Surgical Ethics Academic Half Day
Medical Mistakes

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"There are two types of physicians: those that have made mistakes and those that will"
- James Reason

"Do not fear mistakes. You will know failure. Continue to reach out."
- Benjamin Franklin

Medical Mistakes: Outline

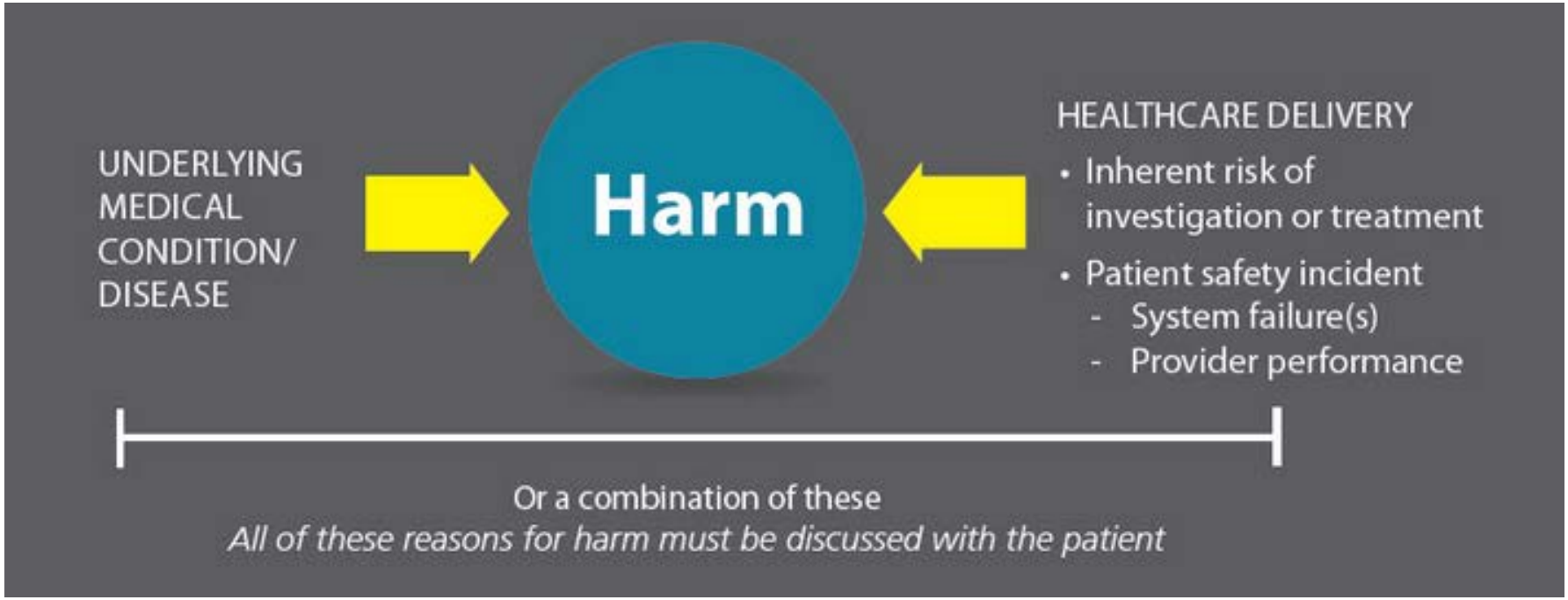
- Mistake versus complication
- Principles of admitting a mistake
- When and who to disclose to
- Legal responsibilities and documentation
- Small groups to discuss cases

Medical Mistakes

Meménto, homo, quia pulvis es, et in púlverem revertéris

- You will make mistakes during your career, and these can adversely affect your patient and your career
- There is close to a 100% chance you will be sued during your career

Medical Mistakes



Complications

Complications

- A complication is an adverse event inherent to the procedure/care delivered
- Often outside of the physician's control
- Known complications must be communicated to patients before undergoing surgery as part of informed consent

