Right To Health Through Litigation: Ethical Dilemma In Medical Error

Boniface A Ushie¹ and David B Ugal²

¹University of Ibadan, Nigeria, ²Federal College of Education, Obudu, Nigeria
boniface.ushie@gmail.com

ABSTRACT
Health caregivers often face dilemmas in the choice of whether to disclose or cover-up their own preventable medical mistakes, which are harmful to patients’ health. Patients have to choose between suing a caregiver who reports medical errors to them and forgiving them. The decision about whether to report errors and whether to litigate can cause serious moral and ethical dilemmas. We examined voluntary reportage of error and its effects on medical negligence or malpractice litigation. We also examined the difficulty patients or their relatives face in proving that indeed the errors the patients alleged were ‘preventable’, as well as the burden of litigating a health caregiver who has voluntarily reported their own error. There is need to create an environment whereby disclosure becomes standard practice and medical errors are minimised, to reduce the potential for conflict between caregivers and patients and generally improve care.

Keywords: Preventable medical error, Dilemma, Voluntary reportage, Medical Negligence, Litigation, Patients, Caregivers

Introduction
Globally, health reforms are focusing on the principle that all individuals have a right to good health and if that right is denied, they can seek redress through litigation. The litigant can sue the government, group or individual they perceive to be impeding their right to good health. Putting this principle of right to health through litigation into practice can be a daunting task; this can come in the form of medical errors. Preventable errors in health care pose an enormous threat to patient safety, especially in low income countries where the level and quality of medical services are poor. In Nigeria, for example, available data show that there are only about three doctors to every 10,000 people in the population. Knowledge of the incidence of medical errors in the health system (especially by the public) is lacking. What people know is based on conjecture as little scholarly research

One of the most difficult aspects of the caregiver-patient relationship in health care is the difficulty of reporting one’s own error to the patient and litigating one’s caregiver. Whereas the principles of ethics demand that any error in patients’ care be communicated to them, actually doing so can be difficult. Physicians, for example, do not embrace the ethic of voluntary reportage of error (Woolf et al., 2004); reportage means that they open themselves to criticisms, litigations and other patients’ reactions. The patients are most likely to take action against the health care personnel who make a mistake in their care. On the basis of this, are the caregivers to risk being prosecuted by telling the patients that they made a mistake while caring for them? Is it right then for the health personnel to cover up their errors since without their say-so the patients may never be aware of the errors? How would the patient or their relatives receive the information that the illness they were trying to relieve has
been aggravated or that their relative may have died due to human errors? Should the patients or their relatives sue the government for not providing adequate health care service which can guaranty their safety? These are weighty questions that raise ethical considerations and place both the health experts and patients in a dilemma. This paper grapples with these questions. The rest of the paper is divided into three sections. In the sections that follow, we highlight the issue of how health care providers (are expected to) handle medical error situations and how patients and their relatives react to error disclosure while a concluding section summarizes the paper.

**How should health care providers handle medical error situations?**

According to the Doctors’ Guide (1997), physicians and indeed, all medical personnel have an ethical obligation to tell patients about serious medical errors when such disclosure will benefit the health of the patients and to show respect for the patient’s autonomy. Failure to do this will bring caregivers into direct opposition to principles of justice. One of the principles of biomedical ethics, according to the Helsinki Declaration, is respect to human subjects. In spite of the implied risk that care providers would be sued when an error has come to the knowledge of patients or their relatives, it is ethically correct to report any adverse medical event to the subjects involved. The risk involved in doing so is that patients may then proceed to sue them or report them to their professional associations. This risk could be removed if the caregiver chooses not to report the error, but which violates ethical principles guiding care provider - patient relationship.

According to Liam Donaldson, Chief Medical Officer of the United Kingdom and Chairman of the World Alliance for Patient Safety, ‘to err is human, to cover up is unforgivable. To fail to learn is inexcusable’ (in PAHO, 2007). If research and interest in medical error is to improve the quality of health care delivery, then Donaldson could not be more apt. When mistakes are made, it is necessary to report them so that adequate safeguard can be built against future occurrences, and the caregivers, acting on the knowledge gained from the mistakes, can then provide better services in the present and be better equipped for the future. Of course, there is the weighty question of whether reporting medical error to patients or their relatives would heal the wound created by such errors and whether legal action against the individual health officer would eliminate the fact of the problem.

