exposition of facts by a physician independent of the patient's treatment means that, even if cause for malpractice exists, the ritual suit is robbed of some of its revenge-seeking motive. The patient can then more objectively determine whether a lawsuit will achieve its desired end and is worth the time, effort and expense. Many argue that malpractice suits diminish when disclosure is the norm.

Full disclosure is, however, always a risk and Vogel and Delgado (1980, p. 87) argue that a legal duty to disclose is always more persuasive than a moral duty.

This brings us back to my question posed in Chapter one: can law, by imposing morality under pain of punishment, render a society more moral in its behavior? Ideally, all of us act according to high moral principles, unaffected by hope of reward and fear of punishment (Kohlberg's stage six, Kohlberg, 1985, p. 489). This is a rather sanguine view of human nature. Even those who usually act according to high ethical principles will be tempted, when their income, reputation and professional standing is threatened, to keep quiet about mistakes.

As we will see from the doctors interviewed, most said that they hoped that they would be honest, no matter what the situation. The operative word is "hope". Which of us truly knows how we would act, given the risk of

disclosure and the benefit of silence. If there were no outside agencies operating, the internal method of control described by Bosk would have some restraining effect, but might be ineffective on its own. As Bosk so clearly pointed out, normative errors such as withholding information or lying are viewed as far more serious than technical errors. Physicians may be forgiven technical errors by their colleagues but unless there is a corresponding ethic that non-disclosure of errors to the patient is a normative error, patients will remain in the dark. Vogel and Delgado argue that punishment for undisclosed technical error is the most effective restraint on physician behavior (Vogel & Delgado, 1980, pp. 86-87).

I would argue, with Vogel and Delgado, that a requirement on physicians to disclose their errors has a strong symbolic value (Vogel & Delgado, 1980, p. 88). Every society and group has internal social controls. Those who ignore them are shunned by the group. The doctrine of informed consent communicates an important value (Vogel & Delgado, p. 88) — that patients in North American society are viewed as autonomous individuals whose rights may be defended. This belief is made concrete by hospital Bills of Rights, institutional ombudsmen and government watchdog agencies and those policies and positions function in a symbolic way, reinforcing the notion that the relationship between patient and physician or institution is one in which communication, conversation and respect (see Katz, ***The Silent World of Doctor and Patient***, 1984) are essential. No legal norm is universally obeyed but it could be argued that a legal requirement for disclosure has strong and significant symbolic value.

Chapter seven
Eight Doctors speak

Introduction

An elderly and extremely debilitated man was admitted to a large teaching hospital because his family thought he was dying. A team of doctors on the ward ran a series of tests but were so sure of what they were looking for that they missed something significant that could have been treated and might have helped the patient to survive this episode of illness. The following day, it became obvious to the intern, the residents and the attending staff members that they had all failed to note the significance of what they had missed. By then, it was too late and the patient died.

The doctor who recounted this story, many years after the event, says he still remembers the incident with pain. At the time, he said, he was upset for weeks but he didn't know what to do because he was only a medical student. He says that the family never knew about this mistake and he still feels they should have been told. In retrospect, he says, he would have consulted the hospital's director of professional services. But at that time, he was so new that he had no idea how the medical hierarchy worked and so kept his questions, and his pain, to himself.

It is easy for experts in ethics and law to speak about the obligation of doctors to be truthful with patients, whatever the cost. As I said in my introduction, the real situation, with its pain, threat to professional reputation and the risk of exposure, is a much finer test of the ethical stance of physicians. I interviewed eight doctors for this thesis, presenting them with four hypothetical situations in which a mistake had been made in patient care. Although hypothetical situations do not give a picture of how a physician would act in "real life", many of the doctors interviewed recalled incidents that presented them with the conflict of telling, and risking the patient's or family's anger and a possible lawsuit, or not telling

and carrying a weight of guilt and anguish. "It must be very hard to tell a patient or family that you made a mistake," I commented to a senior surgeon. "God, yes," he shuddered. "We all make mistakes but it really shakes you when it happens."

The eight physicians interviewed included five men and three women drawn from family, internal and emergency medicine, cardiology, nephrology and two surgical specialties. Because of the small sample size, I have protected their identities by selecting my interviewees from three Montreal teaching hospitals. I have excluded from this tiny sample any analysis of their responses in terms of their age, gender or years of practice. I have also distorted and disguised all incidents they recounted from their own experience. As Dena S. Davis indicates in an article ***Rich Cases: The Ethics of thick description*** (Davis, 1991, p.12) the ideal standard of confidentiality in case description is that neither patient nor doctor, reading the cases, should be able to recognize them as theirs.

I presented the physicians with four scenarios: the case of the 80-year-old man who died from a medication overdose who was the subject of Novack's survey presented in Chapter one of this thesis (Novack, et al.,1989, pp. 2982-2983); the patient who had difficulty discovering the results of a liver biopsy in which insufficient tissue had been removed quoted from Millman (Millman,1978, p. 138-144) in Chapter two; a woman who had the wrong eye operated on though she was scheduled for surgery on the other one at a later date; a patient who was revived with no ill effect from a hypoglycemic coma caused by a medication error.

I also asked physicians questions regarding their sense of responsibility to or for other staff, particularly residents and students, to see if their responses supported Bosk's descriptions of roles and responsibilities in the hospital hierarchy (see Bosk, Chapter four of this thesis); questions about

their response to seeing a colleague or senior person making a mistake and hiding it to see what suggestions they had regarding responsible whistle-blowing (see Chapter five of this thesis); and questions about the weight they gave to legal obligations (see Chapter six). Their responses to the four scenarios gave me ample material on their attitudes to truth-telling, deception and incomplete disclosure (Chapters one and two) and on the way in which they described and tried to prevent risk (chapter three).

This chapter is organized in the following manner: The first section summarizes the responses to each of the four scenarios and discusses the issues of truth-telling in this context. The second section divides the interview material in the same order as chapters three to six.

Responses to the scenarios

Scenario one

An 80-year-old man with severe hypertension comes into the hospital with confusion, papilledema and a blood pressure of 250/150 mm Hg (hypertensive crisis). Having decided to start him on diazoxide, you administer a vial labeled with the usual dose of 100 mg. Shortly thereafter, the patient's blood pressure drops and despite resuscitative efforts, he dies. In reviewing his medications, you find that the vial actually contained 1000 mg of a "100 mg/cc" solution. You are thus sure you accidentally administered a fatal dose.

(Would you:)

a.Emphasize that the patient was very sick but despite your best efforts, he died

b.Emphasize the patient was very sick and required strong medication. As an unfortunate, but known risk of the medication, his blood pressure dropped too low and he died.

c.Say you inadvertently gave him too much medication over too short a time, which given his serious condition probably caused his death.

d.Other

(Novack, et al., 1989, pp. 2982- 2983)

Doctor one, medicine

"You don't have much of a choice. I would probably tell the family that I inadvertently gave him too much medication over too short a time." This physician said that he would investigate the source of the error, to see if the vial had been improperly labeled. "If the error was mine, I'd say so. I'd say how urgent the decision was. It's a bad excuse but I'd say it was urgent and I had to give it to him and I made a mistake because we had to do it fast. But I don't think I'd cover up." This doctor said that he would not tell the family immediately, but would delay a few hours. He would first go back, speak to the nurse, and try to find out how the mistake had occurred.

Doctor two, surgeon

"I think we should tell the family. We have to tell the family that the patient was very sick and 80 years old but for some reason he got the wrong dose. That despite our best efforts he was very weak and [what we did] helped him to die. I'd explain to the family that he was very sick and might have died anyway but it seems he died because of the wrong dose."

Doctor three, medicine

"I would tell them he did get too much medication accidentally but that the same thing could have happened at a lower dose as well as at the higher dose he received. I would emphasize that he was quite sick and required strong medication but I would definitely tell them he got the wrong medication [she probably means the wrong dose] or too much." I asked this doctor if she would consult with anyone else. No, because if you make the

mistake yourself you have to face up to it. I think I would probably talk to somebody about it afterward because I'd feel bad about it but I wouldn't talk to anybody beforehand. I would speak to the family right away.

Doctor four, surgeon

"I would first of all go back and investigate how the mistake happened. I would need to do a fair amount of legwork just to decide. For example, was the vial poorly identified? I would look at [the contents of] the emergency cart to make sure it doesn't happen again."

This doctor said that telling the family was a decision that she would find hard to take alone, especially because it involved a death. She says that she might meet with the hospital ethics committee but then suggested that she might first call the Canadian Medical Protective Association (CMPA), a step they strongly recommend in situations like this. She said she had confidence in them because they are, in her opinion, fair to both sides and have a lot of experience with these kinds of cases. Furthermore, she found the CMPA more anonymous and might therefore go to them before she starting raising questions within the hospital. "Sometimes it can be more damaging [to go to a hospital committee] because people are not all professionally discreet and they may know somebody and then suddenly [the mistake gets out within the hospital] . Then I would tell the family that he was very sick, if he was extremely sick. Probably the broadest way of telling them is 'you tried what you could and it didn't work. It was a strong medication.' [But] that's starting to deceive. I don't like that. [To talk of]the known risk of medication, it's starting to skate. I don't think that is honest. It's kind of sneaky and not right."

Doctor five, medicine

"I wouldn't hide but I would consult the director of professional services or a lawyer or the CMPA as to how to explain to the family. I would bring the

family together with the patient representative, the director of professional services, the chief of service. I would tell the family that it was an unfortunate situation. I would feel I would have to take the consequences." This physician said that his own conscience tells him that it is always better in the long run to be truthful. He says that he would check very carefully but that one can do something inadvertently and accidents can happen. It is not necessarily negligence. Furthermore, there might be mitigating factors. He suggested that if this incident took place in an emergency room, another patient might have been in the middle of a cardiac arrest which would distract the physician.

