Last week in JAMA Surgery, A. Rani Elwy PhD and colleagues presented survey results [1] gathered from Veterans Affairs medical center surgeons at three facilities disclosed to families after both minor events (such as blood loss) and major adverse events needing to be returned to the operating room, or death.

I was interested in their conclusion:

“Surgeons who perceived an adverse event to be extremely or very serious, also reported being negatively affected by the event. This finding makes sense: in general, surgeons strive for perfection, and an association exists between a perfectionist personality type and choosing surgery as a medical specialty. Indeed, when surgeons reported experiencing difficult conversations disclosing adverse events, they also reported being more negatively affected by the event.”

This paper contributes to the literature concerning apology for medical error and speaks to the movement of "acknowledge, apologize and amend" in malpractice litigation. Rather than deny errors, physicians and medical facilities quickly admit them, apologize and make amends to the patient. Much of the current literature in this area revolves around the reduction in malpractice costs and protection of physicians who make apologies from their use in subsequent malpractice lawsuits (apology laws).

Although the authors make some effort to examine the behavioral responses of doctors who have made errors, unfortunately, to my mind, it still treats physicians as Vulcans—wholly logical and without emotion.

Failure is a given in medicine; it is impossible to aspire to the ideal and settle for the possible without failing some of the time. While all doctors ‘strive for perfection’, the hands-on nature of surgery, makes it more evident when failures occur. Learning from our mistakes is a hallmark of
medical care in all settings. It is a regular practice to discuss our failures in a weekly or monthly morbidity and mortality conference.

Like every surgeon I know, I have stood in front of my peers to acknowledged my errors. It is emotionally intense because these failures are personal. As with almost all surgeons, my mistakes reveal my inadequacies. The paper describes in 'objective scientific terms,' sorrow. For physicians, this is the irrecoverable “loss of a stable, valued part of your world”, specifically their self-worth before their peers and patients.

A more explicit acknowledgment of our emotional involvement would better recognize physicians as more than technicians; but as humans that have failed to meet their own standards, in work that is important to them and others.

Note:

(1) Guy Claxton Intelligence in the Flesh