COMMENT

Dual loyalties: Commentary on "to talk or not to talk", by Ashok Sinha

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"Whistle-blowing" can be defined as speaking out about sub-standard practice or flawed systems which put patients at risk of harm. It has become a vital aspect of doctor-patient trust and much is written about the duties of all doctors to minimise risk and improve the safety of patient care. This includes monitoring colleagues' performance and alerting the colleague (or if necessary the regulatory authority) when errors or signs of incompetence occur.

Taking positive action to protect patients is also a key facet of ethical guidance on doctors' "dual loyalties". Dr Sinha (1), however, neatly exposes the difficulties in trying simultaneously to protect patients without being disloyal to professional colleagues. As he points out, exposing bad practice publicly can rebound on the professional standing of all doctors if patients' confidence in them plummets. He flags the ethical conundrum that has survived a long history of collusive silence. Every profession has some poorly performing members but the notion of bad doctors makes us all feel uncomfortable.

Historically, medical ethics never focused on veracity as a virtue and the notion of professional loyalty or covering up for colleagues goes back to the earliest days of ethics. The Hippocratic Oath highlighted the doctor's duty to be loyal to his teachers and to their offspring. Over time, this came to be interpreted as a more general duty of loyalty to medical colleagues. Doctors were supposed to encourage hope in patients. Therefore they were perceived as having an obligation to conceal errors that would demoralise the patient and would undermine public confidence in the profession. Telling patients the truth was seen as subversive and meddlesome.

Percival's Code of Medical Ethics

Yet the problem had long been lurking unacknowledged in the shadows. Dr Thomas Percival published an early code of medical ethics in 1803 (2) which emphasised, among other things, the importance of secrecy. Until the mid-20th century, the legacy of Percival's ethical code often resulted in doctors not telling patients the truth about their illness and so avoiding "gloomy prognostications" which might create fear and anxiety. It also meant showing respect for colleagues, displaying "fraternal courtesy" and avoiding criticism. "No rivalry or jealousy should be indulged; candour, probity and all due respect should be exercised towards the physician having charge of the case", said Percival, and his successors agreed. Furthermore, doctors were warned never to imply to patients that they disagreed with a colleague's opinion. For medical practitioners in the 19th and early 20th century, there was a clear moral duty to ensure that their own skills were properly competent but no obligation to ensure that colleagues met the same standard. This was because doctors were seen as self-regulating and altruistic. "There is no profession," Percival said, "from the members of which greater purity of character, and a higher standard of moral excellence are required."

By the 1920s, however, the dilemmas associated with detection of poor medical practice were starting to be openly recognised. The 1926 Ethics Code of the American Medical Association (AMA), for example, said that doctors should expose corruption or deliberate dishonesty by colleagues but only to "proper medical or legal tribunals", certainly not to patients. It did not address the issue of mistakes or poor clinical judgement. As far as honesty with patients was concerned, the AMA said that a doctor "should not make comments or insinuations regarding the practice of the doctor who preceded him. Such comments or insinuations tend to lower the esteem of the patient for the medical profession (2)." Even at that time, however, this advice was being questioned. Commentators gave examples of how, when a medication mistake resulted in a patient's death, the hospital would declare that the patient died of heart failure and sack the doctor without telling the family the truth. An obstetrician who found that a colleague's negligence resulted in the death of a normal infant felt pity and resentment but could not make comments or insinuations about the colleague (3).

The British Royal Infirmary Inquiry

Attitudes had changed rather radically by the end of the twentieth century, however. In the UK, one of the key triggers for major change was the public's realisation that for over a decade children at one of Britain's most prestigious hospitals – the Bristol Royal Infirmary – had been dying due to doctors' underperformance, combined with the hospital's failure to acknowledge problems. Doctors who had tried to act as whistle-blowers had been silenced. Exposure of what had occurred proved to be a watershed event for the profession in the UK.

The Bristol Royal Infirmary was a regional centre for paediatric heart surgery but by 1994, its mortality rate was double that of other comparable hospitals. Concerns began to be expressed by doctors and other health professionals but no specific individual was seen as having an obligation to take action. Junior staff were intimidated by the fact that speaking out

against senior colleagues would be professional suicide. Finally, in 1995, some staff at the hospital tried to prevent surgery being carried out on a child called Joshua Loveday. This proved to be the catalyst for intervention by the authorities after the child died during surgery. A public inquiry took place (4) which shook the profession and the public. Two cardiac surgeons and the hospital's chief executive were found guilty of serious professional misconduct.