Doctor six, medicine

"I would not tell the family immediately but I would do it later. I would first consult with the CMPA [for guidance] and with the nurses to find out where the error had occurred. I would function within the structure and do whatever had been recommended to me. But I would disclose. I would probably emphasize to the family that the patient was very sick but that as an unfortunate effect of the medication error, he died." However, this doctor qualified her desire to disclose with: " If the person is terminally ill and isn't going to make it anyway and we give an overdose, I'm not sure what it would contribute to the outcome if he is going to die within hours or days. The overdose may not immediately contribute to his death. This may not be honest, but it's more practical." I asked if it was more practical for the doctor or the family. "For the doctor, because he doesn't have to deal with an irate family but also for the family. Why add to their worries? It might be patronizing but you have to deal with the whole person."

Doctor seven, medicine

"I hope I would answer that I inadvertently gave him too much medication over too short a time, which, given his serious condition, probably caused his death." It was probably a mistake in the vial, this doctor said.

Doctor eight,medicine

"This is a very difficult situation and I think it would be difficult for me to predict how I would react in this situation. I would have great difficulty though in lying to the family and I probably would, at least, consider telling them that I had inadvertently given too much medication."

Analysis

All the physicians said they would disclose the error but three softened it with one of the other possible explanations presented by Novack: that the patient was very sick but despite your best efforts he died. These three still insisted that they would say they made a mistake although one said it would depend on whether or not the man was very close to death anyway. The comment of physician number six articulates the dilemmas I presented in chapters one and two regarding self-deception, self-justification and the desire to protect by withholding information or using mental reservations. This doctor was honest enough about herself to admit that doctors might fear dealing with angry families and justify it by using the time-honoured argument that it is wrong to add to people's sorrow by telling a truth when failure to communicate might be kinder. This argument was also used by many of those surveyed by Novack who said they would give families misleading information about a mistake which led to a death. And more than a third of the physicians in Novack's survey said they would mislead (Novack, et al., 1989, p.2984). Four of the doctors I interviewed felt it important to trace the error to its source to prevent it happening again, an important aspect of risk prevention. Three said that they would consult others — the director of professional services, the CMPA, the ethics committee. One said emphatically that she wouldn't consult anyone else but would discuss it afterwards. Like the respondents to Novack's survey, all said that they felt being honest with patients was important. Where the individuals I interviewed differ is the importance some give to investigating the source of the error and in consulting experts

before disclosing.

Scenario two

A thirty-five year old female patient with a history of abdominal pains arrived in her doctor's office jaundiced and in pain. He admitted her to hospital and diagnostic x-rays were performed to exclude gastrointestinal or gall bladder disease. During the gall bladder x-ray the patient's liver did not release the visualizing dye and so the doctors suspected something wrong with her hepato-biliary system. Because of the results of blood tests, the doctor suspected intrinsic liver disease independent of any gall bladder disease. He said that a liver biopsy should be done immediately.

The biopsy was performed with the patient awake and feeling no pain. The patient waited anxiously for two days for news of the results. When her doctor returned, he was vague about the test results, claiming that he had not examined the specimen himself. Upon looking at her latest blood tests he told the patient that her liver function had now returned to normal and that the jaundice and liver disorder had been caused by a stone in the bile duct. She was told "Don't worry, the biopsy didn't show anything wrong with your liver." The patient continued to be puzzled about the doctors' evasiveness about the results of the liver biopsy and finally insisted on reading her chart where she read the report. It said "No analysis, Specimen Insufficient For Diagnosis." (Adapted from Millman,1976, pp 138-144).

Would you tell the patient about the insufficient specimen even if you did not have to repeat the test?

Would you tell the patient about mislaid test results if you did not have to repeat the test?

I presented this case to the interviewees and all agreed that getting an inadequate sample was a routine event that could hardly be categorized as an error. The problem, most said, was the unwarranted and, seemingly, inexplicable, evasiveness of the doctors.

Doctor one, medicine

"The problem is in her doctor not acknowledging that the biopsy was done according to standard procedure and looked all right and when the pathologist looked there was not enough liver tissue. This happens in any biopsy and therefore is something you can't get around. To me it is sort of normal — a mishap — something that doesn't involve the skill of the physician or a mistake [on his part]. The problem is in the way the physician told her. In fact, he should have said 'we were there, we did the biopsy, but we didn't get enough tissue. Now we have other tests that show it's not critical and so instead of repeating it now, I suggest we wait and see.' The mistake here was in not telling her in a way she would understand and creating anxiety on her part. To me, it's a little bit sad she had to insist on reading her chart." This physician said he would tell a patient about this type of mistake if the test had to be repeated. He says he probably wouldn't if a simple blood test had been lost because "it happens so often" but he would tell the patient about a delay or loss of a pathology sample. This doctor said the case was so clear cut he was a little surprised. "Any doctor would know that if you don't give the results of a biopsy it's bound to make the patient puzzled."

Doctor two, surgeon

"We have this very often. I would tell the patient ' Look.We did the biopsy, but the pathologist said there's not enough tissue for diagnosis. We should

tell the patient. We do it all the time. Patients call us up for answers about the results of their biopsies. We ought to tell them. It's not fair for the patient not to know. This isn't like the first case. That was tough!"

Doctor three, medicine

"Would you say to the patient in this situation, 'we did a liver biopsy but there is not enough tissue to make a diagnosis?' " I asked this physician. "Oh yes. Absolutely, because it is so common. I wouldn't feel badly about this. It's not like the first case where I was kind of nervous about the whole thing because it didn't sound very good. But this one, I wouldn't feel badly about because it's very common. So I would tell the patient right from the beginning and, as here, if blood tests return to normal and they find out it's a stone, you say 'well, it doesn't make any difference,' otherwise you might have to repeat it and that's why I'd tell the patient. It's not the only reason, but you really have to [if you have to repeat the test]."

I asked this doctor if you should tell the patient about a mistake when the result, as in this case, causes no harm. "Patients have the right to read their charts anytime they please. I guess it's one of the valves on the system that makes you have to tell the truth and that's good. " I then asked if she would tell even if the patient couldn't read the chart. "Yes. It's a very common thing. It's a blinded thing that you're doing [the biopsy procedure] and it's one of the risks of these procedures that you don't get adequate tissue. It happens all the time. I wouldn't feel badly about it."

Doctor four, surgeon

A surgeon said, emphatically, "That is something you have to tell your patient. Even starting to say ' don't worry ' that is really immoral. This guy has ethical problems. This is not honest. To be vague about the results. This is the kind of thing where, sometimes with a witness even, you need to sit down and say 'listen, I am concerned about the results and

the pathologist was concerned there was not enough of a specimen to conclude anything. I realize it's a strain and it's not fun, but I don't want to miss a cancer, or something that would be life-threatening to you, and, if you'd let us do it again, if I were in your shoes, I'd suggest it.' " This surgeon explained that similar situations occur in taking other types of samples. They can get lost or the doctor needs a bit more of what he has taken. She said she would tell the patient even if there was no need to repeat the biopsy. "I certainly wouldn't lie about it. The patients accept that if you have a good relationship with them."

Doctor five, medicine

"There is nothing wrong here. I would say; 'we did a biopsy and didn't get a proper specimen.' I might consult with a colleague to ensure whether or not we needed to do it again."

Doctor six, medicine

"This is a non-issue. If we do the test and it's inadequate, there is nothing wrong in saying so. There is nothing wrong with an inadequate test, even if it is our fault. For example, tests get lost in the lab. Or, sometimes, we take three tubes of blood and need four. This kind of thing happens all the time with biopsies."

Doctor seven, medicine

"There is only one answer to this. The specimen is insufficient. I would tell the patient what happened and what the clinical impression [of the patient's condition] is, even if it is an impression. I have seen this kind of thing before."

Doctor eight, medicine

"I certainly would have told the patient that an insufficient specimen was obtained. If I had mislaid the results, I would also tell the patient that I

had mislaid the results and I would certainly make an effort to obtain the original report."

Analysis

My conclusion is that is easy for physicians to disclose an inadequate biopsy sample to a patient because it barely makes it even into Bosk's category of a technical error. They described it as "normal", "nothing wrong", "even if it is our fault." It is an extremely common event and not usually caused by technical incompetence. However, no one suggested that patients might be told of this possibility when consent was obtained. That might be recommended because of the pain, inconvenience or stress of undergoing a second liver biopsy, lumbar puncture or other invasive procedure. This case reminded physicians of the many times samples are lost or lab reports missing. I will discuss their attitudes to these system problems in the section on risk. Physicians found this an easy scenario to deal with because it did not involve a technical error or personal responsibility and had no unfortunate effect on the patient's health, although one mentioned that he himself might have mislaid the results, in which case he would say so. Most could not imagine why the doctors described by Millman were so evasive. Some seemed relieved to be presented with with a scenario so innocuous compared to case one.

Scenario three (simulated for teaching purposes)

An elderly lady was scheduled for surgery on her right eye, with the possibility of surgery on the left eye at a later date. The surgeon mistakenly operated on her left eye, rather than the right. In addition to the fact that there had been no authorization to operate on the left, this eye had not had a pre-operative antibiotic, creating a risk of infection.

Scenario three is somewhat similar to scenario two in that the outcome is

not as serious as it would be if the eye that was operated on had been perfectly healthy. However, it is unlike scenario two in that it is a very obvious error which carries some risk to the patient and cannot be admitted to obliquely.

