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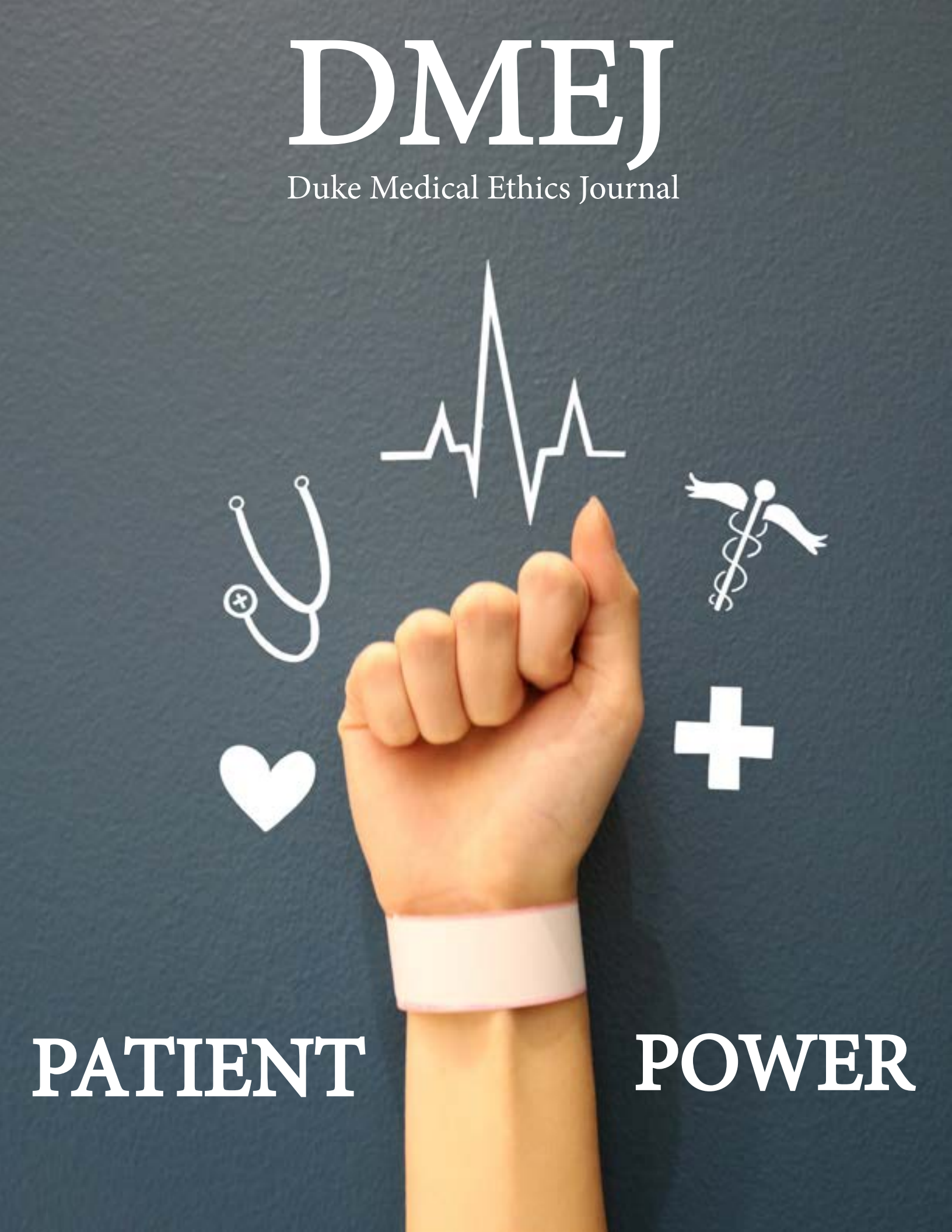

PATIENT POWER

DMEJ Staff 2019-2020

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"I Didn't Sleep Last Night"

Implications of Physician Disclosure of Health in Informed Consent

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In 2010, a group of sleep specialists published a paper in the New England Journal of Medicine, proposing a thought experiment in which a surgeon stays awake for an entire night after receiving a call for surgery at 11:00 p.m. and not being able to sleep before having to perform an elective surgery at 9:00 a.m. (Nurok et al, 2010). After presenting arguments about the effects of sleep deprivation, the authors argue that the physician must disclose their sleep deprivation as a potential risk to surgery to the patient, and a new informed consent must be acquired.

Two years later, Dr. Charles Czeisler, an author from the original paper, wrote a second paper published in the Annals of Thoracic Surgery, debating the pros and cons of obtaining a new informed consent (Czeisler et al, 2013). Whereas Czeisler wrote in affirmation, Dr. Carlos Pelligrini negated the idea that a new informed consent was needed. Pelligrini aired on the side of caution, pointing out that the lack of consistent research showcasing that sleep deprivation in surgeons affects surgery outcome, requesting a new informed consent before a surgery, in which the patient is most vulnerable, is inhumane, and the issue of the sleep deprived surgeon could be avoided through institutional intervention. Pelligrini argued that disclosure is important, but questions how far this disclosure should go. He posited that if physicians had to disclose whether or not they slept due to being on call, should they also be compelled to disclose whether or not they were able to sleep well? Taking it one step farther, what about other personal information such as financial or marital problems that might also affect their concentration? Although Pelligrini's hypotheticals are made in jest, his questions touch upon a key issue: how far should physician disclosure go?