The investigation recognised that these doctors were neither uncaring nor intending to harm. On the contrary, they were dedicated to children's welfare but lacked insight into their own flawed practice. Hospital managers had failed to listen to the concerns raised by other staff. There were no systems for assessing the quality of care and nor was there systematic monitoring of the clinical performance of individual doctors once they qualified. Surveillance of doctors' performance was said to be hampered by a club culture in which power and control were in the hands of a few individuals. This meant that open review and discussion of mistakes among staff were discouraged. Events at the hospital were not unique and raised complex issues about how individual competence and conduct could be monitored while recognising the acceptable variation in practice and outcome.

One of the effects of this major scandal was a profound change in attitude within the public and the medical profession. The public already expected to be told the truth by their doctors and to have the opportunity to discuss a mistaken diagnosis or error in treatment. Indeed, frankness with patients was increasingly seen as the best way for doctors to avoid litigation for their errors. Many patients said that they would be satisfied with a timely explanation and apology, whereas the frustration of a cover-up goaded them to legal action. Guidance from professional bodies advised doctors to be open with patients about the uncertainties of treatment and equally honest in retrospectively acknowledging mistakes. The UK regulatory body for doctors, the General Medical Council, advised that if patients suffered harm due to an error, doctors should act immediately to put matters right if possible and explain to the patient the likely implications. This is painful advice to implement for both doctor and patient if, for example, a mistaken histopathology report has led to a healthy patient undergoing unnecessary surgery because his results have been misread or confused with those of another patient. Such mistakes are hard to admit to and traumatic for patients to learn about, especially as patients are normally grateful for treatment in the mistaken belief that a life-threatening condition has been avoided. Some think that the patients situation is made worse rather than better by such disclosure of an error and there is a temptation to "let sleeping dogs lie". Nevertheless, the current consensus is that it would be unethical and unfair to withhold factual information and that patients should be given support and counselling to cope with it. Clarifying what has occurred in the past is likely to involve contacting the previous clinician and reviewing records made at the time of diagnosis. If it is obvious that an error was made, there should be discussion about how the patient can sensitively be prepared for that information and who should take responsibility for doing so.

Telling patients about past mistakes by other clinicians and having them investigated is not uncontroversial. Some see it as going against the principle of loyalty set out in the Hippocratic Oath and fear it could seriously undermine public confidence in doctors. One of the positive outcomes of the Bristol Infirmary inquiry, however, was the recognition by the public that, even with the best intentions, some doctors make mistakes. Doctors need to recognise that and learn from their mistakes, which cannot happen if "a culture of blame" prevails. It sometimes seems that whenever a treatment fails, patients assume that a doctor is responsible and owes them compensation. In the past, this view contributed to a strong reluctance for doctors to talk openly about adverse events and underperformance. The Bristol investigation highlighted that safety can only flourish in an open and non-punitive environment in which doctors feel able to talk about adverse events and the errors. Ultimately everyone, including patients, must accept that some errors inevitably happen because that is human nature but that it is also a duty for health professionals to minimise them.

There is no scope for complacency. The onus for keeping their skills and knowledge up to date still rests primarily with individual doctors. As in Percival's time, they are expected to have the purity of character and moral excellence to monitor themselves and ensure that they act only within their sphere of proven competence. But in case individual integrity is not enough, doctors also have a duty to take action if they witness evidence of colleagues failing. Risk management systems also mean that doctors' performance and competence are tested by their peers through periodic appraisal and revalidation.

Conclusion

In some countries, appraisal, clinical audit, and revalidation have led to more open and regular discussion of adverse events and make it less likely that serious errors or bad practice can go undetected. This does not mean that mistakes and incompetence are eliminated. But when substandard practice occurs, all doctors have an obligation to do something about it. This is never easy but an important consideration must be whether the error was a one-off occurrence or part of a pattern of mistakes that present an ongoing risk of harm to future patients. Whistle-blowing involves drawing mistakes to the attention of the person or organisation who can best remedy them as well as to those who have suffered from them. Ideally, locally agreed procedures should set out how a review can happen without necessarily embarking on a blaming exercise. The main thing is that lessons should be learned, future errors avoided and natural justice dispensed to patients who have been inadvertently harmed.

References

1. Sinha Ashok. To talk or not to talk. *Indian J Med Ethics* 2008; 5: 163-4.
2. Leake CD. *Percival's medical ethics*. Baltimore: Williams and Wilkins, 1927.
3. Leake C D. Ethics and medical ethics. In: Leake CD, editor. *Percival's medical ethics*. Baltimore: Williams and Wilkins, 1927.
4. Bristol Royal Infirmary Inquiry. *Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*. Command Paper: CM 5207. [cited 2008 Aug 26]. Available from: http://www.bristol-inquiry.org.uk/final_report/index.htm.