Nevertheless, one of the main findings of Woolf et al.’s (2004) study is that physicians do not like to reveal or disclose their errors and that when they choose to report, such reports are hardly complete, accurate, free of bias, or representative of all errors in health care. Primarily, Woolf et al noted that physicians attempt to cover up their errors for fear that their regulatory bodies may sanction them and because of litigation from the patients or their relations. Reporting medical errors may be viewed by health personnel as a way of calling their competence into question. The fear that their peers or professional bodies may devalue them if it became public knowledge that they were sued for medical error may be a strong factor in the decision not to report. The problem with non-reportage of errors in health care is that patients are left in the dark regarding actions which affect them directly and oftentimes affect their health adversely, especially given the general low level of medical knowledge (Jegede, 2002), and poor awareness and knowledge of medical error in particular.

Whereas people seek medical help to maintain a favourable state of health, preventable errors undermine this, and given that patients are mainly unaware of the occurrence of errors and how they may harm them (Oyebode, 2006), their basic right to good health is put in jeopardy. Errors may cause patients to stay longer in the hospitals, pay more (especially in a fee-for-service context), and generally be unable to pursue other basic life activities. Apart from this, it is difficult to prove that an error occurred in one’s care or indeed to prove
that the mistake was ‘preventable’. This burden of proof, lack of adequate information, high level of illiteracy and poverty, work both independently and jointly to foreclose litigation against medical negligence or malpractice in countries with high levels of illiteracy. So in the light of this, would it not serve the caregivers better if they covered up medical errors? The truth is, cover up may be better for them, but they would be violating the biomedical ethics of openness and lack of harm and betraying their fiduciary duties to the patients.

The emphasis on disclosure is a clear pointer to the fact that the patients themselves may not know anything about medical errors. This may be more striking in many developing countries where patients do not access to their own medical records, and even when they do access their records, they may not be able to decipher the ‘medical handwriting’ and ‘jargons’ of health professionals. In fact, many times, patients are not even told what exactly their health problems are. Thus, Cleopas et al. (2006) contend that appropriate response to medical errors must take account of patients’ expectations. For example, patients expect that errors should be openly disclosed (Vincent, et al., 1994; Hingorani, et al., 1999; Wu, 1999; Cantor, 2002; Gallagher, et al., 2003; Mazor, et al., 2004).

However, open disclosure of errors by caregivers is not a complete safeguard against malpractice litigation. This places the caregiver in a moral and ethical dilemma: should they just carry on as if nothing harmful happened to the patient (since there is the likelihood that the patient would not know about it if not informed by experts)? Or should they do the right thing by reporting the error in spite of the risk of their medical license being seized by their professional associations?

The Institute of Medicine’s (2000) report on patient safety issued a central statement that medical errors should be viewed primarily as failures of institutional systems rather than failures of individuals. However, Landrigan et al. (2004) found that the public do not embrace such a view; rather, they feel that persons responsible for medical errors should be sued, fired, and subjected to suspension of their professional licenses. Yet, Blendon et al. (2002) report that a significant percentage of respondents in a study thought that patients were very often or somewhat often, at least partially, responsible for errors made in their care (see also Donchin, et al., 1995). It is within the purview of such confusion on whom or where to place the blame that it may appear necessary to seek solutions rather than blame. Thus, it is necessary for caregivers to report errors not only to patients but also to management so that measures can be sought to forestall future occurrence.

Generally, patients place their health in the care of health professionals on the trust of their competence to restore them to a healthy equilibrium, any adverse event in the process of doing so needs to be reported so that the trust is not betrayed. Such a report would go a long way to helping the patient in the recovery process.

**How would patients and their relatives react to error disclosure?**

One of the expected benefits of medical error disclosure is that it reduces the level of animosity resulting from knowing that one’s health had been compromised as a result of error. There is considerable recommendation right now for the disclosure of errors to patients as standard practice (Liang, 2002; Gallagher, et al., 2005), but there is limited evidence about the impact of such policy on malpractice litigation and relationships between caregivers and patients (Cleopas, et al., 2006). Nevertheless, Kraman and Hamm (1999) have suggested from their study that a policy of open disclosure does not increase malpractice claims, while Vincent et al. (1994) claim that lack of openness itself is a motivation for lawsuits. This can only be so if the patient or the relatives are knowledgeable about the error or if they base their claim on conjecture, in which case, they would be faced with the burden of proving that the error did occur and was indeed, preventable.
A survey of hospital management in the United States revealed that disclosure of errors to patients is increasing but also that the fear of malpractice litigations remains the main barrier to disclosure (Lamb, et al., 2003). Whereas this can be said to be a positive development, the same cannot be said of many less developed countries. Although research is scarce, it is obvious from the lack of national databases on malpractice litigation and medical error disclosure that caregivers in many hospitals may not be ready to report ever committing an error (Ushie, et al 2013) and patients are largely ignorant of medical errors. Therefore, without disclosure, patients and indeed the public, go on oblivious of the problem while it flourishes in the health care system.

