Debating the patient's "right to know"

I write further to the contributions by Eike-Henner W. Kluge[1] and C. David Naylor[2] on whether physicians' practice profiles should be made available to the public.

Kluge's proposal is much like Swiss cheese — tantalizing but full of holes. Even if we accept Kluge's expansion of the concept of informed consent — and some recent lower court decisions suggest he is on the right track — there is no evidence in his article that the information he proposes to provide to patients and (or) health care consumers is relevant or helpful in selecting a competent physician. Naylor does a good job of pointing out the practical problems associated with Kluge's suggestion and of proposing how we might find solutions.

The question that needs to be answered is whether there is any connection between a physician's involvement in a legal action or a disciplinary proceeding and the competence of that physician (not to mention the ability to provide quality care in a compassionate manner acceptable to patients). Although licensing bodies can begin to look at this question, there is only one source that provides the link with legal actions — the Canadian Medical Protective Association (CMPA).

The CMPA's annual reports indicate that it has a database of almost 20 000 legal actions involving Canadian physicians. Several hundred disciplinary matters and several thousand matters regarding licensing body complaints are also available for analysis. We must begin to learn from this gold mine of bad outcomes. To date, the efforts of the CMPA's own Education and Research Department, although interesting, have not begun to address even remotely the questions raised by Kluge and Naylor.

Any such analysis must be done in a fashion that meticulously respects confidentiality. It is hard to imagine that conditions could not be put in place that would overcome the CMPA's reticence about allowing outside physicians access to data. Indeed, it is very hard to imagine that a research scientist of Naylor's reputation should not be allowed to examine the potential relationship between a physician's involvement in a legal action or disciplinary matter or both, and the competence of that physician through analysis of the CMPA database.

For the CMPA to allow such a scientific and confidential examination of the database would be to provide some of the basic building blocks that will ensure the provision of quality care to patients in Canada. Even as it continues to provide physicians with legal defence assistance, the CMPA can also play an important role in helping to develop a better understanding of the issues raised by Kluge and Naylor.

Where is evidence-based medicolegal investigation when we really need it?

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References
1. Kluge EHW. Informed consent in a different key: physicians' practice profiles and the patient's right to know. *CMAJ* 1999;160(9):1321-2.
2. Naylor CD. Reporting medical mistakes and misconduct. *CMAJ* 1999;160(9):1323-4.

[Dr. Kluge responds:]

I thank Robert Robson for likening my proposal to Swiss cheese, which is a classic that has stood the test of time, the holes notwithstanding. If my proposal attains similar status, I shall be well pleased.

Jokes aside, his letter raises 2 interesting and important points: that it is up to the medical profession and "research scientists" to decide what information about physicians is appropriate or useful for patients to know before they select a doctor, and that the CMPA is the appropriate agency to provide such information.

Regarding the former, it strikes me as odd that Robson, a risk-management consultant, should have missed the point of my ethical analysis and the significance of the lesson provided in *Reibl* v. *Hughes*[1] and *McInerney* v. *MacDonald*.[2] In these cases the courts stated very clearly that it is not up to the medical profession to decide what should be revealed and what may be withheld from a patient. Arguing the very ethics of informed consent that I sketched in my article, the court stated that the standard of disclosure should be what the objective, reasonable person in the patient's position would want to know. Therefore, both the ethics and case law make it very clear that it is not up to the medical profession (or research scientists) to decide what should and what should not be revealed. It also bears emphasizing that these decisions were not "some recent lower court decisions" but rulings by the Supreme Court of Canada.

As for the second point, I think the CMPA would be the last agency one would turn to for the information Robson mentions. The CMPA's mandate is to provide legal assistance to physicians, so its perspective is litigious and physician oriented. How would this organization address the ethics of patients' demands for information on physicians? Further, the CMPA's mandate is not to do longitudinal follow-up studies of the practice patterns of physicians who have been subjected to legal or disciplinary action. Consequently, the CMPA database could not possibly yield the information that Robson suggests is relevant. Databases of the licensing authorities could do this, a fact I did not mention in my article because of space limitations.

