Because every encounter between a doctor and a patient has a moral dimension, competency in ethics is essential to being a good doctor.

“Everyday ethics in internal medicine resident clinic: an opportunity to teach”
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DISCLOSING ERRORS, TRUTH TELLING-Clinicalforum6Ethics

C-6 Avoiding Deception and Nondisclosure

The text describes different ways that a physician might provide misleading information to patients. Be able to describe and distinguish: lying, deception, misrepresentation, nondisclosure.

Lying to a patient is always considered ethically wrong even if the physician has good motives. Lying shows disrespect for the patient; undermines the essential trust relationship between physician and patient; it makes the patient feel “manipulated or betrayed”; and a patient will not be confident that other statements are truthful. Lying also undermines the physician’s integrity and one lie often requires more lies and leads to continuing deception.

Historically, codes of medical ethics have not required physicians to be completely forthcoming/truthful to patients.

Be able to identify and describe-
A-reasons for non disclosure or deception including withholding bad news: 1- to prevent serious harm to patients who might lose hope or become clinically depressed; 2-to accommodate to different cultural traditions; 3- to respect a patient’s right to autonomy if the patient does not want to know; and,

B-reasons against non disclosure and deception including: 1- what does the individual patient want to know notwithstanding the patient’s cultural background; 2- patients need information to make informed decisions; 3- disclosure of information can help patients to adhere to treatment regimes and prevent them from imagining worse diagnoses; 4- deception requires more deception; 5-deception is impossible because another provider will inadvertently disclose.

The author emphasizes how to tell the patient – not whether to disclose information to the patient.

The author carves out an exception to the principle to disclose medical information: the covert administration of medications to psychiatric patients when medications serve their best medical interest, to restore their autonomy and when informed surrogate authorizes the deception. He caveats- 1- exceptions are a last resort, 2- all deception if not checked is subject to slippery slope and 3- continued, long term deception is subject to abuse. Physicians will forget to reexamine the patient.

Know steps to avoid and to resolve ethical dilemmas relating to nondisclosure and misrepresentation: Anticipate dilemmas by determining what patient wants (talk to patient), respect the patient’s preference, elicit and discuss concerns, try to persuade patient to choose disclosure, minimize non disclosure (Maybe patient wants some information or will change his mind) and maintain transparency and accountability by documenting nondisclosures in the
patient’s record. Discuss with family when they are decision makers or do not want the medical information to be disclosed to the patient. Focus on how to tell not whether to tell, and if withholding information, plan for future contingencies, based on non disclosure (advise patient other care givers may tell him).

Avoid deception and non disclosure to third parties including colleagues. Deception always undermines trust in future interactions and one physician’s deception impacts on trust for the entire profession. Deception to third parties such as payers is not only unethical but also illegal and sometimes constitutes a criminal act. Third parties expect truth. Anticipate third parties will discover the deception.

Deception should not be necessary. Resolve a patient’s request for deception by talking with the patient and exhausting other alternatives.
Deception to colleagues(such as a medical student or resident making up information to avoid embarrassment) regarding patient medical information is always wrong and may harm the patient.

Appendix: When breaking bad news to patients:
Provide a calm setting, warn the patient (I am afraid I have some bad news), avoid jargon (patient may misunderstand euphemisms), allow time for the patient to react, keep first discussion brief, elicit patient’s concerns, provide realistic hope, show concern, repeat the news at subsequent visits, share uncertainty with the patient)

C-7 Keeping Promises
Physicians who make and keep promises to patients promote trust in the physician/ patient relationship and may reduce the uncertainty and fear, inherent in illness,.

A promise is a commitment to act in a certain way in the future, to do something or to refrain from doing something. Physician promises to patients generate expectations by patients who modify their plans in reliance that the promises will be kept. Promises by physicians, such as a promise to keep a patient’s medical information confidential, establish mutual expectations that benefit both patient and physician.

Breaking promises to patients may violate the ethical principles of patient autonomy, cause harm to the patient, reduce patient trust in future promises and undermine the physician’s integrity and the patient’s trust in the surrounding medical community and medical profession as a whole.

Sometimes promises to patients are hard to keep. They are made with inadequate information, under emotional stress, without enough deliberation or they depend on other people outside the control of the physician. Physicians should not make promises lightly and often do not have to make promises to patients. Physicians should instead elicit and address the patient’s concerns underlying the request for a promise.

Promise keeping is important but not an absolute duty. In exceptional circumstances breaking a promise to a patient may be justifiable as the “lesser of two evils”. Examples include: keeping promises made by others, keeping promises that violate other ethical guidelines, such as promises that would require deception to a third person, promises when the clinical situation has changed or when countervailing ethical considerations have come to light after the promise was
made or when the promise was implicit and not explicitly made. Physicians should admit that
the promise was a mistake, or explain to the patient why the promise cannot/ should not be
kept.