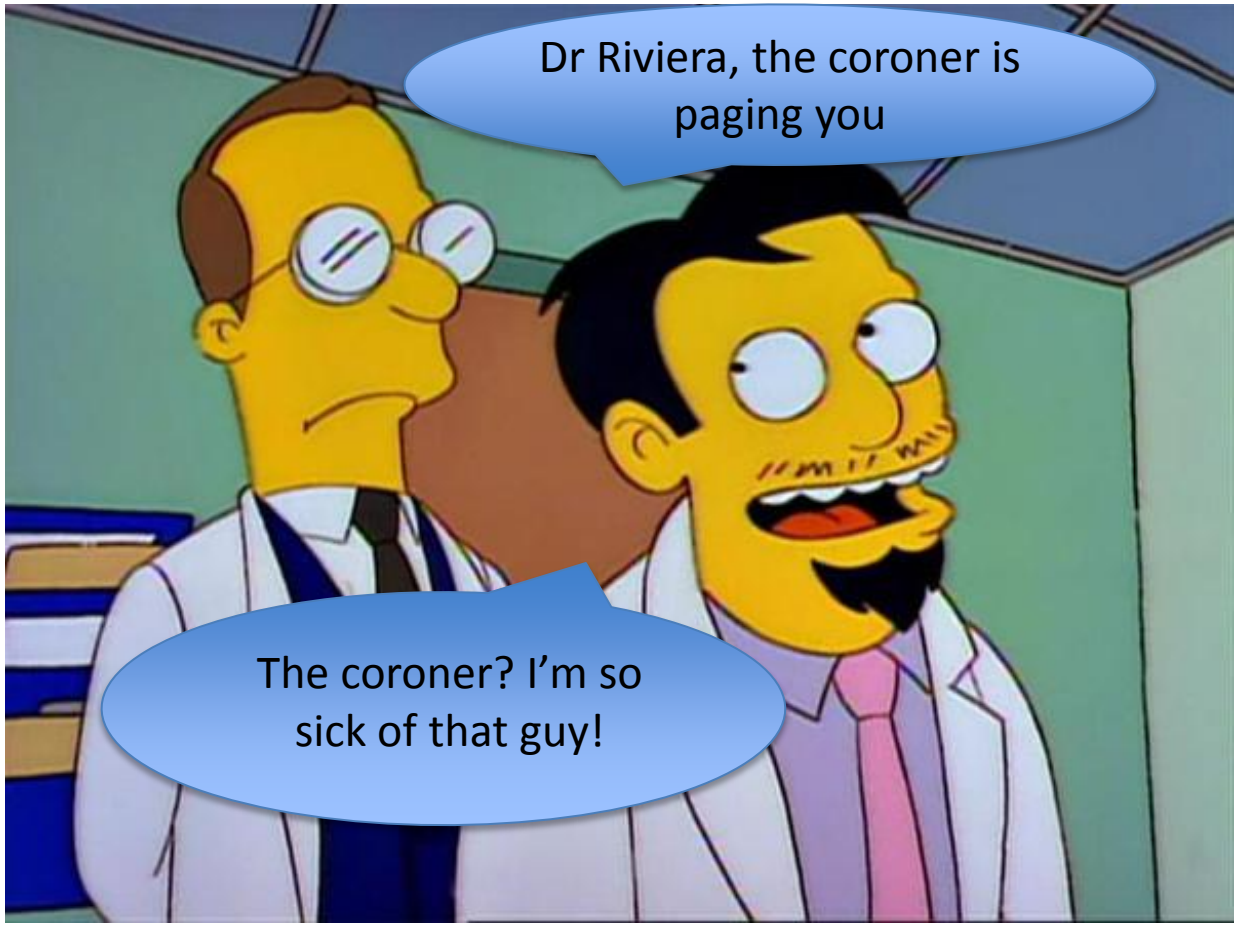
Mistakes

- A mistake is an action (or inaction), that given the information available and the patient's condition at the time, was performed wrongly or incorrectly
- This includes both events where there was an adverse event, and events where there was a near miss

Mistake or Complication?

