The Physician-Patient Relationship and the “White Wall of Silence”

As a medical student nearing the long awaited time for the start of residency, I eagerly anticipate the opportunity to take on a more significant role in patient care. Residency is truly the beginning for most medical students in a very long path of education at which point real responsibility for patient care begins. With this responsibility, legal liability inevitably accompanies the start of medical residency. Many medical students have learned directly or indirectly to fear and indeed loathe attorneys viewed as the pending menace prepared to pounce on and devour a fledgling medical career. The television and radio channels seem dominated by law firms seeking patients with real or perceived injury, promising compensation and implicitly promising a measure of revenge against someone painted to be a malicious, money hungry villain.

The fact that I have several family members who are attorneys has provided me with the opportunity to discuss the current state of affairs in the medical-legal field. Impromptus debate has perhaps been made easier by the fact that my family members work toward limiting the liability exposure of physicians as they strive to care for patients and conduct business in a field that grows ever more complex. On occasion, a point of view has been raised that is cause for contemplation and reflection. One such point was that our current medical-legal state of affairs is at least in part due to the historical conduct and practices of healthcare professionals including physicians. While it may be true that there seems to be an increasing number of “ambulance chasers” vying for medical malpractice cases, there is a perception commonly shared in the public domain that there is a conspiracy among health care professionals to cover up medical errors. This perception whether based in fact derived of delusion has come to be known as the “great white wall”, the “white wall”, or “the white wall of silence”. Wall of Silence, a book said to expose the ugly truth behind medical malpractice was written by Rosemary Gibson, a senior program officer of a foundation specializing in healthcare. The text published first in 2003 became a top seller promising to reveal stories of medical malpractice, careless misdiagnosis, and downright neglect on part of healthcare professionals and the efforts of physicians, nurses, and healthcare administrators to cover up the errors that lead to patient injury or death(1). The internet is littered by sites of varying technical quality all with similar messages that patients are being injured and that healthcare professionals are actively conspiring to cover up errors. Regardless of the degree of truth or sensation, this perception of a conspiracy to hide the truth at the expense of the patient is extraordinarily threatening to the physician-patient relationship.

