ETHICAL ISSUES AND COMMUNICATION OF MEDICAL ERRORS

I. Introduction Part

Addressing ethically relevant issues is part of the medical profession. For example, limited resources may need to be considered during medical decision making, or there may be cases when medical indications and patient preferences are difficult to harmonize. In such cases, it is of paramount importance to analyse and evaluate the ethical and/or legal implications of the situation. Analysing ethical dilemmas or a case from an ethical perspective plays an essential role both in medical decision-making and in the doctor-patient relationship. Closely related to this is the form and manner in which medical errors are communicated. This is a particularly difficult situation for practitioners, since an error can affect patients' the quality of life to a greater or lesser extent, and the patients concerned are in an emotionally sensitive state. Therefore, a well devised communication strategy is needed.

II. Theoretical background

The diversity of the doctor-patient relationship requires that medical communication is to be based on flexible strategies. The various expectations towards the doctor and patients' multilevel ideas may often result in communication situations where it is necessary to harmonize differing perspectives and objectives. In such situations, it can be beneficial if the doctor can identify the critical points and pitfalls before performing a medical intervention or making contact. However, despite all the preparations, mistakes can happen and problems can arise before, during and after treatment.

The general perception is that most doctors try to conceal mistakes. However, this cannot produce positive results concerning legal and heathcare implications, and doctor-patient relationship. Therefore, it is of utmost importance to be open and honest with the patient, especially when a problem arises. Research results show that a full description of the error, its details and the circumstances leads to greater trust and positive opinions among patients and their relatives. This is particularly true when the doctor has admitted responsibility for the error. It is important that the acceptance of responsibility is accompanied by an apology, otherwise this positive effect cannot be achieved and may even lead to further negative opinions.

Definitions

Medical error defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.

Adverse event defined as an injury caused by medical management rather than by the underlying disease or condition of the patient.

Errors are defined as "an act of commission (doing something wrong) or omission (failing to do the right thing) leading to an undesirable outcome or significant potential for such an outcome."

An adverse event as "an injury that was caused by medical management (rather than the underlying disease) and that prolonged the hospitalization, produced a disability at the time of discharge, or both." The Institute for Healthcare Improvement uses a similar definition: "unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment), that requires additional monitoring, treatment, or hospitalization, or that results in death." Adverse events may be preventable or nonpreventable.

Example Adverse Event Cases

"Case 1: During angiography to evaluate coronary artery disease, a patient had an embolic cerebrovascular accident. The angiography was indicated and was performed in standard fashion, and the patient was not at high risk for a stroke. Although there was no substandard care, the stroke was probably the result of medical management. The event was considered adverse but not due to negligence."

"Case 4: A middle-aged man had rectal bleeding. The patient's physician completed only a limited sigmoidoscopy, which was negative. The patient had continued rectal bleeding but was reassured by the physician. Twenty-two months later, after a 14-kg (30 lb) weight loss, he was admitted to a hospital for evaluation. He was found to have colon cancer with metastases to the liver. The physicians who reviewed his medical record judged that proper diagnostic management might have discovered the cancer when it was still curable. They attributed the advanced disease to substandard medical care. The event was considered adverse and due to negligence."

Medical error communication should be based on the CONES model, which includes:

- **Context** (disclosure of the error that occured)

- **Opening Shot** (prepare what to say and anticipate the patient reaction)

- **Narrative** (explanation of chronological sequence of the event; avoid blaming others or making excuses; acceptance of responsibility where appropriate, apology)

- **Emotions** (addressing strong emotions with empathy; using E-V-E protocol {Explore the Emotion; Validate the Emotion; Empathic Response}; do not make promises that you cannot deliver! Be aware of it!)

- **Strategy & Summary** (summarize the discussion, make action plan what can and will be done to correct the mistake; how to avoid a similar mistake in the future)

There are therefore four main communication elements, in order of importance, for communicating a medical error:

1. apology,

2. description/explanation of events,

3. acknowledgement of responsibility

4. reassuring the patient that every effort will be made to avoid similar occurrences in the future.

