African Vision and Eye Health
ISSN: (Online) 2410-1516, (Print) 2413-3183

Disclosure of errors in optometric practice in Nigeria

Authors:
Jennifer A. Ebeigbe[1]
Donald S. Iperepolu[1]

Affiliations:
[1]Department of Optometry, University of Benin, Nigeria

Corresponding author:
Jennifer Ebeigbe,
jenniferebeigbe@yahoo.com

Dates:
Received: 25 Aug. 2016
Accepted: 04 Nov. 2016
Published: 31 Jan. 2017

How to cite this article:
Ebeigbe JA, Iperepolu DS. Disclosure of errors in optometric practice in Nigeria. Afr Vision Eye Health. 2017;76(1), a372. https://doi.org/10.4102/aveh.v76i1.372

Background: Human beings are prone to making mistakes, whether in their personal or professional lives. Errors in health care are not uncommon. However, it is not certain if public and professional expectations of disclosure of these errors are met in everyday practice by practitioners.

Objective: The purpose of this study was to investigate patients' and optometrists' attitudes towards disclosure of errors in eye care.

Method: This was a qualitative study conducted in Benin City, Edo State, Nigeria, using focus group discussions (FGDs) and in-depth interviews (IDIs). The study population comprised 24 patients aged 18–42 years, with a mean age (±s.d.) of 38 ± 2.2 years, and 16 eye-care practitioners (ECPs), with a minimum of 5 years' work experience. The optometrists were aged between 32 and 50 years with a mean age (±s.d.) of 42 ± 2.1 years. Three FGDs were conducted with the adult participants, while 16 IDIs were conducted with ECPs.

Results: All participants agreed that errors do occur in eye care. Poor communication between doctors and patients, patients lying to doctors and negligence on the doctor's part were some of the reasons given for the occurrence of errors in optometric practice. Most of the practitioners (14) agreed that major errors should be disclosed when they occur. While many of the patients (20) would want detailed information about the error, a few (4) would prefer the doctor to rectify the error rather than explaining it to them. Practitioners reported fear of litigation as a factor that could discourage them from disclosing errors. Eighteen patients reported litigation as a last resort, in the event of an error. Both parties agreed that errors caused emotional distress to them and also added that additional charges incurred should be borne by whichever party was the cause of the error.

Conclusion: Errors are an unfortunate part of clinical practice. However, if patients were truthful and open in communication with their doctors and if doctors practiced within the ambit of ethical principles, the occurrence of serious errors should be few and far between.

Introduction

It is commonly said that nobody is above mistakes. This means that anywhere human being are involved or have influence, there is bound to be errors or mistakes made. Errors in health care are not uncommon and over 1 million preventable adverse events occur each year in North American hospitals in the realm of health care.[1] Disclosure of errors can be difficult for a doctor, especially when he has to confront the patient or members of his family with the news that his efforts to make the patient well had inadvertently made the condition worse.[2] Disclosure is the process of imparting information pertaining to any health care events affecting or likely to affect patients' interests to them or their families.[3] Research has shown that patients always want full disclosure of errors during their care.[4,5]

Despite the challenges involved in disclosure of errors, both doctors and patients agreed that it was a vital aspect of the doctor's responsibility to his patient. This vital aspect of the doctor disclosing errors to their patient is generally emphasised by most stakeholders in health care.[6] General opinion is for disclosure of errors by doctors in health care, it cannot be ascertain however, if this opinion is carried through in actual practice.[7] By law and ethically, doctors are expected to be truthful to their patients. This is because the patients have absolute trust and dependence on their doctors as experts in the field of medical sciences. For the patient to make appropriate decisions, he should be able to rely on the information given by his doctor as the whole truth.[8]

It is expected by law that relevant information be given to patients who are able to consent to treatment.[4] A few exception, such as the therapeutic privilege exist. According to Cote[9]:

> the therapeutic privilege refers to the withholding of information by the clinician during the consent process in the belief that disclosure of this information would lead to harm or suffering of the patient. (pp. 199–216)

Although this might be relevant in the management of some patients in certain cases, it is arguable whether the doctor is always capable of making such crucial judgement about when to tell the patients the truth or not.

