Pragmatic considerations aside, there is a more fundamental reason why expecting or requiring physicians to reveal error is wrong. In a free country all individuals are guaranteed the right to be secure in their own person. The recognition of this right leads to the recognition of other rights, including the right of the individual not to incriminate himself and to be presumed innocent. If physicians are to be obliged to reveal error, they will be obliged to give up these rights, serving themselves up on a platter for immolation by the state through its regulatory agencies, such the colleges, or through civil and possibly criminal litigation. This would be a flagrant violation of a physician's right to the security of his person and cannot be supported.

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Reference

1. Hébert PC, Levin AV, Robertson G. Bioethics for clinicians: 23. Disclosure of medical error. *CMAJ* 2001;164(4):509-13.

[The authors respond:]

We are not entirely surprised by Michael Aubrey's rather strong reaction to our article.[1] Indeed, we believe his views may be shared by other physicians. Aubrey's main concern is not, however, an ethical one, but rather one arising out of legal prudence. This caution is based on the feared ill consequences of disclosure for the *physician* — that revelation of error might increase the risks for successful malpractice actions against him or her. Experience, reason and, perhaps most importantly, current research should allow the practice of medicine to move beyond this fear.

Research suggests that honesty with patients and their relatives about medical error tends to strengthen the physician–patient relationship and so reduces the likelihood of lawsuits and professional misconduct hearings. Disclosure that is thorough and timely prevents the feelings of dissatisfaction and discontent that are often the real trigger for complaints against physicians. Thus, even seen from a narrow "prudential" approach, honesty with patients about error is generally the best policy. Such disclosure need not, and indeed should not, imply negligence or malpractice by anyone.

Currently, when medical error results in harm and, in turn, creates financial hardship for a patient (such as loss of employment), the patient has only one way to seek compensation for his or her losses: through the legal system. Is Aubrey suggesting that patients who have suffered serious injury owing to medical error be prevented, by lack of honesty about what caused the injury, from exercising their right to seek needed compensation? Such dishonesty would compound the harm suffered by the patient and be a breach of professionalism.

True professionals admit their errors, seek to understand them and prevent them for recurring, and move on. Candidly disclosing harmful errors to patients simply closes the loop of learning, compassion and trust that is the foundation of the practice of medicine.

Yes, being sued can be painful and perhaps even destructive. But it would be far worse, for individual patients and for society, if we failed to use the commission of an error as an impetus to be frank about our mistakes and as an opportunity to improve patient safety.

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Reference

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Take a lesson from the drug companies

The authors who recently reviewed the barriers that inhibit the implementation of hypertension management guidelines in Canada[1] neglected to mention what might be one of the most important factors: the powerful influence of pharmaceutical manufacturers' marketing campaigns on physician practice patterns.[2] The freebie phenomenon was addressed in a news item in the same issue of *CMAJ* in which the review appeared.[3] Flip through the pages of that particular issue and you will come across 5 glossy advertisements promoting angiotensin-converting-enzyme inhibitors or AT_1 receptor blockers in the treatment of hypertension. Clinical practice guidelines are reflected only in footnotes in tiny print stating that the drugs being advertised are indicated when treatment with diuretics or β-blockers is ineffective or not appropriate.

If the groups that create clinical practice guidelines are wondering how to influence physicians' practices more effectively across the country, perhaps they should take a lesson from the drug companies: give out lots of free samples and promotional items, host elaborate events at which physicians are told about the excellent safety and tolerability profiles of the recommended drugs and place glossy 2-page ads in each issue of *CMAJ*. Apparently, it works.

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1. McAlister FA, Campbell NRC, Zarnke K, Levine M, Graham ID. The management of hypertension in Canada: a review of current guidelines, their shortcomings and implications for the future. *CMAJ* 2001;164(4):517-22.
2. Wazana A. Physicians and the pharmaceutical industry: Is a gift ever just a gift? *JAMA* 2000; 283(3):373-80.
3. Sibbald B. Doctors asked to take pledge to shun drug company freebies. *CMAJ* 2001;164(4):531.

Choosing family medicine

As a third-year medical student trying to choose a specialty, I was interested in your recent article on the residency match.[1] I am attracted to family medicine's breadth and its emphasis on the total care of the patient. I recognize the value of continuity of care: by knowing your patients, you can see their medical problems in context. In other words, you can treat the patient, not just the disease.

However, to a person in his 20s, the concept of continuity of care can seem stifling: "For the good of your patients, you must never leave!" What if you are a family physician who ends up in an underserviced community and after a few years you are miserable? If you pack up and leave, you betray your patients. Furthermore, the energy (and money) you invested in your practice may be lost.

Sadly, most family physicians must become business managers as well as doctors: they must buy their equipment, hire staff, recruit patients, struggle with office expenses and hope that their practice stays afloat. Sometimes it seems much more attractive to work as an internist in a hospital because the office, the equipment and even the patients may be provided. Thus, you are free to practise medicine instead of trying to run a business. You are also surrounded by colleagues with whom you can discuss cases, socialize and engage in research projects.

On one hand, being a family doctor who provides total care seems exciting. On the other hand, I am scared that in doing so I will be trapped forever in some isolated community, cut off from the world of research and buried under a mountain of office expenses and paperwork.

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Reference

1. Sullivan P. Family medicine loses lustre as students "vote with feet" in 2001 residency match. *CMAJ* 2001;164(8):1194.

I was surprised your article on the 2001 residency match[1] did not mention the introduction of the 2-year family medicine residency, albeit almost 10 years ago, as a factor in the declining popularity of family medicine among medical students.

I graduated from Dalhousie in 2000 and am currently a first-year resident in anesthesia. During medical school I considered a career in family medicine and enjoyed my rotations in it during clerkship. I would love to have had a chance to practise it for a few years before ultimately deciding whether to specialize further. However, my decision to apply only to anesthesia was based, among other reasons, on the belief that it would not be worth losing 1 to 2 years of training (which is the cost of doing a 2-year family medicine residency and later beginning in another specialty program and having to repeat PGY-1 or PGY-2 or both). This and