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CLOSED CASES? – THE MENTIONING OF MEDICAL ERRORS IN DOCTORS' MEMOIRS

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Abstract

The concession of errors in the pursuit of the art of medicine, where mishaps can lead to deleterious consequences is at the center of this paper. The social costs of medical errors and a professional culture with a strong tradition of self-regulation and shielding itself via a more or less permeable "Wall of Silence" make the issue not only interesting but keep it timely. The focus is on how and within what framework medical errors are admitted in the memoirs of American doctors. The times remembered reach from the 1950s and 1960s to the present.

Keywords: Medical errors, memoirs, medical ethics

Instruction

Readersof autobiographies expect interesting storiesthat truthfully disclose very personal circumstances and experiences (Barrington, 1997, pp. 26, 70-75). The humanity of the writer interests them, his/her accomplishments and, also, errors and failures and how they were overcome. Thus, there is a voyeuristic aspect to the reader's interest in autobiographic stories, especially with regard to the tales of those belonging to professions that have traditionally had a culture characterized by self-regulation and with fiduciary relationships to their clients that are not just under moral but also under legal principles.In the case of medical doctors, these confidentiality rules can be traced back to at least the Oath of Hippocrates, which obliges the professional to keep secret that what ought not to be divulged. To keep conversations between doctors and patients as well as among medical professionals privileged is necessary for trust to develop so that the doctor can diagnose, prescribe therapies, and gain the patient's participation in healing and treatment processes. Consequently, medical doctors who want to share their memories will have to take that into account and gain permission, even if names and circumstances are modified. That means, the doctor must carefully consider the feelings of the patient, the patient's confidants and family as well as of his/her own family, of the family's close circle of friends and his/her colleagues and coworkers. The social and moral prestige of the profession as well as any vulnerabilities to possible litigation need to also be taken into account.Consequently, since memoirs are also written to validate one's life and share lessons (Zinsser, 1987, pp. 24, 110-114), that which is presented will consist of a mix of confessions, admissions, omissions, allusions, and personal valuations of events.

The concession of errors in the pursuit of the art of medicine, where mishaps can lead to deleterious consequences is at the center of this paper. The social costs of medical errors and a professional culture with a strong tradition of self-regulation and shielding itself via a more or less permeable "Wall of Silence" make the issue not only interesting but keep it timely. Medical errors cause extensive emotional stress and extra medical and social costs for both health-care givers, patients and their families and friends, not to speak of the at least 98,000 deaths of hospitalized Americans (Allen, 2013). Overall, considering the amount of

books and online posts belonging to the self-help and "what your doctor doesn't tell you" genres, in recent years, the trust between doctors and patients seems to have been eroded. Moreover, real or perceived mistakes on the side of health care providers and government agencies that are also entrusted with health issues, can instigate public scares and panics, as in the case of AIDS, MRSA, or Ebola… Earning and maintaining the public's trust, therefore, is more than an issue of personal doctor-patient relationships and concerns social trust into the profession, health and information policies, and the sciences.

Out of the wide range of issues that are mentioned above, this paper will reflect upon: How openly are mistakes admitted and what kinds of? How are the stories of having either witnessed or done something with deleterious consequences unto a patient framed and what kinds of value judgments are handed over to the reader to evaluate? How is the Hippocratic dictum of, First do not harm interpreted? What epistemological and moral positions are taken concerning the possibility of avoidance of harming? What roles do responsibility and guilt play?

The discussion will restrict itself to memoirs that have been relatively recently published in the U.S. and not go further back than to the 1950s.

 The working definition and the typology of medical mistakes that will be utilized are mainly based on the approaches of D. Hilfiker (1998, pp. 59-66), J. Groopman (2008), and J. James (2013).