A Medical Case and Ethical Issues

I was assigned the task of choosing a medical case which I was involved in during my medical school training and providing an ethical analysis. Preparing to enter residency and face the medical-legal environment including the perception of the white wall of silence, one case came promptly to mind. During my internal medicine rotation during my third year of medical school, I came across a case which raised several ethical as well as legal and professional questions. The case involved a patient who was a transfer to Memorial Health in Savannah from a small rural ER in Hinesville, Georgia. A 36 year-old Hispanic male had presented to the rural emergency department with complaint of a sudden onset of headache and left lower extremity weakness. A CT scan revealed evidence of an acute stroke. The rural emergency department attempted to stabilize the patient as the decision was made to transfer him to Memorial Health for a higher level of care, including consideration of specific medications such as tissue plasminogen activator (tPA). Upon reevaluation of the patient in the emergency department of
Memorial Health, it became clear that the patient’s weakness had progressed from mild left lower extremity weakness with a question of left upper extremity dysesthesias to frank paralysis of both left upper and lower extremity. The rural emergency department promptly forwarded patient records of treatment provided prior to transfer. These records demonstrated that the patient had presented with a blood pressure of 210/105. Records clearly noted medications and times administered. The physician at the rural emergency department clearly sought to reduce the patient’s hypertension. The patient was subsequently treated with five different blood pressure medications over the course of approximately one hour and thirty minutes. The result was a reduction in blood pressure to 118/70. My introduction to the patient was made shortly before he was taken to the neuro-intensive care unit. An internal medicine intern pointed out the record reflecting the forced reduction in blood pressure and was the first to suggest to me that this action could have had a harmful effect. The patient spent the night in the neuro-ICU and the following day was transferred to a less intensive neuro hospital floor. The attending doctor, as leader of the internal medicine team taking over care for the patient on the hospital floor, chose to make a teaching point out of the treatment provided for the patient prior to his transfer to Memorial Health. The attending doctor pointed out to the team that in the case of an ischemic stroke like this patient seemed to have suffered, hypertension was the body’s defense mechanism as an effort to maintain cerebral perfusion and limit the extent of tissue damage or death. Reducing the patient’s blood pressure to “text-book” normal levels was in fact an error in the face of a developing ischemic stroke. Lower blood pressure likely contributed to an exacerbation of ischemic tissue destruction in the brain and resultant clinical worsening. It seemed likely that the error had lead to a worse outcome for the patient. Over the next several days, the patient who spoke little English, used a translator to ask details about his condition. While the patient was not well educated, he seemed to be very inquisitive and almost suspicious. While this suspicious may have arisen out of concern for his status as an undocumented immigrant and migrant farm worker, it also seemed to come from a lack of trust in his caregivers. This suspicious nature was not missed by the physician team. Over the course of 4-5 days, the patient seemed to ask similar questions as to why this had happened to him, what could have avoided it, and what he could expect in recovery. While the patient never asked specific questions in regards to his treatment over the course of his stroke, when he began asking questions there seemed to be a tension among the physician team. The answers to his frequent and persistent questions were typically brief while there was effort to be supportive and encouraging. But, when his questions seemed to steer closer to issues of treatment, there was clearly a failure to fully disclose any possibility that the treatment in the rural emergency department may have in any way contributed despite the fact that this treatment was held out as a teaching point due to its error. Over the course of his hospital stay, the answers to his frequent and persistent questions became brief and more conservative. It seemed as if obvious efforts were made to avoid any suggestion that his eventual extent of injury was in any way due to the initial management at the rural emergency department. But, I questioned my own perception of the interactions between the team and the patient and I hoped that any lack of disclosure was not intentional. However, by the third day of the patient's hospitalization, I had reason to reflect on the issue of the *white wall of silence*. On review of the patient’s chart, I noted that portions of the medical record that had been forwarded from the rural emergency department, specifically a page noting the use of blood pressure medications, times given, and subsequent lowering of blood pressures had been removed from the chart. If the failure of complete disclosure had been concerning, the apparent intentional deletion of medical records was alarming. This case clearly raised multiple ethical, legal, and professional issues. As a student, I was definitely not in any position to raise such questions. But, once assigned the task of an ethical analysis of a case, this case came to mind as it had remained as a disturbing experience.
The AMA’s Principles of Medical Ethics

The American Medical Associate’s web site provides Principles of Medical Ethics:

Preamble
The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Principles of medical ethics
I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

(Adopted by the AMA's House of Delegates June 17, 2001.)

Review of AMA’s principles raises ethical questions specifically in respect to principle number II and VIII. An argument could be made that nondisclosure of facts surrounding the patient’s treatment at the rural emergency department represented a failure in principle number two in that dealings were not truly honest. Certainly removal of medical record posed both clear ethical honesty questions as well as legal malpractice concerns. If the perception of the white wall of silence at work is in fact reality, the eighth principle is in question as the responsibility to the patient was definitely not of paramount interest. Instead, the fact that medical record that would tend to incriminate the treating physician at the rural emergency department was removed would add weight to claims of a professional conspiracy to cover up medical error as part of the white wall of silence. In regards to principle II and report of physicians deficient in competence, my position as a mere medical student in this case prevents me
from knowing if any communication was ever attempted with the physician who provided care at the rural emergency room. Principle V would suggest that an effort should be made to make the physician in question aware of the error and that he or she as a physician following the AMA’s principles should maintain commitment to medical education, including learning by practical experience. We have entered an age of risk management and peer review in which processes and procedures exist on a formal basis for correcting conditions or practices which may lead to worse clinical outcomes. The goal of medical peer review is to improve quality and patient safety by learning from past performance and errors. Unfortunately, surveys continue to demonstrate that a significant number of physicians would be reluctant to refer a colleague for peer review. The reason for this reluctance is clearly at least in part due to financial implications and legal liability. Meanwhile, the public belief in the white wall of silence continues.