C- 34 Disclosing Errors

Medical error is defined by the author as either a failure of a plan to be completed as intended
or the use of a wrong plan to achieve an aim. Errors can be either acts or omissions. Medical
error might or might not cause harm (close call or near miss) to a patient. An adverse event is
an undesired patient outcome that results from medical error and not the underlying disease or
trauma. Adverse events can arise from an appropriate treatment plan carried out correctly such
as drug related side effects. There is a trend to focus on a systems approach to avoid or
respond to medical error. Focusing on systems approach- check lists, bar coding,
computerized ordering of medications- is likely to improve the quality of care for populations of
patients not just for an individual patient.

Disclosure of medical errors is becoming the standard of care. The Joint Commission of
Accreditation of Hospitals requires hospitals to tell patients when unanticipated outcomes have
occurred.

Physicians are reluctant to disclose medical errors to patients/ surrogates for a number of
reasons including:

i. Physician is not responsible for the error. Systems flaws or other
   condition beyond the physician’s control caused the error.

ii. Physician fears the patient/s/ family’s response to the disclosure such
    as a law suit, punitive responses of colleagues and supervisors and
    damage to their careers. (Some states have shield laws that protect
    expressions of regret not apologies from being used as evidence in a
    law suit; LA’s shield law protects both regrets and apologies from being
    used as evidence.)

Reasons for disclosing errors to patients/ surrogates include:

1- Disclosure respects the patient- patients need (have a right to) information in order to
   make informed decisions relating to their health.

2- Disclosure benefits the patient- It enables physician & patient to openly mitigate the
   injuries/ damages.

3- Disclosure benefits the physician- the author approaches this benefit as truth/ disclosure
   will mitigate adverse impact on physician and reports a study that patients feel less
   anger if physician discloses and takes responsibility. (I would say that disclosure/ truth is
   usually the right moral choice for physicians in part for reasons 1 & 2. It is not clear
   whether disclosure mitigates legal actions taken by patients.)

4- Even in cases when patient suffers no harm/ adverse event- disclosure may benefit the
   physician- patient relationship. Patients respect honesty and truth may promote
   patient’s well being.

What should physicians say when disclosing errors?

1- The author suggests that when medical error has caused serious patient harm &
   suffering and poor outcome, the physician’s responsibility to patient over self interest
   should prevail. I think the ethical rule should be that patients’ interests should always
   prevail with very limited exceptions.

2- For purposes of what to say: physician should disclose, express regret that error
occurred, fully explain the error and consequences, discuss steps that are being/ will be taken to mitigate/ prevent patient’s injury and suffering resulting from the error (And I think when patient has suffered injury and other damages, institution/ risk management should offer a fair out of court settlement to compensate patient/ family for the injuries and damages caused by the error.)

Near misses/ medical errors which have not caused patient harm/ adverse effects should be reported to quality improvement departments/ programs for identification, analysis and steps to avoid recurrence of the same error.

The author suggests that when outcome would have been poor - error did not change the outcome - physician should not discuss the error with the patient or family as a contributing factor since it did not contribute to the poor outcome. (This doesn’t make sense – why state a contributing factor when the error was not a contributing factor)

Some adverse outcomes cannot be avoided such as: (a) when patient suffers an adverse event/ outcome which is a known risk or complication of a medication or procedure; (b) when the standard of care was followed relative to the procedure or prescription; (c) when the risk was explained to the patient as part of the informed consent process; and/ or, (d) when the patient agreed to the procedure or medication.
Physician should still explain the unintended outcome.

When trainees make mistakes they should report them to a supervising physician, as this physician is responsible for the patient’s care. The author suggests that when it is appropriate to disclose the error to the patient the supervising physician should inform the patient together with the trainee. Such joint discussions offer trainees emotional support and role modeling. The supervising physician should in addition review with the student the medical issues and changes in student’s practice such as seeking more advice to avoid future errors.

Ethical responses of physicians to errors made by other physicians might include:
Ask the physician who made the error to disclose the error to the patient,
Arrange a joint conference with present physician, the previous physician who made the error and the patient/family;
Disclose the error of the other physician after giving the other physician the opportunity to disclose the error to the patient first, and telling the other physician of the intent to tell the patient of the error.
(Disclosure of another physician’s error must be in context of having incomplete information of what happened.) (My caveat: do not confuse another physician’s medical judgment which in hindsight might not have produced best outcome or just differing clinical judgment as medical error.)