



Reactions to adverse events among Australian and Norwegian doctors

Ivar J Araas, MD, PhD, is Associate Professor and Lecturer in General Practice and Public Health, University of Tromsø, Norway.

Barbara Jones, GradDipClinEd, MCISc, FRACGP, is National Manager – Education Policy, The Royal Australian College of General Practitioners.

Tarun Sen Gupta, FRACGP, FACRRM, is Associate Professor of General Practice and Rural Medicine, James Cook University School of Medicine, Queensland.

Honest disclosure is emerging as the ideal approach toward adverse events, in contrast to the previous approach of concealing them.¹ Nevertheless, errors and complaints still cause negative emotions and personal crises among doctors, making them the 'second victims'.²⁻⁴ This can threaten doctors' relationships with their patients, colleagues and themselves.

Method

We explored doctors' attitudes toward adverse events in a series of workshops in Australia and Norway in 2002 and 2003 as a means of learning and raising awareness of this issue. Doctors completed a questionnaire about their personal experience and reactions to a personally experienced serious adverse event. The ensuing session was a reflective discussion about the professional approach toward adverse events. The majority of participants (88 out of a total of 103; 46 from Australia, 57 from Norway) were general practitioners.

Results

Most agreed on the appropriate way of responding after a serious adverse event in nine of the 10 suggested reactions (*Table 1*). There were no differences between Norwegian doctors and Australian doctors. One question was contentious – whether to

seek legal advice before contacting the patient (Q2) (*Table 1*); with doctors in both countries equally divided in their responses.

Subsequent workshop discussion revealed that sharing the story with a colleague (Q3) and making an apology to the patient (Q7) (although opted for by most) nevertheless left them emotionally uneasy. To apologise was acknowledged to be 'politically correct'. However, this would not always be in accordance with their honest,

personal feelings, because to apologise would imply taking an unfair proportion of personal responsibility for the inherent uncertainty of medical practice, and an apology would imply admission of guilt and encourage litigious patients and relatives to make claims.

Other colleagues suggested that to approach a lawyer before the patient and not apologise would raise patients' distrust and increase rather than reduce the risk of litiga-

Table 1. Possible reactions after an adverse event has caused permanent health loss or death

Question presented to the 103 doctors Following an adverse event...	Doctor answers (n)	
	Yes*	No**
1. Try to avoid further contact with the patient/family	8	93
2. Seek legal advice before contacting the patient	49	53
3. Share the story with a colleague you can trust	100	3
4. Contact the patient and disclose in full what happened	101	2
5. Inform the patient about their avenues of complaint	80	23
6. Try to persuade the patient not to complain	8	94
7. Make an apology, at least for the outcome	101	1
8. Encourage the patient to ventilate any bad feelings	88	13
9. Express openness for long lasting follow up contact	101	2
10. Express interest in learning from the experience	100	3

* Yes includes 'yes' + 'possibly yes'

** No includes 'no' + 'possibly no'

tion. This conveyed one essential learning point in the workshop, important for eight doctors who initially would have tried to avoid further contact with the patient, and for 49 doctors who would have tried to obtain legal advice before contacting the patient.

Another important learning point concerned the emotional discomfort of many doctors after a serious adverse event resulting in mistrust between colleagues when doctors had escaped responsibility for adverse incidents by blaming another colleague. In one example, a GP was blamed for insufficient prenatal care by the specialist following a caesarean section in which the baby had died. Several doctors had been humiliated by colleagues who had criticised their management with the wisdom of hindsight.

Discussion

Our data confirm previous work⁵ suggesting most doctors think they should share the story of an adverse event with a trusted colleague. The impact of trust (as well as distrust) in professional relationships is probably underestimated. We found that doctors are still inclined to self protection, perfectionism and distrust; attitudes that are counterproductive to appropriate resolution of adverse events. The approach outlined in these workshops is a strategy to raise doctors' awareness and understanding of the importance of trust related issues in adverse events.

Implications of this study for general practice

What is already known

- After an adverse event it is appropriate:
 - to contact the patient and disclose what happened
 - to make an apology (at least for a bad outcome).

What this study shows

- sharing the story with a colleague one can trust may be helpful
- GPs are cautious about trusting some colleagues.

Conflict of interest: none declared.

References

1. Coulter A. After Bristol: putting patients at the centre. *BMJ* 2002;324:648-651.
2. Allsop J, Mulcahy L. Doctors' responses to patient complaints. In: Rosenthal MM, Mulcahy L, Lloyd-Bostock S, editors. *Medical mishaps: pieces of the puzzle*. Buckingham: Open University Press, 1999;124-140.
3. Wu Albert W. Medical error: the second victim. *BMJ* 2000;320:726-727.
4. Cunningham W. The immediate and long term impact on New Zealand doctors who receive patient complaints. *NZ Med J* 2004;117.
5. Kennedy EM, Heard SR. Making mistakes in practice. Developing a consensus statement. *Aust Fam Physician* 2001;30:295-299.

AFP

Correspondence

Email: ivar.aaraas@ism.uit.no

The 5 domains of general practice



1. Communication skills and the patient-doctor relationship



2. Applied professional knowledge and skills



3. Population health and the context of general practice



4. Professional and ethical role



5. Organisational and legal dimensions

Call for GPs to participate in innovative research

The Centre for Health Informatics, University of New South Wales (UNSW) is inviting GPs to participate in an innovative research study to determine the impact of online evidence.

This trial has been approved by the RACGP QA&CPD Program as a clinical audit activity for this triennium TOTAL CPD POINTS for Steps 1-4: 20 (Group 1).

The audit will be run into the next triennium and points will be awarded upon completion.

The chief investigators are:
 Prof. Enrico Coiera, UNSW
 Prof. Michael Kidd, University of Sydney
 A/Prof. Johanna Westbrook, UNSW
 Prof. Richard Day, UNSW.

For more information and registration please visit:
<http://quickclinical.med.unsw.edu.au/QCPR>

email:
 QuickClinical@unsw.edu.au

Fax your contact details to:
 02 9385 1813 or call 02 9385 1074



THE UNIVERSITY OF
 NEW SOUTH WALES
 SYDNEY · 2052 · AUSTRALIA