In the end, I believe that the court findings in *Reibl* v. *Hughes* and *McInerney* v. *MacDonald* — as well as in *Malette* v. *Shulman*[3] — speak for themselves.

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References
1. *Reibl* v. *Hughes* [1980], 2 SCR 880.
2. *McInerney* v. *MacDonald* [1992] 2 SCR 138.
3. *Malette* v. *Shulman* [1990], 67 DLR (4th) 321.

[Dr. Naylor responds:]

I will address one issue that, from media accounts, has galvanized public interest in seeking more publicity about college disciplinary proceedings: venue-

shopping by physicians who have lost their licences in one province and successfully seek licensure elsewhere. I do not know how often this occurs, but the solution is tougher and more consistent self-regulation. This includes cooperation among the colleges to keep sexually abusive, chronically impaired or incompetent physicians out of practice in every province unless there is unequivocal evidence that it is safe for them to resume clinical work — with or without ongoing conditions and supervision.

I understand that the Federation of Medical Licensing Authorities of Canada has initiated more systematic sharing of information on discipline and assessment proceedings, and it is also testing a system of unique national identifiers for all licensed physicians.[1]

As Robson argues, available research suggests that successful malpractice suits are neither specific nor sensitive measures of clinical competence. Disciplinary actions appear more specific but are hopelessly insensitive to most of the systematic quality problems in modern medical care. Although I accordingly question whether individual patients will truly benefit from better access to this information, informed consent is not the only rationale for Kluge's proposal. In an essential-service sector where the state has ceded substantial self-regulatory privileges to providers, the balance must inevitably be weighted in favour of transparency — the public's "right to know." With due attention to practicalities and potential pitfalls, Kluge's proposal merits serious consideration on the latter grounds alone.

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Reference

1. Wharry S. Every MD will soon have unique "cradle-to-grave" identifying number. *CMAJ* 1999;160(6):896.

Fruitful discussions about drug interactions

I was struck by the similarity of a recent *CMAJ* editor's preface on drug interactions[1] to a piece I wrote a couple of years ago.[2] To date the drug interactions with grapefruit appear to include inhibition of gut wall cytochrome P450 3A4 by naringin and dihydroxybergamottin,[3] as well as an interaction with P-glycoprotein.[4] In the case of drug–drug interactions, there are mechanisms for warning physicians, pharmacists and patients. However, in the case of grapefruit, special efforts are required: grocers seldom take a drug history when dispensing grapefruit.

In the Australian state of Victoria, it has been required for some time that pharmacists provide warnings when dispensing some drugs with known grapefruit interactions[5]; however, not all drugs have been tested for the interaction.

A simple rule of thumb for anticipating grapefruit interaction with drugs is that if erythromycin is a problem, then grapefruit is a problem.

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References

1. Drug interaction: Who warns the patient? [editor's preface]. *CMAJ* 1999;161(2):117.
2. Spence JD. Drug interactions with grapefruit juice: Whose responsibility is it to warn the public? *Clin Pharmacol Ther* 1997;61:395-400.
3. Bailey DG, Arnold JMO, Bend JR, Tran LT, Spence JD. Grapefruit juice – felodipine interaction: reproducibility and characterization with the extended release drug formulation. *Br J Clin Pharmacol* 1995;40(2):135-40.
4. Soldner A, Christians U, Susanto M, Wacher VJ, Silverman JA, Benet LZ. Grapefruit juice activates P-glycoprotein-mediated drug transport. *Pharm Res* 1999;16:478-85.
5. Roller L. Drugs and grapefruit juice. *Clin Pharmacol Ther* 1998;63:87.

Correction

A recent article stated incorrectly that Raheem Kherani of Edmonton is president of the Canadian Federation of Medical Students.[1] When the article was written, that post was held by Marc Zerey of McGill University and Kherani was the federation's western regional representative. We apologize for this error.

Reference

1. Sullivan P. Concerns about size of MD workforce, medicine's future dominate CMA annual meeting. *CMAJ* 1999;161(5):561-2.

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