TH. 3 MAN **Daniel K Sokol**

The hardest thing: admitting error

he interests of the wronged patient should trump those of the clinicians

ven the best close-up magicians ake mistakes. They are, simply, navoidable. Good magicians ierefore prepare for mistakes by hearsing alternative endings nd memorising quips in case irreparable failure: "The real agician will be here in a minute," or, t worked fine in the magic shop." A iend of mine says, "At least if I make mistake, no one dies."

Doctors cannot use that line. Their istakes can lead to serious harm. hi agician's error is usually ppa t to all, a doctor's error can e difficult to spot, especially by ose who are not medically trained. ne patient is, after all, already nwell by the time of the doctor's volvement. The first people who now that an error has occurred are sually the clinical team.

I remember speaking to a doctor ho had been consulted by a couple ith a severely disabled baby. On ading the medical notes, it dawned n her that the child had probably een subject to negligent treatment. he doctor nonetheless felt torn etween her loyalty to her hospital olleagues and her desire to tell the uth to the couple. To my mind, this as not a moral dilemma. The doctor hc ave advised the couple to eek legal advice.

It is hard to overstate how much f a difference an award of damages ould make to a family. It could over the astronomical cost of care nd allow the family to find suitable ccommodation or modify their omes. I wondered why the doctors t the hospital had not revealed the istake to the family. What happened luring that morbidity and mortality neeting when the trainee presented he case to the department? Did no ne speak up on behalf of the family? id no one realise that silence might ondemn the family to decades of itter struggle?

Kroll and colleagues remarked n a 2008 study of junior doctors' icc of errors that "we know remarkably little about the day-to-day management of medical error in the UK."[1] To find out more, the authors conducted interviews with 38 preregistration house officers. The authors identified a "strong sense of professional loyalty in which doctors, despite discomfort, kept quiet over others' errors." They also observed that "team feedback after error often prioritised reassurance: errors were normalised, dealt with through teasing, or minimised as being 'not the juniors' fault,' 'not serious,' or 'not a matter of life or death.' Deaths after an error were often framed in the context of inevitability: the patient wouldn't have made it anyway."

It is odd how doctors are reluctant to make prognostications in some contexts ("It's not possible to give an accurate prognosis") but quite willing to do so in others. In any event, it is not for the doctors to determine what would have happened in the absence of any error. As the source of the error, or close to it, they are at high risk of bias.

In another case a patient developed a swelling of the eye after endoscopic sinus surgery.[2] A consultant assessed the patient and recommended conservative management. The eye got worse, and, despite an urgent decompression procedure, the patient lost the sight in his eye. The patient was told that the blindness was caused by air in the orbit. A registrar carefully explained how the air caused the damage to his optic nerve. The ophthalmic surgeons at the hospital published the case in a peer reviewed journal, describing the cause of the injury as air in the orbit. The patient eventually sued the hospital, which, remarkably, defended the case on the basis that the injury was caused by an infection rather than air in the orbit. The claim was settled in the patient's favour, although the hospital did not admit liability. As the lawyers involved in this case note, the trust's steadfast refusal to accept an error explains why "the public's faith in the medical profession's willingness to admit mistakes is somewhat jaded."

For those doctors who disagree, who are willing to let injured patients and relatives suffer without any compensation or explanation to lighten the burden, who are unable to put themselves in the shoes of the victim, I recommend an alternative career in magic

bmj.com
Previous columns by Daniel K Sokol are available on bmj.com.

The General Medical Council's *Good Medical Practice* at paragraph 30 states that doctors should be open and honest when things go wrong: "If a patient under your care has suffered harm or distress, you must act immediately to put matters right if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects." A similar professional duty exists for lawyers.

I will not tediously list the pros and cons of disclosure, nor will I dwell on the trite observation that admitting a mistake is painfully difficult for any self respecting professional. In this situation, ethics has a right answer: forget loyalty to colleagues, forget the reputation of the department, forget about standing and promotion, forget about what the patient or relatives will think, the patient (or, if not mentally competent, his or her relatives) must know if a harmful error has occurred. The patient can then decide what to do.

There should be no more closing of the ranks. The interests of the wronged patient should trump those of the clinicians. And for those doctors who disagree, who are willing to let injured patients and relatives suffer without any compensation or explanation to lighten the burden, who are unable to put themselves in the shoes of the victim, I recommend an alternative career in magic.

Daniel K Sokol is honorary senior lecturer in medical ethics, Imperial College London, and barrister, Inner Temple, London
daniel.sokol@talk21.com

Competing interest: DKS is a member of the Zodiac Magical Society.

1 Kroll L, Singleton A, Collier J, Rees Jones I. Learning not to take it seriously: junior doctors' accounts of error. *Med Educ* 2008;42:982-90.
2 Wright J, Oppermans G. The disclosure of medical errors: a catalyst for litigation or the way forward for better patient management? *AvMA Medical & Legal Journal* 2008;15:193-6.

Cite this as: *BMJ* 2012;344:e3085