It has long been a truism in medicine that doctors learn most from their mistakes (although most doctors don't tell this to their patients). (Reilly, 2013, p. 59)

The concern with efficiency and financial and legal accountability of the increasingly specialized and technologized health care system resulted, among others, in efforts to boost patient safety. In this context, knowledge and performance deficiencies on individual and organizational/corporate levels have been analyzed, which, then, led to attempts to categorize and measure medical errors or "preventable adverse events" (PACs). J. James typology (2013, pp. 122-124) has been developed with a view to the occurrence of PACs in hospital and clinic settings and differentiates between five different types of errors that may lead to the immediate or delayed (months or years) experience of harm by a patient. These five types are: (1) errors of commission (wrong action or improper performance of the right action), (2) errors of omission (a particular action was not performed that is necessary to treat or heal a patient according to institutional protocol or professional standard), (3) errors of communication (between health care service providers or between provider and patient), (4) contextual errors (disregarding unique and possibly constraining circumstances or conditions of the patient, such as mental retardation, finances, religious or cultural beliefs) and (5) diagnostic errors, which can also lead to (1) or (2). According to recent studies, among them Groopman's *How Doctors Think,* the majority of misdiagnoses is due to flaws in the thinking of medical professionals. In his book, Groopman stresses again and again the importance of self-awareness of the limits of their skills and knowledge for the physician. They should always generate a "short list of alternatives" to what appears, on first sight, to be the right answer (2008, p. 66) and become aware of factors in their internal and external environments that are influencing their decision-making process (e.g., conflicting rules and expectations, time constraints, emotional stressors, liability fears). Moreover, Groopman's analysis reveals that the identification of errors often is not as simple as it might seem; there exist grey zones, which, in turn, raises the questions of when to really admit and what. What harm could have been prevented and what not? Furthermore, the practice of medicine involves risk taking, which increases the possibility of errors. Being too fearful of legal liability might lead to absolute caution and risk avoidance, which, in turn, can lead to mistakes, too. In contrast, being interested in preventing the repetition of mistakes can make one push for a full disclosure of errors and failures, as the transplant surgeon Starzl, for instance, did. He argued

against a policy of non-concealment and for institutional oversight and public debates to reach consensus on what should be done to allow for innovation in medicine and provide patients with the best possible treatment. His argument relies on his rich experience with the fleeting borders of what is patient care and what is clinical research, experimental treatment, innovative medicine and error/mistaken assumptions (1992, pp. 164-165, 234-242, 256-287). More than once he discussed what and why he and his colleagues' considered "best judgment" concerning beneficial actions, that is, actions that minimize possible harm and maximize possible benefits to the patient. His explications of the unavoidability of harm were free of cynicism and invited the reader to partake in his deliberations on determining the best possible treatment. Starzl makes the reader realize that this determination requires knowing what is harmful; even obtaining this information might expose a person to the risk of harm (p. 236).

So, no matter whether it is experimental or "regular" medicine, errors are not as unique an event in the life of a medical professional as one might assume; their emotional impact can be tremendous, though. Many of the memoirs that are reflecting back on the first years of medical practice of young doctors in the 1950s and 1960s, if not solely focusing on the doctor's adventures and delights in small-town America, warrant that. They often include at least one account of a medical error, experienced either first or second hand experienced. Ingrained in the physician's memory, the incident became a constant reminder of the difficulties of diagnosing, the limits of skills and knowledge (Betts, 1998, pp. 82, 150), the relevance of good communication skills, and the need to consult with others (e.g., Cronin, Lown, Mitchell, Nuland). – And that at a time when malpractice litigation was rare. Starzl, for instance, recalled the tale of someone who incurred severe brain damage because an inexperienced doctor had applied the right method incorrectly (p. 33). This story was formative for him and stayed with him from the time he was a medical student. Starzl also remembered his sense of grief and horror because of having to watch the effects that inadvertency in the operating room had on a patient (p. 42). In difference to this, the family doctor Cronin's story is a humorous one. Cronin talked about his learning process as a young doctor whose lack in experience in his profession and of child's play made him mistake a squeaker in a child's nostril for a pneumothorax (1952, pp. 77-81). The error, uncovered by his experienced older colleague, taught him the importance of consulting colleagues in case of doubts. The surgeon Richard Selzer warned against allowing oneself to be taken over by anger over a patient's unruly behavior and then acting impulsively, in his case, exposing an unruly patient to punitive and somewhat cruel treatment (1996, pp. 59-69). In his account of present day medicine's crisis, the cardiologist Bernard Lown went back 50 years in time when his teacher, Dr. Levine, admitted an erroneous diagnosis because of the deep impact this experience had on him and other trainees (1999, p. 6). From this his teacher he did not only learn the utmost importance of carefully listening to and observing the patient but also of the need to have the humility to learn from younger colleagues (pp. 161-175). More so, he described how, in 1948, he himself was hit hard by the tragic death of a patient that resulted from his, Lown's, ignorance and how this incident fueled his research, thus leading to improved treatment. He also recalled, and this is a recurring theme in many narrations about the 1980s, 1990s, and later years, how difficulties to distinguish between what is likely and what is highly improbable as well as how over-reliance on tests led to patients' exposure to unnecessary, highly invasive procedures and, with it, to needless suffering.