Moral arguments in favour of truth-telling can be justified on the basis of beneficence, non-maleficence and right of autonomy and justice. Truth-telling shows respect for patients, promotes patients' well-being and life choices and reduces the risks of harm to patients thus reducing the doctor's liability.[10] It is important for trust to exist in the doctor-patient relationship. This can be facilitated if doctors and patients have open and honest communication in the management process. A lot of different factors could promote or mitigate against this, especially with patients wanting disclosure of errors and clinician being careful because of the fear of litigation.

Various studies[11,12,13] have been done on disclosure of errors in medical practice but none so far have been carried out in optometric practice in Nigeria. The primary purpose of this study, therefore, was to investigate patients' and optometrists' attitudes towards disclosure of errors in eye care.

Method

This study is a qualitative one conducted in Benin City, Edo State, Nigeria. The study population comprised both patients and eye-care practitioners (ECPs) in Benin City. A total of 24 patients aged between 18 and 42 years with a mean age (±s.d.) of 38 ± 2.2 years and 16 ECPs with a minimum of 5 years' work experience were recruited. The optometrists were aged between 32 and 50 years with a mean age (±s.d.) of 42 ± 2.1 years.

Procedure

Stratified purposive sampling of adult patients who had accessed eye care services at one time or the other or were parents or guardians of children or wards that had benefited from eye care services was done. The adults were those who were willing to participate and were able to understand and speak English or Pidgin English (colloquial English) comfortably.

ECPs were recruited by homogenous sampling; included were those practicing independently and those working in a tertiary facility. Based on the convenience of the participants, they were included either in a focus group discussion (FGD) or in a one-on-one in-depth interview (IDI). FGDs were homogenous. IDIs were conducted in various locations for ease of participation.

All interviews were recorded after obtaining informed consent from the participants. Three FGDs were conducted with the adult participants while 16 IDIs were conducted with the practitioners. Interviews and discussions were conducted in English or Pidgin English. The FGDs and IDIs were conducted until redundancy of responses was obtained in each domain.

Verbatim transcription of all interviews was done by a transcriber. The analysis of textual data was done by data familiarisation. The familiarised data were then coded and themes were generated.

Ethical considerations

Ethical clearance was obtained from the University of Benin Ethics and Research Committee.

Results

A total of 40 subjects participated in this study. Twenty-four patients (14 males and 10 females) were interviewed in three FGDs: 15 of the subjects had tertiary education, 5 were undergraduates and 4 were artisans. Their ages ranged from 18 to 42 years, with a mean age of 38 ± 2.2 years. All participants had accessed eye care services at one time or another, either for themselves or for their wards. Sixteen ECPs were also interviewed (nine females and seven were males). Their ages ranged from 32 to 50 years, with a mean age of 42 ± 2.1 years. The doctors had been in practice for a minimum of 5 years to a maximum of 20 years. Six themes emerged from the study as explained below. Some key statements made by the participants are included to buttress each theme.

Constituents of an error and the general attitude towards errors in eye care

All the participants agreed that errors could occur in eye care. An error was said to have occurred when an ECP gave a patient any form of medication or eye wear that was not appropriate for the condition presented, or intervened in an inappropriate manner leading to a wrong diagnosis. Nine patients considered it gross malpractice for doctors to make serious errors in diagnosis or in the treatment of patients. Fifteen patients stated that doctors were human and as such were prone to human errors which included making mistakes. These errors, however, should be few and far between. They added that most of the errors in judgement that doctors make could be due to the wrong or unclear ways whereby some patients communicate. If patients explained their problems properly, the doctors would understand the issues clearly and would be able to treat accordingly. Eighteen patients added that some patients knowingly mislead doctors, for example, when they fail to give an accurate time of onset of a condition or the duration of a particular ailment. Twenty-two patients stated that people sometimes lie about the forms of medication they had used before seeking eye care services while others may lie about their age. All these could result in errors in diagnosis or in the treatment of a patient.

Poor communication was also reported as a factor that could lead to errors in judgement; however, nine patients did not agree with this. They felt the onus was on the doctor to ask proper questions of the patients so as to get the right information. Ten patients stated that some doctors do not give their patients enough time to explain their complaints before interrupting them and writing down medications for them. Another factor reported that could lead to an error in

management was when senior doctors leave their patients in the care of younger and inexperienced doctors without proper supervision:

> An error means poor judgement that could be due to deficiency in knowledge, the emotional state of the doctor or the withholding of relevant information by patient … (Doctor, Male, 42)

> I know a person who went to the eye clinic for an eye problem. He was given the wrong medication which complicated the problem and the eye was removed … (FGD Participant, Male, 39)

Disclosure of errors by optometrists

Twenty-one patients would prefer that they be informed when an error occurred in diagnosis or in treatment, especially if it results in permanent damage. Three of them said they would rather not know, as long as it did not cause permanent damage and the doctor was doing everything possible to rectify it. They said being told about an error would worry them. But the majority were of the opinion that doctors should volunteer this information.

