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When a Surgical Colleague Makes an Error

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Professionalism requires that doctors acknowledge their errors and figure out how to avoid making similar ones in the future. Over the last few decades, doctors have gotten better at acknowledging mistakes and apologizing to patients when a mistake happens. Such disclosure is especially complicated when one becomes aware of an error made by a colleague. We present a case in which consultant surgeons became aware that a colleague seemed to have made a serious error. Experts in surgery and bioethics comment on appropriate responses to this situation.

abstract

Thirty years ago, Hilfiker wrote of doctors, "It is highly likely that sooner or later we will make the mistake that kills or seriously injures another person."¹ This is a truth that doctors both acknowledge and dread. Mistakes happen. Some have serious consequences. Professionalism requires that doctors acknowledge their errors and figure out how to avoid making similar ones in the future. Until recently, doctors would generally only acknowledge errors to each other, not to their patients, if they acknowledged them at all. Over the last few decades, doctors have gotten better at acknowledging mistakes and apologizing to patients when a mistake happens.²

Disclosure is especially complicated when one becomes aware of an error made by a colleague. Who, then, has the responsibility to deal with the disclosure? To whom should disclosure take place? Who is accountable to whom? We present a case in which consultant surgeons become aware that a colleague has made a serious error. We then present responses from experts in pediatric surgery and surgical ethics, all surgeons themselves, from the Mayo Clinic, Children's Mercy Hospital, The

University of Chicago, and Children's Hospital of Philadelphia to discuss the appropriate response.

THE CASE

A newborn was diagnosed with Hirschprung's disease on day 6 of life. A local surgeon, with limited pediatric surgical training, operated on the neonate. Postoperatively, the neonate developed serious complications. He was unable to take adequate nutrition by mouth, became malnourished, and, after a few weeks, was transferred to a children's hospital. The surgeons there discovered that, during the first operation, the original surgeon had become confused about the child's anatomy, and removed the healthy portion of the colon while leaving in place the diseased sigmoid colon and rectum. In essence, his error converted a manageable case of Hirschprung's into the total colonic type that was far more difficult to manage and vastly more costly for the patient and family to endure. Final reconstruction was not feasible for years.

The parents were unaware that a mistake had been made although they were aware that this was an

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unanticipated outcome. The surgical staff at the children's hospital was deeply troubled by the child's previous care and ambivalent about what to do about it. Should they confront the referring surgeon or inform his supervisors? Should they report the case to the state licensing board? Should they tell the parents what happened? Should they encourage the parents to sue the original surgeon?

Ryan M. Antiel, MD, (Mayo Clinic) and Thane A. Blinman, MD, (Children's Hospital of Philadelphia)
Comment

What is the surgeon's responsibility when she or he encounters an instance of surgical incompetence? Incompetence is a loaded word. It drops heavily, like a verdict: incompetent actions are performed by incompetent surgeons. We are reluctant to invoke this word, shying away from its damning finality. Today, many talk about error and imagine that patient safety lies protected behind a moat of protocols and guidelines. But medicine is a complex activity. Errors, even grievous errors, are statistically inevitable. What is troubling about this case is the moral shyness. Medicine has been given the responsibility to self-regulate, and yet, when we encounter a gross surgical blunder by a peer, we are reluctant to act.

Flexner³ claimed that for an occupation to be considered a true profession, it must meet specific criteria, two of which are self-organization and self-regulation. Irvine⁴ gives 3 arguments to support the need for self-regulation. First, medical science is too complex for nonprofessionals to regulate. Second, physicians are generally thought to be personally accountable. Finally, physicians have been trusted to rectify peers who violate norms.

This last justification garners the greatest scrutiny and skepticism.

Shaw said of professions, "They are all conspiracies against the laity."⁵ Professions tend to close ranks within a membership caste or, in Flexner's words, a "brotherhood," that acts to shield its members. To counter this impression of cronyism and maintain public credibility regarding professional self-regulation, the members of the profession must visibly and reliably curb problematic physicians. Yet, as this case demonstrates, we are hesitant to do so.

At least 4 factors make physicians reluctant to take action against peers.