A specific concern of the cardiologist Isadore Rosenfeld is the complexity of the communication process both among health care providers and between physicians and their patients. As an intern, Rosenfeld learned about the need to never remove hope from a patient under the guise of honesty and forthrightness. When and how the problem is explained to the patient can make an enormous difference with reference to the quality of life left for the

patient and might prevent or, even, cause tragic acts (2010, pp. 50-56). Rosenfeld also shared his awareness that a doctor's misdiagnosis can have the power to label a patient for life and, with it, drastically change this person's life. Furthermore, he stressed the need for both, the doctor checking out his/her patient's intuitions and seriously considering every reasonable explanation of the patient's symptoms (pp. 61-66, 91-96, 156-161) and the patient voicing his/her concerns not just during the anamnesis but if he/she suspects that there is something wrong during or after a medical procedure (pp. 162 -166, 237-247). Other physicians, such as Lown, Reilly, Nyland, and Groopman, gave similar advice to their readers, thereby expressing their support of a non-paternalistic approach to the doctor-patient relationship. They stressed the rights of the patient, their autonomy and dignity, which enable them to become or simply make them partners in the process of managing their health or illness. That this is, by no ways, a new approach was articulated by the surgeon Sherwin Nuland. He referred to an aphorism that has been attributed to Hippocrates, "The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and the externals, cooperate." (2008, p. 142). Nyland provided with numerous examples of unsuccessful treatment and mistakes because of failure to make patients and their families and friends partners in the healing process. He pointed out that these inefficient attempts were related to personal prejudices and concerns of health care providers (cost saving versus treatment of someone who might be prone to abandon treatment; moral judgments that blame the patient for acquiring certain diseases), cultural differences (inability to successfully communicate across cultural differences, and, consequently, to enroll a patient into a highly promising course of treatment) as well as psychological factors on the side of the sick patient (inability to be vigilant because of being frightened, weakened, scared or distracted) (pp. 34, 142- 145). In this context, he raised several interesting ethical questions, such as whether there could be too much insistence on self-determination, causing a "tyranny of unrealistic expectations for both the sick and the well." He also raised the issue of to what degree people can be reasonably expected to take good care of themselves. To him, the reward for taking good care of oneself is not the attainment of moral superiority on the side of the caretaker but the probability of good health, which, in turn, presupposes having the resources to do so. This however, raises the questions of the boundaries of medical responsibility and health regulations, aspects that surely influenced why he titled his book, *The Uncertain Art*.

Overall, the memoirs show that it would be a misconception to assume that medical errors are only a problem of some "bad apples" among the physicians or happen only during high risk and/or surgical procedures. At the roots of the problem is that both physician and patient swim in a sea of uncertainty and have complex and often contradictory expectations towards each other and themselves. The physician, for instance, is expected to appear confident and to act decisively and with assurance for he patient while being aware of his/her limited knowledge and skills and the difficulties of correctly diagnosing patients and, consequently, making the right choice of treatment. More so, he/she is supposed to stay calm and reassuring, no matter the stress put on him/her because of time limitations, sleep depravation, conflicting organizational rules, and bureaucratic hierarchies. His/her knowledge is expected to stay up to date, despite the rapid changes in technology, technique, or medications and to include information that is also available to the patient, including that of alternative treatments. By writing about the difficulties of pursuing his/her art, the well but imperfectly trained healer wanted to his/her audience to know about the long time it takes to gain the experience that the young doctor cannot have. Furthermore, the authors tried to communicate that they also suffered; each and any of the mistakes they made came with high emotional costs. Nonetheless, the mistakes inspired them to strive to be *good* doctors (in the sense of excellence). Thus, the mistakes functioned as stressors and inspirations. What also shows is that the process of dealing with these incidents was a quite lonely one.

The memoirs also corroborate that the issue of disclosure, whether to oneself, to colleagues, other health care providers, and/or to patients its lost anecdotal character in the 1990s. What once was depicted as an almost unprecedented incident with formative character lost in uniqueness and gained in "normalcy" and, because of that, in importance.

