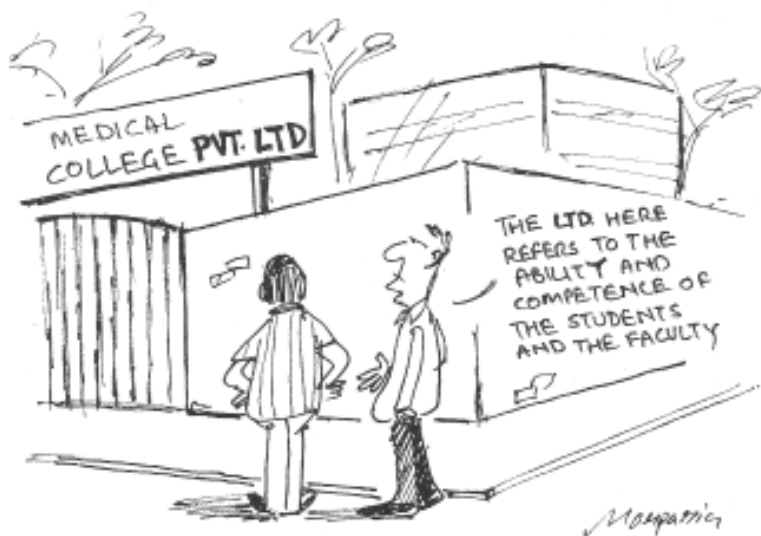


Communication

Communication is the vital link between the doctor and patient and between doctors. It can make or break a relationship. Difficult situations in clinical practice call for good communication as well as empathy. Good doctors develop this trait, which patients often call 'good bedside manners'. Unfortunately, this tool for success in clinical practice does not find a place in medical schools today and students are deprived of role models. So most learn to communicate through the expensive school of experience or do not learn at all. This void is apparent when doctors speak to the media, write articles or have to speak in lay parlance. Poor communication has been the single most common reason for doctors being prosecuted under the Consumer Protection Act in India. In a litigious world, the fact that doctors speak ill of other doctors instigates patients to decry the medical profession and sue their physicians. A doctor's communication skills are put to the test while breaking bad news to the patient or relatives. With increasing specialisation and fragmentation of medical practice, the traditional role of the general practitioner as communicator and friend of the family has gradually been eroded. Alternative medicine has seen a resurgence despite technological advances, as it caters to patients' need for holistic health care. This selection of articles tackles some of these issues.



Informed consent in public hospitals

S P Kalantri

A medical teacher and physician at a community hospital reflects on the fact that communication takes a backseat in busy public hospitals. This essay describes the problems of seeking informed consent in the Indian setting. Doctors are not trained to respect patients' autonomy. The problem is compounded as public hospitals are usually used by the very poor and doctors' patronising behaviour reinforces class hierarchies. As doctors in such settings are almost always viewed as God, they are reluctant to institutionalise the procedure of seeking informed consent. They choose instead to treat questions from patients as signs of a lack of trust, and threaten to discontinue treatment. The article also discusses practical difficulties such as improperly designed forms, inadequate training, and the dearth of good role models. The discussion is contextualised within the larger problems affecting the system, such as cultural differences between provider and patient, scarcity of resources, and a working environment that does not allow space for ethical practice to develop. A question worth exploring further is that of systems of accountability. Doctors should not view informed consent as a simple defence against potential litigation.

Informed consent is a commendable concept: it gives patients the power to participate in decisions concerning their own management, to a greater degree than ever before. The qualifying adjective is superfluous (1), for the word consent (*cum*, 'together', and *sentire*, 'to feel' or 'to perceive') clearly implies sharing of information. Patients do have problems understanding the nature of their illness and management plans. It is the duty of the doctor to ensure that the patient is helped to make a rational decision.

What do patients want? The priority is honest, unbiased, up-to-date information about their illness, its likely outcome, and the risks and benefits of different interventions. They also want help to identify and secure their treatment preferences. When uncertainty

exists they want a full and frank discussion without omissions or glossing over, and advice explicitly supported by the best available evidence (2).