1. Error is a contested concept. Errors are not contested in the sense that there is disagreement about what an ideal outcome ought to be. Instead, there is often controversy about whether the physician or surgeon is blameworthy for the deviation from the ideal. Human ability is finite, and medicine is an imperfect art of strategic probability. A skilled surgeon may have a bad outcome without error, while another may make an error and still have a good result. The central question then becomes: Was the poor outcome due to a "blameworthy error or blameless misfortune?"⁶ This ambiguity leads physicians to be cautious. Bosk writes that surgeons "claim that, unless they were there, they do not know what kind of situation the surgeon faced, what kinds of factors may have compromised his ability to perform the optimal procedure... and they cannot say for certain what they would have done in the same situation."⁶ This "you-had-to-be-there" presumption of innocence stems from physician's own personal experiences with imperfect performance or results.
2. The glass house effect. The old proverb, "People who live in glass houses shouldn't throw stones," is well engrained in the surgeon's psyche. Surgeons sense that they are only 1 case away from making an error, or experiencing a "surgical misadventure." Despite the general caricature of the arrogant surgeon, in reality, surgery humbles. In the churn of meritocratic triage, complications are the great levelers. All surgeons have had a turn publicly presenting private failures in morbidity and mortality conferences. The criticism in morbidity and mortality conferences has traditionally been thought to be enough self-regulation. Disclosure outside the professional group is seen as unnecessary.
3. Fear of retaliation. Pediatric surgery is already demanding without the burden of taking action against an errant colleague. Correcting or reporting a colleague is hardly a benign activity. Psychologist Joan Sieber, who studies whistleblowing, writes, "When the other side is powerful, the whistleblower hardly stands a chance of surviving the conflict unscathed."⁷ Furthermore, she argues, "Virtually no one will be on their side when the case gets underway." Thus, the fear of isolation and retaliation is likely enough to dissuade surgeons from taking action in a situation like the case under review. In a small profession like pediatric surgery, everyone knows everyone. There is no anonymous whistleblowing.
4. Diffusion of responsibility. Another barrier to confronting a colleague in error is the psychological phenomenon of responsibility diffusion. When others are present, an individual is much less likely to take responsibility to intervene. In this case, a surgeon may assume that if an individual is repetitively making errors, others will notice and act. The former may be

true but the latter rarely is. This inaction may be the rule when the surgeon who is making the error is at a different institution. A diluted sense of professional responsibility may lead a surgeon to say, “I suppose it will work out in court.”

Recognizing the factors that contribute to our failure to take action is important. Idleness fuels public skepticism about professional self-regulation. While the remedy is by no means straightforward, the surgeon who assumed care of this child needs to have the moral courage to give feedback to his peer. We are all vulnerable to self-serving bias: the tendency to associate successes with our own abilities and to associate failures with external factors. We need others to help us see that which we cannot see on our own. While the case at hand clearly involved a technical error, it more importantly involved poor judgment. The surgeon failed to recognize his limits. What was needed in this case was the practical wisdom to know when not to apply the blade. We do not know if the surgeon recognized his poor judgment as blameworthy unless we confront him.

How do surgeons acquire sound judgment? Bosk correctly recognizes that surgical training is primarily a “moral education.”⁶ Surgery is the application of mechanical interventions to medical problems. But the mechanics—cut, tie, dissect, sew—are the mere beginnings of surgical learning. The majority of surgical education lies in knowing whether to intervene, when to intervene, and which intervention minimizes each individual patient’s risk. This surgical virtue is gained only by experiential learning. MacIntyre⁸ argues that virtue is cultivated through embodied practices within particular communities. Surgery is 1 such community. New surgeons embody the practical wisdom of the surgical

tradition by dwelling within it. The profession must resist allowing the focus on technique to overshadow the development of practical wisdom.

Any surgeon confronted by a case like that presented here has moral obligations to different players. To the patient, we owe our best effort at a rescue. To the parents, we owe a plain and honest discussion of what was done, without inflammatory remarks that would only feed anger and the tort system. To the surgeon, we owe a frank conversation of what we see that went wrong and an offer to help correct his system, or, in the case of a recidivistic surgeon, official disapprobation from the local administration or even the medical board. To the profession, we owe a moral education based on personal demonstrations of virtue.