From the *Confidential Friend* (Worthington Hooker, 1849) to the *Confessing Friend*: Pealing away the layer of the white coat of silence

The changing approach to medical errors in memoirs reflects political, economic, legal, and cultural transformations in the research and practice of medicine and health care. Technological and technical advances, research in clinical epidemiology (population-based research, specifically, randomized controlled trials), the development of Evidence Based Medicine and the implementation of Medicare and Medicaid changed the ways of medicine and led to a re-structuring of the health care sector. However, neither the creation of HMO's nor the increasing corporatization and privatization of the health care sector, including the implementation of the business model in clinics and hospitals, could drastically dampen the escalation of health care costs. Because of the rising costs of the newly available technologies, tests, treatments, and pharmaceuticals, increasing specialization among health care providers and extra-costs because of an increase in malpractice lawsuits and the amounts granted, the pressure to reduce costs accumulated. One of the effects of the pressures to diminish costs and increase performance is that Morbidity and Mortality Conferences, a traditional form of confidential peer review of PACs at medical centers, gained in importance both as educational tools and a means to change behaviors on individual and systemic levels. Another effect is the establishment of the Agency for Healthcare, Research and Quality (1999) in order to gain evidence for measures that can improve patient care. Related to the agency's report *To Err Is Human: Building a Safer Health System* (1999), new federal regulations to report and reduce PACs were introduced, which lead to state regulations and safety indicator systems for hospitals. Nevertheless, there exists sufficient evidence for underreporting, be it because doctors tend to minimize the occurrence of mistakes and/or do not even admit the error to themselves, or because they fear for their reputation, are afraid of administrative and legal punishment or worry about financial losses because of a loss of referrals and patients (Ruggiero, 2012, pp. 87-90).

For the reader of the memoirs, though, it is not the mushrooming costs but the doctors' concerns about the status of their profession that them led step forward and publicly debate medical errors.The physicians put the issue of errors into the broader framework of the challenges that health care providers nowadays face. Their worries include: having too less time for too many patients, having to "standardize the patient," colleagues who practice "defensive medicine," or who rely overly on technology and tests. Other concerns are the experience of a high level of stress and emotional drain. The need to adjust to fast changing conditions and to meet contradictory demands can lead to alienation from patients, burn out symptoms, and overall dissatisfaction with the ability to be the healer and partner to the patient that the doctors want to be. To those doctors who recognized the patient's autonomy and their right and need to be collaborating partners, it seemed only natural to reach out to both other healers and prospective patients and toconfess. Others were made step forward by the newly emerging legal and administrative frameworks mentioned above. The line of voluntary confessions was started by the general practitioner David Hilfiker'scourageous and honest accounts *Facing Our Mistakes*(1984) and *Healing the Wounds* (1985); they were sometimes met with hostility by other health care professionals but often acknowledged with respect. Hilfiker stated that doctors generally behaved like competitors or were put into such a position and that they rarely talked about their mistakes and how they left them feeling (1998, p. 129). According to him, "neither the structure of their profession nor society at large in any way equips them" (8) to speak honestly about the problems in their professional lives. Hence

his plea for a social and communal environment that gives doctors the possibility to admit wrongdoing and discuss feelings openly, such as, sadness for patients and themselves, a sense of inadequacy that especially dedicated doctors might develop, and, also, frustration, despair and cynicism. Hilfiker pointed to the need to not let the *wounded healer* become a second victim of the mistake he/she allowed to happen,a problem that the profession alone cannot resolve. This problem became a recurring concern in other memoirs.