The four key elements of disclosure are apology, explanation of what went wrong, acknowledgement of responsibility and commitment to prevent recurrences. *Proper disclosure* should include:

- Explicitly state that an error occurred **if that is conclusively known** (this means using the word "error" or "mistake" without equivocation)
- Describe the course of events and the reason for the error, using nontechnical language
- State the clinical implications of the error, the consequences, and the corrective action
- Reveal how similar errors will be prevented
- An apology for the error

  Apologize with a clear and honest communication of regret. "I'm sorry for what happened to you" is acceptable after any adverse event when error is not suspected. "I'm sorry that we harmed you with our mistake" or "I'm sorry for this mistake" is appropriate if an error has occurred. Avoid apologies that include the word "but" (e.g., "I'm sorry, but if the lab had only called me..." or "There was a mistake, but it wasn't that bad"). Avoid rationalization (e.g., "These things happen to the best of people" or "The mistake didn't change the outcome"). Avoid blaming others. For example, saying, "the lab always does this," or blaming the system. It is always appropriate to acknowledge the patient's situation and suffering and to convey empathy: “We're so sorry that this has happened.” or “This must be so upsetting for you and your family.”

- Elicit questions or concerns and address them. Make sure the patient and their relatives understand everything and answer any questions they may have

Example video:

https://www.youtube.com/watch?v=x-lGN_nQJeg

Ethical dilemmas and medical errors

The doctor has a duty to provide the patient with as detailed information as possible. Simultaneously, the patient has the right and responsibility to fully participate in his own recovery and treatment. However, there are circumstances that may prevent the patient from making an informed decision. For example, in the case of young children; unconscious or elderly patients with cognitive impairment, the needs of the person seeking help may remain unknown. Such sensitive situations often complicate or make medical decision-making difficult or almost impossible, thus hindering or delaying access to appropriate care.

The four aspects of ethical analysis of medical cases help to address this multi-level communication challenge. It is a schema that helps to weigh up the perspectives of the doctor, the patient and the healthcare system in each situation, thus helping to avoid possible errors and shortcomings. According to international research results, complaints against doctors are most often due to inadequacies in questioning, listening to and informing and educating patients. Therefore, the analysis of individual medical cases from an ethical perspective can be beneficial for doctors to be able to determine the appropriate approach to communicate with the patient and/or the relatives.

4 aspects of ethical case analysis (more detailed document in annex)

1. **Medical Indications** – Beneficence anf Nonmaleficence; how might expected management decisions benefit or harm the patient and how can harm be avoided?

2. **Patient Preferences –** Respect for Patient Autonomy; if the patient's wishes are ethically and legally justifiable, have they been taken into account,?

3. **Quality of Life** – Beneficence, Nonmaleficence, Respect for Patient Autonomy; What are the physical, mental, emotional and/or cognitive risks associated with starting, continuing or discontinuing treatment?

4. **Contextual Features** - Loyalty and Fairness; Assessment of the patient's resources and social network, and consideration of the interests of the healthcare team and system, and possible conflict of interest.

III. Summary:
Analysing a case along ethical principles can help not only to facilitate decision-making but also to avoid medical errors.

Annex

NOTIFICATION OF MEDICAL ERROR

NOTES:

The Health Care Act states that "*All patients, regardless of the title of the care they receive, must be treated with the care expected of those involved in their care and in accordance with professional and ethical rules and guidelines*".

The aim of medical activity is to preserve and improve health, prevent disease, cure the patient(s), save life, prevent deterioration of health, alleviate pain and reduce suffering. However, this objective is not always achieved, so that deterioration in the health of the person receiving health care results in worsening, aggravation or death.

HEALTH IMPAIRMENT:

I. Which cannot be prevented by any medical treatment.

II. which arises in connection with a medical activity.

III. Which arises as a result of medical activity

Health impairment e.g.:

-The slower than usual rate of recovery

-Lesser degree of recovery

-Temporary deterioration of health

-Permanent deterioration of health

-Residual physical or mental conditions, wasting

-Loss of working capacity

-Disability

-Death

RISK

1. The intervention (activity) is not, according to the current state of science, necessarily associated with

2. Unforeseen consequences

3. Thus cannot be prevented

4. Occurred in the course of an activity that complies in all respects with professional standards.

If all the above conditions are met, **the doctor is not liable** for the harmful consequences

The risk arising from the medical activity is borne by the patient!

Therefore

4/a The patient (or his/her relative) **must be informed**,

4/b and written **consent** of the Patient (or his/her relative).

Disclosing **medical errors** is considered necessary by patients, ethicists, and health care professionals. Disclosure is important because the patient has the right to know whatever has happened. Honesty and openness is the foundation of trust, and trust is the foundation of the doctor-patient relationship. So it is extremely important to be upfront and honest especially when something go wrong.