What doctors feel about informed consent

I asked several doctors what informed consent meant to them. Most disliked the very concept of informed consent and considered it an obligatory legal formality forced on them by the Consumer Protection Act. Their arguments were:

- Informed consent breeds suspicion and mistrust. Patients are uncomfortable with doctors who merely give them options and ask them to choose one. Our patients want us to take responsibility and not shift it onto their sagging shoulders. If we do not act on their behalf, we might be accused of dodging duty.
- Patients fail to understand our misplaced emphasis on consent forms. Our patients have full faith in our knowledge, skills and competence. Are we not capable of choosing the best treatment for them?
- Informed consent seriously erodes the doctor-patient relationship. Openness and frankness make patients anxious, reluctant and distressed.
- How do we share information during an emergency? Can patients respond appropriately during a crisis? Can patients weigh the pros and cons of a treatment and make a logical decision?
- Informed consent is an intellectual exercise for armchair ethicists. The emphasis on autonomy and equality is misplaced and lacks knowledge of practical difficulties.

Doctors love to patronise and dominate. Their arrogance and indifference to the philosophy of informed consent is widely known. Medical and public fora have passionately debated these issues. Surprisingly, most residents and doctors in teaching public hospitals tacitly endorse such reservations against information sharing. To most of them getting informed consent is a needless nuisance, to be delegated to a raw resident whose sole responsibility is to get the patient's signature on the dotted line.

A few exceptions apart, public hospitals sorely lack good quality information leaflets or audiovisual material to disseminate information to their patients. Residents working under tight time

constraints find it impossible to explain procedures to the patient. Nor are they sufficiently motivated to do so, for providing explanations and sharing information bring no tangible rewards. No attempt is made to ensure that the appropriate type and amount of information has been provided and the patient has understood the procedure.

Any query or request for an explanation meets with stern disapproval and arouses a characteristic, callous response from the resident: "If you don't trust us, you had better leave the hospital." The resident, always in a tearing hurry, lists all possible risks (death gets cruelly emphasised) and disappears before the patient can absorb the blow.

Consent forms in most hospitals are either too brief or sketchy, or full of incomprehensible medical and legal jargon. They carry hastily scribbled, badly worded, and at times illegible, text. The text is seldom read aloud to illiterate patients, who, being unable to decipher the draft, simply leave their thumbprints on the case sheet. Seldom do they get the opportunity and time to understand the intervention. The nagging fear that not signing the consent form might amount to incurring the displeasure of the treating doctor weighs heavily on their mind.

Insensitive forms

I reproduce below a consent form obtained in a busy surgery ward of a teaching public hospital:

"I am suffering from a strangulated intestinal hernia. I need immediate surgery to save my life. I also have mild hypertension. I shall be operated on under general anaesthesia. I run a high risk for surgery. I might develop life-threatening complications during anaesthesia. My surgery might lead to some complications, which could kill me. After surgery I might run into problems, which are well beyond the surgeon's control. In spite of all these risks, which have been fully explained to me, I agree to undergo surgery. Should anything go wrong, neither doctors nor nurses shall in any way be responsible for an adverse outcome. The responsibility shall be entirely mine."

What makes taking consent so insensitive and crude? I picked up, at random, several residents from a teaching public institution

and asked them if they were ever taught how to obtain a patient's informed consent. Most sheepishly admitted their ignorance. To some of them, consent was a legal vaccine that reduced the risk of litigation. Many residents were conscious of their lack of communication skills: an inability to use simple words in patients' regional languages left many of them tongue-tied at the patient's bedside. They were not getting across to their patients, but could do nothing about it.

Dr Franz Ingelfinger's two-decade-old description (3) seems to come straight from one of our busy wards:

“Even if a physician takes pains to use appropriate language, he may still lack empathy if he is not acutely sensitive to the emotional needs of the patient seeking consultation. Distracted by anxiety, fear and perhaps suspicion, the patient hears the sounds but not the meaning of words; reassurances that cancer is an unlikely diagnosis and a barrage of tests to prove this point may convince the patient that the opposite is true. ‘We shall not need another operation’ is recorded in the patient's mind as ‘another operation’. Advice that anti-hypertensive drugs or insulin are in order, possibly for a lifetime, may give the patient an idea of incurability. Even advice on smoking and overeating may elicit negative instead of positive results in the susceptible.”

