Case: Medical Error

Editor's Note: On occasion, we would like to present cases with commentaries in the newsletter to serve as a valuable educational tool for our readers. We invite you to write up your interesting cases and send them to us at HCEUSAEditor@chausa.org The cases can appear with or without identifiers. We are also interested in knowing if you or someone at your organization would like to be a commentator on the case. We welcome your participation in making these important educational resources available to the broader ministry. Thanks!

The Case:

A 57-year-old male was admitted to your health care facility four weeks after undergoing a complex surgery at an unaffiliated hospital to correct a congenital heart defect. The patient was originally admitted to your facility for inpatient rehabilitation services, but just five days after his arrival, he had an unexpected cardiac arrest for which he was resuscitated. For the past 62 days the patient has been in your ICU where he is receiving, among other things, ventilation, nutrients and fluids via a PEG tube, and dialysis 3x/day.

The patient appears alert at times, but most of what is known about his wishes has been articulated by his wife, who is a nurse at a local pediatrician's office and is very knowledgeable about her husband's condition. In addition to other consults, the attending physician recently called palliative care to address pain and symptom management as well as advance care planning. To familiarize herself with the patient, the palliative care physician reviewed the patient's chart, both from his stay at your facility as well as the chart from the unaffiliated hospital where he underwent the surgery. While reading the latter, the palliative care physician discovered a note that stated: "A foreign object was removed from the patient during emergent open procedure to correct an internal bleeding complication that developed two days following patient's cardiac surgery. Object was a needle that apparently broke off during the original surgery. Disclosure to patient occurred shortly after he regained consciousness."

That same day the palliative care physician met with the patient and his wife. The patient was unable to participate in the conversation for the most part, but his wife was very participative, expressing profound frustration about her husband's situation and confusion as to how "he got this bad" when they had been told that "he should be on his feet in no time." Throughout the course of the conversation, it became apparent to the palliative care physician that the wife was

unaware of the error that occurred at the other hospital. When asked if she knew why her husband developed complications after the original surgery, the wife stated that she "was not sure" and that "all of this was totally unexpected." After the conversation with the patient and his wife, the palliative care physician met with the attending to discuss whether he was aware of the error and if he knew whether or not the patient and his wife were aware. The attending physician was in fact not aware of it and suspected that neither the patient nor his wife were either. To further complicate matters, the attending noted that the patient was nearing the lifetime limit on his health insurance policy and that soon all subsequent care would have to be paid out-of-pocket.

Concerned and unsure about what to do, the palliative care physician sought an ethics consult to determine whether she or someone else from your facility should inform the patient and his wife about the error that occurred at the unaffiliated hospital. The palliative care physician felt strongly that the patient and his wife had a right to know and to be compensated proportionately for the troubles that the patient has experienced since the surgery, especially since over $300,000 of the patient's $1,000,000 lifetime insurance limit has been expended since the original surgery.

What are the ethical issues in this case? What should be done ethically, and why? Can any generalizations be made from this case that might inform other similar situations?

Case Response One

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Key elements of the foregoing case include retention of a foreign body following surgery and disclosure thereof, the second procedure to remove the foreign body, rehabilitation therapy complicated by myocardial infarction, and what disclosure is appropriate at the rehabilitation facility.

First, one needs to determine if retention of the needle following the first surgery is a medical error. As defined by "*failure of a plan to be completed as intended or the use of a wrong plan to achieve an aim",* a medical error did occur. However, patients and physicians perceive medical error differently. That is, patients may take a broader approach and include in addition to deviations from the standard of care, non-preventable adverse events, poor service quality, and deficient interpersonal communication skills, while physicians take a more narrow view related to standard of care only. [1] Thus, one must consider the perspective of the individual in determining whether or not a medical error has occurred.

Second, was disclosure of the error indicated and, if so, how should it have been handled/documented? Disclosure of errors has become the standard of care

over the last several years. However, one could argue it has always been appropriate to disclose, but given many medical professionals' self-image as well as our increasingly litigious society, it is not surprising that physicians have been reluctant to share this information with patients and their families. Based on the medical record, the patient was informed and the discussion was documented. However, given the immediate post-operative setting, was it an adequate disclosure and should the family have been involved? That is, was the patient able to understand the disclosure at that point in time?

While the note is not clear as to who may have been informed in addition to the patient, if anyone, the narrative suggests the wife was not aware of the error. Disclosures should be conducted in the presence of family members in order to provide an opportunity for better understanding by the patient and family, as well as to serve as a knowledge reservoir should the patient wish to clarify what was said or has questions when the physician is not available. That is, engagement of family and other stakeholders reinforces communication and facilitates deeper understanding of the issues at stake.

At this point in the patient's treatment in the rehab center, the discussion around disclosure moves from what should have been done at the previous hospital to what needs to occur now. Directly asking the wife what she knows about the reason for the second procedure would be the most expedient approach. The rehab physician should be prepared to respond to questions and thus it would be reasonable to include the surgeon from the previous hospital in this discussion. A transparent approach with the key participants present can facilitate communication as well as allay many concerns. Regardless of the approach, disclosure is appropriate and even more so due to the confusion the patient's wife has about her husband's prognosis and course of treatment.

Third, the issue of compensation may appear controversial, but the patient and family members cannot address compensation issues without knowledge of the event. Thus, disclosure allows the patient to mitigate harm related to the error. While disclosure is the correct course, the content of the discussion needs to be well-balanced and factually based without speculation on events at the previous hospital. Specific comments as to the impact of the second surgery on recovery and its potential relationship to the myocardial infarction would require a thorough understanding of the events.