- Necrotizing infection at EVAR groin site
- Retained foreign body
- Transfused incorrect blood
- CABG to coronary vein
- PE after colorectal cancer surgery

Principles of Admitting a Mistake



Admission

- Honest, timely and forthright admission of the mistake and full disclosure to the patient, their family and the patient's care team
- If the cause of the mistake is known, this should also be disclosed at this time
- This is not only ethically mandated, but is legally mandated

1. First things first: Attend to clinical care

- Address clinical needs and deal with emergencies
- Consider the next steps in clinical care
- Provide emotional support
- Document the adverse event

2. Plan the initial disclosure

- What are the facts
- Who will be involved
- When and where will the meeting occur

3. The initial disclosure meeting

- Provide the known facts
- Be sensitive
- Do not speculate or blame others

Apology

- It is important to clearly and unambiguously apologize for the mistake

Apology Act (2009)

- "Apology" means an expression of sympathy or regret, a statement that a person is sorry or any other words or actions indicating contrition or commiseration, whether or not the words or actions admit fault or liability or imply an admission of fault or liability in connection with the matter to which the words or actions relate

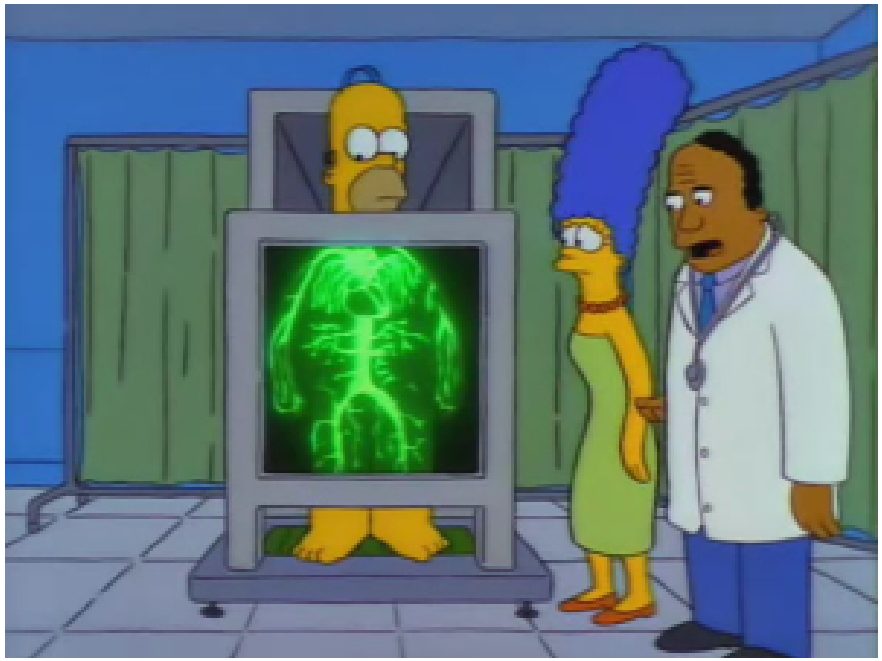
- Despite any other Act or law, evidence of an apology made by or on behalf of a person in connection with any matter is not admissible in any civil proceeding, administrative proceeding or arbitration as evidence of the fault or liability of any person in connection with that matter

Maintaining Rapport

- It is important to maintain a positive relationship with your patient and their family
- The discussion around the mistake should involve the following:
  - **Appropriate body language, seating at eye-level**
  - **Discuss in a private setting, devoid of distractions**
  - **Tell the truth, avoid jargon and euphemisms**
  - **Do not be defensive or abrasive, do not deflect responsibility**
  - **Express regret, emphasize your continued care**
  - **Have a clear plan for the patients care**
- Compassionate and honest conversations have been shown to mitigate litigation

Resolution

- Outline any and all implications of the mistake that will affect the patient
- Have a plan on how future mistakes of this kind will be corrected



Error and Blame

- Do not rush to point fingers at other people (RNs, pharmacy, co-residents and staff, etc.)
- The “blame and shame” approach has been well-documented to not improve care and causes under-reporting of adverse events
- As leaders in healthcare, we all share responsibility when mistakes occur

Terminology

- Adverse event – a mistake reached the patient and harm occurred
- No harm event – a mistake reached the patient, but there was no harmful sequelae
- Near miss – the event did not reach the patient because of timely intervention or good fortune