Doctor one, medicine

"The evidence says we have to tell. There is no way round it. There is every argument to support telling and no excuse not to. It is different from case one. Case one involved an emergency setting. In a real medical emergency, you must give medication in minutes. One can understand that mistake. It is excusable, but not totally. This is purely elective surgery. To argue that you shouldn't tell the patient because she is scheduled for bilateral cataract surgery is an excuse, a bad one."

Not all agreed, however.

Doctor two

"If I know the patient is comfortable, or that she might need surgery in the next few months, I wouldn't tell the patient. But if she had only one bad eye, I would." I asked this doctor if he would tell the patient if a mistake had been made with no negative effect. "No," he answered. "If it's not harming the patient, let it be. There is no reason to tell the patient if there is no ill effect and the other eye has to be operated on anyway. If you tell the patient you operated on the wrong eye, I think it will create more distress for the patient. The patient will get more nervous." This doctor felt that one should not alarm people without a good reason.

Doctor three, medicine

"You have to tell the patient. It's pretty obvious. This actually happened to an acquaintance of mine who had cataract surgery on the wrong eye but who needed it in both. When he was told, he said it was no big deal. In fact, he laughed about it. " This doctor emphasized that one cannot

underestimate patients. "We have to put ourselves in the position of patients. We all might end up in hospital for one reason or another. I wouldn't want to be treated like I don't know anything. If I go to a lawyer's office, I wouldn't want to be not told certain things because I'm not a lawyer myself. It's not right."

Doctor four, surgeon

"In this situation I would give the patient a lot of support. I would give a topical antibiotic to compensate and reassure the patient that I realize there was a problem but that it is not of any major consequence as the eye needed to be operated on anyway. I would say that I was sorry. I would follow the patient more often than usual. If the patient feels taken care of they're OK but others will sue. If you leave them [patients] alone too long they will see someone else and say how awful [what happened] was."

Doctor five, medicine

"You must tell the patient 'we did the wrong eye.' " This doctor says he would tell the patient that it is not a big mistake because the eye required surgery anyway. He would explain it was not dangerous but he was aware that the patient could say that he was negligent or threaten to go to a lawyer.

Doctor six, medicine

A medical doctor pointed out that the patient is going to wake up and realize the mistake. Therefore the best thing for the surgeon to do is to re-establish a relationship with the patient to prevent a lawsuit. Even if the patient is confused or mentally incompetent, a family member would notice the error. "How I would deal with this depends, unfortunately, on the type of people I am dealing with." I asked "what would make a difference?" She said that although she would disclose the mistake, the type of people she was dealing with would determine how she would

disclose it. She would consider whether the patient or her family were anxious and worrying or litigious and ready to jump down the surgeon's throat. If and how she would disclose would also depend on the type of error. "I don't disclose every error that exists because it would create unnecessary anxiety, leading to over-vigilance on the part of the patient." She recounted a story, familiar to most hospital staff, of the anxious and angry patient and family who have been kept waiting in emergency for tests and then for results. Patients in this type of situation can be very aggressive and threaten to go to hospital administrators, the media or a lawyer. Hospital staff have all met patients who are angry at the world and at all types of authority and are simply waiting for a mistake as an excuse to pounce. "If there is a mistake with this type of person and the outcome is nil, for example, we give them too much morphine and reverse it with another medication, the patient and family might crucify you if you told them."

Doctor seven, medicine

"I would tell the patient that I had made a mistake and that I had taken the necessary protection against infection afterward." This physician felt that this type of mistake was rare compared, for example, with taking out the wrong rib on the correct side of the body.

Doctor eight, medicine

"I can't see any other way but to tell the patient of the error but if, in fact, there was a legitimate reason for doing the operation, I would support this to the patient. I would also probably explain to the patient that because the incorrect eye was done there was a higher risk to the procedure. Certainly, after the procedure, I would have tried to minimize this problem."

Analysis

This scenario introduced the concept of explaining an extremely obvious

and potentially serious error that in most cases would not result in injury. It is debatable whether the patient could sue because, under Canadian law, the negligent act must result in proven injury. The "wrong" eye was scheduled for surgery at a later date. The only possible cause of harm would be the fact that it was operated on without being prepared with an antibiotic. Perrow's analysis of risk (***Normal Accidents***, 1984) supports the comments of physician one. The elderly man who received a medication overdose may have been the victim of a mistake made in an emergency and it is in such tightly coupled and complex systems that one false step can have extremely serious effects. If an emergency room doctor must keep her eye on several emergencies at once, and no one else has the expertise to stand in for her, which is a feature of the complex system, it is easy to make a mistake. The elderly woman in scenario three is the victim of a tightly coupled linear system that has gone wrong. It does not take the specialist of the complex system to ensure that the correct eye is marked for surgery.

Doctor two clearly saw no reason to distress the patient with explanations. He invoked distress to the patient and possible lack of confidence in physicians as a reason not to make too much of this error. Chapters one and two point to this type of reasoning as the historically dominant one. Physicians with a strong ethic of beneficence tend in this direction. Doctor six invoked another reason to be cautious — fear of the wrath of the patient. She based her decision to explain this error on what sort of people she was dealing with. This is a consequentialist position. Novack also spoke of a study which demonstrated that physicians made rare exceptions to their habit of disclosing a difficult diagnosis based on a number of factors which included emotional stability (Novack, et al., 1989, p. 2984). The dangers of self-deception are, however, fairly obvious here. It is easy to decide that someone is emotionally unstable and therefore not open to information when in fact they are normal people driven to anger by the hospital system.

The problem of the overly-anxious or angry patient is, however, very real. One physician interviewed said that there were some rare situations which demanded caution and described the type of patient who was extremely nervous and easily upset about very small matters. She says that, with this type of patient, if you explain the details of a mistake with no effect whatsoever, the effect on the patient is more detrimental than explaining would be. Another doctor said that he might opt not to tell a patient who was extremely suspicious and vigilant about an error with absolutely no significance. These responses indicate that the relationship between doctor and patient is crucial. The patient or relative who is so mistrustful that she checks the garbage cans to make sure the correct medication was given or even tape records all conversations with staff, can create, with her suspicion, the situation she fears and find the treating team afraid to be open with her. Whereas if trust can be cultivated, it is clearly much easier for physicians to be candid. Both a surgeon and a medical doctor emphasized the importance of a supportive relationship with the patient after an error has been made. This approach probably has the best chance of success.

Scenario four (simulated for teaching purposes)

A patient went into a hypoglycemic coma due to a medication error,was given glucose and revived. The patient was aware that something had gone wrong before slipping into the coma because she heard the intern say to the nurse, "you really blew it." Two days later the patient's husband came to visit and the patient told him that she was sure that some mistake had been made. The nurse admitted to the husband that there had been a medication error but that the patient was now all right. The husband asked why, when he phoned the day before to ask about his wife, he was told that she was "just fine." (adapted from Keyserlingk, 1990, p.59)

Doctor one, medicine

"I'm trying to debate how significant this mistake is. If the patient is a diabetic and needs six units of insulin and the nurse gave eight, to me this is not a significant error and I don't think I would say anything to the patient or the family. However, if the patient is minding her own business and she gets the insulin for someone else and it causes her a significant mishap, i.e. hypoglycemia, and she needs glucose, I think I would tell the patient. But I wouldn't go the extra step to speak to the family if the patient is competent and understands. It really depends on the situation. I don't think the husband should be told over the phone. And I don't think it is the nurse's responsibility to inform families about mistakes. If it is a nursing error, personally, the correct procedure is that the physician in charge should be warned as well as the nurse in charge of the floor. They should decide how they're going to speak to the family, when and how — by phone, or in a meeting. To me, I think that the answer given over the phone was right. She was fine and they should not have told the husband over the phone unless he is calling from another city.

This doctor said that he felt that the truth must be told, but carefully, in the same way that you tell a patient he has cancer. He also said his decision to disclose would depend on how serious the mistake is. For example, is it ten times the amount of insulin or just two more units? He also commented that the intern should never have made the remark "you blew it" because, in his experience, comatose patients should be treated as if they do hear, even though he said he had no evidence that this was so.

Doctor two, surgeon

I asked a surgeon what he would do if the intern were a member of his staff. Did he think that the husband should be told over the phone or should he be asked to come in. He said that the husband should be told immediately "we gave your wife the wrong medication but she revived right

away. We knew it was a mistake but we treated her right away and she is fine." He said he felt it important to tell the husband immediately to prevent problems. I then asked if he felt that being straightforward and honest with patients prevented problems down the line. "I have been doing this all the time," he said. "I have been very honest with the patient." He then told a story of a mistake so unusual and so serious that I cannot describe it here. The mistake was made by a resident and the staff doctor went straight to the patient and explained and apologized. The patient accepted the explanation. "I believe it pays off if you are honest with a patient and, so far, I have never been sued" he said.

Doctor three, medicine

A medical doctor said that the husband should have been told. I asked whether, if the staff, for example, knew that the husband phoned the ward every evening at 7 o' clock, whether they would tell him the moment they received the phone call. "I would just tell him that his wife's sugar had gone down but now she was OK, if she was, and that it was due to giving a little bit extra of a certain medication. I would tell him the mistake that was made, but I would definitely make sure he heard first that his wife was fine." She says she would still speak to the husband herself, even if it was clearly a nursing error.