Finally, it is prudent for medical practitioners to consider a standardized approach to discussing medical errors with their patients. Key elements to include are a) intellectual honesty in determining when a medical error has occurred and how to characterize the error (e.g., preventable, effect on patient) [2]; b) identifying who should be informed and when they should be informed based on accreditation, ethical, legal, and regulatory considerations; c) developing a clear understanding of what information should be included in the discussion. According to Bernard Lo, "Patients want to know

what happened, why it happened, how adverse consequences will be mitigated, and how recurrences will be prevented." [3] d) ensuring questions are answered at the time as well as subsequently; and e) understanding that one's self interest during the disclosure process will influence the presentation of information (e.g., conflicts of interest, [4] addressing questions about who is to blame for the error, etc.).

[1] Gallagher, Thanks, et al, Patients' and physicians' attitudes regarding the disclosure of medical error, *JAMA 289*: 1001, 2003.
[2] Beauchamp, TL and JF Childress, *Principles of Biomedical Ethics*, Oxford University Press, New York, 6th edition, 2009, page 294
[3] Lo, page 244.
[4] Defined as "A conflict of interest is a set of circumstances that decreases a risk that professional judgment or actions regarding a primary interest will be unduly influenced by a second interest." Lo, Bernard and MJ Field, *Conflict of Interest in Medical Research, Education and Practice*, The National Academies Press, Washington, DC, 2009, page 46.

Case Response Two
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As I see it, some of the ethical issues in this case are the following:
1) The surgeon has an ethical obligation to "deal honestly and openly with the patient."[1] The surgeon's chart entry states that "Disclosure to patient occurred shortly after he regained consciousness" and the patient and his wife seem to have no understanding that there was a broken needle that caused the need for the second surgery. Therefore the "disclosure" was inadequate.
2) Without the information about the broken needle, the patient and his wife are not able to fully participate in medical treatment decisions.
3) The health care providers at the current facility are caring for the patient without all the pertinent clinical information.
4) Insurance coverage is being depleted and the patient and his wife may soon be financially obligated to pay for further care and, due to the error, they may be owed a financial compensation that could defer some of the cost.
5) We do not know if an investigation was completed at the first hospital that may have found the needle to be defective. It may be that the patient is owed compensation from the manufacturer and that this was an error that was not under the control of the surgeon.[2] An investigation may also provide an opportunity to prevent this type of error from occurring in the future and mitigated sooner. If the broken needle was discovered at the first surgery the intervention could have taken place and further complications may have been avoided.

What should be done ethically and why?

If legal counsel and/or risk management are not represented in the ethics consultation process, these disciplines need to be included in the discussion. There is a potential liability issue for the

first hospital where the original surgery was performed in that if the information disclosed to the patient and his wife is incorrect or incomplete, the second hospital may have some complaint against the first hospital. That noted, the patient and his wife have a right to know what happened so that they can process the event and make decisions accordingly.

Although controversial, one action may be to contact the surgeon who made the chart entry and ask for more information about what was disclosed and inform the surgeon that the patient does not recall the conversation that the surgeon documented in the chart. Perhaps he wants another opportunity to talk with the patient. I doubt the first hospital and surgeon will provide any information other than what is in the chart.

The obligation is on the part of the first hospital and surgeon to disclose the medical error and, when we have limited knowledge about the facts of the case, we may be inclined not to tell the patient and his wife anything or to merely tell the patient what the chart entry says and stop there. However, our Catholic Social Teaching and the *Ethical and Religious Directives* require us to do more. While the error was not ours, the patient was harmed and we are now responsible for his care. Part of that respect for the patient and his wife as human persons requires us not to perpetuate the lack of understanding.

The next question to answer is what to tell the patient and wife now, and who will tell them. Our information is limited to the cryptic chart note so there is not much information to convey. We must be prepared to deal honestly with all their questions. A very important aspect of this communication is to answer only with the knowledge we have and not speculate about answers to questions about which we don't have factual information. The attending physician may decide that the patient is too sick or unable to comprehend the information and that it should just be delivered to his wife. In either case, the wife may need support of another family member or a trusted friend or staff member. If there is a trusted staff member, e.g., a nurse or chaplain, who can be present, this may smooth the transition into ongoing support of this family. Keeping in mind the need for ongoing support as they process the information is of critical importance and should be kept in mind when deciding who should be the person to deliver this difficult information. Often that person would be the attending physician. However, if one's hospital policy identified someone else or the hospital has people particularly skilled in this type of communication, that person might be selected to talk with the patient and wife.

In general this case offers us the opportunity to look at our own organizations and review our own policies, people, and environment that shape our response to unanticipated events. What resources and training are available to the physicians and staff? What resources are available for patients and their families? Is our environment such that these painful but human errors are examined and

worked through or is the culture one of shame and blame so that the tendency is to hide, avoid, or rationalize the error?

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[1] Joint Commission Hospital Accreditation Standards. Oakbrook Terrace, IL: Joint Commission, 2002 RI 1.2.2 (now RI.2.90) Council on Ethical and Judicial Affairs. Code o Medical Ethics: Current Opinions with Annotations. 2002-2003 Edition. Chicago, IL: AMA Press, 2002

[2] Council on Ethical and Judicial Affairs. Code of Medical Ethics E-8.121 Ethical Responsibility to Study and Prevent Error and Harm