The Case of Omer: Who Should Talk to the Family and What Should They Say?

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Omer was a ninety-four-year-old widower who had lived independently in his own home for seven years after the death of his wife. He had worked all his life building conveyors for the automotive industry. His attitude toward life was mechanical. If it was broken, fix it. If it can't be fixed, scrap it. He had his hypercalcemia fixed with extensive surgery to chase down the parathyroid gland hiding in his chest. His prostate cancer was aggressively treated and controlled. He had his ruptured abdominal aorta fixed. He had his arthritic left hip replaced. He had cataracts removed - all after the age of ninety.

One year ago, he began having rectal bleeding. Colonoscopy revealed no pathology. In the past few months, he required blood transfusions at three-week intervals to keep his hemoglobin above eight. He entered a long-term care facility for respite care and experienced a very severe hemorrhage. He was hospitalized and the decision was made to repeat the colonoscopy because of the need to control the bleeding. During the procedure the colon was perforated. Surgery followed and the colon was found to be bleeding diffusely and required removal with permanent colostomy.

Omer did fairly well for two post-operative days. Then renal failure developed, and a nephrologist was consulted. A family conference was arranged by his nephew, who is a physician, but not attending Omer. At that time the family decided to ask the attending physician to withdraw life-sustaining treatment. Conversation about the bowel perforation was intense. The gastroenterologist had not talked to the son and daughter, but the daughter's husband had called and talked to him.

What is going on here? And what is the fitting response?

Questions:

1. Who should talk to the family about the perforation of the bowel?
2. When should that conversation take place?
3. What ought to be disclosed?
4. Should an apology be made?
5. Should compensation be offered?
6. Should the ethics committee review this case?
7. Is this a sentinel event that requires root cause analysis and reporting to JCAHO?
8. How ought we to distinguish among complications, mistakes, and negligence?