

CONTRACT OR COVENANT?

In recent years, increased vigilance for and identification of medical errors has sparked discussion concerning the responsibility of health care providers to disclose and discuss such errors with patients. This is especially important for physicians, the primary providers of care. Little debate concerns the ethical and moral responsibilities of health care organizations and physicians to make patients aware when an error has occurred that may have affected their care. This is especially true of, but should not be limited to, errors that result in serious harm or even death. It is well known, however, that when and how disclosure occurs varies greatly according to the particular patient-provider situation. Actions may be based more on personal feelings, beliefs, and fears than on standards of practice.

The state of patient-physician relationships becomes a prime determinant of the events that occur after a medical error has occurred. In this article, we will explore these relationships and look into the foundations on which relationships—and thus behaviors—are formed. We will also relate the issues of medical errors to the theological principles that underlie our Catholic health ministry.

The Gospel Context of Catholic Health Care Should Ease the Disclosure of Medical Errors

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THE ROLE OF PHYSICIANS

The medical profession has historically attracted talented young people who, by their nature, are individualistic and value their autonomy. Unlike management and business education, which emphasizes organizational behavior and systems thinking, medical education has traditionally nurtured independent behavior and single-minded decision making, attributes that in many ways define the profession. Independent behavior is of obvious importance when specific patient care situations require it.

Unfettered physician autonomy can be a problem, however, when consistency and systematic behaviors are needed—when a medical error has occurred, for example. Physicians, because of their nature and training, may be uncomfortable with full disclosure of medical errors and as a result may act in a way that could be perceived as inappropriate or possibly unethical.

Working to make decisions that are both in the best interest of patients and acceptable to physicians is a significant challenge. Hospital and health system leaders must create environments that allow physicians to express their concerns and to understand the alternatives, along with expected outcomes, that ultimately lead to decisions that are clinically appropriate, ethically sound, and maintain professional integrity. Understanding the underlying elements of physician decision making is key to creating such an environment.

PHYSICIAN-PATIENT RELATIONSHIPS

The physician's response to medical errors, and what he or she ultimately decides to disclose to a patient, is primarily determined by the type of relationship existing between the physician and patient. Is the relationship a contract or a covenant? A contract says, "I agree to provide my

skills and knowledge; you provide adherence to my suggestions and advice." A covenant joins two parties in a common commitment and common fidelity. How does either relationship affect the physician's obligation and willingness to disclose medical errors?

A *contract* is a transaction based on finite boundaries and responsibilities. A contract is an agreement for goods or services. It has legal implications and can generally be written in legal terms. Success and failure can be identified and measured. For example, a request by a prospective patient to a doctor for a surgical procedure or treatment, followed by signed informed consent, is a contract for services. Contracts as the context for medical care have distinct and unique value to those involved: clarity of roles and responsibilities, provision for resource planning, and clear expectations of performance. When outcomes fall outside contractual parameters, failed expectations are apparent and cause is clear. Disclosure is a nonevent; the errors are there for all to see. Surgery on the wrong limb is an example of this type of medical error.

However, health care is rarely this straightforward. Apart from purely technical services, as in the surgery example, the delivery of health care services usually involves shared responsibility and a measure of unpredictability. In most of medicine, only a covenant will do.

A *covenant* is an agreement between individuals based on deeper meaning. A covenant is a promise, a gift that says, "I will do what I can, based on what you need at the time that you need it." A covenant is timeless and does not lend itself to writing. A covenant can be described—but only in general terms, not precisely. It is based on relationships and is steeped in empathy, understanding, and sensitivity. Success is communal and often goes unspoken. A covenant between patient and physician establishes a reciprocal relationship between an empathic professional and a committed person. And, yes, sometimes a covenant is marked by forgiveness.

