July 2003 Article of the Month

This month's article selection is by Margot Hover, D.Min., ACPE/NACC Supervisor at Barnes Jewish Hospital, supervising the St. Louis Cluster's Community-based CPE program.

[Editor's Note: Margot Hover is a former Convener of the Research Network. While the article that she highlights here does not deal with spirituality per se, she has used it successfully with her CPE students, in terms of its treatment of a subject that may be pertinent for chaplains in the course of their work, as an illustration of a methodology which may be employed by chaplain researchers, and as a catalyst for interdisciplinary dialogue. See especially her Discussion section, below.]

Gallagher, T. H., Waterman, A. D., Ebers, A. G., Fraser, V. J. and Levinson, W. "**Patients' and physicians' attitudes regarding the disclosure of medical errors**." *Journal of the American Medical Association* 289, no. 8 (February 26, 2003): 1001-1007.

SUMMARY AND COMMENT: While there is little doubt that both public interest and professional concern is beginning to focus on medical errors, little is actually known about how either patients or physicians think medical errors should be discussed. This study, funded by a Patient Safety grant, looked at that issue from both sides. The initial point of the study was to determine whether physicians disclose the information that patients wish, to define each group's emotional needs when an error occurs, and to assess whether those needs are being met.

Design: Thirteen focus groups were organized, including 6 groups of adult patients, 4 groups of academic and community physicians, and 3 groups including both. A total of 52 patients and 46 physicians participated. The patient-only and physician-only groups were to obtain a baseline understanding of each groups' attitudes about error disclosure and to allow discussion of topics that they might be reluctant to discuss in front of each other. The goal of the mixed groups was to arrive through dialogue at a better understanding of the two viewpoints.

The patient-only groups began by discussing what the terms *patient safety* and *medical errors* meant to the participants. Then a hypothetical situation involving a medication error, followed by a number of outcome variations, was presented. The participants were asked whether and how they would wish the error to be disclosed to them. A similar situation, but from the physician's viewpoint, was presented to that group. The mixed group format employed a "fishbowl" discussion of the topic.

Sample: Patients were recruited by newspaper advertisements and fliers distributed in the St. Louis area; eligibility included active use of health care, defined by hospitalization in the last 2 years, chronic illness, or having a regular source of health care. Physicians were recruited by direct mailings to area primary care physicians and surgeons. The physicians were predominantly male (83 %) and white (78%), in practice for an average of 16 years. Patient participants were predominantly female (71 %) and white (88%), with a mean age of 60 years.

Analysis: Standard text analysis of audiotaped focus group transcripts was used to identify major themes.

Findings: Clearly, both sets of groups were concerned about medical mistakes. However, this study points to a number of striking differences between patient and physician attitudes about medical error disclosures. For example, despite being given a standard definition of medical errors, many patients also included poor service, such as long waits; unavoidable adverse events, such as new drug allergies; and poor communication skills, such as rudeness. Physicians defined the term only as deviations from the accepted standard of care. Both sides were worried, scared, and angry about errors; but physicians also feared lawsuits, loss of patient trust and collegial respect, as well as diminished self-confidence and loss of career. Patients were divided in their wish to know about near misses; physicians would not disclose them. Patients wanted to be told "everything" about a mistake, and wanted truthfulness and compassion from their doctors. They especially wanted to know what steps were being taken for future prevention. Physicians valued objectivity, amid their concern that an apology could create legal liability. Some patients would file lawsuits so that a systemic remedy for such mistakes would be sought; others wanted to understand what happened to them and to know that an institution learned from the event.

Some patients were surprised that their physicians were upset about harming a patient, and thought it might help if the physician shared that with them. Others, on both sides, wanted solutions and apologies more than confessions. One participant commented, "Forgiveness is something that I think is tougher for the physicians to give themselves than to get from the patient." Some patients--but no physicians--recommended looking to a patient advocate or psychologist for assistance with the emotional aftermath; physicians looked to morbidity and mortality conferences as an opportunity for a kind of confession of sins and absolution; others would speak to a trusted colleague.