The ECPs said that ethically they should disclose errors in diagnosis or management of patients. However, because not all patients would react the same way, care should be taken when disclosing these errors. Ten practitioners agreed that they would not disclose an error that they could rectify. They said it was usually better and more productive to go ahead and rectify the mistake that had been made instead of aggravating the patient needlessly. Fourteen practitioners said major errors that could lead to permanent damage should be disclosed to patients by carefully choosing your words so that the doctor or the practice is not open to legal actions.

Among the doctors, fear of litigation was reported as a major factor in deciding whether to disclose an error or not. Eighteen of the patients said legal action would be a last resort for them and they would only consider it, if the doctor is not seen to be doing his or her best in trying to correct the error that had been made. The patients agreed that the doctor's attitude would also play a major role in their decision to seek legal action or not:

> I will not want to be told about an error as long as the doctors can rectify it … (FGD Participant, Female, 34)

> I would want to be told everything about my treatment and condition…. (FGD Participant, Male, 28)

> Doctors owe it to their patients to disclose errors of judgement that occur in the course of treating patients, however there are varying factors that might hinder full disclosure as it affects patients in different cases … (Doctor, Male, 48)

Disclosure of near misses

Both doctors and patients agreed that there was no need to disclose near misses. Since these were errors that never occurred, probably due to the quick thinking of the doctor:

> No … I will not disclose a near miss, because it does not help anybody and it brings ill feelings and make patients question the ability of the doctor … (Doctor, Female, 36)

> If the doctor was able to prevent it, then there is no need for me to know. That is what l am paying the doctor for … (FGD Participant, Female, 31)

Amount of information to be disclosed when an error occurs

Twenty participants reported that they would like to be given details about an error that occurred. They said they would like to have knowledge of how the error occurred, at what point it occurred and if there was anything they could have been done to prevent it. Above all, they would like to know if the error could lead to permanent damage or if it could be corrected and the steps that would be taken to correct the error or the damage that had occurred. Four of them reported that they would not like so much details but would only be interested in the way forward, that is, the steps the doctor was planning to take to rectify the error.

Ten doctors said they would only divulge enough to make the patient understand the current condition. They all agreed on the need for properly worded explanation to protect themselves as well as the practice from litigation. Four doctors were of the opinion that at the point at which an error had occurred, the important step would be to find ways of rectifying the error and not waste valuable time explaining the situation. As such, they were of the opinion that correcting the error would be paramount on their mind and they might not see the need to inform the patients when they had everything under control:

> If an error on the part of the doctor leads to a permanent damage, l would like to be told everything about it and possibly the way forward … (FGD Participant, Male, 24)

> When disclosing errors to patients, the doctor has to tread cautiously so as not to expose himself or the practice to litigations. Words have to be chosen carefully. Not all patients are reasonable … (Doctor, Male, 50)

Emotional state following an error

Twenty-two patients agreed that they would not be happy if the doctor made an error in their management or treatment. They felt this was like a breach of trust, because doctors are supposed to be experts and trained in health matters. The participants reported that errors in management will lead to a distrust in orthodox medicine practice in general and eye care in particular. They reported that errors in diagnosis and management were common with traditional healers or native doctors, but to have to contend with the same issues in orthodox practice was disheartening.