Doctor four, surgeon

A surgeon pointed out that we have here a mistake, an angry husband and an intern who has not been discreet. She also said that patients in a coma might hear and mentioned two of her patients who remembered their surgery. She added, emphatically, "you have to talk to the family. This may be irreversible. This could go to court." In this situation, she said, the doctor has to be prepared to offer the husband support. He may not want it because he is angry about the remark ["you blew it"] and that somebody lied to him. "This means he has completely lost trust and it is very hard to

reverse that. The staff should meet, devise a strategy, call the CMPA. She said that the incident report should state clearly who is responsible and who was involved. "It must be very hard to talk to that husband. I'm not sure if you can manage. Even if she's all right, he sounds extremely angry. He got very scared and that's very hard to reverse. If he still has some trust in the hospital or in one of the physicians, maybe with some support it [his reaction] can be moderately reversible without a lawsuit."

Doctor five, medicine

"This is clearly a medical error and no one has lied or denied it. The question here is the fact that the patient came back to normal with no consequences. The right thing to do would be to [tell the husband] at the time the patient goes into the coma. This is not easy. But, if there is any doubt that anything serious that is not quickly recoverable has happened, or if there is a serious consequence, like death, the family must be notified immediately. First, you must tell the truth with the help of a person who knows the family. Then, you must look at the cause. Was it an accident, due to carelessness or was it an urgent situation which might mitigate the mistake. You must ask why it happened. Was the intern or nurse overtired? Was there something wrong with the team? If the patient has recovered you might ask if you should tell the husband. What if the husband has a bad heart? What would the effect of telling be on him? Perhaps, once everything is under control, you can say ' your wife if OK, we gave her insulin. ' It is a question of timing. If I don't know the husband and he phones, I don't know the effect on him. I would say ' don't worry, everything is fine. When you come in I will explain in more detail.' I would say ' we gave a bit too much insulin and it is almost certain she will completely recover.' "

Doctor six, medicine

This doctor said that when the husband phones he should be told the

situation if his wife had not recovered at that point. "But," she said, "if she was fine, and the incident happened several hours earlier, I would wait to speak to him face to face, not on the phone. But I would make a point of speaking to him." She said that she would also call the CMPA.

Doctor seven, medicine

"In terms of patient management, I think they did absolutely the right thing. I think that when the patient was fully lucid, the truth should have been told as 'look, a mistake was made and we took immediate action to correct it and, thankfully, nothing has happened.' " This physician said that he considered it to be a passive error not to speak first to the patient and then to the husband about the mistake and the fact that appropriate action had been taken. "I think being candid about the situation would have resolved the problem."

Doctor eight, medicine

This doctor said that first he would look at the situation to discover why it happened. Then he would try to put it into the context of the treatment of the patient. He said that if he felt the patient was being treated with something which was reasonable to try but which didn't work, then what happened could be an adverse effect of something the doctors did. It might be a justifiable error (what Bosk would call a judgemental error). "In this case, I wouldn't be very happy that the nursing staff or the intern tried to cover up the mistake. I would speak directly to the husband and explain the situation." I asked this physician if he would delay speaking to the husband. "I think you just get in deeper if you delay. You're setting yourself up for a lot of negative feelings. A lot of the reaction of the family depends on whether they feel the patient is getting good care. If the patient is getting good care and a misadventure happens, many families would say 'that's unfortunate but we still appreciate the care you've given.' If they feel there is deception then I think you would be getting into big trouble. And

also I think it's important to keep these things above board because you don't want them to happen again. Not only do you have to feed it back to the family, you have to feed it back to the people who did it and go over what happened. So I wouldn't necessarily hold back at all. Not even if the patient had not heard that she had taken a turn for the worst. I would probably have explained it and said that in the treatment of the patient she received too much insulin and as a result she became hypoglycemic. I've always been someone who likes to tell the patient. Usually, they figure things out anyway. [Also], you're dealing with life and death situations. It's very hard to carry all the responsibility yourself and its easier to share it with the patient. So, if there is a misadventure, I usually share it."

Analysis

All the doctors considered it important to tell the truth in this situation. However, three analyzed what sort of error it was. One thought that it would make a difference whether the overdose was ten times the normal dose or only two units extra. Another thought the mistake would be mitigated if the insulin had been given in an emergency situation. A third pointed to the fact that, medically, the situation was well-managed but that it was a passive error not to speak to the patient first and then the husband about the mistake. One physician took a completely different approach. What, he suggested, if the insulin had been given as something which might have seemed worth trying but which didn't work? Although this is not so in this case, in another, it might have been. He called this sort of error justifiable. Bosk calls this a judgemental error and one that many doctors would not call an error at all but, as Bosk was quoted as saying in chapter four, " an uncomfortable fact of life" (Bosk,1979, p.50). Most physicians focused on the method of approaching the husband with much debate as to whether the phone was an appropriate medium to communicate an error. One felt that the reaction of the husband would depend upon whether he was, in general, satisfied with the care given.

Another thought that the anger of the husband could lead to a lawsuit and that the focus should be on building a relationship with him. But this physician was not the only one who suggested calling the CMPA.

Summary

It is clear, from the responses to all these scenarios, that the CMPA plays an important role in offering doctors an anchor and a haven when faced with the maelstrom of feelings and fears that accompany the knowledge that one has made a mistake. But it is also clear that most of the physicians interviewed were concerned with the relationship with the patient. As I said in Chapter two, it is the physician who spends more time worrying about malpractice suits who might be more likely to deceive. One can still show proper concern for legal protection without compromising one's duty to the patient. As several physicians noted, they would call the CMPA to determine *how* to approach the patient, not to ask if they should. Physicians who care place the components of what they must say to the patient within the larger reality of the feelings and attitudes of the patient and family. As Bonhoeffer said "Every utterance or word lives and has its home in a particular environment..." (Bonhoeffer,1955, p. 367).

I will now turn to comments made by physicians on error and how they define and prevent it.

Error

The second scenario led to a number of comments on how the system can fail you. "No matter how good the system is, you will always get a blood tube that's going to fall and, to me, I accept that. I don't think I would tell the patient because, to me, if the system is running with a certain efficiency, I think it's all right. I just accept that there are mistakes like I accept that when I go to the bank that somewhere, there might be a mistake. As long as a mistake doesn't jeopardize patient care, I wouldn't do

anything about it. If it does, I not only would speak to the patient but to the people in charge of the department responsible, to make sure it doesn't happen again."

This physician says that he sees two kinds of error: of omission, or not caring, and negligence (what Bosk calls normative errors) and errors in which the physician has tried and failed (what Bosk calls judgemental errors). "The physician uses a medication he is not comfortable with. There is good justification and the book says that he can do it but an experienced physician would say it was an error. This is a different kind of error and I see it everyday." This physician, like those in Bosk's study, judges the first error as more serious, the second, much less so. "I see people who lack experience or training or lack experience in a particular clinical situation. For example, you could have a good family physician who has been working in an emergency room for ten years who gets into a situation he has never seen before. He will order something and I will come along and say ' No. Don't do this.' Is this an error? I don't know. But we commonly see this in our residents. We always supervise residents and often change their orders. The resident applies the text book but we, in our experience, know that the text book does not always apply in a particular case. So, if an error was made by not caring, it needs to be reported and I would do this. If I am told this by my staff, I would go to the chief of my department so he can discuss this with that doctor. If the doctor works in another department, I would still go to the chief of my department and decide whether this is negligence (a normative error) or an error from inexperience, which, in a way, is excusable (the technical error which, as Bosk says, is forgiveable in those still learning, as long as they don't make too many mistakes or cover them up). If a fellow did his best and used the medication according to the dose recommended but the patient died, to me, that's not an error. An error is a dose that is ten times the normal."

This doctor pointed out that a lot of errors are really complications. "In other words, if you have your gall bladder taken out, you might have a complication. Then the patient says ' they really botched it up.' I would say 'I don't know if they botched it up but the result is serious complications. I'm not a surgeon but it seems to me that these things occur and I would encourage you to discuss this with your surgeon. ' "

Another doctor focused on system errors, the types of glitches which Charles Perrow says occur in a linear system, causing problems if the system is also tightly coupled. Breakdowns in the linear system can cause havoc when speed and the need for accuracy render the system tightly coupled. If the vial in scenario one was mislabelled, this is a breakdown in the linear system. Similarly, the error in scenario three is probably the result of a member of staff in the linear system, perhaps a nurse, not double-checking that the correct eye is marked for surgery. "When test results are lost, it is not usually one person who loses them. A lot of the time, the problem is caused by mislabelling, or whatever." Scenario three led a surgeon to say that it is important to have a "dumb-proof" system. The surgeon should have a consistent method. In this case, she says, maybe a nurse on the floor could put a black mark on the side of the eye to be operated on. The patient should be seen beforehand if he is admitted the night before, or a member of the surgical team should visit him just to make sure. "It is always when you are too busy with something else — you get a phone call, for example [—that errors can occur]." This surgeon says that she always checks and double checks and makes a point of seeing the patients before they are put to sleep to discuss a few things. She also marks the area to be operated upon with a big black pen. She pointed out that when a person is lying flat, certain things do not show. If they are supine, for example, a bulge or hernia may not be obvious.

An emergency room physician said that a lot of mistakes that are made in

the emergency room are mostly errors in clinical judgement. For example, "do you tell a patient 'I treated you for pneumonia when you really had heart failure?' But doctors will say 'well, we thought you had pneumonia so we treated you for pneumonia, but it turns out that you had heart failure so we are treating you for that now.' " These are the types of judgemental errors of which Bosk spoke. The emergency room is also an area which is, in Perrow's typology, both complex and tightly coupled and dependent on linear interactions. As this doctor says " things can go wrong in a short split second of timing where things can be missed." The medication overdose which killed the elderly man of scenario one was the result of a mistake in a tightly coupled system. Many mistakes are made in emergency rooms because of speed. Just as a mislabelled vial is an error in the linear system, so errors of judgement are errors in the complex system. Only an experienced doctor can make such errors and it is irreplaceable specialists who exist in the complex system. "It's clinical judgement. You make a choice and you're wrong. You see what the therapeutic outcome is and, if there's no difference, you might try a different method. You're not really sure what's going on so you take a stab at something."

