SURGICAL ETHICS CHALLENGES

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Dealing honestly with an honest mistake

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A 70-year-old woman was admitted for a symptomatic left iliofemoral deep vein thrombosis. She underwent percutaneous mechanical thrombectomy, followed by overnight thrombolysis. The next day her clot had resolved, and a culprit left iliac vein stenosis was identified. After stent placement, a heparin infusion was initiated and the patient was taken back to the ward. At 11 the evening after the procedure, the resident on call was contacted to verify the written order. The resident stated that the heparin dose was to be 250 U/h; however, the nurse documented 2500 U/h and changed the infusion pump at the patient's bedside. At 5:30 the next morning, the resident was notified that the patient's partial thromboplastin time was >300 seconds and promptly shut off the heparin infusion. No noticeable adverse events occurred because of the high heparin dosing. The charge nurse was notified, as was risk management. What should the patient be told?

A. Nothing—no one should tell the patient because no complication occurred from the heparin.
B. Mention in passing to the patient only that the dosing was changed.
C. Tell the patient the truth, but focus the blame on the nursing staff.
D. Wait to have risk management explain the situation to the patient.
E. Tell the patient the truth and apologize for the mistake.

In this case, there was no adverse outcome for the patient. Is this not a "no harm, no foul" situation where telling the patient might create additional unnecessary distress? Some might argue that the answer depends on the definition of an "adverse event" or "error." However, most authorities are clear and unequivocal on the correct course of action: tell the patient the truth.

The American Medical Association *Code of Ethics* states: "It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions . . . the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred."[1]

Likewise, the Joint Commission (TJC) accreditation standard RI.01.02.01 element #22 states, "The licensed independent practitioner responsible for managing the patient's care, treatment, and services, or his or her designee, informs the patient about unanticipated outcomes of care, treatment, and services related to sentinel events when the patient is not already aware of the occurrence or when further discussion is needed."[2] The accompanying intent provision further specifies, "The responsible licensed independent practitioner or his or her designee should clearly explain the outcome of any treatments or procedures to the patient, and when appropriate the family, whenever those outcomes differ significantly from the anticipated outcomes."[3] Furthermore, one of the National Patient Safety Goals mandated by TJC is "Reducing Harm from Anticoagulation Therapy" (NPSG.03.05.01).

Following this code of ethics, the question then becomes: is there a de minimus standard in which disclosure depends on the magnitude of consequence of the medical error? In this case, outcomes could have been compromised with the large dose of anticoagulant, but thankfully, they were not. Even though there were no observable sequelae or delays in discharge, the physician was still ethically mandated to be honest with the patient about this gross variation from treatment. However, there are times when disclosure is not mandated, such as an antibiotic dose being given to a patient an hour late, but still within the timeframe of efficacy.

So what is the best course of action in this scenario, where harm done appears nonexistent? Option A allows the patient to remain ignorant of the situation but clearly violates the ethical bounds of the physician-patient rela-

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tionship by not disclosing the occurrence of the error. Option B allows the physician and team to minimize the situation by omitting the mention of a mistake and misleading the patient to believe that the dosage change was simply a planned occurrence instead of the correction of a medical error. Because of misdirections by omission, options A and B are incomplete and, therefore, incorrect.

Options C and D both involve truthfully explaining the situation, including the error, to the patient. In both of these choices, however, the physician evades responsibility for the error by involving other parties; this is not the desired behavior for a health care professional who has taken charge of directing the patient's care. These two answer choices can thus be eliminated. In fact, multiple studies support the need for the physician to apologize and shoulder responsibility for outcomes of patient care, regardless of whether the outcome is desirable or not. These studies also show that patients' perceptions of the mistake often depend upon the timeliness and quality of the physician's communication with them. These studies further indicate that a patient's expectation of quality communication in these studies includes disclosure and apology, as well as how the situation can be prevented from happening to them again.[4] Therefore, option E is the best choice: the patient is truthfully informed of the situation and an apology is given, with no omission or misdirection.

The idea of disclosure and apology may initially, understandably, give some physicians pause. Many doctors naturally shy away from any appearance of admitting fault, if only because of the perception that this provides more incentive for patients to direct complaints or file lawsuits against them. However, in practice the opposite seems to be true: studies have repeatedly shown that most patients appreciate physician honesty and react accordingly, ultimately preventing many more lawsuits and patient complaints than would be generated. As one author notes, "In their fear and self-protectiveness, many health care professionals initially underestimate the constructive impact that honesty and sensitive disclosures can have."[5]

At this point the patient has been informed of the situation and is satisfied with the explanation, but what about ensuring that mistakes don't happen again? In addition to addressing the current situation with the patient, the physician also should report these medical errors to the relevant quality control body to improve future outcomes and address system faults. TJC and other leading accreditation agencies encourage the reporting of adverse events to correct system failures and other problems that may affect patient care.

In this scenario, the physician promptly reported the error to risk management, but this is often an area of physician responsibility that is overlooked and underused. A recent study showed that ". . . physicians were more likely to discuss serious errors, minor errors and near misses with their colleagues than to report them to risk management or to a patient safety official. Few physicians believed that they had access to a reporting system that was designed to improve patient safety and nearly half (45%) did not know if one existed at their organization. Only 30 percent agreed that current systems to report patient safety events were adequate."[6]

For physicians to feel comfortable reporting errors, the quality control system should be focused on improving the quality and efficiency of patient care while reducing mistakes by health care professionals; however, these systems should also be fair to caregivers at the same time. Although accreditation organizations such as TJC have attempted to strengthen these systems by providing leadership guidelines for improving the handling of medical errors, it is still ultimately up to individual organizations to decide implementation of such guidelines.[7]

Medical errors remain an unavoidable, albeit unwelcome, part of health care that if used correctly can further the quality of patient care. The most important aspect of medical errors, however, still revolves around the communication between the provider and the patient: we must all come to recognize disclosure and apology as important continuations of the honesty and openness that patients have come to expect from their physicians.

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