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RESOLVING ETHICAL DILEMMA: AN APPLICATION OF A THEORETICAL MODEL

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ABSTRACT

Human error can occur in any profession. Medical errors most commonly occur in a health care system, which may delay patient's recovery and produce harm to patients. However, when a medical error occurs, it is challenging to inform the incident to patients and their family. Health care professionals follow a professional code of ethics to do well and not harm patients. Historically, many of these errors were not disclosed to patients but the trend for more open disclosure of medical errors to patients and their families is a mutually beneficial and welcomed change.

KEY WORDS: Medical Ethics, Medical Error, Disclosure

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INTRODUCTION

Medical error is defined as an error or mistake, which may or may not harm a patient.[1] Moreover, it is a failure to a planned action in the course of client's treatment (i.e. error of treatment planning and execution).[2] There could be several types of medical errors, which include error in diagnosis (detection errors, miss-interpretation of laboratory findings), medication errors (in prescribing, transcribing or administration), and errors in performing surgical procedures/ therapy.[2]

According to the joint commission statistics, total 908 (13.4%) wrong-site surgery events were reported from 1995 to March 2010.[3] The national practitioner data bank (NPDB) USA recorded 5940 surgical errors in following categories wrong-side/wrong site, wrong-procedure, and wrong-patient adverse event (WSPE). Out of 5940 surgical errors, 2217 wrong side surgical procedures and 3723 wrong-treatment were reported between 1990-2000.[4]

A medical error may not essentially result in harming a patient; however, when an error occurs, health care professionals may find it challenging to "disclose or not to disclose?"[5] Because family could file a lawsuit on the health care provider or health care agency; as error may endanger patient's life, prolong their recovery, induce discomfort and increase cost of their treatment.[4,6] The literature suggests that it is the right of a patient to have full knowledge about the course of their treatment, recovery and any delays in their recovery.[4-8] The aim of this paper is to share a clinical scenario about an incident of wrong site surgery and its analysis in the light of ethical principles. The paper will also integrate an ethical decision making model MORAL, which is a systemic approach to handle an ethical dilemma.

CASE SCENARIO

A 35 year old male came to post anesthesia care unit (PACU), after his bilateral knee arthroscopy. His surgeon visited him after the surgery in PACU and called his relative (brother) and told him that he has performed the procedure successfully, and patient is fine PACU. The patient's brother noticed that both of the patient's knees are covered with surgical dressings and enquired from the resident, "my brother was planned for his right (Rt) knee arthroscopy, how come his left knee has the dressing?" The resident replied patient's brother yes he was planned only for Rt. knee arthroscopy but during the procedure, the surgeon has assessed his left (Lt) knee and felt the need for Lt. Knee arthroscopy. Therefore, the procedure is done on both the knees.

Soon after the patient's brother left, the assigned nurse of the patient noticed that patient consent form was also indicating the procedure for the RT knee arthroscopy only. This made the nurse enquire from the resident, what was the consultant observation for the Lt Knee that the procedure was carried out without the prior knowledge and consent of the patient? The resident verbalized, "It was a mistake". He ventilated, actually patient was planned for Rt knee arthroscopy but unfortunately the team mistakenly performed the Lt Knee arthroscopy and when they found it normal then the team realized and checked from the consent form that his Rt knee had problem and needed arthroscopy. So anesthetist was asked to continue general anesthesia and later the arthroscopy for Rt knee was performed.

DISCUSSION

Reporting Medical Error; Disclosure Versus Non-Disclosure

In routine daily practice, doctors and nurses are uncertain whether to disclose or not to disclose any error to

a patient.[9] However, literature on this phenomenon revealed that patients are interested to be aware of any error that caused them any harm.[8,10] It is a patient's right to have full disclosure of an error. It has been documented that patients may feel annoyed initially, however later disclosure had enhanced their physicians' trustworthiness and reassured them that they were getting complete information about their care even if it is bad. Furthermore, the findings also affirm that patients acknowledge that health care professional is human being who is not perfect; thus, there are chances of error. Patients are also aware of the fact that "human nature" may also influence health care professionals to hide their errors from patients.[8-11]