Role and hierarchy

Bosk spoke at length about the way in which attending staff take responsibility for those under them. "We tend to protect our residents,"one doctor told me in casual conversation. "They're learning. We tend not to be too hard on them." As Bosk says, forgiveness of technical errors helps the subordinate to be more vigilant in future and reduces the incentive to cover up (Bosk,1979,p. 178). He who confesses to his attending staff doctor is forgiven, bound to the group, indicates his moral worth and finds, in this ritual, a way to avoid being immobilized by guilt (Bosk, pp. 178-179). It is this type of training that gives physicians the courage to try different methods of cure even if they don't always work out. Thus, the technical errors of early medical practice give way to the judgemental errors of

experience. As noted in some of the interviews, not all doctors would consider these mishaps errors. Too much caution is not considered to be helpful when there are lives to be saved. Bosk describes the "hair shirt" ritual in which attendings openly admit their mistakes during mortality and morbidity rounds (Bosk, pp. 178-179). Many attendings routinely take responsibility for the mistakes of subordinates (Bosk, p. 191). In disclosing an incident, one doctor said that she "would encourage a resident to talk to the family if he made the mistake, but if he doesn't feel up to it, then I would speak to the family and tell them that it was a team mistake rather than an individual mistake because we are supposed to overlook more junior people's actions. If they make a mistake, in a way, we're all responsible. The way it works here with the hierarchy is that, ultimately, it is the attending who is responsible if there's a lawsuit. It would be the attending who is under the knife." This doctor also pointed out that, if she were faced with the sort of situation described in scenario four, she would assume responsibility for speaking to the husband. "I think some people do have some antagonistic feelings about having interns or medical students take care of them or their families. So I feel it's important for a more senior person to disclose mistakes because it doesn't put the poor medical student or intern on the spot. In any case, if someone is really junior, they should have been supervised."

I asked one doctor about her response to a resident who made an obvious mistake and then tried to hide it. "I would be very angry at him," she said. "I would have lost all my trust in him. That means that this guy is not honest and his integrity is borderline. I would probably get him in my office and try to find out why. It may be useful for his future to hammer him in an evaluation system with a zero for integrity." I asked if it would be different if he came straight to her admitting his mistake. "Yes. I have made a mistake as a resident." What this doctor says clearly bears out Bosk's contention that a technical error, hidden, becomes a normative error

which calls into question the doctor's moral and professional integrity. It would be different if he admitted his mistake because "I made a mistake as a resident." All attending staff remember the long apprenticeship in which they made errors , were forgiven and kept within the fold. As Bosk says, by learning early "to suspend judgement about the failure of others", they cope with their own uncertainties (Bosk, 1979, p. 174). Acting in good faith is the key to forgiveness (Bosk, p. 174). This doctor says that some residents will never learn. "We had some residents who were good technically, who knew a lot, but they were so poor in judgement that they were dangerous." I asked her why residents conceal mistakes. "It can be two things: it is our fault if we are too tough and they are afraid and think they will lose their job or position. We have to allow some kind of openness. It can also be just their education. It depends on how they were brought up and how much human values are important [to them]. I see a lot of disrespect for the patient. The patient is a vulnerable person and should be looked upon with more respect. Sometimes a patient looks a bit retarded or slow but they are all 'with it' inside." She suggested that patients, especially those who have become disfigured, should have a photograph of themselves when they looked well placed by the bedside to remind staff of their human dignity and value.

Another aspect of the medical hierarchy is the responsibility of physicians when nurses are involved in an error. If a nurse or other member of hospital staff is also responsible for the error, who should tell the patient? "Part of the problem is that it is easier to disclose an incident if you are not responsible, for example if the patient under your care suffers a mishap but it is not you who ordered the medication or procedure. I'd be a little more cautious and speak to hospital administration, if it involved administration, before disclosing an incident because I believe they have a full right to decide how they are going to [handle it]. It is important to take the time necessary to think about the mistake, to meet with the people responsible

and to choose a convenient time to talk to the patient. I would make sure that the act of disclosing an incident to a patient would not be blunt. It should be given by the physician in charge and not the resident alone, even if the resident make the mistake."

One doctor said that even if the mistake, as in scenario four, involved a nursing error, she would still speak to the family. "I think it's better for the doctors to tell the patient's family because when nurses say it, it doesn't go over as well with the family and they start blaming the nurses. I would say it's a nursing error without naming the people." She says, however, that she would definitely discuss it with the head nurse first. In the case of a very serious error she would get both the attending physician and head nurse involved in a conference so as to plan what to do.

Another doctor stated his position succinctly as "the doctor is the captain of the ship and he is responsible for everything that happens." It is evident from this small sample of physicians, both the old and the young and both the men and the women, that physicians tend to take total responsibility, not only for protecting residents but also nurses. Although it is certainly true that attendings take responsibility for residents, I have seen situations in which the doctors happily blamed the nurses, or the administration or the technician. The physicians quoted here, however, seemed to think that families would respond better if a doctor, rather than a nurse, explained an error that involved the nurse and the reason given was so the patient wouldn't blame the nurse. Some nurses might view this as paternalistic and certainly the nursing hierarchies of most teaching hospitals would take full responsibility for correcting nursing errors and meeting with the patient. In many cases, the director of nursing would be the one to disclose, in a system parallel to the medical hierarchy in which the most senior person takes responsibility for the mistakes of the junior staff. Nurses can be sued and nurses cannot use the excuse that they were acting on doctor's orders.

They are responsible for questioning orders that they feel are wrong.

Whistleblowing

I asked doctors what they would do if they saw a serious error and thought that it was being hidden. One answered that if the doctor were a stranger to him he would sit down with the chief of service. This would be important, he said, to prevent further errors. Another said that if a person told him of a mistake he had made or seen, he would encourage him or her to disclose it. Another doctor said that this sort of situation is very difficult because it depends on where the person who observes the mistake is located in the hierarchy. "If you're junior, you're nobody and nobody's going to listen to you, no matter what you say. If you go and tell the patient, it's against the team spirit. On the other hand, you know the other person has made a mistake. I think that in a case like that, the way you would deal with it would be again, with a team approach. In other words, speak to the other people around you who are almost at the same level and deal with it as a team rather than as an individual. The hierarchy is very very marked and if you don't respect it, you get crushed. So it's easier to speak against the more senior person as a group than as an individual." If the situation were serious and dealing with the problem as a team didn't work, would this doctor find a way of telling the patient or family without getting into trouble? Could she blow the whistle? "If it was something very serious I think there are other mechanisms whereby you can go and speak to someone. If you are a medical student, you can speak to the program director. Or even if you are a surgical resident, there would be someone else in surgery at the same level as the person who made the mistake. You could go and speak to him or her and get advice as to how to proceed before you go and speak to the family. Because the family might not respect what you say anyway if they have total respect for that surgeon. What are they going to think of the medical student [doing this]?" I asked if the family might assume that it must be the student or the nurse's fault. "Yes. That's

probably how the finger would get pointed in the long run." In the long run, she said, she'd use the system that was in place. "There's usually a safety system where you can go and talk to someone."

A surgeon said that if she saw a colleague or chief make a mistake and hide it she would lose respect. I asked if she would try to persuade this person to disclose. "Most of the time it's almost impossible, unless it's a patient or relative of mine." She said that if a patient was suspicious of a particular doctor, she would insist that he go and see him. "I would try to see if, by communication and support, he will manage [to disclose]. The only thing you can offer is moral support when you have something like this."

"If I am involved with the patient, [I would do something]. If not, I have no right to speak. If I feel a patient's life is in danger I would tell the doctor I need to speak to him very confidentially in a two-person conversation [so as to avoid the danger of] libel."

The culture of the institution is of crucial importance in determining whether or not mistakes are honestly examined and disclosed or simply swept under the carpet. One physician said that if she is working in a hospital which has a culture of hiding things, she is not inclined to stick her neck out.

As these responses show, the issue is sensitive because of fear of betraying team spirit, of placing oneself in a situation where one might be accused of libel, of not being taken seriously because one is an "inferior" in the hospital hierarchy. Possible solutions included moral suasion (see Nielson, 1989, p.129), seeking advice from colleagues or seniors, confronting the doctor as a group, insisting the offending doctor visit the patient in the hopes that he or she might find it difficult to avoid disclosing.

All of these solutions are solutions within the closed system of the medical profession and bear out Bosk's theory that the medical profession tends to focus on individual, not corporate responsibility. As one doctor pointed out, individual doctors hesitate to breach the loyalty of the team, a point which Sissela Bok mentioned (Bok, 1983, p. 214) when she spoke of the inherent dangers of whistle-blowing. Bosk (1979, p.191) also pointed out that during the "hair shirt" ritual, attendings are silent about the mistakes of subordinates so as not to destroy team solidarity.

This small group of physicians did not mention ombudsmen, perhaps because few worked in institutions which had such a position. Ombudsmen provide a system in which a mistake can be made known in a legitimate way.

Legal constraints

Although Canadian doctors are not as vulnerable as American doctors to lawsuits, all were aware of the legal implications of mistakes, as is evident from their frequent appeal to the CMPA for advice. One physician said that she felt Canadian patients had more human values and would therefore not sue simply to get the money, saying "we love you as a physician but we know you're well-insured." In Canada, moreover, legal settlements are smaller. It is not a system which would encourage patients to amplify minor medical complaints so as to pay off a mortgage. I asked this surgeon if the different legal system encouraged doctors to be more open here about mistakes. "Definitely," she said.