Peter Angelos, MD, PhD (University of Chicago) Comments

The case described is tragic. A surgeon has committed an error that has resulted in an infant unnecessarily losing the entire colon. This error will lead to lifelong problems for a young child and inestimable health care costs over a lifetime. The treating surgeons at the children’s hospital where the child was transferred know that the original surgeon’s error has led to this devastating complication, but neither the parents of the child nor, presumably, even the original surgeon know of the error that has led to this complication.

The challenge of what to do when errors occur in the operating room has been a longstanding concern for surgeons. Although there is a history of surgeons not disclosing such errors, contemporary ethical standards require surgeons to disclose errors to patients or to the patients’ parents in cases involving children. The challenge in this case is that the error was not committed by the surgeons who have now discovered it. What is the ethical

responsibility for disclosing the errors committed by someone else?

In this case, it is critical for the parents to understand what happened and why it happened. Although I would never encourage the parents to sue the original surgeon since such a lawsuit cannot undo the error, the parents must be informed that their child’s complication was not a random event, but the result of a surgical error. This disclosure is central to the honesty in the relationship between the parents (and eventually the child) and the surgeons who will be assuming care moving forward. However, it is not enough for the surgeons at the children’s hospital to disclose the original surgeon’s error to the parents. The original surgeon must also be made aware of the error. One of the challenges of the lack of knowledge is that we often do not know what we do not know. For the original surgeon to realize that an error was made, the current treating surgeons must confront this surgeon with the error.

In many circumstances, just realizing that one has made an error is enough. In this case, however, I believe that it would also be necessary to inform the surgeon’s supervisors or department leadership. This case must be reviewed by the Quality Management Committee at the original hospital and a full investigation of whether the original surgeon should be allowed to continue to operate on children should be undertaken. I believe that this review of the case and the consideration of what consequences the original surgeon should suffer should be done as part of the peer review process that is the foundation for all quality assurance programs. For this reason, I would not recommend reporting the case to the state licensing board. The issue is not whether the original surgeon should lose his or her license to practice surgery, but whether children should

be protected from the possibility of being operated upon by this surgeon in the future.

A case such as this one raises many questions. How could the original surgeon have made such a horrible mistake? Did anyone else in the operating room during the original operation have any idea of the error that was being made? Were there other more qualified surgeons available to perform the original operation? All of these questions are important and would help to define the consequences for the surgeon and the institutional changes that should be made to minimize the chances of such an error harming any future patients. However, for any disclosure to occur, the parents, the original surgeon, and the surgical leadership at the original hospital all must understand the cause of the child's current condition.

G.W. Holcombe III, MD and Pediatric Surgery Fellows (Children's Mercy Hospital) Comment

This case brings to light an issue that is often seen at quaternary care hospitals. We would hope that the goal of all physicians would be *primum non nocere*, or "first, do no harm." Unfortunately, sometimes our actions lead to less than optimal results and raise a question of incompetence or unethical practice. Still, it can be problematic to respond to another physician's behavior that seems incompetent or unethical. Before we can respond further, we need to determine whether the transferring physician(s) was incompetent or unethical.

Determining competence is not always easy. In 1993, Morreim⁹ suggested 5 categories of medical decision-making that might result in an adverse patient outcome. In the first 3, she claims, there is no incompetence. Those are when (1) an adverse event occurs that is completely independent of the provider; (2) an adverse event occurs

despite the physician following the standard of care; or (3) a situation where multiple avenues of care are possible but all are recognized as acceptable to most physicians/surgeons. The final 2 categories suggested by Morreim represent situations where lapses in judgment occurred and education or correction is appropriate. The first of these categories is when a physician exercises poor, but not horrible, judgment or skill. This can happen to all physicians from time to time and is an isolated event. If there is no recognized pattern of these events, then we do not identify these physicians as being incompetent. Education may be sufficient in preventing further problems.

