“Ooopps”: Medical Errors and the Ethical Landscape

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Limited by time constraints..
Simple definition

- Medical errors can be defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.
Consequences (in simple terms)

Patients who experience a long hospital stay or disability as a result of errors pay with physical and psychological discomfort.

Health professionals pay with loss of morale and frustration at not being able to provide the best possible care.

Society bears the cost of errors loss of worker productivity, reduced school attendance, lower levels of population health status.

To Err is Human: Building a safer health system, 2000
Let us begin with a narrative that stirred public and professional opinion in Lebanon.
These concerns cannot, and indeed should not, be ignored. Patients feel physicians “owe” them answers. This is why they are angry when they are faced with silence.
Patients trust their doctor’s scientific skills but have doubts about the interpersonal and moral skills of their physicians…
Sample remarks made by patients

- ‘Doctors in general are ok, but you find some that want to make money only.’
- ‘Curing patients is second on the list. First comes making money.’
- ‘Doctors these days are robots, they have no heart!’
- ‘They reduce medicine to a cold lifeless prescription.’
- ‘The medical sector has no ethics at all.’
- ‘Doctors are pretentious and full of themselves. They have no consideration for our feelings!’
- ‘I do not trust doctors in Lebanon and, in my opinion; doctors are inhumane merchants.’
The good physician is someone who, in addition to being skilled, also possesses certain character traits.

Admission criteria should include assessment for character traits, not only GPAs and scientific scores.

Character can be molded, it cannot be taught.
Dr. Swango, 2000

- Graduated as a valedictorian from high school
- Went to Southern Illinois Medical School and graduated summa cum laude and won the American Chemical Society Award.
- Yet, he was nearly expelled for faking checkups during his obstetrics and gynecology rotation.
- He was later dubbed Dr. Death for killing many patients by poisoning them.
- He was tried and was sentenced to life imprisonment without the possibility of parole.

1. Medical Schools in Lebanon should revisit their entrance criteria because medicine is a moral endeavour.

2. Even after entrance to medical schools, students who fail “ethically” should be asked to leave.
Hippocratic Oath

- Primum Non Nocere
How do mistakes happen?

• No physician wakes up in the morning with the following thought:

Today, I feel like making a medical mistake!
ABC report
Mistakes do occur

• Reporting is important
• Tracking is important
• Action is important ➔ reduces the rate of errors
  – Dr. Sharaf Abou Sharaf has an interesting story
Not all mistakes are a result of negligence. Mistakes may occur because of..
an incomplete knowledge base

an error in perception or judgment

a lapse in attention

making decisions on the basis of inaccurate or incomplete data

pressures to see patients in short periods of time

lack of sleep

distractions

medicine is complex and uncertain

system failure - most errors result from the system - inadequate training, ampoules that look the same, long hours, lack of checks, etc.
Root Causes of Sentinel Events

(All categories; 1995-2005)

- Communication
- Orientation/training
- Patient assessment
- Staffing
- Availability of info
- Competency/credentialing
- Procedural compliance
- Environ. safety / security
- Leadership
- Continuum of care
- Care planning
- Organization culture

Percent of 3548 events
Root Causes of Medication Errors

Communication
Orientation/training
Patient assessment
Staffing
Availability of info
Competency/credentialing
Procedural compliance
Environ. safety / security
Leadership
Continuum of care
Care planning
Organization culture

Percent of 326 events

0 10 20 30 40 50 60 70 80 90 100

The Joint Commission, 2007
Root Causes of Wrong Site Surgery

Communication
Orientation/training
Patient assessment
Staffing
Availability of info
Competency/credentialing
Procedural compliance
Environ. safety / security
Leadership
Continuum of care
Care planning
Organization culture

Percent of 370 events

System Failure – Reason’s Swiss Cheese Model

• Every step in a process has the potential for failure, to varying degrees. The ideal system is analogous to a stack of slices of Swiss cheese. Consider the holes to be opportunities for a process to fail, and each of the slices as “defensive layers” in the process. An error may allow a problem to pass through a hole in one layer, but in the next layer the holes are in different places, and the problem should be caught. Each layer is a defense against potential error impacting the outcome.