DISCONNECTION

When a medical error occurs within a covenantal relationship between patient and physician, only timely and complete disclosure will suffice. Why, then, is this not always the case? More often than not, medical errors are not disclosed to patients. Many physicians prefer to mitigate the risks of disclosure by withholding or giving incomplete information to patients. Is this a willful, unethical act? Or might there be an explanation as to why this could occur?

One explanation suggests that physicians and patients may believe they are working in a con-

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tractual way when, in fact, this kind of clarity does not exist. That is to say, patients believe they know what they are getting, and while they may be able to recognize whether a final outcome has occurred (e.g., the correct surgical procedure was completed), they have incomplete information concerning the many steps that lead to that outcome. This leaves errors along the way "up for interpretation" and allows the well-intentioned physician to make an independent judgment as to whether an unwanted event is an error or just a "deviation from the expected."

For example, should a physician disclose the fact that an error occurred while a patient was under general anesthesia even though the error resulted in no serious harm? Should a patient be told when the treating physician forgets to prescribe a medication that might have been helpful or even essential? For physicians, these decisions are most often made in isolation, and one can easily see how nondisclosure in this context of contract might be rationalized as neither a violation of contract nor an unethical act. But in the context of a covenant, nondisclosure would be viewed as violation of the reciprocal relationship. Disclosure of medical errors and unwanted events between patients and physicians in a covenantal relationship is an expectation, guided and understood by the participants under the influence of trust and empathy, with an allowance for forgiveness. The problem, it would seem, is the understanding of what it means to offer and work in the context of a covenant. Fortunately for us, a model exists: the healing work of Jesus taught to us in the Gospels.

THE GIFT

When and why would physicians choose to relate to patients in a covenantal way? There are likely myriad reasons, but one noteworthy explanation is what we like to call "the Gift." We all know doctors and health care providers who have "the Gift." These are physicians and others who recognize that their work is an invitation to *participate in healing*, not to cause it themselves. Such people know that true healing is the work of a "higher being" and that they are privileged to be called to serve. They have the ability and desire to work as equals with patients, shunning the hierarchical traditions so prevalent in the profession. Some may not see a religious context in "the Gift"; they are the fortunate few who have it and use it innately. For many, however, "the Gift" is a gift from God, known and practiced by the teaching and example of God's son as healer. It is, as one writer has said, "the sense that one is inexhaustively the object of gift."¹

Recognition of the invitation to healing profoundly alters the physician's concept of self and

of his or her own skills. The doctor is transformed from technician to facilitator and healer, to knowing himself or herself as a person called to and supported in a work that is for the service of others. The goal of the physician-patient relationship, then, is not technical expertise, not "fixing the ailment"; it is, rather, service to another and participation in God's activity of healing. Recognition leads to transformation, and central to this transformation is the movement from hubris to humility, from total confidence in one's own knowledge and skill to cooperation with and participation in God's gift of healing. Such a shift makes room for imperfection and frailty. Such a shift makes room for medical errors, which can be seen within the context of the limits of humanity. They can be recognized, owned, corrected when possible, and forgiven when appropriate.

A physician has conveyed a story that shows this well.

I recall vividly an occasion when Loraine, the daughter of one of my longtime patients, decided that I was worthy of being her primary doctor as well. What she was saying was, "I trust you." After doing a routine history and physical and declaring her healthy, I sent her off for a screening mammogram; her first despite being well into her 50s. It was almost 18 months later that she came back to see me complaining of a lump in her breast. I examined her and was alarmed to detect the obvious cancer. Upon looking back over her chart, I was shocked to find the abnormal mammogram report sitting right there, with no action having been taken on my part. My heart sunk. The consequences of my error were clear and unavoidable. What do I do now? What are my alternatives? How would she respond? With no hesitation, I told her what had happened and of the missed report. I informed her that we had likely missed an early cancer some 18 months ago and that I was sorry. I expected outrage and anger. What I got was empathy and understanding. In short, Loraine forgave me.