Today's role models

To whom should residents turn to pick up the art of communication? Teachers? (4) Most residents expressed gratitude to their teachers for teaching them the art and science of modern medicine, but said that apart from a few exceptions their teachers were poor role models for learning the ethics of the doctor-patient relationship. Medical teachers, said several residents, are generally stiff-lipped and discourteous when patients seek information. Students tend to imbibe their teachers' arrogance and ill manners during their impressionable years and subconsciously emulate them in their professional practice. And, as a resident asked in exasperation: “Where are good role models left in medical colleges now?”

Residents welcomed the idea of learning communication skills and behavioural sciences. Several suggestions emerged during discussions: Had we been taught how to talk with patients and

what to say (5) during our clinical postings, we would have felt more comfortable with our patients. Many thought that introducing medical ethics in the undergraduate curriculum (6) would help them be more humane, sensitive and responsive to patients' needs. Few thought that they should have also been taught how to discard a patronising attitude and get more interactive with patients.

There were some discordant notes too. A resident asked me: "Most rural patients attending public hospitals do not insist on an intensive, informative discussion. Their main priority is to get cost-effective treatment. Could we make use of their trust in us and practise a bit of paternalism and dominance? What is the evidence that published (western) guidelines for getting informed consent are equally valid in our setting? Could we find ways to make consent more accessible, acceptable, tangible and practical? More patient-friendly and less legalistic?"

A senior medical teacher, who is deeply respected in the rural community for his compassionate and committed approach, shared his residents' concerns. A patient must know his disease and management plans, he agreed, but then should entrust the responsibility of taking the final decision to his doctor. How can a doctor-patient relationship flourish in an atmosphere where autonomy and equality overrule trust and faith? A quest for information might make patients more knowledgeable, but it would also render them insecure and indecisive.

He quoted Charaka: "No gift is greater than the gift of life. The patient may doubt his relatives, his sons and even his parents, but he has full faith in his physician. He gives himself up in the doctor's hands and has no misgivings about him."

The teacher admitted honestly: "I might continue to treat inquisitive and sceptical patients – and their tribe is rapidly increasing thanks to the internet – but my heart won't be there in their management."

Teaching tomorrow's doctors

Neither teachers nor residents nor patients seem to know how to handle the issue of informed consent without anguish. Let us concentrate on residents, the future consultants. How can they be helped? Could communication techniques taught in classrooms ease

their burden? Or should students passively imbibe these skills from their mentors and patients as life moves on? There are no easy solutions. Nor can there be cut-and-paste shortcuts for information sharing and obtaining consent.

As Dr Ingelfinger (3) summed up years ago: “In medical schools, a student is told about the perplexity, anxiety and misapprehension that may affect the patient as he enters the medical care system, and in the clinical years the fortunate and the sensitive student may learn much from talking to those assigned to his supervision. But the effects of lectures and supervision are ephemeral and are no substitute to actual experience.”

References

1. Laurence D, Carpenter J: *A dictionary of pharmacology and clinical drug evaluation*. London: VCL Press; 1994.
2. Entwistle V A, Sheldon T A, Sowden A J, Watt I A: Supporting consumer involvement in decision-making: what constitutes quality in consumer health information? *Int J Qual Health Care* 1996; 8: 425-437.
3. Ingelfinger FJ: Arrogance. *N Eng J Med* 1980; 303: 1507-1511.
4. Gupta P: Bedside case presentations: thin ice? *Natl Med J India* 1997; 10: 182.
5. Calnan J. *Talking with patients – a guide to good practice*. London: William Heinemann Medical Books; 1983.
6. Ravindran GD, Kalam T, Lewin S, Pais P. Teaching medical ethics in a medical college in India. *Natl Med J India* 1997; 10: 288-89.

Published in Volume 8, Number 4, October-December 2000

Ethical dilemmas in breaking bad news

K M Mohandas

In the Indian context, patients often seek care for an advanced cancer, with consequently higher morbidity and mortality. Many also believe that cancer is inevitably fatal. And desperate patients often go “doctor shopping,” viewing medical care as a commodity. Many of them take recourse to indigenous medicine.