The majority of the patients agreed that their emotional state would depend to a large extent on the doctor's attitude after the error had occurred. The doctor's level of commitment or dedication to seeing that the problem caused was resolved, so as to prevent permanent damage would go a long way in alleviating the patients' fears. It would be more traumatic if the doctor was arrogant, wanting to avoid or shift blame or is un-cooperative in following the condition to a logical, healthy conclusion:

> If a doctor admits to me that he made an error, I will not be happy but I will want to know if it can be corrected. If not, I will leave it for God. Making trouble will not correct it … (FGD Participant, Female, 38)

> I will only seek redress if the doctor is arrogant and wants to avoid blame or pass it to someone else … (FGD Participant, Male, 28)

All ECPs said they would not be happy if an error occurred while they were managing a patient. Errors create an atmosphere of distrust among patients and this would make any doctor sad. Errors also raise questions of incompetence when doctors make mistakes in diagnosis and in treatment. They reported that this does not usually go down well with clinical review boards where the doctor could be sanctioned or reprimanded. These errors usually cause emotional trauma for the doctors, especially if such errors resulted in legal action being taken against the doctor. Such errors have led to the dismissal of some doctors or the withdrawal of their practice license:

> No doctor is happy when mistakes happen, especially the sort that affects patients permanently. Luckily these are not common occurrences and most hospitals have processes put in place to review cases and handle mismanagement … (Doctor, Female, 44)

Responsibility of additional cost of treatment following an error

All participants agreed that if the error was caused by the doctor or the practice, then it would not be fair for the patient to incur additional fees. However, if the error was caused by the patient withholding vital information from the doctor or by not complying with the recommended treatment regimen, then the patient should be made to bear the additional costs of treatment:

> The person that caused the error should bear the additional cost of treatment… if the doctor or hospital staff was responsible they should treat the patient for free. But if it was caused by the patient then he should incur the extra charges … (FGD Participant, Male, 45)

Discussion

Generally, health care professionals are saddled with higher expectations than those required from regular non-health care businesses. These expectations are positive in that they protect patients from incompetence of, or uncaring or selfish exercises by the professionals.[14,15] Health care professionals, including optometrists, have long understood the fundamental responsibility that practitioners have towards their patients. Every profession, every practice and every practitioner are governed by not only legal constraints but also by the ethical concerns of ensuring that the patient is properly served.[16]

The ethical obligations of optometry towards patients are the same as with other health professionals. The requirements of these obligations are that the optometrists recognise, respect and protect the rights of their patients.[17] This generally encourages the patients to develop trust for their optometrists and to participate actively in their management. There are four major ethical principles in eye care, and optometrists are expected to practice within the ambit of these principles.

Beneficence

The principle of beneficence refers to a moral obligation to act for the good of the patients and to do the best one can for them. The patients must leave better than they came. The doctor should have the welfare of the patient uppermost on his mind. Failure to disclose to a patient that a major error had occurred in his management violates the principle of beneficence. This breeds distrust in the doctor-patient relationship. When doctors are truthful and open to their patients, it creates a favourable environment for progress and the patient is able to adhere to the treatment regimen.

Most time doctors would not want to disclose errors to their patients because they want to avoid getting them anxious. Some patients in this study actually reported that they would not want to be told about an error that might have occurred during the process of their management. This would prevent them from worrying unnecessarily. They would rather the doctor just went ahead and corrected whatever error that might have occurred. While trying to practice within the ambit of the rule 'above all, do no harm', doctors might feel justified in withholding certain information which they think might cause some distress to their patients. However, not all patients agree with this position.

Trust is very important in the doctor-patient relationship[18]. This usually works both ways. On the one hand, the doctor needs to trust that the patient has divulged all the necessary information pertinent to the care and management of his condition. This enables the doctor to plan an appropriate course of treatment for the benefit of the patient. On the other hand, the patient also needs to trust that the doctor is telling him the true state of his condition and is not downplaying any aspect, because he does not want to cause the patient any distress. This helps the patient in making informed decisions about their care. Overall this promotes the principle of beneficence.

Non-maleficence

The principle of non-maleficence has to do with the avoidance of harm. Doctors above everything else, seek to do well by their patients. They aim to make patients feel better than they were previously [19]. This avoidance of harm to their patients at whatever cost is exhibited when a doctor has to weigh the options of risks versus benefits before prescribing a drug for a patient. The principle of non-maleficence thrives when there is open and honest communication between doctor and patient.