After Hilfiker's outcry, it was like a dam burst open: Whole chapters in memoirs or auto-biographically inspired discussions of the medical profession reflected on reasons for medical errors, on what unnecessary treatment and judgment calls are, on the mistaken assumption that new technologies, methods, and drugs allow for absolute exactness, and how uncertainty produces the need to follow one's gut feeling - as fallible as it might be. Other issues were the importance of honesty and the need to recognize and correct unexpected errors without creating a culture of blame and shaming, the existing mechanisms of peer review and reporting of errors and the nonetheless continuing existence of the "white coat code of silence." Also again and again articulated were the doctors' pain and suffering, their feelings of guilt and need for forgiveness – by others and themselves (e.g., Ruggieri, 2012; Lown, 1999; Reilly, 2013; Banja, 2005, pp.132-149, 200-202, Jones, p.127, Austin, 2008, pp. 64-68, 126-165, 291-293). Concerning the latter, the hospital physician Brendan Reilly, for instance explained: Despite the fact that doctors and nurses have become part of a health care industry that provides services, which, in a sense, commodifies care or, as the surgeons Atul Gawande and Paul Ruggieri called it, turn care into treatment, health providers still feel guilty when things go wrong with their patients. Reilly linked the feeling of guilt to self-disappointment because of not living up to one's own standards. He suggested that the act of making a mistake should not be considered a moral failure, except for cases of intentional or callous misdeeds or utter incompetence. He suggested to think about errors in terms of excusability, which would eliminate the need for forgiveness and moral repair. The question is, though, whether that would presuppose an environment that is characterized by policies, rules and regulations and working procedures that are requesting total disclosure, grant justice, and do repair, which includes apologies and mediation.

More so, if the doctor is part of a "care" system, reduction of mistakes strongly depends on systemic failures, an issue addressed by, among others, Gawande, Ruggieri, Austin, Lown, Ofri, and Jauhar. As explicated by Gawande, for instance, "The important question isn't how to keep good physicians from harming patients; it's how to keep good physicians from harming patients." (2002, pp. 56-57) Furthermore, it's not primarily medical malpractice suits that are remedying systemic and individual failures but systemic quality improvement measures within the health care system, improved peer review procedures (56-57, Ruggieri, pp. 44-45, 63-74; Reilly, pp. 179-184) and rule and therapy changes based thereof as well as initiatives of doctors that create new care practices (Reilly, pp. 246-247).

Other messages by the writing doctors addressed to their readers can be summarized as follows:

- We care. However, errors are part of our daily lives. Although we are highly educated and trained, our skills and knowledge is limited. It is not always easyto recognize what constitutes patient harm or that a particular event harmed a patient. Not even the use of protocols and algorithms, as helpful as they are, can prevent the occurrence of mistakes. Illnesses have an individual face and rules and regulations are imperfect and can be contradictory. Moreover, decisions are made not just by me but also by a complex group of agents.

- We care and are talking about our mistakes to our peers but you might not be aware of it because you are unfamiliar with the peer review mechanisms. Hospitals, for instance have performance data. But you need to understand that hospitals and clinics

are afraid to admit system-based mistakes, too; after all, they function as a service provider in a market economy. Doctors and clinics have a reputation to loose and the media love sensations. So there is still some kind of a protective wall…

- We care but it is hard to talk about mistakes in a competitive environment that includes other doctors and hospital administrations; confessing might endanger our livelihood and that of our families.

- We care and would like to talk to patients or their loved ones about mistakes that we made. But, please couldn't we have our conversations without right away being threatening with legal steps? When treating a patient, you want us to be decisive and not constantly second-guess ourselves. So give us a chance to not feel continually threatened by lawsuits. More so, it is very hard to face people one has hurt by erring; one doesn't only have to overcome one's ego and correct one's self-image but deal with suffering and grief. Maybe, we need a bit of help to learn how to communicate mistakes. Official disclosure statements are written in legalese…

- We care and want you to understand that we, too, suffer when mistakes are made; the case is never really closed for us. We would like to have a support system that helps us to heal our wounds, thereby allowing us to stay the good doctor we want to be, despite all the stress.

- We care, so, please, help us by becoming more active as a patient. Become a good partner and ask educated questions or have someone do that for you – even if some doctors don't like it.

Conclusion

After a period of relative silence, the "white gods" have taken it on themselves to honestly and seriously discuss medical mistakes with the general public. They have done so because of their growing concern for the condition of the health care system and the future of their profession. Moreover, their accounts are pointing to a number of complex and contradictory wider issues: On the one hand, Americans often have exaggerated expectations towards "scientific medicine;" they trust in the capacity of sciences and technologies to "fix" what is wrong. On the other hand, there exists an undercurrent of distrust concerning the sciences, linked, among others, to ideological beliefs (Valdesolo, 2014) and mistrust of government, business ethics, and the news media. The calms about business and government regulations and the distance between media image and real activities seem to have spilled over to attitudes towards the health care system as well. Any discourse on improvements of the system or medical errors will have to take this ambiguity into consideration.

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