This article was written when the discipline of medical ethics was just beginning to develop in India. A gastroenterologist speaks candidly about the difficulties he faces in breaking bad news to his cancer patients. It reflects the clinician’s struggle to apply ethical principles in daily practice. With little formal training available on the essential skill of communication, the author documents his own practise. He adapts his procedure to suit the patient’s character and needs. He emphasises the role of collective decisions involving the family, rather than the individual alone.

Introduction

One of my concerns after joining a cancer hospital was the manner of conveying the diagnosis to the patient with cancer. Most of us receive little formal training on this aspect of medicine during undergraduate and postgraduate training. All I can recall is telling the relatives of patients with acute myocardial infarction or stroke of a 25 per cent possibility of death.

Observing the approach of colleagues has been of little help. Some colleagues embark on a very positive approach, giving the patient and relatives hope (albeit false) and believing that the patient is blissful in his ignorance. Others take a middle path and explain all the facts to the relatives while keeping the patient in the dark. Few explain at length the diagnosis, stage of cancer, options on treatment,

side effects, financial burden and short- and long-term prognosis. Thereby they upset some patients and families.

Keeping the diagnosis from the patient

“Please do not tell the patient that he has cancer,” is a frequent request made to me by relatives. I recently came across a situation where the relative who accompanied and then looked after a bachelor patient with terminal cancer kept the patient and other relatives in the dark and managed to change the patient’s will before his death. Many factors such as illiteracy, ignorance, misconception, superstition, domestic and social problems, fatalistic attitudes and other prejudices add hurdles to the information process. Patients returning with recurrence or progression of disease complain about the lack of proper information during the primary treatment. I have realised that there is no simple solution.

Osler cautioned those dealing with fatal illness: “It is not for you to don the black cap and assuming the judicial function, take hope away from any patient...hope that comes to us all.” Unfortunately, several medico-legal and ethical factors make us don the black cap.

Relevant issues

The first issue concerns the confidentiality of the doctor-patient relationship. Can the doctor discuss the illness with the relatives and friends who accompany the patient, without first telling the patient about his disease and obtaining his permission to tell others? Second, because of the Consumer Protection Act and the high cost of investigating, treating and supporting patients with cancer, should we not inform the patient fully about the disease, the benefits, complications and economic costs before he signs the consent form? Third, many cancer therapies are still experimental and can be provided only in the setting of a clinical trial. Bearing in mind the ethical aspects of experimental therapies, a fully informed, written consent needs to be obtained. Would not informing the brave ones lead to selection bias in studies? Fourth, many patients with advanced disease have already been told the nature of their illness and come for a second verdict with lots of hope.

Attitudes towards cancer

In India, the fear and hopelessness engendered by the diagnosis of cancer is very strong and is often based on hearsay or anecdotal experience of relatives or friends. The degree to which people are adversely affected by the diagnosis of cancer is related to the individual's ability to adapt and come to terms with thoughts and feelings focused on their own mortality and altered body image.

In the West, some are unhappy with the diagnosis of cancer but most surveys indicate that the majority of patients seek more information from their doctors. Although the number of doctors in the West who shy away from disclosing the diagnosis of cancer to their patients has decreased, there are many who genuinely believe that what the patients do not know will not harm them.

The convenient practice would be to give information only to those patients who actively seek it. The ideal balance between frankness and details that may provoke is not universally established, nor is it the same for all patients. In cancer, more than in any other illness, the dynamic view emphasises the beneficial effect of participation by the patient in the outcome of therapy.

For many cancers there are no standard treatments and for many others different therapies provide similar results. Furthermore, conflicts of interest between various specialists (surgeon, chemotherapist, radiotherapist) result in raising hopes beyond those justified by the facts.

Possible solutions

The specialist-dominated, often autocratic approach to cancer treatment, the standard pattern in the 1960s in the USA and the UK, has undergone a change to a more open dialogue where the patient and physician are equal partners in decision-making. A multi-dimensional approach is required to meet physical, psychological, social and spiritual needs.

The need for specific information varies between patients. In general, patients wish to be well informed about the diagnosis, therapeutic options, side effects and outlook. Some prefer details. Others are content with limited information. Still others prefer to have the possibilities of complications minimised or blunted.