One doctor was aware of the dangers of receiving a libel suit if he disclosed an error made by another physician. That is why he suggested that he would approach a colleague who had tried to hide a mistake with a confidential, off- the- record conversation with no one else present. His

fears are among those which led Vogel and Delgado (1980, pp. 58-61, 94) to suggest that courts should give serious attention to enforcing on physicians the duty to disclose the malpractice of colleagues. However, physicians are also silent out of sympathy, as I pointed out in Chapter five.

Physicians did not think that fear of lawsuits should prevent them from disclosing a mistake of their own. "Even if I believe that what I have done is not a mistake, but the family is in a litigious mood, I would discuss it with a superior or the director of professional services to see if there is a reason to warrant my calling the insurers. But that is not an excuse not to disclose an incident." I asked this physician what he would do if a superior told him not to disclose because of fear of a possible lawsuit. "I'd be inclined to disclose anyway, but it really depends on what the setting is. In other words, if a mishap occurs to a patient under my care and it is a serious mistake, but not at my level, I'd still feel obligated to say it. I don't see any other way. I am not afraid of legal things. I should be more afraid but I'm [not?] of a cautious nature. If there is any doubt, I take the advice of someone else and if that advice is not to disclose if an error has been made, I have to disclose. However, it depends on what you qualify as an error."

Another doctor said that he might call the insurance company, just for protection and so that they'd know what was happening, but he would be straightforward with the patient "otherwise it will create more problems." I asked if he would disclose even if the patient might sue later on. "Yes. If they don't sue you now, they'll sue you ten years later because they realize it [the mistake] ten years later."

There are penalties connected to disclosing if one has been expressly told by the insurance company not to. One doctor said that an insurance company might say "you have been sued three times. We can't [therefore] insure you. He suggested that in such a situation one might have to balance the

possibility of losing the licence to practice and thus, perhaps, jeopardizing one's own family. "I don't know if you can always be honest in this world." He noted that, depending on the system and the risk of a suit and a loss of license, he might not mention the small things. He said that he had heard of American doctors running into these sorts of problems. "If you tell the truth about little things and then you are sued and you lose your license, this is an important consideration." This doctor thus weighed the benefits of disclosing all errors against the risks to himself, his livelihood and his family. Another doctor mentioned the same problem from another perspective. " A lawsuit could imperil the care of other patients if a lawsuit is lodged against the hospital," she said. I am not so sure it would imperil care directly, but well-publicized lawsuits tend to erode public confidence and render unlikely the good will needed to raise funds for patient care.

Good communications skills can prevent lawsuits, at least in Canada, according to one doctor who said that in the States, patients can sue for anything. He pointed out, however, that Canadian doctors could run into the same problems because he thinks their communications skills are getting worse. That, accompanied by the fact that doctors are engaging in more complex and invasive procedures, could increase litigation unless physicians make sure that they communicate well. He finds that, even with difficult patients, "biting the bullet, telling them what's going on, is the best way to go." He believes that each situation is highly individual. "You've got to tailor the care and the communication to the individual. If we ever lose that, we have lost something major."

Personal and professional values

My final question concerned personal and professional values and the influence of religious upbringing on truth-telling. Most of the doctors seemed uncomfortable with this question, saying that the way they acted was simply a part of the way they dealt with life. Upbringing and general

humanitarian values seemed to be of much more importance than what one doctor called the rules of religion.

"It guides it. I see physicians who don't care and have no morals. The fact that I have ethical principles and try to make them understand...and the fact that I wouldn't be able to sleep if I knew I had made a mistake, guides me in speaking to patients. To me it is a direct reflection of my morals and sense of what's good, what's not good and sense of what a doctor-patient relationship is. I asked him if his religious convictions lay behind the way he dealt with truth-telling. "Not directly. It is much more indirect. Religion might be a part of why I care, or give more care than is to be expected and it's sort of [an influence] in a very indirect way. It's my way. Instead of going to practice in Zaire or giving my time to my fellow humans, I do it in my own milieu and try to care more, give more time and be a bit more empathetic. Disclosing errors goes directly with what is your moral and ethical stance. I see a lot of people who do not have any morals or ethics and are not in the doctor business to care." I asked him if this was a result of his upbringing. "No matter how educated or how good and moralistic an education you have had, if you get to (he describes a large city reputed to be ruthlessly competitive) you might have to just survive. You might get caught in a vicious situation ."

Another doctor said that he was sure that other physicians were not as straightforward as he was. He was not sure if this had anything to do with family, religious or societal influence.

One doctor answered that even if people tell you that personal, professional or religious values do not influence the practice of medicine, she thinks they do. "What I do at work is not very different from what I do outside." She attributes her attitudes to honesty to her upbringing. "In my family, it's really wrong to lie. Even if you make a big mistake it's better to just say it

rather than lie because we have a saying that basically means that if you lie it comes out in the open anyway and one lie leads to another. You basically dig yourself deeper. As a kid I think it happened to me a couple of times and, since then, I've learned not to." She thinks a lot of people have attitudes similar to hers "otherwise you'll feel really badly about the world." She acknowledged that white lies were sometimes necessary. "What I was telling you about that nervous patient who's not going to benefit from knowing something. In a way, you are lying to the patient by not telling them, but, on the other hand, you can justify it." I asked if she would say it is worse actively to tell someone something that is untrue rather than say nothing when, for example, an extremely nervous patient experiences an error made in his care with no untoward result. "Oh. I think telling something untrue is definitely worse because it is more active. The other one, you can sort of ignore." But, she said, one must respect values and tell the truth. She reiterated her feeling that she did not know how people separated their professional life from the values they held. "They're probably not telling you the truth" if they say they can.

"Patients always know if you are hiding things," another doctor said. "My parents always said if you are honest, [and remember that] no one is perfect and everyone can make mistakes and try to do your best, [everything will be all right]. If something happens, try to tell the other party, who can blame you or not." I asked him if honesty could be taught to medical students. "You are born with a certain type of honesty but this society can teach you to be honest [or not] because of the consequences." He feels one can educate oneself and change one's approach to honesty.

"We all have a self-preservation instinct. My own values are always to be as honest as possible and deal with people in a straightforward manner. In training [to handle] the doctor-patient relationship, they teach you to develop rapport. In medical-legal issues, the single most important [cause of

problems] is the absence of rapport. So they try to teach you, if not for humanitarian but for legal reasons, to develop your rapport." As far as religion goes, this physician said that it is part of one's value system in terms of how one deals with people. "This is not due to religion directly but it makes up an approach to the way one does one's work," she said. It has nothing to do with the rules of religion.

Conclusion

Sissela Bok said that a lie was any stated message which is intentionally deceptive (Bok, 1978, p. 14). But she included within intentional deception the act of withholding information. Joseph Ellin argued that deception was not as bad as lying (Ellin, 1981, p. 84). A number of the physicians interviewed, even though they all genuinely believed in honesty, could point to situations where deception might be desirable. They used the same sorts of arguments used by Ellin, that one may deceive so as not to injure a patient's physical or mental health (Ellin,p. 83). The majority, however, faced up to disclosing mistakes to patients with a rigour which would satisfy as strict a moralist as Augustine or the absolutist positions of the deontologists. In Chapter two, I noted that protection of the weak stands out as the most notable exception to religious and philosophical objections to lying. The great religious and philosophical writings on this topic focused on truth and the dying. Doctors in the time of Augustine, Kant or even Bonhoeffer did not have to deal with patients who are acutely aware of their rights and are provided with many avenues to seek redress. In more hierarchical and authoritarian societies, patients would probably not consider questioning a doctor's judgement or skill. As I said in that chapter, ours is a culture of deep mistrust. Furthermore, patients relate, not to one benevolent physician but to a series of interchangeable medical experts whose names they may not even know. Responsibility for the medical product is dispersed among a variety of people — governments, hospital administrators, doctors, housestaff, nurses, students, technicians. It is not

surprising, therefore, that doctors must take into account so many factors when deciding to tell a patient about an error. It is a tribute to the honesty of those to whom I spoke that most would disclose an error to a patient even when it might not be detected and often against the advice of an insurance company. What is notable, however, is that the temptation to deceive seems to come more from the fear of a patient who responds aggressively to minor errors rather than a desire to protect a sick person from an anxiety-provoking truth.

I cannot tell, from so small a sample, whether this is generally true, but it would be interesting to discover whether or not physicians now perceive themselves to be powerless. As long as people could turn to physicians trustingly, confiding their bodies and their lives to a person once believed to have been anointed with the sacred power of healing, the profession was understandably seen as powerful. That trust, to a great extent, has been eroded because health care is delivered by a system, not one or two individuals. The patient may trust her own personal physician. She might have little confidence in a bureaucratic, under-funded hospital which misfiles charts, loses laboratory reports, fails to check equipment safety on a regular basis or ensure optimal nursing coverage. The physician, in such a setting, is powerless to control so simple a thing as ensuring a hospital bed by a certain date. It is little wonder that patients are often angry and physicians beleaguered. Telling the truth about errors in this type of setting may well be the way in which the individual physician protects herself from misplaced blame. As we saw from the interviews, physicians will own up to what they or their subordinates did wrong; they will exercise moral influence to persuade others to admit mistakes; they will even go to nurses and technicians to find out how system errors occurred. Most will fight for their own patients because the ethic of care for the person designated as one's own patient is still strong, even if the person is only one's patient for a week. Essentially, then, physicians are often

caring for strangers. Relationships between strangers are at best tentative, with each party gently probing the other to see what is acceptable. Hence the emphasis on the type of patient who can safely be told the truth. The physician fears the patient or family who might explode in seemingly irrational anger or march off to a lawyer without an explanation. Experienced and socially skillful physicians might easily handle such people. Others find that they add immeasurably to the stress of their professional lives.