The authors of the study comment that, while no consensus emerged regarding disclosure of near misses, knowing about them would help patients make better informed health care choices and bolster their trust both in the system and in their doctors. They also conclude that physicians' propensity for limiting disclosure may actually make things worse. They advocate for better education about systemic reasons for mistakes and for addressing seriously the emotional needs of physicians, patients, and other health care workers. The authors plan next to focus on medical care providers. Specifically, they plan to look at defining various kinds of medical errors, participants' experiences with actual disclosure, the impact of past errors on their lives, and their openness to counseling, as well as to training.

One of our chaplains [in my CPE group] noted the predominance of white subjects in both study groups, leading me to wonder what persons of color might say about trust in institutional care, or how women in some cultures might express their feelings about their care. What are some other contributing factors in patients' loyalty to their doctors? I'm also curious about how physicians and patients outside large metropolitan areas might respond to a similar inquiry. The present study was an exploratory one; the authors are currently wondering about the connection between disclosure of medical mistakes and the style in which that is done, with lawsuits. I've had occasion this year to talk extensively with chaplains and other staff in a number of small rural hospitals, and have noted townspeople's unstinting loyalty to some, and alienation from others. Of course, this broadens the topic before it has been narrowed quite enough--but it may suggest some variables worth considering.

DISCUSSION: I am pleased that qualitative research methodology is gaining greater currency in prestigious professional literature. Actually, qualitative research is second nature to chaplains. Spiritual assessment is a kind of text analysis, and verbatim seminars employ close, analytic readings of interactions for the purpose of contributing to the knowledge one has of one's own professional practice. Research!

I selected this research article to present for discussion for several reasons. First, one can hardly pick up the newspaper or tune in to television news these days without hearing about "medical misadventures." The topic is definitely on the public's radar. Second, chaplains often find themselves in the middle. Many of us serve on hospital ethics committees where these cases are frequently brought and discussed. At the bedside, patients and family members often discuss with chaplains their misgivings and other feelings about the care they receive,

feelings they may not share with other members of the treatment team. For a variety of reasons, physicians as a group are less likely to seek a chaplain's ear for their feelings.

Finally, the appearance of this article precipitated an interesting discussion between one of the authors of the study (Amy Waterman, PhD, psychologist at the School of Medicine of Washington University in St. Louis) and the staff chaplains in the Department of Spiritual Care at Barnes Jewish Hospital. The discussion stretched and defined the numerous issues and layers of meanings attached to both sides of the topic, and served as encouragement for us to continue to look for opportunities to extend care to physicians. It was also an opportunity to reinforce the role that chaplains have as caregivers to all segments of an institution, including staff and family members who may be touched by a medical mistake. I am once again reminded of the wealth of professionals who are expert in their various fields in every hospital, and the benefits for all to be had in discussions across discipline lines.

Suggestions for the Use of the Article for Discussion in CPE:

Some of the physicians quoted in this article used some theological terms and concepts to describe the process of dealing with a medical mistake. Can you recall any situations where a medical mistake figured in a conversation with a patient or staff member? Did you hear any wishes, expectations, and feelings that surprised you? As a chaplain, how did/would you deal with them? What are the formal mechanisms in your institution for addressing these situations? What are the informal channels?

From your position, how might you go about setting up a study of treatment errors? What questions in this area would you want answers to?

Related Items of Interest:

Anne Fadiman's bestseller, *The Spirit Catches You and You Fall Down* (New York: Farrar, Straus and Giroux, 1997), is the detailed account of the cultural collision between a Hmong child and her American doctors. Surrounded by a caring, dedicated and bright treatment team as well as by loving parents, the child is nevertheless a tragic victim of two systems, which, in that instance, were mutually exclusive. This article also describes what sounds a bit like two different cultures, but with a number of overlapping areas. How might a chaplain position herself to be of assistance to both? How does one in your role in your particular institution balance relationships with Risk Management, Patient Advocates, the Ethics Committee, physicians and patients, and Administration? If you serve a congregation, same questions. What if a parishioner came to you for help with this issue?
