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Symposium articles *are solicited by the guest editor for the purposes of creating a comprehensive and definitive collection of articles on a topic relevant to the study of law, medicine and ethics. Each article is peer reviewed.*

Independent articles *are essays unrelated to the symposium topic, and can cover a wide variety of subjects within the larger medical and legal ethics fields. These articles are peer reviewed.*

Columns *are written or edited by leaders in their fields and appear in each issue of JLME.*

Next Issue:

Genetics and Group Rights
A Symposium
Guest Edited by
Joan L. McGregor

Letters to the Editor

Dear Editor

In "To Tell or Not to Tell: Disclosing Medical Error" (*Journal of Law, Medicine & Ethics* 34, no. 4, Winter 2006), William Winslade and E. Bernadette McKinney describe a case in which an anesthesiologist's error in the operating room eventuates in a death. In such instances, the authors recommend that physicians should, upon discovering such an error, disclose that information to hospital administrators and then to the family. However, the authors have a differential standard when it comes to the timing of each of those disclosures. They say that the hospital administrators should be informed right away, but – with reference to the specific case under discussion – they say that the patient's family should be advised about the error only when it "becomes clear that the patient has not and is not likely to regain consciousness." They do say that this disclosure should be made as fully and as honestly as possible, but it's not clear to me from the arguments presented why the family should be kept unadvised until the full and final force of the error is clear and, in this case, irreversible. Why not make the disclosure of error as soon as the error is disclosed to hospital administrators? Or at least as soon as the apparent medical effects of the error become evident? Or at least at some point prior to the established irreversibility of the medical error? Certainly, it shouldn't be just the irreversibility of the error that mandates its disclosure.

Even if a patient falls into unconsciousness and remains unconscious because of a medical error, disclosure of that error can be useful to family members or other surrogate decision makers early on, even before determination of what the overall effects of the error might be. For example, given information about a mistake, patients or their surrogates might wish to change medical providers or hospitals, in other words take steps to limit further care from the very folks that made a mistake in the first place.

This is to say that the timing and point of disclosure are ethical issues. If I read the rest of the Winslade and McKinney article correctly, the arguments there even point in the direction of early disclosure, not disclosure only in the fullness of time. Or at least, I can't see from those arguments why one shouldn't start to engage the patient and/or family about the error as soon as the hospital gets its information about the error.

Timothy F. Murphy
Professor of Philosophy in the Biomedical Sciences
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The Authors Respond

Professor Timothy Murphy has raised an important question: When should a patient or a surrogate be notified of a medical error? In the case we discussed, only the anesthesiologist knew that he had made an error. But he remained mute. The anesthesiologist should have informed the surgeon, the hospital administration, and the patient's family as soon as possible. When the surgeon told the family that the patient had not awakened from the anesthesia, he did not know that the anesthesiologist failed to restart the ventilator. The surgeon told the family that the possible causes of the patient's continued unconsciousness were being investigated. That was all he knew at the time.

In general, when something unexpected in a patient's care is discovered, several steps should be taken. First, the attending physician should inform the hospital administration so an investigation can be initiated. Second, the patient or the patient's family should be informed of what is and is not known as soon as possible and that the causes are being investigated. Third, quality of care issues should be examined to determine if the unexpected outcome is due to medical error. If so, action should be taken to prevent similar errors in the future. However, unless it is verified that the unexpected outcome is a result of medical error, it would be premature and misleading to attribute the unexpected outcome to medical error.

Professor Murphy suggests that we imply that truthful disclosure to the patient or surrogate should be delayed until a final prognosis is determined. The sentence in our article from which he quotes may be misleading. We hope that our response makes it clear that what is known, including known error, should be disclosed as soon as possible to all of the relevant parties. However, mere suspicions or speculations should be avoided. Disclosures about medical error must be based upon verified information, not unverified possibilities.

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