MacIntyre sees our society as one in which moral and ethical values are wrenched from the traditions in which they were grounded (MacIntyre, 1984, p. 2). Patient and doctor, meeting for the first time in an emergency room or intensive care unit, are, equally, wrenched from the societies in which they normally spend their lives. Neither side quite knows what to expect from the other and so each have an awareness that they may need the law as protection. Law is the mediator in a culture with a babel of values (MacIntyre, pp. 252-253) and it is to the law that each can turn. As ethicist Roger Balk said (private communication, November 28, 1991) rights are appealed to when conflicts arise in patient care because the relationship has broken down. One claims through the language of rights what one feels one cannot get in any other way. If a relationship has deteriorated, or has not been effective, then the language of rights can be used both as effective strategy and as a means of protection. Rights are often invoked when one party feels he needs protection from abuse. Both patients and doctors fear abuse. Patients fear that they may not be treated properly and doctors fear that they will attract anger, vituperation and, perhaps, a lawsuit, if they disclose every error, no matter how innocuous. Over both hangs the law, as protector and punisher.

Chapter eight

Conclusion

We live in a society that seems obsessed both with truth and disclosure. Popular newspapers and television talk shows feature well-known individuals engaging in rituals of confession, and, presumably, of purification, by letting the world know that they are the victims of childhood abuse; that they have AIDS, not cancer; that they were secret alcoholics. Information either shameful or merely private, which once might have been confessed to an intimate other or known within a private circle of friends, is now considered matter for public discussion. As Sissela Bok says, says, (1984,p.7), secrecy is viewed as suspect and is often linked with deceit. Secrets are seen as discreditable (Bok, 1984, p.8) particularly in the field of medicine (Bok, 1984, p.154). Although this fear of secrecy has a long history (Bok, 1984, pp. 8,154) the pressure to reveal is particularly intense in our society. Governments and professional associations audit institutions and procedures. Disaffected individuals can blow the whistle by phoning a newspaper reporter to complain about a hospital. The hospital public relations officer may then tell the beleaguered physician or administrator to tell the truth because a "no comment" response to the media invites suspicion. Patients can read their charts and discover within them incident reports giving the names of people who may have injured them. We no longer live in a world in which secrets are easy to keep. Better, then, to have no secrets to tell at all or, barring that, to tell them before someone else does.

As I said in Chapter two, the media is quick to expose dishonesty on the part of governments, the church and the medical profession. This, combined with the empowering of individuals to speak up for their rights, makes it difficult for health care institutions, or the individuals within them, to practice serious dishonesty for very long.

In Chapter one I asked if social pressure shapes moral action. In other words, do we become more moral in act and attitude because of external demands? I believe that we do, not only because legislation and easy access to information can enforce moral behavior, as I suggested in Chapter two, but because legal and social pressures force us to think about issues we might otherwise have ignored. For example, physicians might always have cared deeply for their patients' well-being. They may not, in the past, have assumed that patients feel cared for when they are given complete information. When legal changes demanded that physicians comply with the doctrine of informed consent (the legal birth date of this doctrine in the . U.S. is1957 [Katz,1984, p. 6]), doctors had to stop and ask themselves if they were being fair in withholding information from patients. Likewise, it was and, in some places still is, unthinkable that patients should read their charts. In England, which has only recently granted patients this right, one study revealed such chart entries as "I've seen the patient, I've seen his wife, I've seen the two kids and I've seen the pet rabbit. And in my opinion, the most intelligent of the lot was the rabbit" (Kesterton, 1991,Nov.18, p. A.16). It is unlikely that this physician would have made such a cavalier and dismissive entry had she known the patient might read it.

The morality enforced by society is not necessarily a morality that is based on the traditional codes handed down by religious authority or a natural consequence of well though out philosophical positions. As Bird and Waters say, it is social relationships that often help people to honour moral standards, not some abstract norm communicated from above (Bird & Waters,1989, p.82). Therefore the culture of the organization is what will promote either honesty or deception. Guidelines on disclosing incidents to patients may be given to medical staff; the director of professional services may circulate memoranda to all chiefs of service encouraging disclosure of incidents; the mission statement of the hospital might even speak loftily of

a commitment to honesty and good human relationships. And none of this will make the slightest difference if medical students are told to keep quiet about incidents "or else"; if residents see the chief of service make a mistake and seemingly get away with hiding it; if the people responsible for the training and supervision of nurses respond punitively to mistakes in patient care. Waters and Bird say "corporate 'codes of ethics' by themselves do not" encourage a sense of moral responsibility; open discussion does (Waters & Bird, 1985, p.6).

As Waters and Bird (1985) point out, cultures, rather than bureaucracies, are the most effective agents of social control (Waters & Bird, 1985, p.6). Smoking was ubiquitous as long as the only people campaigning against it were surgeons general and chief medical officers. When hosts started to ask guests to smoke in the garden, the level of public smoking decreased. It is the same in any organization.

I am arguing here for the advantages of organizational openness. At the end of Chapter five, I said that legal enforcement of disclosure has potent symbolic value in that it indicates that society believes that doctors and patients should communicate honestly. I believe, however, that more effective tools than the law are institutional measures which encourage honest action and speech with no blaming and no reprisals after a mistake has been made. The law is a minimal standard of morality. Hospitals that take steps to encourage openness will enhance staff morale and make it easier for errors to be analyzed and corrected, making the hospital a safer place to practice and inspiring confidence in patients. Hospitals which have effective risk management programs, organizational troubleshooters in the form of ombudsmen both for patients and employees, and an atmosphere which makes it possible for employees as well as doctors to question practices which seem to deviate from an ethical norm, will encourage all within their walls to do what they can to protect patients both from

incompetent care and from lies and evasions about that care. Even though it is clear that doctors have their own system of internal control (Chapter four), the medical system alone is not capable of ensuring that patients are protected from undisclosed errors. Openness between professional groups goes a long way towards ensuring that patients are protected because so many mistakes are a result of failures of the system, rather than the individual physician. Physicians have traditionally seen themselves as autonomous professionals. In the modern teaching hospital, however, the physician depends on good relationships with others to achieve her goals of good patient care. The physician who is able to share power and information with other professional groups will probably find it easier both to give and to get the information needed to investigate a systems error and so contribute to preventing future problems.

Factors which impede openness and cause the condition described by Bird and Waters as "moral muteness" (Bird & Waters, 1989) include fears of raising uncomfortable questions about current practices (Bird & Waters, 1989, p.76); fear that efficiency will bog down in endless moral debate (Bird & Waters, p.77); threat to a well-honed image of professional and therefore moral superiority caused by lack of training in and therefore lack of comfort with ethical debate (Bird & Waters, p. 78).

Perrow's approach to risk (Chapter three) is particularly helpful because it focuses on mistakes as the interaction of many failures (Perrow,1984,pp.7-8). His focus on corporate responsibility is, I believe, the most helpful approach to telling the truth to patients about mistakes and taking steps to prevent mistakes in the future. Human beings, characteristically, respond to blame with feelings of shame. Many people deal with shame either by hiding, deceiving themselves that the mistake was not really a mistake, or by angrily pointing the finger at someone else. That someone else could be the nurse, the medical resident, the hospital for

not providing proper equipment or support, the government for cutting staff, or even the patient who arrived for surgery in a self-inflicted debilitated state of health. It would be idealistic to assume that any group of human beings can be trained to communicate honestly, fairly and even lovingly when under stress. But I believe that it is possible to create an organizational culture where such behavior is more likely. A well-running institution, with the majority of the staff trained to communicate well and encouraged to be honest without fear of reprisal, need have little fear of government-mandated truthful disclosure. The institution which is already conscious of and committed to honesty with patients is unlikely to attract outside notice for wrong-doing because frustrated patients and staff alike have official channels to redress wrongs.

Although many people and institutions encourage honesty because it is, in that trite old phrase, the best policy in a society of rapid and open communications, this utilitarian stance is not necessarily bad. What is important is that the commitment to honesty be articulated. Many individuals are brought up short by a demand to articulate the reasons that they consider a particular act moral or immoral. This is what Bird and Waters (1989, pp.75-76) call moral muteness. Although physicians are less likely than the business managers these authors interviewed to avoid moral discourse, they may still avoid seeing issues which have moral weight and ignore or tolerate abuses (Bird & Waters, p.82) of the requirement to tell the truth. If the institution and the people who work within it are silent about issues of truth telling in patient care, this silence will reinforce denial and self-deception. If moral dilemmas are not even seen as dilemmas (Bird & Waters, p.82) but are reduced to a simple "tell the truth about a mistake when it's obvious but don't bother the patient when it isn't" then the issue of disclosing incidents to patients may never be discussed until the unhappy day that an irate patient or junior staff member decides to blow the whistle.

Waters and Bird (1985) suggest that communication of institutional standards alone is insufficient (Waters & Bird, 1985, p. 7). Effective methods which foster openness include workshops and discussion groups (Waters & Bird, p. 7). It is common in teaching hospitals to find nurses and doctors who organize such discussion groups on their own initiative, either conducting informal ethics rounds to discuss specific cases or inviting different members of hospital staff to present a topic for discussion. With the increased popularity of ethics as a topic of interest, support staff may be included in these informal discussions.