Kantian theory

Kant believed in ethical obligations and thus he stressed on absolute duties or be accountable for actions.[12] This theory implies doing well to people, do no harm, respect autonomy of individuals, and telling truth. Kantian theory emphasized physicians to follow standards of best care, designed for patients protection.[12,13]

When a patient accesses a health care system, they have faith in the system and health care team. They expect competent care in which they get the best treatment and speedy recovery from their illness. Deontology or obligation based theory by Kant guides physicians and nurses to practice biomedical ethics with obligations. Kant affirms that "ethics without obligation is no ethics"[12] and therefore the theory by Kant emphasized on "absolute duties" or be accountable for actions.[12] This theory ensures doing good, and do no harm, respect individuals' autonomy and telling truth.[12,13] Telling the truth encompass honest communication between client and health care professionals. Whereas, lying or concealing information is not acceptable and thus it becomes an obligation of a health care professional to reveal facts with the patient about an error that might or might not have caused harm to the patient. That is how Kant's theory justifies disclosure of facts in cases of error as the best option.

In the above scenario the principles of beneficence and non-maleficence were compromised. Moreover, the incident was not shared with the patient and his family. In other words true information was with held with patient because the consultant did not inform the actual scenario to the patient and made up a story to cover this incident. Kantian theory emphasized truth telling and thus disclosure of medical errors is part of truth telling by health care professionals. The disclosure of errors may develop patient's trust more on health care providers as well as on system. In addition, it may lessen the chances of lawsuits cases over hospital/health care providers.[10,13] However, some of health care professional may not agree in disclosing an error or some may not disclose complete information with the patient. They may justifying this by saying that if patient is not enquiring any information then there is no need to reveal facts.[5,7,9] However, closure and disclosure needs to be accepted as an ethical dilemma. To develop a comfort level for the disclosure, an analysis of the dilemma would be needed to weigh the option to disclose or not to disclose. Therefore, it is important to have frameworks/models that help health care professionals to take appropriate decision to resolve such ethical dilemmas.

'MORAL' Ethical decision-making model

The ethical theories or models are the may not resolve ethical dilemmas but it can be used as a tool which may provide a systematic direction to weigh and choose the best option to resolve a dilemma. This paper utilizes the MORAL, an ethical decision making model comprised of five steps, which is proposed by Patricia Crisham in 1985. The name of this model "MORAL" is an abbreviation which describes its steps: "M" for Massage the Dilemma, "O" for outlines options, "R" for review criteria and resolve, "A" for affirm position and act, and "L" for look back (p. 44).[14]

As mentioned above, the first step of this model involves "massage the dilemma"; this includes collecting data to analyze the context in which error occurred about an incident, people, their positions and their values.[14] The case identifies three main positions which include the patient, the physician and team and the nurse. The patient was severely affected by the error (wrong site surgery) and patient had borne physical and financial harm because of this error. First of all, patient had tolerated unnecessary trauma and harm as his non-affected leg was operated. This added surgical trauma, increased his pain, impaired his mobility and delayed his recovery. Thirdly, the prolong anesthesia also had its own risk. Finally, the patient had also borne all the financial cost of this unnecessary surgery and operation room charges.

The second important position was of the consultant and his team, who not only exposed the patient to physical and financial harm and withheld the information regarding the incident. Therefore, it was obvious from the facts that the surgical team did not want to disclose the error. Later, the nurse involved in the situation after the surgery; she picked up the incident when patient's brother enquired about dressing in his left leg. She verified surgery site from patient' consent form, where the procedure was planned and documented as right arthroscopy. She enquired the reason for bilateral Knee arthroscopy from the resident and he shared facts with the nurse how this error had happened (as mentioned above in case). Although, the nurse had sympathy for the patient rights which have been violated but the nurse remained quiet in this case. When an error occurs or witnessed, a practitioner may experience guilty, embarrass and feel discontents for the failure. They may blame themselves to be unsafe and incompetent. They may develop fear about the error's repercussion on their professional growth and future licensure practice. In addition, if they disclose an error it may make them anxious concerning the lawsuit against practitioner or to the hospital in which they are working. Due to these personal, professional and organizational reasons, they might hide an incident and avoid its

disclosure. Therefore, it is important to identify these barriers before moving to next step.