The desire not to cause harm to their patient might make some doctors withhold the truth from their patients. Although this is with a right motive, it could make matters worse because it could actually cause the patients to speculate about their condition that is not based on facts. This could delay healing or prolong recovery time.[4,20] Withholding of information by the doctor in the doctor-patient relationship can cause a mistrust for eye care services. Patients might feel they are not getting quality services or treatment for the money paid or the time invested in seeking eye care services.[21]

Respect for autonomy

As stated by Sithole[16]:

> respect for autonomy requires a practitioner to respect the choices and decisions that a patient makes about his or her health. This involves keeping the patients informed of their condition, treatment choices and options so that decisions made are based on pertinent facts. (pp. 93–99)

If vital information is kept from patients, it could impede their decision making process. The principle of respect for autonomy can only be effective in a truthful relationship. No matter how bad the prognosis of a condition is, it would be better if the patient is truthfully informed about it, so they can know what to expect and prepare better for the process.[4]

Justice

Justice refers to being fair to patients in every aspect of their care. Patients usually want to get their money's worth. When patients pay for treatment, they expect to get quality care. Principle of justice ensures that patients get what they deserve and are not treated less than they deserve. Therefore, if an error occurs in the course of managing a patient, it is fair that the doctor discloses this to the patient. This is justice. Ideally, patients should also be refunded any additional cost of treatment that they might have incurred due to the occurrence of such errors.[22] In this study, both patients and physicians agreed that if the doctor was responsible for an error, the financial burden should be borne by the doctor or the practice. On the contrary, if the patient was responsible for the error, then the patient should be responsible for the extra cost of treatment.

Doctors avoid disclosure of errors for a number of different reasons, which include fear of litigation, fear of losing the patient, loss of reputation or even fear of losing their practice licence or their job.[23] Most of the patients in this study reported that they would seek redress in a court of law, only as a last resort. This shows that although patients could sue for compensation if they feel that they have been treated badly, this was usually not their first course of action. As reported by some patients in this study, sometimes, a simple apology from the doctor would suffice. Doctors need to be trained in the act of communicating bad or difficult news to patient. It should not be left to the doctor to manage anyhow they deem fit. Some people advocate that medical students should have this inculcated into their basic training. They should be trained in the act of being honest and communicating openly with their patients. This will go a long way to preparing them for actual practice.[24] When doctors practice within the ambit of their professional ethics, it serves to protect the vulnerable public from practitioners who would want to take undue advantage of them.[25]

Errors are an unfortunate part of clinical practice. They can stem from patients when there is little or no accuracy in the information they give to the doctor or when some patients deliberately mislead their doctors when they fail to give accurate information about the onset of their condition, previous medications used or actions taken before visiting the clinic.

In this study, patients and practitioners agreed on disclosure of errors that cause harm, but they disagreed on the extent of information to disclose regarding such errors. While patients wanted information regarding the cause and consequences of an error, many of the practitioners, while striving to be truthful, were reluctant to provide patients with detailed information. This was as a result of the fear of litigation or withdrawal of their licence by relevant boards.

There was unanimous agreement among the patients in this study that appropriate behaviour from a doctor, such as rendering an apology and being truthful may pacify them. Also, there was a general agreement from both patients and ECPs to be quiet about a near miss because it does not help anybody.

If ECPs understand the reasons why patients want full disclosure of errors in eye care, it may increase their willingness to provide the information that patients seek. In addition, talking with patients about standard measures put in place for prevention of errors may make disclosure conversation more positive and less threatening to the ECPs.

Conclusion

Honesty, they say, is the best policy. This should be the rule of thumb in the doctor-patient relationship, where communication is key. Both parties should relate truthfully with each other, in terms of the patient revealing pertinent information relevant for the doctor to make a proper diagnosis and map out a good treatment plan, to the doctor passing out detailed and comprehensive information required by the patient to make an informed decision. Trust is built where honest interaction exists. When doctors and patients relate truthfully in their dealings with each other, each party gets the desired outcome from the eye care experience.

Acknowledgements

The authors thank the African Vision Research Institute for financial assistance with publishing page fees.

Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

Authors' contributions

J.A.E. was responsible for the concept and writing of the paper. D.S.I. and J.A.E. both participated in conducting the FGDs and IDIs.