Legal Responsibility

- The Canadian Medical Association's *Code of Ethics* states physicians must "take all reasonable steps to prevent harm to patients; should harm occur, disclose it to the patient."
- If the event reaches the patient, even if it does not cause harm, it must still be legally reported to the patient
- In general, a near miss does not need to be disclosed to the patient unless there is an ongoing safety risk to that patient
- Adverse events must also be reported to the institution (risk management) to help mitigate future errors

Documentation

- “If it’s not documented, it didn’t happen”
- Physician notes regarding mistakes need to include:
- **Time, date and location of meeting**
- **Names and roles of all members present at the meeting**
- **Facts presented in the discussion**
- **Families responses and reactions**
- **Agreed-upon next steps**
- **Plan for follow-up and further meetings**
- Documentation must be timely
- DO NOT alter medical records, may add addendums that are timed and dated

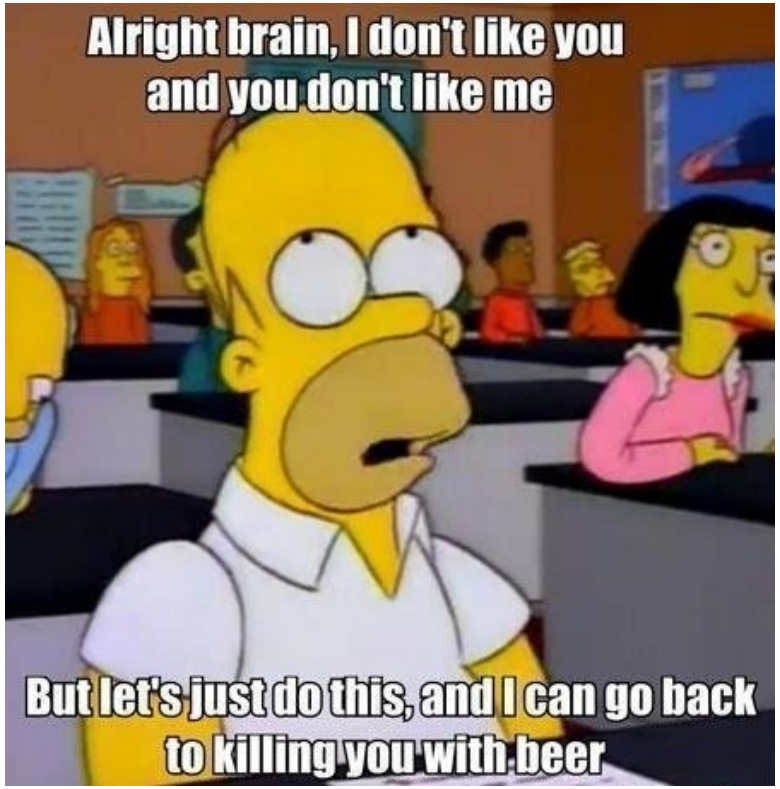
Litigation

Litigation

- Despite timely and honest disclosure, legal action may sometimes be initiated
- If a patient files suit, or there is a strong belief they may do so, care should be switched to a different provider
- Contact the CMPA and initiate all further contact with the plaintiff via legal counsel

Small Group Discussions

- Please take 30 mins to go over the cases with your small groups



Case one

Case one

- Wrong-sided surgery

  1) What is your ethical duty to disclose, and who do you disclose to?
  2) How do you deal with your superior resident in this situation?
  3) Where would you discuss this with the patient? In PACU? Day surgery? Follow-up? Who would you want to be there?