A moral rule relevant to this case but absent in the AMA’s principles of medical ethics and traditionally not included in codes of medical ethics is veracity. Veracity refers to comprehensive, accurate, and objective transmission of information. Furthermore, veracity involves the way that healthcare professionals foster the patient’s understanding (2). Neither the AMA’s Principles of Medical Ethics nor the Hippocratic Oath recommend veracity. In fact, the Hippocratic Oath traditionally encouraged physician’s to promote patients’ interests by providing care based on their own judgment regarding appropriate care including what information to share with the patient and what information to divulge. But, strong arguments have been made in favor of veracity. Sir Geoffrey James Warnock (1923-1995), philosopher and Vice-Chancellor of Oxford University stated in his book The Object of Morality, 1971, that veracity should be an independent principle and as a virtue is as important as beneficence, nonmaleficence, and justice.

There are major arguments as to the importance of veracity. Failure to recognize veracity compromises the very basis of the physician-patient relationship. First, it infringes on a patient’s autonomy as autonomy requires freedom of choice that is not limited by inadequate understanding or interference due to lack of disclosure. In the context of this analysis, the lack of veracity tragically undermines an already weakened physician-patient relationship. This relationship is vitally dependent on trust. In accepting the responsibility to care for a patient, a physician promises to deal honestly. The physician accepts an obligation and the patient has a right to the information that has shaped his or her condition. Intentionally withholding information presents an ethical violation and the removal of medical record represents paternalism at the least and malpractice at the worst.

Arguments for Limited Disclosure

Aside from the argument that reasonably could be made that there is no way to know if the treatment error at the rural emergency department contributed to a worse outcome in this patient or that the removal of the medical record was malicious or performed with ill intent, there are arguments for limited disclosure. Limited disclosure has deep roots in western medical ethics. The AMA Code of Medical Ethics, 1847, indicated that in fact physicians had a “sacred duty…to avoid all things which have a tendency to discourage the patient and depress his spirits.”(3) This paternalistic view of disclosure has since given way greater patient autonomy. While a greater openness in the physician-patient relationship is now a patient expectation, there remains debate over the manner of disclosure. The virtues of compassion and sensitivity and concepts like “truth dumping” and “terminal candor” leads to arguments for variation in the manner in which disclosure is performed (4). Arguments are made for “staged-disclosure” and cautious choice of language in order to achieve full disclosure and maintaining autonomy without compromising beneficence or nonmaleficence. But, does painting an optimistic picture or rose-colored view of disease with such approaches meet the standard of objective
provision of information required of veracity? These approaches have been called “benevolent deception” or “therapeutic privilege” and as previously noted have a long paternalistic tradition (5).

Conclusion

The medical profession faces many challenges. I will soon be entering a profession which will undoubtedly require the ability to be adaptable. As the profession attempts to face the challenges ahead, it will best be able to do so successfully only with a public that has faith that we “regard responsibility to the patient as paramount”. But, the physician-patient relationship is in need of rehabilitation. Whether due to the unintended, far reaching impact of traditional paternalistic ethical practices, the malicious intent of a few over-shadowing the better intentions of many, or the creation of money hungry attorneys, the public is distrusting and suspicious of the very physicians who count on their trust to perform our duties. While we may quietly wish for an incoming federal administration with a goal of tort reform, if all the malpractice attorneys were gone tomorrow, this alone would not repair the damaged physician-patient relationship. This case both in the questionable disclosure of information and the removal of medical record reflects a concerning compromise in medical ethics and medical law with the suspected intent to cover medical error and protect a fellow physician. A step back and a view of the bigger picture suggest that if the intent is to protect someone it should be the patient. Secondly physicians as a whole would be better served by ending practices which inflict greater harm on the physician-patient relationship. Physicians must be honest and completely open in a consistent fashion and we must be beyond reproach with a public that already suspects our intentions. Rehabilitation of the physician-patient relationship requires that we strictly adhere to the AMA’s Principles of Medical Ethics and strive to meet the ethical and moral expectations of our position as physicians. Veracity is essential if as physicians and healthcare professionals are to dispel this perception of the white wall of silence.

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References


5. James Childress. Who Should Decide?: Paternalism in Health Care (NY: Oxford University