In the second step of the model, require to "outlines options" one has to identify the possible options to rectify this error. This step requires unbiased, constructive thinking and reflection to analyze each option of disclosure versus non-disclosure. As in this case, the disclosure of the error with complete information to the patient and the management could be a best possible option. First of all, patient's bill of rights demands to provide patient full knowledge regarding their course of treatment. Thus, an error and its management as part of course of treatment require full disclosure to the client. Secondly, as health care professionals, we pledge to provide beneficence and do no harm to our clients therefore it is an absolute duty of health care team that patients should be informed about any error that caused harm (additional trauma, excessive anesthesia, prolong anesthesia; prolonged recovery and additional financial charges); however, some of health care professionals may not feel the need for reporting those errors which did not cause harm.[10] Thirdly, if one chose not to disclose this error with patient and with management, this means, team is going to hide the true information from both. Finally, this error could be reported, as it could be analyzed for the system errors and thus with the help of this scenario hospital management can learn and improve it systems by preventing other patients and their employees. Consequently this error will help organization to set safe systems and safe and quality care for the patients. Based on the above analysis of case scenario, ethical principles and evidences in literature; the best option could be, disclose this incident with the patient as well as with the management.

In the third step "review criteria and resolve", one has to identify the moral criteria and laid down steps to resolve a dilemma. In the above scenario when the disclosure is analyzed and selected as best option then it is important now to plan how and who will disclose the error.[13] A stepwise action plan can be initiated by patient's consultant and may be an operating room before they meet patient for the disclosure of this incident. This action plan could include first the acknowledgement of patient suffering due to error. Secondly, it would be important to apologize for the mistake, without being defensive. Thirdly, it will important to assure patient for the constant support and care till his recovery. Moreover, patient could be informed that there will be no extra charges on patient which could be handled at management level.

In the forth step "affirm position and act" one should implement the selected option in the patient's scenario to resolve the dilemma based on the ethical principles of doing good. The last step is "looks back" which emphasized on evaluating the ethical dilemma and its resolution and implementation. It is important to also evaluate patient's response and resolve any concern by the patient.

Recommendation to Disclosure of Medical Error

The literature affirms that errors should be disclosed to the patient; yet, this practice is not very common in health care.[9,15] To inculcate ethical practices in health care, it is important that principles of ethics that reinforce truth telling and honesty should be part of all health care professionals' curriculum.[16] Moreover, the curriculum should also help them practice as a reflective practitioner whereby they learn on reflecting and empathizing patient's values related to disclosure.

In addition, health care providers' curriculum should encourage them to utilize self-awareness and identify barriers that force them to withheld complete information related to an error with the client and management. Moreover, health care practitioners should be encouraged to consult hospital ethics committee to resolve such issues or incorporate the ethical decision making framework like 'MORAL' in their clinical practice to weigh all the options and chose a best possible alternative.[14] In addition, they can be taught about the specific communication techniques to accept and apologizing for their mistake. Moreover, health care organization should create a non-penalizing error reporting culture; this will promote incident reporting which will improve the health care system. Furthermore, as a quality indicator, health care organizations can continuously observe the patterns of error and use this data to improve their system[9,16] It is also observed that an error is not particularly the fault of an individual but a system error like in this scenario site marking an intervention to identify the location of surgery before patient is taken to the operation theater was missing which had led to this error.[8,16] Furthermore, health care organizations should be assist practitioners as well enhance patients' satisfaction. It is also recommended that health care organization should develop pertinent guidelines to disclose an error by health care providers.

CONCLUSION

In conclusion, disclosure of medical errors to the patient as well as to the management can be challenging for the health care professionals. There could be several personal, professional and organizational barriers that may hinder its complete reveal to the patient and management thus it remains as ethical dilemma most of the time. The decision to disclose or not to disclose may require a systematic approach as guided by "MORAL" an ethical decision making model to analyze individual situation to resolve a dilemma based on ethical principles. However, the disclosure of an error could be difficult for a practitioner. Thus they should be well prepared through their curriculum how to disclose an error. In addition, they may require organizational support to reveal an error and save their patients for further harm.

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CONFLICT OF INTEREST

Authors declare no conflict of interest

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