Breaking bad news therefore requires skills in communication and an understanding of the patient's mind and preferences.

We can take a cue from screening for AIDS and counsel all those who are afraid to face the diagnosis of cancer. Since up to 75 per cent of patients with cancer in the West seek alternative therapies that offer hope, another approach may be to provide non-conventional therapy under the same roof.

Once I have identified the brave ones after a few meetings, I prefer to talk directly to them. For those who are scared, I disclose the news first to the spouse or an adult son or daughter. As rapport builds up during therapy more information can be provided directly to the patient. Unfortunately, many patients with advanced disease come for a single consultation when palliation of symptoms is only therapy. Should we tell these patients the bitter truth? I follow Ambroise Pare's advice: "Always give the patient hope, even when death seems at hand." I believe that if your time has not come, even your doctor can't take you away.

References

1. Burke C, Sikora K. Complementary and conventional cancer care: the integration of two cultures. *Clin Oncol* 1993; 5: 220-227.
2. Fallowfield L: Giving sad and bad news. *Lancet* 1993; 341: 476-478.

Published in Volume 3, Number 4, October-December 1995

When the patient wants to try another system of medicine

G D Ravindran

Indigenous systems of medicine have existed for centuries in India. Today they are viewed as 'alternative' to western allopathic medicine. The relationship between these different systems, and between the respective practitioners, has often been one of conflict and distrust. An added problem is the large number of bogus claims for miracle cures which mislead patients. In this essay, the author, a physician, suggests guidelines based on his experience of dealing with patients who wish to use different systems.

Complementary or alternative systems of medicine are being practised all over the world. In our country, we have a long tradition of alternative systems of medicine, such as ayurveda, unani and homeopathy, which are recognised by law and the government. In addition, we also have newer, novel therapies such as ozone therapy and magnetic therapy. Our patients tend to try these systems when they have chronic illnesses or when they do not get relief from the allopathic system.

As practitioners of allopathic medicine, we face many ethical dilemmas when we are confronted with patients who wish to try alternative systems of medicine. This essay explores these dilemmas and the ethical issues involved.

For many chronic conditions, allopathy has no cure or offers only palliation to the patients. In such circumstances, patients resort to alternative systems of medicine. Often, they ask the doctor's advice. An allopathic practitioner may not have knowledge of other systems. Hence he is not in a position to give advice regarding the therapy. It would be perfectly ethical for him to say that he does not know about the therapy and that the patient has to make the choice.

There are two ethical principles involved in this response. The first of these is the need for not deceiving others. Alternative systems of medicine may have an answer to the patient's problem. By not

allowing the patient their benefit, the practitioner is deceiving the patient through his ignorance.

Other ethical elements involved are the virtues of compassion, honesty and humility. When a patient is suffering and allopathic medicine cannot offer much relief or a cure, it is compassionate on the part of the practitioner to allow the patient to try alternative systems of medicine. A practitioner practises the virtues of humility and honesty when he agrees to the patient's requests because he accepts that his knowledge and skills are limited.

Just as there is a right not to deceive there is also an obligation on the part of the practitioner to see that his patient is not deceived when he undertakes an alternative system of medicine. If a practitioner has the knowledge that a particular treatment is useless and would be a financial drain on the patient's resources, it is the practitioner's duty to inform the patient accordingly.

For example, many alternative systems of medicine profess to have a cure for AIDS. Some patients who have undergone these therapies have spent money and in the end suffered and died. If the practitioner has this prior knowledge and if a new patient asks about such therapies, a practitioner should have no hesitation in advising against the therapy.

Very often, patients ask their doctors whether they should discontinue allopathic therapy when they try alternative systems of medicine. The answer to this question depends on the situation. If there is a definite cure and there is a public health hazard if the patient is not treated then a practitioner should strongly advise the patient to discontinue the medications. For example, in TB there is an effective cure and non-treatment could lead to the spread of infection in the community. Here the ethical principle involved is that of beneficence. The practitioner is acting for the good of the patient while protecting the rights of uninfected persons not to be infected. Practitioners also have a duty to the community. When the allopathic therapy is beneficial for patients, my advice would be to continue both treatments, for example insulin in NIDDM patients.

