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Kiran Shaikh
Aga Khan University, kiran.shaikh@aku.edu

Sharifa Bashir Lalani
Aga Khan University, sharifa.lalani@aku.edu

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CASE REPORT

DISCLOSURE OF MEDICAL ERROR

Kiran Shaikh, Sharifa Bashir Lalani
Aga Khan University School of Nursing and Midwifery, Karachi, Pakistan

With the advancement of medical sciences, lives are being prolonged and practice of medicine is considered an art and no longer as science. 'To Err is Human Report' has been released and gives data of medical errors in United States which opened people's eyes but there is grieving need that health professional in Pakistan also report the medical errors. Medical errors are common, costly, and often preventable. This could only happen when health professional are trained and made aware to report the errors. Evidences shows that full and honest disclosure of error and restitution are factors that may lead to significant improvement in responsibility of medical cases.

Keywords: medical error, honest disclosure, patient safety

INTRODUCTION

Medical errors are a growing concern in health care organisations. 'Medical errors' ―defined here as the failure of a planned action to be completed as intended, or use of wrong plan to achieve an aim, but not including intentional or reckless actions that harm the patients.[1] It has been the leading cause of patient's injury around the world. The study 'To Err is Human: building a safer health system' released by the Institute of Medicine (IOM) in 1999 reported that medical errors are responsible for 44,000–98,000 deaths annually in United States of America. Estimated annual costs of all the adverse events range from $38 billion to $50 billion nationally.[2] These figures are all the more tragic because over half of these events could be prevented. This data is quite alarming for health care team. Medical errors are not reported because of fear of embarrassment in front of peers, fear of medico-legal action, fear of punitive action by patients and complaints to governing bodies.[3,4]

The article reviews disclosure of medical error and highlights the principles in conflicts. Furthermore, it explains the benefits of disclosing the medical error. In the end, the paper will conclude with possible consequences and recommendations.

CASE REPORT

A 36-year-old woman entered the operating room (OR) on stretcher in a private hospital. She looked pale and anxious. She had adenocarcinoma of uterus and was schedule for hysterectomy and bilateral salpingo-oopherectomy. At the preoperative area she was received by OR nurse but she was very much nervous and fearful. Probably she was thinking about her three children and was worried that if she dies and does not awake up after surgery, who will take care of them? The patient was taken in operating room as her turn came. After surgery as soon as she was shifted in recovery room (RR) and a while later the surgeon came and with his powerful voice declared, "Everything went well during surgery". The patient was relieved and closed her eyes. But reality was that when the surgical notes were read, there was documentation of bladder injury and urologist did the bladder repair.

ANALYTICAL PERSPECTIVE

The surgeon's response raised many questions. Why did he not tell patient the truth? Not disclosing the information to the patient; is it ethically right? If the patient would be told about the error, what will be the patient's response? What and how the patient should be told when an error has been made? Will the patient trust the care provider anymore?

There are many competing principles, virtues and theories, emerging from such a scenario; these are veracity, deception, non- maleficence, beneficence and deontological theory. After analysis of ethical dilemma faced by health team members was to disclose the medical error, i.e., use of veracity to the patient and family or not disclosing the medical error, i.e., use of deception.

DISCUSSION

Medical error should be disclosed. The moral philosophical theory by Immanuel Kant (i.e., deontology) states that it is the physician's obligation and responsibility to disclose the medical error to the patient. The term veracity relates to the practice of telling the truth and patients have the right to obtain complete, current information concerning diagnosis, treatment and prognosis in terms they can be reasonably expected to understand. Based on virtue ethics, it is the physician's legal duty to inform the patient about the reality.[5] In addition, disclosing the error will help the physician to diagnose the medical problem and prevent further health complications.

Benefits of Healthcare systems are improved patient safety through acknowledgment of errors (learning from others' errors) decreased number of malpractice claims and lawsuits, lower litigation costs due to fewer claims, easier settlements and increased confidence in the integrity of the medical establishment. Our religion also guides us to tell the truth always. Islam

also encourages us to tell truth and avoid lying. Telling lie is considered a great sin.

In this scenario, nurses can play the role of patient care liaison between the surgeon and the patient. An important step in disclosure of error is to educate physicians and other providers regarding appropriate focus of quality improvement system. Medical errors training should be done for medical students during rotation, which should include error theory and disclosure of medical error. Moreover, ethical grand round should be conducted more frequently. Real scenarios should be discussed at case base learning at undergraduate level, so that they do not face problem in making decision in practical situation. Special courses, which create awareness of moral and ethical dilemma, should be developed in professional school.

CONCLUSION

Three 'As' are very well 'acknowledge the error', 'apologies to patient' and family', and 'acquire knowledge' which will help avoid committing the same error again.[5] This means errors should be used as opportunity for learning and strategies should be developed to prevent repeating the error again. On the contrary, it seems like a very easy notion —to 'disclose medical error', but practically it is a very difficult and challenging task. The health care providers always have fear of legal action, which becomes a significant barrier to disclosure. Beside this, disclosure of error should be reported and awarded as it will prevent the re-occurrence of error and promote patient safety. Therefore, the culture in hospitals should be transparent where such cases are taken positively and not punished.

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Address for Correspondence:

Kiran Shaikh, Lecturer, Aga Khan University School of Nursing and Midwifery, PO Box 3500, Stadium Road, Karachi, Pakistan.

Email: kiran.shaikh@aku.edu