References

1. Koln L, Corrigan J, Donaldson M. To err is human: Building a safer health system. Washington, DC: National Academic Press; 2000.
2. Seyedeh M, Ahmad K, Fariba A. Medical error disclosure: The gap between attitudes and practices. Postgrad Med J. 2012;88(1037):130–133. http://dx.doi.org/10.1136/postgradmedj-2011-130118
3. Gallagher TH, Lucas MH. Should we disclose harmful medical errors to patients? If so, how? J Clin Outcomes Manage. 2005;12(5):253–259.
4. Edwin AK. Don't lie but don't tell the whole truth: The therapeutic privilege – Is it ever justified? Ghana Med J. 2008;42(4):156–161.
5. Lauris K, Elizabeth W, Barry J, Valerie L, Benjamin H, Gary E. Disclosing medical errors to patients: Attitude and practices of physicians and trainees. J Gen Intern Med. 2007;22(9):1384. http://dx.doi.org/10.1007/s11606-007-0299-9
6. Robert J, Blendon R, Catherine M, et al. Views of practicing physicians and the public on medical errors. N Engl J Med. 2002;347:1933–1940. http://dx.doi.org/10.1056/NEJMsa022151
7. Muhammad M, Sahar A, Mohammad A. Which medical errors to disclose to patients and by who? Public preference and perception of norms and current practices. BMC Med Ethics. 2010;11:17. http://dx.doi.org/10.1186/1472-6939-11-17
8. Kathleen M, Steven R, Jerry G. Communicating with patients about errors: A review of literature. Arch Intern Med. 2004;64(15):1690–1697.
9. Cote A. Telling the truth? Disclosure, therapeutic privilege and intersexuality in children. Health Law J. 2000;8:199–216.
10. Edwin AK. Non-disclosure of medical errors an egregious violation of ethical principles. Ghana Med J. 2009;43(1):34–39.
11. Mazor K, George W, Robert A, Fischer M, Joan B, Jerry H. Disclosure of medical errors – What factors influence how patients respond. J Gen Intern Med. 2006:21(7):704–710. http://dx.doi.org/10.1111/j.1525-1497.2006.00465.x
12. Bailey RN. Professional behaviour and the optometric profession. J Am Optom Assoc. 1997;68:693–698.
13. O'Connor E, Coates H, Yardley I, Wu A. Disclosure of patients' safety incidents: A comprehensive review. Int J Qual Health Care. 2010;22:371–379. http://dx.doi.org/10.1093/intqhc/mzq042
14. Bailey RN, Heitman E. Ethics in clinical optometry: An optometrist's guide to clinical ethics. Am Optom Assoc. 2000.
15. Sullivan R, White R, Menapace L. Truth telling and patients diagnoses. J Med Ethics. 2001;27(3):192–197. http://dx.doi.org/10.1136/jme.27.3.192
16. Sithole HL. Ethical issues in optometric practice. S Afr Optom. 2010;69(2):93–99. http://dx.doi.org/10.4102/aveh.v69i2.130
17. Sandra P, Alexia T, Gabriel B, Steven I, Lucia W. Disclosing medical mistakes: A communication management plan for the physicians. Perm J. 2013;17(2):73–79. http://dx.doi.org/10.7812/TPP/12-106
18. Stirrat G, Gill R. Autonomy in medical ethics after O'Neill. J Med Ethics. 2005;31:127–130. http://dx.doi.org/10.1136/jme.2004.008292
19. Stewart C. Strange bedfellows: How medical jurisprudence has influenced medical ethics and medical practices. J Med Ethics. 2003;29(4):e10. http://dx.doi.org/10.1136/jme.29.4.e10
20. Fallowfield L, Jenkins V. Truth may hurt but deceit hurts more: Communication in palliative care. Palliat Med. 2002;16:297–303. http://dx.doi.org/10.1191/0269216302pm575oa
21. Capozzi J, Rhodes R. Lying for the patients' good. J Bone Joint Surg Am. 2004;86:187–188. http://dx.doi.org/10.2106/00004623-200401000-00038
22. Beauchamp T, Childress J. Principles of biomedical ethics. 5th ed. Oxford: Oxford University Press; 2001.
23. Fein S, Hilborne L, Kagawa-Singer M, et al. A conceptual model for disclosure of medical errors. In: Henriksen K, Battles JB, Marks ES, et al., editors. Advances in patient safety: From research to implementation (volume 2: Concepts and Methodology). Rockville, (MD): Agency for Healthcare Research and Quality (US); 2005.
24. Hobgood C, Peck C, Gilbert B, Chappel K, Zou B. Medical errors – What and when: What do patients want to know? Acad Med J. 2002;9(11):1156–1161.
25. Heitman E. Ethical decision making in clinical practice: An optometrist's guide to clinical ethics. Am Optom Assoc. 2000.