Establishing a precedent of mandating physicians disclose health-related variables has the potential to implicate how a physician is treated, especially in the context of physicians who experience illness and disability. Disclosing such information reinforces the stereotype of the "super able" doctor and disproportionately affects disabled doctors. Initially, requiring physicians to disclose health in the informed consent process bolsters a culture in medicine of the "super able" doctor. Doctors are often held to a higher standard of physical and mental health despite operating in environments that often fail to facilitate either. Viewing doctors as the cornerstone of health puts them at risk when they fail to live up to these expectations. Moreover, accessing a physician's proficiency on the appearance of physical and health metrics alone has proven to be inexact. For example, patients often base expected physician success and skill on length of experience and reputation instead of a more accurate metric, which is a physician's engagement in "deliberate practice" (Ericsson, 2008). Adding in a metric

such as "sleep hours" has similarly been shown to be a weak way to determine physician ability (Banfi et al, 2019). Allowing patients to decide their doctors based on perceived ability and stereotypes without compelling evidence of the implication on outcome, effectively punishes doctors for not being able to meet unrealistic standards on how to apportion their time to practicing.

A much stronger approach to mitigating possible damage from lack of sleep health is by focusing on improving the work environment for surgeons and physicians overall by implementing rules and changes at the administrative level. Instead of relying on the physician or surgeon to make an ethical decision on how to balance practice and sleep while also adhering to rigorous expectations, creating administrative stops and policies that prevent surgeons from engaging in rigorous on call hours and immediately performing elective surgeries the next morning help reduce unproductive competition and peer measuring within surgical units and hospitals (Czeisler et al, 2013).

Additionally it must be recognized that decisions based on the design of operating theaters and protocol can greatly affect the performance of surgeons, which can mitigate specific symptoms of exhaustion that are of concern for patients. For example, surgical checklists and the integration of multiple layers of accountability can greatly assist with human error (McCarroll et al 2014). Requiring information related to physician health be utilized within the informed consent process without clear evidence of impact on outcome does little to solve a greater problem. Instead of expecting the patient to assess the ability of the physician in a moment of vulnerability, better effort could be allocated to placing responsibility on hospital administration as well as careful attention to the design and engineering of the surgical environment to reduce any negative outcomes tied to lack of adequate sleep or other factors that undermine the well-being of physicians.

The disclosure of health related physician variables could also disproportionately affect doctors with disability and chronic illness. Despite the strides that have taken place to diversify medicine in the last few decades, disabled individuals in biomedical fields continues to be underrepresented. It has been argued that the presence of disabled doctors could improve the quality of care provided for disabled patients, and disabled academics and doctors have called for institutions to go beyond mission statements and follow a multifaceted approach in insuring access (Iezzoni, 2016; Bonnielin and Meeks, 2019). Mandating that informed consent should now include the health and disability of the physician could effectively undermine the agency of disabled doctors. Patients would have the decision making power to turn away a physician based once again on the perception of ability. Harmful stereotypes, stigma, and widespread ableism skew awareness of what people with disabilities or chronic illness can accomplish. Ultimately, a patient has the power to reduce a physician to their medical status even if said physician is healthy, well-adjusted, and capable. This reduction reflects the antiquated notion that a disability will always compromise the physician's efficacy, even if the condition has no impact on the physicians work.

Failure of a physician to disclose their medical condition in informed consent has already been challenged in courts before. In the 2001 case of May v. Cusick, a surgeon was accused of not disclosing his medical history of strokes despite having two in the past and making a full recovery. Later that year in the case of Halkyard v. Mathew, a surgeon performed a hysterectomy which later resulted in complications that led to the patient's death. It was argued in court that if the doctor had disclosed his history of epilepsy, the patient, a nurse at the time, would have chosen a different physician. In both instances, the courts ruled that because the medical condition did not influence the procedure or the outcome, then it wasn't necessary for the physician to disclose (Bal and Choma, 2012).

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Some legal scholars have disagreed. In the case of Halkyard v Mathew, the courts have been criticized for linking the lack of disclosure to health risk and injury in order to appeal to liability in negligence. Instead, the true injury sustained by the patient is they were denied full information and thus the right to decide if they want a different doctor (Ginsberg 2010, 45). However, this still operates under the impetus that one's disability will affect outcome. If the argument stands that it isn't related to disability but the patient's right to decide, then why should disability be a decisive factor in disclosure? Without a clear association between disability and outcome, the disclosure of one's health status as a doctor walks a fine line between obtaining true informed consent and facilitating discrimination.

One of the driving reasons behind informed consent is providing relevant information to patients that they may construct sound decisions about their health care choices and options. It is imperative then to only include information within the process of informed consent that is based on proven standards. Without clear evidence of patient outcome, mandating the disclosure of any physician variables related to health has serious implications beyond elective surgery. Securing proper informed consent is vital to maintaining trust in the medical profession, but asking doctors to disclose unnecessary medical information is a short term solution to a widespread problem. Institutions should prioritize the health of their physicians as much as physicians prioritize the health of their patients. Mandating this type of disclosure could set back progress made by disabled doctors in the medical field and could further facilitate a culture where doctor's body is meant to be an able one.

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