Patients and the public generally react negatively to medical errors. Several studies have explored people’s opinions through experientially manipulated hypothetical scenarios that describe a medical mishap to them and then ask their opinions about the mishap. These studies have established that perceptions of the public are more negative when an error has severe health consequences (Blendon, et al., 2002; Schwappach & koeck, 2004), and when the error is not disclosed to the patient (Witman, et al., 1986; Mazor, et al., 2004). Both adverse health outcomes and non-disclosure of the error concern the patient directly, so that the importance of these variables for people’s perceptions is not surprising.

However, it is doubtful whether patients are sensitive to the responsiveness of health care staff once an error has occurred, in particular the prompt recognition and management of the error (Cleopas, et al., 2006). In a study conducted through the use of simulations and hypothetical patient and errors, Cleopas et al. found that 71.4% of real patients were of the opinions that the care received by the hypothetical patient was bad or very bad, 60.2% considered that the patient was treated in unsafe conditions, and 25.5% would not recommend the hospital based on the scenario. But the assessment of the care varied considerably according to the version of the scenario. Only 34.0% of respondents assigned to the best-case scenario considered that the hypothetical patient received bad or very bad care compared with 89.5% of those assigned to the worst-case scenario. The apportionment of blame to both the care-giver and the condition or environment where the care is given as reported by Cleopas et al. underscores the importance of approaching medical error research from both the individual and system perspectives, that is, error can both be caused by institutional and individual factors. Perception has a pivotal part to play in how patients would react to error disclosure or non-disclosure.

CONCLUSION

The picture of the modern health care system as a tensed, conflict ridden environment where both the caregivers and the patients are perpetually on the lookout for each other makes it unsafe for medical attention. The need to have a comfortable and understanding caregiver-patient relationship is thus precipitated on the fact that it provides a good working environment. Unless a two-way understanding – the humility to disclose error and the humanness to see error as a mistake – is reached, the dilemmas of error reportage and litigation may not be overcome. First of all, in an error incidence, the health care system should be able to decide whether a caregiver, pressed with the burden of attending to many patients in need, with a bounded time-frame, should take the time to talk to a patient who has suffered a medical error. Or whether it is much better to attend to other patients in the belief that it is more politically correct to save other lives when the problem of the injured patient may not be remedied.

It is at a time like that the service of social workers and sociologists is so much needed. The duty of speaking to the patients (including disclosure of error) is delegated to the social
worker while the caregiver goes on with other patients. Now, the caregivers who made a mistake in the patient’s care may be so internally distraught that he may not be able to handle the patient directly themselves. This is where the social departments of hospitals become very useful. The disclosure of the error is handled not specifically as a particular caregiver’s problem but as a problem to be borne by the system. The job of the social worker in an error situation would be both that of gently breaking the news of the error to the patients and educating them on the possibility of the error being like other errors that humans make (tact and finesse are highly needed since other human error may not result to permanent disabilities, death, etc.). Only in this way can a good health and social order environment be guaranteed and the dilemmas of whether to disclose or cover up and whether to litigate or not may be resolved.

In such a situation, it becomes necessary for caregivers to report errors not to the patients themselves but to management or some other body. Thus, the disclosure of medical error becomes institutionalised and functions through this body or management to convey information to the patients. The disclosure by health caregivers may also be in form of daily, weekly or monthly report of work. This work reports are then reviewed for consistency with standard practice.

Another good way may be the periodic review of safety practices or case histories by a body commissioned to do so. This, apart from resolving the burden of having to disclose error to patients, can also help the health care system to have a view of its own safety standards since the rate of mortality in a hospital is partly a reflection of its safety standards and quality of service (Dubois, 1999).
REFERENCES


