General practice ethics: Disclosing errors

Annette Braunack-Mayer, Yishai Mintzker

This is the last in a six-part series on general practice ethics. Cases from practice are used to trigger reflection on common ethical issues where the best course of action may not be immediately apparent. The case presented in the article is an illustrative compilation and not based on specific individuals.

Case

Dr Warburton works in a large and busy metropolitan general practice. One evening, after he turns his computer off, the receptionist hands him a written request for an urgent medication renewal for one of his patients, Mr Thomson, who is 60 years of age with hypertension and diabetes. Dr Warburton is in a hurry to leave, so he quickly writes a prescription by hand, leaving it with the receptionist for Mr Thomson's wife to collect the next morning.

Two months later, while Dr Warburton is on holiday, Mr Thomson is seen by his colleague, Dr Schmidt. As usual, Mr Thomson brings his tablets with him. Dr Schmidt notices that his current blood-pressure-lowering medication is twice the dosage previously recorded in his notes. This is considerably more than she would usually prescribe for a patient with Mr Thomson's condition. Mr Thomson is not aware that there has been any change in the dosage. He denies experiencing any possible side effects, including dizziness or weakness. Dr Schmidt writes Mr Thomson a new prescription with the right dosage and advises him to use this new dosage.

When Dr Warburton returns from holidays, Dr Schmidt tells him about her consultation with Mr Thomson. Dr Warburton realises that he had mistakenly prescribed the wrong dose. He is unsure how the error occurred but thanks Dr Schmidt for her intervention.

Should Dr Warburton tell Mr Thomson about the mistake? And if so, what should Dr Warburton tell him?

This case concerns the disclosure of errors in the general practice setting. There are convincing reasons for disclosing errors to patients, including the virtues of being good physicians, preventing patient harm and improving healthcare. However, fears of litigation, loss of reputation and harm to the physician–patient relationship can make this ethical obligation very difficult for physicians to discharge. When a patient has been harmed by a medical error, early disclosure can have legal and financial advantages.[1] However, in our case, Mr Thomson has not been harmed and will probably never know about the error, unless Dr Warburton or someone at the practice tells him.

As with other papers in this series, we will look first at the patient's perspective, then at the duties of the physician, and, finally, at possible actions and their consequences.

The patient's perspective

Regardless of how Dr Schmidt explained the change in medication to Mr Thomson, he is likely to have realised that something was not quite right about his current blood pressure medication, prompting Dr Schmidt to write a new prescription. Although he may be unaware of any error, he may also have questions or concerns about his treatment.

We cannot foretell Mr Thomson's reaction to disclosure of the error. Patients' expectations vary in regard to disclosure of errors that do not harm them.[2] Some patients expect complete honesty from their physician, understanding that this can help to prevent similar errors in the future. Other patients may want harmful mistakes to be disclosed, but are less concerned about small mistakes if no harm arises. Patients may have differing views about the extent to which they are responsible for their healthcare, including an obligation to check their prescriptions. Nevertheless, most patients, and society in general, place the greater part of this responsibility on the physician.

Actions taken by patients after disclosure of errors can also be diverse.[3] Some patients appreciate their doctor's honesty, and regard it as a mark of the trust that holds between them and their doctor. Other patients may think that an error is an indication of failure and lack of competence on the part of their doctor, and may be inclined to trust their doctor less as a result. Relationships between this latter group of patients and their doctor may not necessarily recover, and disclosure in this situation might lead to transfer to another doctor, litigation or criticism of the doctor to other patients. How patients react depends on many factors, including their personal tolerance of mistakes, the quality of their prior relationship with the doctor and attitudes towards the medical profession

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in society generally. It may be difficult to know in advance how an individual patient will react, but general practitioners (GPs) with good relationships with their patients are well placed to predict the types of reactions they will encounter.

The GP's duties and responsibilities

The most important duty of the GP is to prevent harm to the patient. Thus, even if there is only a slight chance that the medication has caused or will cause harm, the doctor must minimise or prevent this harm. In our case of a blood-pressure-lowering drug, with the dosage corrected, we would not expect any harm to have occurred. However, Dr Warburton must take measures to prevent the error occurring again. Disclosing the error to Mr Thomson may reduce the chance of recurrence (eg through self-check of his prescriptions).

Respect for patient autonomy requires that patients be informed about events that concern them so they can make their own decisions about how to respond. In this case, for example, disclosure will allow Mr Thomson to change his GP if he thinks the error is unacceptable.

Doctors have a duty to maintain their knowledge and skills, and improve if possible.[4] This improvement must include the safety of the care they provide. Reporting and reviewing the incident through the practice's management may lead to changes to Dr Warburton's personal practice, and the policies and procedures of the clinic. However, these changes do not necessarily require Mr Thomson to know about the error.

Trust between doctor and patient is extremely important, both as a value in itself and to provide good care.[5] Society and patients must rely on the information they receive from physicians. To achieve and maintain this trust, people need to know that doctors are honest. Trust in the physician's honesty is therefore highly important, and links to trust in the physician's clinical competence. Dr Warburton's error may never come to light, but if Mr Thomson somehow finds that an error was not disclosed, trust in the doctor's honesty may be lost and trust in physicians more generally may be undermined.

Finally, doctors have an obligation to the profession to act in ways that maintain or enhance the quality of care in the healthcare system. Early and regular disclosure of errors by health professionals contributes to a culture of openness and transparency, which is helpful for all doctors and patients.

Possible actions and their consequences

Dr Warburton may decide not to disclose the error in the interests of protecting his reputation and maintaining his relationship with Mr Thomson. However, this action does not respect Mr Thomson's autonomy. In addition, if Mr Thomson does find out about the mistake, both trust and Dr Warburton's reputation will be undermined. Not disclosing the error also places Dr Schmidt in a difficult position, knowing that her colleague has not explained the error.

We think Dr Warburton should disclose his mistake to Mr Thomson. He should consult his insurer, who will agree that early and full disclosure is appropriate, and that an apology is the best course of action. Dr Warburton should arrange to see Mr Thomson, allowing enough time to describe the situation, apologise and address any concerns he may have. He should respond empathically to Mr Thomson's views, accepting any anger he may express and supporting any decision he may make about changing doctors. It would also be appropriate for Dr Warburton to review the practice's prescribing policy with colleagues to prevent similar cases from occurring in the future. Mr Thomson may find it reassuring to know that Dr Warburton and the practice have learned from this incident. Such a response might be difficult for Dr Warburton and Mr Thomson, but will demonstrate to Mr Thomson and Dr Warburton's colleagues the virtues of honesty, courage and beneficence.

Conclusion

There is little doubt that disclosing errors is almost always the best course of action. It is underpinned by duties of beneficence, non-maleficence, honesty and respect for patient autonomy. However, doctors also have legitimate fears about disclosing errors. Programs that encourage disclosure exist in some countries, including Australia.[6] Disclosing errors, even those that did not cause harm, can create an atmosphere that supports and values disclosure and minimises both formal and informal punishment for errors. In this atmosphere, physicians will be able to admit, correct and minimise their errors.

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Competing interests: None.

Provenance and peer review: Commissioned, externally peer reviewed.

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