Patients may try alternative systems of medicine and return to allopathy when they find the alternatives useless. What should practitioners do? Twenty or 30 years ago practitioners would refuse

to treat such patients since they had refused to practise what was ordered.

We have come a long way from that paternalistic model of the patient-doctor relationship. Nowadays most practitioners come to a shared understanding with the patient about his therapy. Many physicians will berate such patients and treat them again as if nothing has happened. Here they exhibit the virtue of tolerance. The patient's experience also enhances the practitioner's knowledge about the efficacy of the alternative therapy and its side effects, enabling him to give better advice to the next patient who asks about such therapy.

Can a practitioner refer a patient to a practitioner of an alternative system of medicine? The code of medical ethics of the Medical Council of India does not permit it. The code states that a practitioner should not associate with a person who does not practise medicine on a scientific basis. As the scientific basis of many of the alternative systems of medicine is not known, a practitioner should not refer a patient to an alternative system of medicine.



Iatrogenic error and truth telling: a comparison of the United States and India

Shishir Maithel

It is not uncommon for health care professionals to make mistakes. All physicians and many lay people are aware of this fact. But it is difficult to openly discuss the subject because of the aura of infallibility that often surrounds physicians and medicine. This paper is among the first pieces of empirical research published in the journal. The writer captures the views of Indian and American doctors on the question of telling a patient that they made a mistake. We learn, rather to our surprise, that similar attitudes and problems exist among both sets of doctors – a lack of training, concern about litigation and a common understanding of ethical practice.

At the core of the doctor-patient relationship is a feeling of trust between the two. If a patient does not trust his/her physician, then the physician's effectiveness is greatly compromised. Patients must know that their physicians have their best interests in mind and are telling the truth about their illness and progress. The physician is also ethically obliged to report the truth to the patient, the exact extent being debatable among different cultures.

The history of literature on medical truth telling dates as far back as 1803 when Thomas Percival wrote: "to a patient who makes inquiries which, if faithfully answered, might prove fatal to him, it would be a gross and unfeeling wrong to tell the truth." (1) This view can be contrasted with, for instance, that of Saul S Radovsky who writes: "doctors are not wise enough to tell in advance who should not be told [and] that shielding is ultimately impossible and that the price of its temporary achievement is an enduring sense of betrayal. Once lied to, even supposedly in their own interest, people will not trust fully again." (2) The trend, from withholding information to telling the truth, is supported by surveys which show

that in 1985 at least 70 per cent of physicians believed in telling patients about their cancers as opposed to 12 per cent just 24 years ago (2). It is safe to say that most people want their doctors to tell them the truth. The only concern is the manner in which it is disclosed. As Norman Cousins writes, "The real issue is not whether the truth should be told but whether there is a way of telling it responsibly. Certainly it should not be allowed to become a battering ram against the patient's morale, impairing his ability to cope with the greatest challenge of his life."(3)

One subject of much discussion is whether or not to reveal iatrogenic error. Many physicians are reluctant to inform their patients of their mistakes. In a study of house officers in the US, the patient and/or family was informed of the mistake only 24 per cent of the time (4). Patients, on the other hand, want to be told of any mistakes. In another study, 98 per cent of the patients surveyed "desired or expected the physician's active acknowledgement of an error." (5) Legal concerns, such as fear of a lawsuit, are considered to be a major reason for physicians withholding information from their patients. However, the same study found patients nearly twice as likely to report or sue their physician if they discovered the mistake independently (5). Thus, it may be in the physician's best interest to just tell the truth.

There is no universal standard for truth telling. The exploratory study reported here compares the Indian and US systems, specifically on the issues of whether iatrogenic error affects treatment decisions and how mistakes are handled. I expected that fewer Indian physicians would choose to resuscitate a terminally ill patient who suffers a cardiac arrest, and fewer Indian physicians would choose to disclose an error to the patient and /or family.

Methods

A questionnaire was distributed to convenience samples of physicians in New Delhi, India, at the Indraprastha Apollo Hospital outpatient department, and in the United States at the University of Chicago Hospitals in Chicago, Illinois.