As I look back on these events, it is apparent that the covenant between us allowed for my full disclosure of the error and her forgiveness. Did it make the mistake acceptable? No, it did not. However, it did allow for humanness; it allowed me to make sure this would not happen again, and then permitted us to move on. Most importantly for me, I was able to continue my practice. How do physicians, nurses, or other colleagues survive without forgive-

ness? Without a promise of hope? I am not sure, but I know many do not. I just know that I was blessed.

VULNERABILITY

One aspect of humility and humanness that no one is comfortable with is vulnerability. To us Americans, citizens of a nation of individuals, to be vulnerable is to be weak and dependent on others. In the medical profession, vulnerability is believed to reveal weakness and inferiority on the part of the professional; it is a distortion of a relationship in which the physician is the expert and the patient is the one who is in need.

It is undeniably true that the patient is in need of care and is in a very vulnerable state. At the same time, the patient brings more than need to the relationship. He or she also often brings strength beyond understanding, faith beyond compare, that rare wisdom that emerges from suffering, and a hope that endures in the face of death. Vulnerability that consists of openness to another and to another's contribution to the work, a mutuality that recognizes we need each other to effect the healing and that leaves room for God's grace—this vulnerability may be the key to a truly healing relationship for both patient and physician.

A RELATIONSHIP LIKE NONE OTHER

What does such a relationship look like? And how might these relationships affect our understanding in dealing with the problem of medical errors? One model exists in the Gospels and their presentation of both the healer and the healed. We frequently say that Catholic health care seeks to "heal as Jesus healed." If this is so, what can Jesus teach us about the healer-healed relationship and our responsibilities in modern challenges such as the problem of medical errors?

Each of the four Gospels devotes significant time to the healing activity of Jesus. It was central to his mission and his identity. As Son of God, come to proclaim God's reign, all that he did and said pointed to and made accessible the saving, redeeming, whole-making power and love of God. Healing the suffering, making whole those in need, restoring people to life and to each other—these were concrete and wondrous manifestations of God's reign. When Jesus healed, the people praised God as the healer. They knew that "something more" was going on. Jesus himself was not the healer; he participated in the healing given by the grace of God.

Jesus healed unlike any other healer. No one in need ever feared to approach him; all found welcome in his presence. All were healed. Jesus entered into conversation with those in need, asking them, "What can I do for you?" He listened

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and acted appropriately. He saw needs even before people asked. Jesus saw the real need and blessed the suffering with the good news that their sins had been forgiven.

At the same time, Jesus was not impervious to the power of others. He was provoked, tested, angered, and troubled by those he encountered—in many ways, not unlike the manner in which health care workers are sometimes tested today. Jesus was saddened by others' sorrow, troubled and moved by others' pain. He was himself, finally, vulnerable to the attacks of those who would see him dead. It is in his total vulnerability on the cross that life is able to triumph. It is in his vulnerability that redemption happens.

Vulnerability makes way for healing. It is in the mutual openness, the shared humanity, the willing vulnerability between patient and physician, that true, whole healing can take place, for it is here that room for grace's power exists. Like the physician in our story, openness to sharing in the common humanity between people, each with specific gifts and needs, means "something more" can happen.

Medical errors are common, and much is being done to rectify and solve these all-too-human problems. Our relationships with others and with ourselves are tested during these times of transition. Understanding our shortcomings and accepting our vulnerability as humans is an essential first step in dealing with errors—errors that will continue into the indefinite future, until the unlikely time when "perfection" is found and implemented. Until then, a covenant among persons is needed, a covenant of understanding and caring, modeled for us by the divine Healer and told to us so that each can glimpse the reign of God. □

NOTE

1. William F. May, "Code and Covenant or Philanthropy and Contract?" in Stephen Lammers and Allen Verhey, eds., *On Moral Medicine: Theological Perspectives in Medical Ethics*, Eerdmans Publishing Co., Grand Rapids, MI, 1987, pp.121-136.

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