SUCCESSIVE LAYERS OF DEFENSES

Some holes due to active failures

Other holes due to latent conditions

HAZARDS
For a catastrophic error to occur, the holes need to align for each step in the process allowing all defenses to be defeated and resulting in an error. If the layers are set up with all the holes lined up, this is an inherently flawed system that will allow a problem at the beginning to progress all the way through to adversely affect the outcome. Each slice of cheese is an opportunity to stop an error. The more defenses you put up, the better.
Prescriber writes order for medication to which patient is allergic

Nurse gives patient a drug to which s/he is allergic

Pharmacist fails to check patient allergy status

Patient’s allergy history is not obtained

Patient arrests and dies

http://www.philblock.info/hitkb/h/HIT_and_error_detection_and_reporting.html
James Reason’s main point

- Fallibility is part of the human condition
- We can’t change the human condition
- We can change the conditions under which people work
To err is human- IOM Report Strategies for Improvement

Create a Center for Patient Safety that would set national safety goals and track progress. Develop a nationwide public mandatory reporting system and encourage healthcare organizations and practitioners to develop and participate in voluntary reporting (enact laws to protect their confidentiality).

Setting and enforcing explicit performance standards for patient safety though regulatory and related mechanisms (licensing certification, accreditation, etc).

Implementing safety systems in health care organizations to ensure safe practices at the delivery level.
In general, even trivial medical errors should be disclosed to patients. Any decision to withhold information about mistakes requires ethical justification. If a physician believes there is justification for withholding information about medical error from a patient, his judgment should be reviewed by another physician and possibly by an institutional ethics committee. The physician should be prepared to publicly defend a decision to withhold from the patient information about a mistake.
The study was done at the University of Michigan Health System, compares 6 year periods before and after the program's launch: between July 1, 1995 to July 1, 2001 and between July 1, 2001 to September 1, 2007. Dramatic decline in legal action taken on the part of patients and their families. "The monthly rate of new claims decreased from 7.03 per 100,000 patient encounters before initial program implementation to 4.52 after,". They decrease was statistically significant for claims resulting in lawsuits, 232 of which were filed per year before the program and 106 of which were filed after.
ABSTRACT: The root causes of medical malpractice claims are deeper and closer to home than most in the medical community care to admit. The University of Michigan Health System’s experience suggests that a response by the medical community more directly aimed at what drives patients to call lawyers would more effectively reduce claims, without compromising meritorious defenses. More importantly, honest assessments of medical care give rise to clinical improvements that reduce patient injuries. Using a true case example, the reader is provided with clinical improvements that reduce patient injuries.
Let us go back to the story of Rita Jebrail and the reaction of her husband.

If the patient’s experience reasonably mirrors expectations, if the patient’s need for information is met readily, if the patient is assisted in processing the information, and if the patient believes that the system has responded to his or her experience with improvements, the likelihood that the patient will feel the need for an advocate or seek satisfaction through the legal system diminishes significantly.
Disclosure and the PPR

• The PPR Is based on TRUST
• Physicians who worry about liability often overlook this aspect of the PPR.
  • ➔ patient is hurt by the one he/she trusted the most.
  • ➔ damage to the profession (lack of trust in physicians and the profession)
The evidence is accumulating in more and more places that full disclosure with apology and restitution dramatically reduces BOTH the number of suits and the total payout in malpractice claims.

-Lucien Leape, Harvard School of Public Health  HIS MESSAGE TO US IN THIS CONFERENCE
Parents’ Perceptions of Medical Errors

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www.journalpatientsafety.com

Objectives: The purpose of this study was to explore parents’ experiences related to events which they believed to be medical errors in their child’s care.

Methods: In-depth qualitative interviews were conducted with parents who believed their child had experienced a medical error; responses were analyzed using qualitative methods.

Results: In 35 interviews, parents reported a variety of events that they believed to be errors. They described physical harm, emotional distress, life disruptions, changes in behavior, and damage to the relationship with the provider as a result of these events. Most parents felt that they had received no explanation of what had happened, no acknowledgement of the impact of the event, no apology and no acceptance of responsibility by a provider. Parents wanted providers to offer these responses, to express caring for the patient and to feel remorse. They also wanted to know that steps would be taken to prevent recurrences.

