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Guest Editorial

Doctors should admit their mistakes

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"Doctors are frightened of malpractice" – a comment recently made on his colleagues by a former director of the United States National Cancer Institute [1]. In Britain a remorseless increase in the number of actions against doctors by patients and their relatives – and the cost of such actions – has led to the government taking over responsibility for compensation for medical negligence [2]. In North America doctors in high risk specialties such as obstetrics and gynaecology are restricting the range of disorders they will treat in order to keep down malpractice insurance premiums. Around the world lawyers are encouraging the belief that any patient who perceives the results of medical treatment as less than 100% successful should go to court to demand damages. Is this ever increasing confrontation between doctors and patients a trend that will continue throughout the 1990s? Will even more doctors practise defensive medicine? Or is there some way of restoring confidence on both sides of the consultation desk so that malpractice litigation reverts to what it should be – a rarity that indicates that something has gone very seriously wrong?

The malpractice epidemic has its origins in a series of related but independent changes in attitudes that have developed in the last two decades. Firstly, in most western countries the general public has become aware that going to law may be financially rewarding. Victims of road traffic accidents have expected recompense since the 19th century, but these expectations have now extended to individuals who believe themselves harmed by defective foods, drinks, or other products, who lose their jobs, or find themselves discriminated against.

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Secondly, consumerism has grown into a powerful force and many of its principles have been extended to the world of medicine. Patients are no longer passive recipients of medical care; they want to be informed about choices and to participate in treatment decisions. In theory at least patients should nowadays be fully aware before treatment begins of all the possible adverse effects or complications – and so if an unexpected disaster occurs the patient may then reasonable claim that he or she should have been warned in advance.

Thirdly, litigation based on negligence has been assisted by highly effective investigative journalism, and in the medical context by victim support organizations. The massive campaign that eventually generated compensation for children damaged in utero by thalidomide showed the way [3] and similar strategies proved successful for the victims in the cases of practolol, benoxaprofen, Debendox/Bendectin, and children damaged by pertussis vaccine – though in the last two cases the courts rules that the plaintiffs had failed to prove that the injuries were caused by the drug or the vaccine [4,5].

Yet paradoxically the best line of defence against these confrontational trends may be found in another parallel trend – the growing interest by the medical profession in medical audit [6]. In Europe and North America death and disasters meetings have become commonplace in hospitals, and systematic reviews of outcome data are becoming routine. Administrators and clinicians are agreed on the need to identify poor outcomes – complications, side effects, morbidity and mortality data – and to take action to reduce them. Greater openness among clinicians in discussing their mistakes has, however, had one drawback in the current environment: there is some anxiety that the records of these discussions, theoretically confidential, may find their way into the hands of lawyers acting for aggrieved patients and families.

Is there a way forward? I believe there is – and this is a view shared by independent investigations of patients'complaints [7]. Consumer groups in Britain and the United States have repeatedly argued that the main reason that many patients consult lawyers after a death or medical mishap is that none of the doctors or nurses would talk to them. The health professions are not very good at talking to relatives after a death even if it was inevitable and well managed. All too often if the patient's management has been less than optimal the reaction of those concerned is to say nothing. And at the first hint of possible litigation the advice from medical defence societies sometimes reinforces this wall of silence.

After a death or disaster what patients or their relatives want is an explanation or an opportunity to ask questions and be given full, honest answers. If they have this opportunity they will usually go away satisfied – not content, necessarily, but probably not angry nor vindictive. And what are the drawbacks for the clinicians concerned? Surely if a death was due to negligence then in equity the relatives should receive compensation. They should not have to fight for it. In Britain the medical defence societies have always asserted that they do not contest justifiable claims in the courts. If the standard of medical care is acceptable then there should be no need for concealment of medical records or reluctance to discuss that happened in any individual case. And if there were greater readiness by doctors to

admit their mistakes much of the current surge of litigious behaviour by patients would, I believe, disappear and doctor-patient-relative relationships would be greatly improved.

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