DISCLOSURE INVOLVING MULTIPLE HEALTHCARE TEAMS

PROFILE

TEXT BY

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Medical professionals have a primary duty to inform patients of any medical information that would be important or material to the patients in making medical decisions for the present and future. Discussing significant adverse medical events with patients and people close to them is seen as an ethical norm. Such discussions would usually include acknowledgement and expression of regret over the adverse event. Patients should be assisted and supported compassionately through their illness.

Healthcare providers have a duty of candour; this enables patients to make decisions based on informed disclosure. Whether the information at hand is complete or not is immaterial; such disclosures should include admissions about uncertainties, apologies for any errors, recognition of feelings and emotional responses towards the event, and a plan forward.

We describe herein a case of disclosure involving two different health care teams from two different centres caring for a single patient with the same condition. We examine the position in law and ethics regarding the disclosure of an adverse event and the boundaries of ethical behaviour. We conclude by suggestion of a way forward to manage such disclosures.

FACTS

Mdm X has been receiving treatment for the past two years at a government treatment centre ("A" centre) for chronic cough. She is otherwise well. Chest X-ray result was reported as normal. She later developed backache and sought consultation at the emergency department of "B" hospital. Investigations showed metastatic lesions of the spine. A review of the same chest X-ray done by "A" centre showed a cancer lesion, which appears to have been missed in the reporting 18 months ago. The conclusion was that the primary lesion responsible for the metastasis was lung cancer.

DISCLOSURE

If the patient were to ask, "B" team would be obliged to state their impression of the chest X-ray findings as findings of fact. This is not a contended point.

However, if not asked, does "B" team have an obligation to disclose their impression of the chest X-ray done 18 months ago by "A" team? Doing so adds clarity for the patient with regard to the time frame of the illness. The inference of "A" team having missed the earlier diagnosis would be inescapable, but one which "B" team would be ill-advised to elaborate on because the patient was not under their care when the chest X-ray was ordered and taken. With this in mind, "B" team decided to go ahead with a voluntary disclosure, but not before a discussion had taken place with "A" team.

"B" team's intention and extent of disclosure, even if unasked, was made known to "A" team, who would then have to decide whether to hold further discussion with the patient. In any case, it was jointly decided between the two teams that "B" team would make the offer for an open disclosure with the "A" team about the chest X-ray findings and the care given at that time, on behalf of "A".

The offer was subsequently not taken up by the patient for reasons that were not pursued.

DISCUSSION

There is no duty in law to incriminate oneself in wrongdoing. From this view, the decision to not offer a disclosure, especially when we can let sleeping dogs lie, is tempting. On the other hand, the risks of being found out and having to face the allegation of concealment because of a self-serving interest, even if not legally damning, or even if there was no intention to conceal — "you did not ask, I did not tell", which arguably may not amount to concealment — would be ethically problematic.

From an ethics perspective, it would be reasonable to expect that the patient would have an interest in knowing this information. A decision based on best interest must be one that is based on the autonomy of the patient to decide on what she wants done subsequent to being informed.

There is a duty of cooperation and collegiality between doctors. This duty in collegiality, of working in cooperation and collaboration with colleagues, is for a common purpose of upholding the primacy of the patient's welfare. This duty does not stand alone and is underscored by the requirement of acting in the best interests of the patient. As such, the two duties do not come into conflict. Conceivably, "A" team would have more to lose if a case of negligence is made out, but this is a secondary consideration.

One study has established that 50% of litigation was initiated following comments made by other healthcare professionals. Never underestimate the power of a raised brow or frown, or the insinuation of the spoken word implying substandard care by colleagues. Comments about care given by colleagues, when perceived as negative, become opinions of expertise, which one should refrain from making unless one is also prepared to do so in an official capacity (eg, as an expert witness for the court). Concerns about the safety of patients should be communicated through other channels.

The line between giving an opinion and stating a factual account is not always discernible. This can be challenging in open disclosure involving two parties who are caring for the same patient, one of whom might have come to know that the patient had suffered a detriment under the hands of the other party.

An account consisting of facts known should be disclosed to the patient, but the speculative nature of why and what the circumstances of care are of another party should not be attempted. This is the limit of disclosure. An open disclosure is not a forum for giving a second opinion about the care provided by another clinician, especially when the other clinician is not present.

TAKE HOME MESSAGE

- Support the patient.
- Disclose the facts of the case.
- Where the disclosure of facts involves other carers, it is highly recommended that all healthcare teams be briefed on the extent of disclosure.
- Do not speculate.
- If necessary and agreed upon, make an offer for discussion with the patient and the other healthcare team whose care has supposedly resulted in the adverse outcome.
- If agreed upon, a discussion with the patient in the presence of the different healthcare teams may be proposed. ◆

Further reading

1. Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor-patient relationship and malpractice: Lessons from plaintiff depositions. Arch Int Med 1994; 154:1365-70.
2. General Medical Council (UK). Openness and honesty - the professional duty of candour. Available at: http://www.gmc-uk.org/Joint_statement_on_the_professional_duty_of_candour_FINAL.pdf_58140142.pdf. Accessed 14 August 2015.