Case two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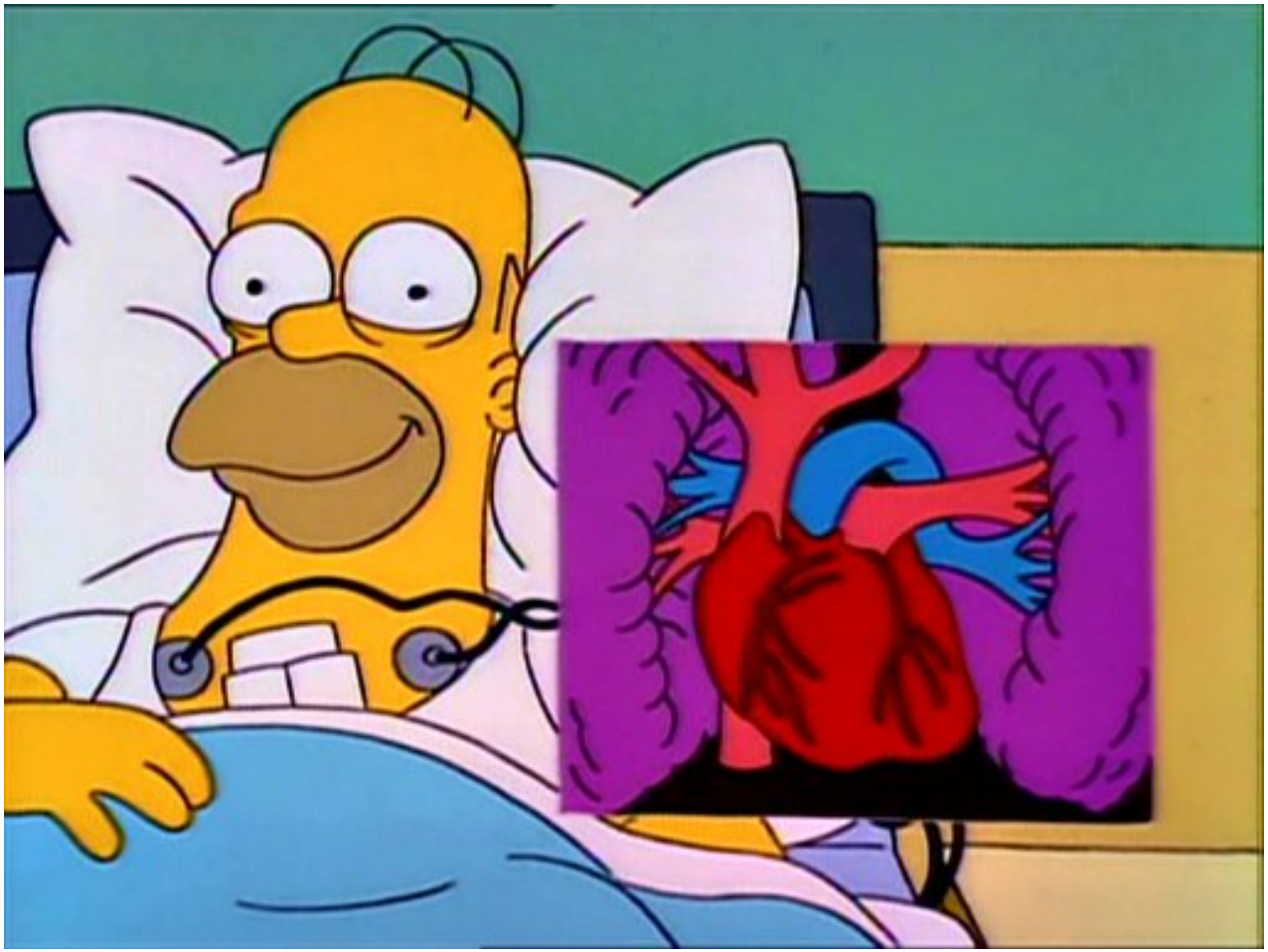
Case two

- Wrong antibiotics

  1) Do you have to disclose this error? To whom are you disclosing to?
  2) If yes, how would you go about it? If no, explain your rationale
  3) How would you deal with the day surgery nurses?
  4) If the patients went on to develop SSIs, would it change your approach to disclosure?

Case three



Case three

- Same patient name

Questions for discussion

1) Do you have to disclose this error to the post-op CABG patient?

2) What do you say the patient sent down to radiology?

3) What concerns might you have moving forward with these patients care?

Case four

Case four

- Too much to drink

1) Is this a medical mistake?
2) What is your duty to disclose? Report?
3) The patient hears about the incident through the recovery room team and is irate, how do you approach this situation?
4) The patient names both you and your staff in a lawsuit before routine follow-up, what are your next steps?

Thanks for your attention

Goodbye Everybody!

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