Conclusions: Perceived medical errors can impact both the patient and the family in many ways. We recommend that providers acknowledge the full impact of a perceived error and tailor their response to meet the specific needs of the patient and family.
Some Barriers to Disclosure

- Apologizing is hard to do!
- The more serious the injury the more difficult it is to apologize
- Worry about how the patient might react
- Lack of skills
- Denial, shame and fear
Is Lebanon Ready?
نتيجة الأطباء عن الأخطاء الطبية ل"النهار": 130 إلى 150 شكو تردد سنوياً
الخطأ الطبي في لبنان: عندما يصبح الطبيب جلادًا

ريما زهار
الاثنين 18 أكتوبر 2010 14:00:00

الخطأ الطبي ليس الوحيد في لبنان بل هناك أخطاء كثيرة تجري سنوياً، منها حالة

ريما زهار من بيروت: الخطأ الطبي جرى مع شخص مقرب لي، من خلال عملية

جراح لمدة ثلاث سنوات، تجمعت حول حياتها إلى مأساة، بدأت القصة عام 1989 وطلبتها أمال لفترة من

لسانين، كانت تعمل في إحدى نواحي جبل لبنان، في تلك السنة أصبحت حاملة

لمرة الخامسة، ظروف زوجها المادية وكونه عاطل عن العمل دفعها إلى الإجهاض، توجهت إلى أحد الأطباء في إحدى المستشفيات حيث أجرى لها

عملية الإجهاض، من ثم عادت إلى عملها بعد 4 أيام، لكن الأم لفي مستشفى وبدأت الفحوصات، توضح أن الجنين لا يزال في الأذين ويد خسرت أمال

تحج ليزرين ونصف من دمها، أجريت لها عملية الإجهاض من جديد على يد الطبيب وسبب غضب أخرى في المشيئة المستمعة في العملية في بطنها.

تتصور كثيرًا فيما عادات كبيرة تدخل ضمن إطار الأخطاء الطبية الرائحة في لبنان، ولا تكنون يدعمها، خصوصًا وإن كان الأطباء الطبيين يمر

مرور الكرام في حال حذرت أي حانة، فضلًا عن أن المستشفيات وقبل إجراء العملية تجلب المريض يوقع على وثيقة بأنه يتحمل بنفسه المسؤولية.

بين القانون والطبيب
The Salim El-Hoss Bioethics and Professionalism Program at the American University of Beirut, Faculty of Medicine and Medical Center announces its 4th Regional conference on

Bioethics in the Media

الاعلام و الاخلاقيات الاحيائية

December 11, 2012
Golden Tulip Hotel, Beirut, Lebanon
With the Patient’s Rights and Informed Consent Article..

The public is not a passive observer but the public must be EDUCATED. Physicians and the LOP play an important role in this education which is a moral and national duty. Education will lead to understanding. Understanding will lead to lesser lawsuits and greater trust. They become partners in care.
The public (culture) is ready!

Will saying "I am sorry" (in the right way, etc) prevent a malpractice lawsuit?

- Yes: 87 (60%)
- No: 58 (40%)

Vote on this poll
Votes so far: 145
Days left to vote: 82

Wednesday, June 13, 2012
Medical Malpractice in Lebanon?

The story is simple but complicated. A mourning husband accuses the physician of causing the death of his pregnant wife and his unborn child. According to the family members, the physician did not answer the phone calls the patient made. The nurses were not cooperative. The patient and her baby died. The media is all over the issue. What really happened or are we told? The only thing that is sure is that there is no end.
Closing remarks

1. The Joint Commission on Accreditation of Healthcare Organizations and the American Medical Association request that patients be informed when complications occur.

2. Patients need to be educated. They need to understand and to be appeased. Physicians need to listen to them to understand their cultural backgrounds, level of education, fears and worries... in order to address them.

3. Checks and balances need to be installed

4. Communication is vital in minimizing errors.

5. The Media needs to be more informed

6. “Full disclosure is the right thing to do. It is not an option. It is an “ethical imperative” (Leape).
Thank you
References

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