The questionnaire opened with a clinical case vignette, based on a model developed for another study by Dr David Cassarett, which presented the physicians with three possible scenarios:

- A 75-year-old, terminally ill patient suffers a cardiac arrest.
- A 75-year-old, terminally ill patient suffers a cardiac arrest as a result of an *unknown* allergy to a prescribed antibiotic.
- A 75-year-old, terminally ill patient suffers a cardiac arrest as a result of a *known (by the physician), but forgotten*, allergy to a prescribed antibiotic.

In each case, the physician is asked whether or not he/she would resuscitate the patient.

This case vignette is designed to reveal any differences in resuscitation decisions when the cardiac arrest is due to iatrogenic error.

The second part of the questionnaire addressed issues such as:

- Who is informed when a mistake is made?
- Are there any legal issues that are of concern when revealing iatrogenic error?
- Was any training received in medical school on how to handle mistakes?

Results

Physicians at Indraprastha Apollo Hospital in New Delhi, India

Of a total 86 Indian physicians available, 41 were approached and 40 complete questionnaires were obtained. Their ages ranged from 28 to 60 (mean = 41) years old, and the number of years in practice varied from one to 36 (mean = 14) years. 82.5 per cent of the surveyed physicians were male. Thirty-four had received a majority of their training in India while six received it in Britain. The majority of physicians were specialists in internal medicine.

When asked whether they would resuscitate a terminally ill patient, with at most a few weeks to live, who suffers from cardiac arrest (scenario 1), 55 per cent responded that they 'certainly' or 'probably' would. However, when the cardiac arrest resulted from an unknown allergy to a prescribed antibiotic (scenario 2), the percentage increased to 87.5 per cent. When the allergy was known, but merely forgotten by the physician (scenario 3), the percentage who would resuscitate climbed to 95 per cent, which is all but two physicians.

There was no significant difference between scenarios 2 and 3, suggesting that the physicians were assuming similar responsibility

when the allergy was unknown (scenario 2) and when they forgot about the allergy (scenario 3). This may imply that the physicians considered the cardiac arrest to be iatrogenic in both scenarios 2 and 3. The most popular explanation provided by the physicians in their responses was that they were ethically bound to resuscitate and felt a sense of moral duty when the cause of cardiac arrest was iatrogenic in nature.

The next question was if there was an office to which they should report a medical error. Twenty-three (57.5 per cent) responded that no such department existed. Of the 17 physicians who said that there was such a department, a variety of answers including “the director of medical services” were given when asked to name the office.

Seventy-five per cent of the physicians practising in India responded that they would report an error to the patient, and 72.5 per cent said they would report to the patient’s family as well. The most common reason for disclosure expressed by the physicians was their sense of ethical duty to be honest with the patient and family. The second most popular reason was that the physicians wanted to discuss the possible complications resulting from the error. Only five physicians would not reveal an error to a patient and five said that it depended on the situation. Thirty-six physicians, or 90 per cent, expressed some concern for legal issues when revealing an error. Because of the recently passed Consumer Protection Act in India, 27 physicians specifically mentioned their fear of a lawsuit.

Sixty-five per cent of the physicians had not received any instruction in their medical training on how to handle a mistake, which interestingly included all six physicians who had received a majority of their training in Britain.

However, when asked to whom a physician is obliged to report an error, the three most common responses were: hospital authorities; patient and family, and the medical director or senior physician in charge. Shockingly, 87.5 per cent of these physicians felt this ‘almost never’ happened, and if it did, only ‘less than half’ of the time.

Physicians practising at University of Chicago Hospitals in Chicago, Illinois, USA

Fifty-three physicians were approached at the University of Chicago Hospitals, and 40 completed surveys were obtained. The age of the physicians ranged from 26 to 75 (mean = 38) years, and the number of years in practice ranged from 1 to 40 (mean = 9.5) years. Sixty per cent of the physicians surveyed were male. The majority of physicians were specialists in internal medicine. Thirty-six received a majority of their training in the United States, one received it in India, and three studied in other countries.

When asked about scenario 1, 50 per cent said they 'certainly' or 'probably' would resuscitate the patient. The percentage increased to 82.5 per cent for both scenario 2 and scenario 3.