The second category, illustrated by this case, encompasses situations where egregious violations of the accepted standard of care have occurred. In these situations, physicians are entrusted to assess and report, as patients and families often have insufficient knowledge to know when a physician's actions have fallen short of acceptable care.¹⁰

In 2004, the American Medical Association outlined the reporting obligations of a physician witnessing an impaired, incompetent, or unethical colleague based on the duty to protect patients from harm.¹¹ In this report, the American Medical Association recommends that incompetence that poses an "immediate threat to the health and safety of patients should be reported directly to the state licensing board." Also, unethical conduct should be reported to the proper clinical authority, and if such conduct violates state licensing or criminal statutes, the physician should be reported to the proper state licensing board or law enforcement authority.

In our current case, it may be that the surgeon was doing what (in his or her mind) was best for the patient. Therefore, we should ask if there was a genuine impropriety, and if so,

to what degree? A distinction must be made between disagreements over reasonable medical alternatives and actions that fall well out of the standard of care. In this case, more information is needed. Was the patient demonstrating instability and the original surgeon felt pressured to intervene? Was he/she concerned with the health of the proximal colon? Had he/she done this procedure before or did he/she call any colleagues for input? At the least, the pediatric surgeon at the receiving institution should listen attentively and then offer assistance in caring for complicated patients in the future.

Only after such a conversation should the pediatric surgeon consider discussing the previous operation with the parents. Complete honesty with the family is required to maintain the physician-patient relationship. With this in mind, the need for disclosing what has happened previously is obvious. Our priority should be to advocate for the patient. Facts should be shared about what has been done and what will be needed to correct the problem. The response by the parents and their decisions about future legal retribution will be based on a combination of their understanding of the case, the emotional response of the pediatric surgeon assuming care, and their own existing belief system. We must remain aware of how our own belief system affects our actions in these complex cases. We control how we present the situation, which nonverbal cues we manifest, how to advise between punishment and rehabilitation, and how to preserve the rights of the child.

There are 2 approaches to be considered: retribution and reconciliation. Parents will be acutely aware of the monetary costs involved in the care to date and for future care. Consequently they may act to recover the maximal medical charges. The pediatric surgeon may feel the need to professionally

retaliate against the referring provider. This could be accomplished through licensing boards and the referring hospital's credentialing process. While the referring surgeon may have acted inappropriately, removing his credentials may remove an additional physician from the work force. Conversely, the receiving medical team can steer the conversation toward an atmosphere of reconciliation, remediation, and forgiveness. This does not imply eradicating culpability or negating the importance of compensation but rather ensuring that the referring surgeon is given the option to meet with the family. This would also provide the parents the opportunity to forgive, even though they do not forget.

In summary, physicians should have a systematic response to complex cases that have resulted in injustice for a patient due to suspected malpractice. All important information should be obtained and used to inform the patient and their family. We should remain mindful of how we present these facts. Also, we are obligated to report unethical conduct as a patient advocate. Above all, our priority is to assume responsibility for this patient and treat him or her as we would any other, with the best care possible.

John D. Lantos Comments

There are 3 levels of response to the mistake of a colleague. One involves responsibility to the patient and

family. In this case, all respondents agree that the patient and family need to be told the facts. The second level of responsibility is to the colleague who made the mistake. Here, too, all the respondents agree that it is essential to discuss the mistake with the surgeon who was responsible. The third level is the most complex. What is the responsibility of physicians to society? How should we police ourselves? That one is the toughest. Many institutions have robust quality and safety programs to investigate errors and build safer systems. But should we also reports mistakes to authorities outside of our institutions?

Physicians are reluctant to criticize other physicians. The responses to this case suggest how carefully surgeons think about their responsibilities when they suspect that a colleague has made an error. Such caution is appropriate. But it cannot be an excuse for paralysis or complacency. Medicine and surgery are both so highly specialized that often only other knowledgeable practitioners can determine whether a mistake has been made and, if so, whether the mistake reflects an unfortunate but isolated event, or a pattern of incompetence. If the latter, it should lead to professional consequences. The privilege of self-regulation requires a willingness to uphold professional standards.

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