Purists may view the consequentialist motive for truth-telling as morally inadeqate and consider the intention behind the moral act to be as important as the act itself. From the point of view of the hospital patient, however, the doctor's motive for telling the truth about a mistake may be less important than the fact that the truth was disclosed. Where intention does matter is within the relationship between doctor and patient. Intention is often part of the how of disclosing mistakes, not the why. A doctor may know that it would be advisable from a legal point of view to be straightforward with a patient. But if the doctor fears the patient's reaction, she may disclose the truth only "because the law, or policy of this hospital, obliges me to". She may, in an act of not so unconscious hostility, disclose the truth when the patient is particularly depressed. At the end of Chapter two, I said that physicians who worry more about malpractice suits than caring for their patients may be more likely to lie, deceive, dissemble or evade. Such physicians may even tell the truth, if they fear punishment for avoiding it. But it is such physicians who may do so in a hurtful manner. Although I have not met this sort of physician, I have met physicians who have a legalistic concept of informed consent and who weary at having to explain anything to the patient. This is the physician who presents the patient with a form and says "under the law of informed

consent I have to give you this and you have to sign it".

Obviously then, the components of what must be communicated to the patient have to be placed in the larger reality of the relationship between the two. And it is here, as I said in the conclusion to the last chapter, that problems arise because relationships between doctor and patient in a teaching hospital are often relationships between strangers. A partial remedy for this problem may be communications training in medical school as well as a hospital culture which rewards good communication with patients as much as it rewards good medical care.

Medical school training is focused, quite rightly, on scientific competence. But it is a mistake, I think, to suggest that competence in curing is an adequate substitute for human caring. Both are needed if the whole person is to be healed. The medical profession, like the priesthood from whom it inherits and with whom it shares a ministry of comfort and healing, exists in a rapidly changing society in which people no longer trust paternalism but still seek care as well as cure. People who are sick in soul or body can be forgiven for turning to these mediators of healing as if they were nurturing parents. In the past, some priests and doctors may have responded to this blind trust by an abuse of power. That sort of abuse is difficult to exercise nowadays and, certainly, impossible to defend. The loss of the paternalistic stance of the past, however, seems to have led many doctors and priests to abandon their roles and merely to perform functions. Belief in the person of the healer has always been more important than the exercise of technique. As most therapists will state, it is the relationship that heals, just as much as the technique (Storr, 1960, p. 129).

Ultimately, then, telling patients the truth about medical mistakes is part of the much larger healing role of the physician. Truthfulness between the person in need and the person with the skill and training to heal is

essential if the two are to form a healing alliance. Patients will not be protected from dishonest communication by laws which tell doctors not to lie about mistakes and doctors will not be exonerated from accusations of deception by using the frail excuse that they care about their patients too much to burden them with unpleasant details. Harmony will be restored to the relationship between doctor and patient only when the inequality between the two is balanced by the recognition that two apparently unequal strangers can meet in a partnership in which conversation is as much a part of care as technology and technique. Hauerwas (1986, pp. 51-52) speaks of the relationship between physician and patient as a covenant in which the physician promises to maintain a steadfast presence while being willing to express his own fallibility. Ramsey (1970, pp.5-6) likewise sees the relationship between physician and patient as that of "joint adventurers in a common cause" and refers to this type of loyalty as a partnership. But as MacIntyre points out, modern society shares no common moral vision (MacIntyre, 1984, p. 252). Modern medicine has thus been forced to describe the relationship between patient and physician as a contract which substitutes for the lack of a shared moral tradition (Hauerwas,1986, p. 52). An individual patient might find a physician with whom she can form a covenant of trust. But even this caring, faithful doctor will be unable to intervene if the hospital gatekeeper insists that there are no beds for the weekend or if the unions decide to strike. Doctors do not run hospitals; governments, administrators and unions do. Fidelity falters and fails when doctors have to contend with the competing rights of patients and workers.

What is needed, then, is a partnership which is neither covenant nor contract but a respectful alliance.

Katz proposes that physicians become aware of their own vulnerabilities and be unafraid to admit to their own uncertainties. Physician and

patient need to relate both as unequals and equals (Katz,1984, p. 102). While the patient lacks medical expertise, he or she knows what she values in terms of a good life or even a good death and, though the doctor may be the expert, he or she has much to learn if she only stays with her patient a little longer and hears what he is saying (see Katz, p. 102). If physicians learn to trust patients, and if the two learn to speak openly with one another, then a climate of respect is created which may go a long way towards clearing up the difficulties presented by a moral requirement to disclose mistakes. Medical curricula have long relied on scientific achievement and technical competence as the measure of the good practitioner. Emphasis on the art of conversation with patients might contribute usefully both to humanity and truth in medical practice.

Imposed legal requirements indicate that trust in the profession is no longer viewed as sufficient protection. In Quebec, patients may read their charts and, under a new law, Bill 120, (Quebec National Assembly, 1991,Chapter 42,articles 29-76) , will have a formal, government-mandated mechanism for complaint review. These requirements make mistake-hiding difficult but offer the opportunity for physicians to earn trust through conversation. Because, ultimately, it is the honest relationship between patient and physician which is the best guarantee of fidelity to truthfulness. And it is the honest relationship among the people who work within the hospital which is the best guarantee that individuals will be open about their own mistakes, knowing that they will be helped and supported rather than blamed. This is, I realize, an ideal. But it is not impossible. And, I believe, it is the only solution which will help hospitals adjust to changes imposed by society.

It is unlikely that our hospitals will be well-funded and well-staffed in the future. If anything, budgets will be smaller and health-care institutions more sparsely staffed than in the past. And it is certainly unlikely that

patients will ever give back the power that governments and the law have granted to them. Hospitals and physicians have tended to believe that they had a monopoly on health care because the sick person has no alternative if he wishes to become well or to avoid death. Even that power has been eroded to some extent as more and more Canadians turn to alternative health care practitioners for all but those illnesses which only scientific medicine can treat. A recent study showed that one in five Canadians and one in three Quebeckers use alternative practitioners for some if not all of their health care needs (Mickleburg, 1991, pp. A1, A6, and see Sutherland, 1990; Thompson, 1990). The December 1990 version of the ***Reform of the Health and Social Services Network*** proposed by the Ministère de la Santé et des Services sociaux of the Province of Quebec goes so far as to propose that the ministry of health discuss criteria for recognizing alternative therapies, ways in which alternative practitioners can be evaluated and accredited and methods of helping alternative practitioners collaborate with the public sector without bringing them under the umbrella of medicare. The document argues that popular support bolsters the demands that alternative practitioners be given legal status (Gouvernement du Québec, 1990, December 7, pp.29-29. English version). What the report does not say, of course, is that people who go to alternative practitioners pay for their own health care out of their pockets or through their insurance companies and therefore reduce the burden on the system. But, as these statistics show, many are willing to pay for kindness and communication. Why go to an uncommunicative allergist in a busy hospital clinic if a homeopath can treat the same malady while taking the time to know her patient? Why suffer the indignity of being told "it's all in your head" when chronic back pain might be alleviated by an acupuncturist or chiropractor? I am not here arguing either for or against alternative medicine but pointing out that patients have more power and more choice.

Attention to care, in the form of honest communication, will ensure that

patients do not neglect to see physicians because of a fear that they will be treated badly. However the relationship is described — as covenant, partnership, alliance or even contract — truthful communication is an essential component of the relationship between doctor and patient, and doctor and colleagues. Clear and effective communication is the doctor's protection against complaints, both unwarranted as well as founded; the hospital's protection against unsafe practices and lawsuits ; and the patient's protection against being abused by a profession which claims to heal.

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Appendix

Guidelines for the disclosure of incidents to patients and/or their families

approved by the Board of Directors of the Royal Victoria Hospital Centre on June 28, 1989

Preamble

Hospital staff need to exercise professional judgment concerning the timing and nature of disclosure of incidents to patients. Situations arise in which a set of clearly articulated guidelines could assist staff in the appropriate disclosure of incidents.

The following guidelines, therefore, are presented as a way of clarifying and consolidating hospital practice and policy, and to assist doctors, nurses, and other health-care professionals in the task of disclosing incidents to patients appropriately, with compassion and with respect for the patient and consideration for other members of the health-care team.

Guidelines for disclosing incidents

Principles

Patients are entitled to receive full information concerning their care. From time to time, unexpected incidents may occur during a patient's treatment, hospitalization or out-patient visit. Generally speaking, the facts of the incident, once collected, will be disclosed to the patient. Disclosure may be deferred if the patient's condition at the time presents compelling reasons not to disclose.

Procedure

1. When an unexpected event or incident occurs in the care of a patient, it should be first discussed by the treating team (staff members involved, treating physician, head nurse), and where appropriate, with

administration.

2. The treating physician should then decide who is to inform the patient of the incident.

3. Information should be disclosed when the treating physician and head or primary nurse determine the patient's readiness and as soon as reasonably possible.

4. If the patient is competent, information about the incident should be disclosed to the patient. The family can also receive information with the patient's consent. If an incident affects a mentally incompetent patient, information should be given to that person's representative.

5. The focus of disclosure should be on the facts of the incident and the potential adverse effects and their likelihood rather than on personal opinions as to fault or responsibility.

6. This information should be presented in an empathetic fashion by someone who has the time and knowledge to answer the patient's questions.

7. If the patient wishes to make a formal verbal or written complaint to the hospital, the person delegated to discuss the incident should put the person in contact with the Patient Representative.

8. Disclosure to the patient in accordance with these guidelines should be recorded in the patient's hospital chart and an incident report filed when appropriate.