Again, there is no difference between the results of scenarios 2 and 3. The physicians expressed an obligation to resuscitate the patient, especially when the cause of the cardiac arrest was iatrogenic in nature.

Eighty-five per cent (34 physicians) of the US physicians said that there was an office to which to report medical errors, and an overwhelming majority of them agreed that it was the medico-legal (risk management) department.

Ninety per cent (36 physicians) said that they would report an error to the patient, and 75 per cent would reveal the error to the patient's family. As with the Indian physicians, a sense of moral duty to be honest with the patient and family was the motivation. The decrease in percentage to reporting to the family may be explained by the opinion of some physicians that it is the patient's decision whether or not to tell the family. Thirty-four physicians, or 85 per cent, expressed some concern for legal issues when disclosing the error. Of these, all but two specifically mentioned the fear of a malpractice lawsuit.

Fifty per cent of the physicians said their medical training did not include instruction on how to handle mistakes. However, when asked to whom a physician is obliged to report an error, the majority agreed that the patient should be informed. Compared to the 87.5 per cent of Indian physicians, only 52.5 per cent of the US physicians felt that this rarely or almost never happened.

Conclusion

Except for two of the survey questions, the responses of the Indian and US physicians did not differ significantly.

One difference was when the physicians were asked whether or not an office or department existed in the hospital to which to report a medical error. Twice as many US as Indian physicians said that such a department existed.

The second major difference was in how often physicians in the two countries felt medical errors were reported. In India, 87.5 per cent of the physicians felt that it happened 'less than half' of the time to 'almost never', compared to 52.5 per cent of the US practising physicians.

Discussion

The similarities in the responses of two groups of physicians are striking and unexpected. This study was conducted with the expectation that physicians in the US would be more likely to resuscitate than those in India, mainly because the US has more resources and its legal system encourages resuscitation. It was also believed that in India, physicians would be less likely to resuscitate a 75-year-old, terminally ill patient because of cultural or spiritual beliefs. In fact, the actual percentages of resuscitation were higher, though not significantly so, for the Indian sample.

It was also believed that the US emphasis on having informed patients and the emphasis on truth-telling as a part of ethical medical practice would encourage US physicians to disclose errors to the patient and / or family.

However, similar percentages of Indian and US physicians responded that they would discuss the error with the patient and/or family. The Indian physicians also had the same legal concerns and a similar percentage had received training on how to handle mistakes.

This exploratory study thus serves to point out similarities between the two countries. One cannot assume that a developing country with limited resources will differ in every aspect when compared to a rich country. The results suggest that at least these two samples

of physicians have a common mentality and protocol when dealing with iatrogenic error and truth telling.

However, the significant differences mentioned suggest that the Indian medical system is not as prepared and equipped to handle legal affairs as is the US medical system. In the United States, malpractice suits are common. Thus, the University of Chicago Hospitals have invested the time, money, and man-power to create a department to handle legal affairs and protect physicians. Physicians are aware of this support, perhaps encouraging them to say that the proper authorities or people are informed of a medical error. However, malpractice suits are relatively new in India. Hospitals may not be prepared to handle such extensive legal affairs. This would explain why fewer Indian physicians reported that such an office existed, the variety of responses on which the office was, and why fewer Indian physicians feel the need to report a medical error.

While the small convenience samples and sensitive issues addressed prevent generalisation of these conclusions, these findings suggest that both cultural differences and similarities exist and they are not necessarily what we would expect them to be.

The author would like to acknowledge the contributions of Carol B Stocking, PhD, and the MacLean Center for Clinical Studies.

References

1. Leake CD, editor. *Percival's medical ethics*. Baltimore: Williams & Wilkins; 1927: 186-196.
2. Radovsky SS. Bearing the news. *New Engl J Med* 1985, 313: 586-588.
3. Cousins, N. A layman looks at truth telling in medicine. *JAMA* 1980; 244: 1929-1930.
4. Wu AW et al. Do house officers learn from their mistakes? *JAMA* 1991; 265: 2089-2094.
5. Witman AB et al. How do patients want physicians to handle mistakes? *Arch Int Med* 1996; 156: 2565-2569.