Literature results suggest that **full disclosure of an adverse event** leads to greater trust and more positive regard by patients and family members. This was particularly true when the physician acknowledged responsibility for the adverse event. Acceptance of responsibility without an accompanying apology yielded no such benefit and may have even resulted in more negative judgments.

EXAMPLES

4 SCENARIOS:

1) The more apparent medical error was an insulin overdose due to the physician's handwritten order for "10 U" of insulin being misinterpreted as "100 U," resulting in severe hypoglycemia.
2) The less apparent medical error was a hyperkalemic dysrhythmia due to failure to check the results of a potassium level ordered after starting a medicine known to cause hyperkalemia, an error that the patient would likely be unaware of unless the physician brought the overlooked potassium result to the patient's attention.
3) The more apparent surgical error involved a retained surgical sponge.
4) The less apparent surgical error was bile duct injury during a laparoscopic cholecystectomy caused by the surgeon's incorrect use of a new surgical tool. This later

scenario was considered less apparent because the patient would be unlikely to suspect that the surgeon's lack of familiarity with the new surgical tool caused the bile duct injury.

1) What Would You Most Likely Say About What Happened?

TYPE OF DISCLOSURE	INSULIN OVERDOSE	HYPERKALEMIA	RETAINED SPONGE	BILE DUCT INJURY
No disclosure	Your blood glucose went too low and you passed out.	Your potassium level got too high, which led to a dangerous heart rhythm.	The x-ray showed an abnormality that could be serious. Another operation will be required to investigate and correct this problem.	As we discussed before the operation, sometimes an open procedure is necessary. Your case required that we do an open procedure.
Partial disclosure	Your blood glucose went too low because you received more insulin than you needed.	The new medicine we started caused your potassium level to become too high, which led to a dangerous heart rhythm.	During the surgery, a sponge was inadvertently left in your abdomen. Another operation will be required to remove the sponge.	During the surgery, your common bile duct was injured. We were able to repair your bile duct, but this required an open procedure.
Full disclosure	Your blood glucose went too low because an error happened and you received too much insulin.	You had a dangerous heart rhythm because an error happened and we did not notice that the new medicine had caused your potassium to become too high.	We will have to do another operation because an error happened and a sponge was left in your abdomen.	We had to do an open procedure because an error happened and your common bile duct was injured.

2) **How Much Detail Would You Most Likely Give the Patient About the Error?**

TYPE OF DISCLOSURE	INSULIN OVERDOSE	HYPERKALEMIA	RETAINED SPONGE	BILE DUCT INJURY
No disclosure	I would not volunteer any specific information about the details of the error unless asked by the patient.	I would not volunteer any specific information about the details of the error unless asked by the patient.	I would not volunteer any specific information about the details of the error unless asked by the patient.	I would not volunteer any specific information about the details of the error unless asked by the patient.
Partial disclosure	You received more insulin than you needed.	We did not realize your potassium had gotten dangerously high until it was too late.	We track the sponges used during operations carefully. In your case we were unaware that a sponge was missing.	Your common bile duct was injured by a new surgical tool we were using. We repaired your bile duct successfully.
Full disclosure	You received 100 units rather than your usual 10 units of insulin.	Your potassium was high on the blood test we drew the week after you started the medicine, but I did not see this laboratory result until today. Had I known about the elevated potassium earlier, I would have stopped this new medicine and treated the high potassium, likely avoiding the dangerous heart rhythm.	The sponges were counted incorrectly and we did not know one sponge was missing.	Your bile duct was injured because I was using a different surgical tool than the one I am familiar with. We repaired your bile duct successfully.

3) What Most Closely Resembles What You Would Say About the Cause of the Error?

TYPE OF DISCLOSURE	INSULIN OVERDOSE	HYPERKALEMIA	RETAINED SPONGE	BILE DUCT INJURY
No disclosure	I would not volunteer a cause of the error unless the patient asked me.	I would not volunteer a cause of the error unless the patient asked me.	I would not volunteer a cause of the error unless the patient asked me.	I would not volunteer a cause of the error unless the patient asked me.
Partial disclosure	This occurred because of a miscommunication about your insulin order.	This occurred because of a mix-up regarding your laboratory results.	This occurred because of a problem with the sponge count.	This occurred because of a malfunction with a new surgical tool.
Full disclosure	My handwriting is sometimes difficult to read. I wrote your order for "10 U" of insulin and the "U" looked like a "0." Therefore, you received 100 units of insulin instead of 10. This also slipped by our nurse and pharmacist.	I did not remember to check the results of the laboratory tests you had drawn the week after you started the new medicine. The laboratory and the nurse also did not notify me about the high potassium.	This occurred because I forgot that I had put a sponge deep in your abdomen to control some bleeding. Also, the sponge count was done incorrectly, so I was unaware that not all the sponges had been removed.	This was the first time I had used this surgical tool. I had turned this tool off, but the tip was still cooling down. I was unaware it was still hot, and the tool touched your common bile duct when it shouldn't have.

4) What Would You Most Likely Say Regarding an Apology?

TYPE OF DISCLOSURE	INSULIN OVERDOSE	HYPERKALEMIA	RETAINED SPONGE	BILE DUCT INJURY
No disclosure	I would not volunteer that I was sorry or apologize.	I would not volunteer that I was sorry or apologize.	I would not volunteer that I was sorry or apologize.	I would not volunteer that I was sorry or apologize.
Partial disclosure	I am sorry about what happened.	I am sorry about what happened.	I am sorry about what happened.	I am sorry about what happened.
Full disclosure	I am so sorry that you were harmed by this error.	I am so sorry that you were harmed by this error.	I am so sorry that you were harmed by this error.	I am so sorry that you were harmed by this error.

5) What Would You Most Likely Say About How the Error Will Be Prevented in the Future?

TYPE OF DISCLOSURE	INSULIN OVERDOSE	HYPERKALEMIA	RETAINED SPONGE	BILE DUCT INJURY
No disclosure	I would not volunteer anything about how similar errors will be prevented in the future.	I would not volunteer anything about how similar errors will be prevented in the future.	I would not volunteer anything about how similar errors will be prevented in the future.	I would not volunteer anything about how similar errors will be prevented in the future.
Partial disclosure	We are looking into what happened to you and will try to make changes to prevent this from happening in the future.	We are looking into what happened to you and will try to make changes to prevent this from happening in the future.	We are looking into what happened to you and will try to make changes to prevent this from happening in the future.	We are looking into what happened to you and will try to make changes to prevent this from happening in the future.
Full disclosure	We are looking into what happened to you and we will let you know what changes we make to prevent this from happening to someone else. I will not use this abbreviation in the future. I am also bringing this to the attention of other doctors at our monthly conference so that we can prevent problems like this in the future.	We are looking into what happened to you. I have spoken with my office staff to make sure that I am notified when there are irregular test results. I am also bringing this to the attention of other doctors at our monthly conference so that we can prevent problems like this in the future.	We are looking into what happened to you. In the future, I will get a routine x-ray in the operating room on all patients having surgeries like this to make problems like this less likely to happen again. I will also bring this to the attention of other doctors at our monthly conference so that we can prevent problems like this in the future.	We are looking into what happened to you. In the future, I will make sure I receive more training about new devices like this before using them on patients. I am also bringing this to the attention of other doctors at our monthly conference so that we can prevent problems like this in the future.

References:

- http://medicalonline.hu/download.php?id=10825 legutóbbi hozzáférés: 2019.01.09.

Mazor, K. M., Simon, S. R., & Gurwitz, J. H. (2004). Communicating with patients about medical errors: a review of the literature. *Archives of internal medicine*, *164*(15), 1690-1697.

- Pilling, J., & Erdélyi, K. (2016). Az egészségügyi kártérítési perek kommunikációs vonatkozásai. *Orvosi Hetilap*, *157*(17), 654-658.
- https://pdfs.semanticscholar.org/a901/03ff18c9a4a2f2aa6d60ab9e4be47d8fe9ce.pdf
- https://www.openpediatrics.org/course/disclosure-and-apology
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5536280/
- https://www.ted.com/talks/brian_goldman_doctors_make_mistakes_can_we_talk_about_that
- **https://pdfs.semanticscholar.org/a901/03ff18c9a4a2f2aa6d60ab9e4be47d8fe9ce.pdf**
- **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5536280/**

Further useful videos:

- https://www.youtube.com/watch?v=-oLVuXTNBZk
- https://www.youtube.com/watch?v=3OsA0z7j4WM
- https://www.youtube.com/watch?v=IbhjEjJ3X_4 (Early Disclosure: When Care is Reasonable)
- https://www.youtube.com/watch?v=i2uEHmElX5M (Early Disclosure: Unsure If Care Is Reasonable)
- https://www.youtube.com/watch?v=b7VHNgGHbqA (Early Disclosure: When Care Is Not Reasonable)