Errors happen. What to do when there's no one to whom to say "I'm sorry."

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Informed consent is a cornerstone of medical ethics, not just in terms of making decisions about treatment but also when care doesn’t go as planned because of errors. But disclosing harmful mistakes can be daunting for physicians, especially when patients are incapacitated and unrepresented. A medical student outlines specific steps physicians and organizations can take in managing errors pertaining to unrepresented patients in keeping with the profession’s ethical obligations.

The AMA Code of Medical Ethics provides additional guidance on caring for unrepresented patients, such as opinion 2.1.2, “Decisions for Adult Patients Who Lack Capacity,” to involve patients in health care decisions commensurate with their decision-making capacity, and opinion 5.2, “Advance Directives,” to support continuity of care for patients when they transition across care settings, physicians or health care teams.

Following are highlights from an article published in the AMA Journal of Ethics® by Ryan G. Chiu, a third-year medical student at the University of Illinois College of Medicine in Chicago. Using a hypothetical case of an 82-year-old man with altered mental status who suffers cardiac arrest, is not resuscitated immediately because of a communication error and suffers brain damage as a result, Chiu recommends a three-part framework for error management pertaining to unrepresented patients.

“Errors are not uncommon—counting among other iatrogenic incidents as the third-leading cause of death in the United States,” Chiu wrote. “It is now a generally accepted ethical duty among U.S. physicians to communicate harmful errors and their implications to the patient and his or her family members.”

**Documentation.** Reporting errors can help identify areas of improvement for both the physician directly involved and the organization, so even “latent” errors—what Chiu describes as “less obvious
failures of an organization or system that contribute to human errors or to accidents waiting to happen”—and near-misses should be documented.

“Clear and complete documentation enables root-cause analyses of causal factors underlying systemic sources of variation in clinical practice,” he wrote. “Hospital policies can be tailored to address these factors in order to prevent similar errors in the future.”

**Disclosure.** Ordinarily, error disclosure gives a physician an opportunity to apologize, outline steps for rectification, preserve trust with the patient and limit professional liability.

“For unrepresented patients, of course, those who could seek financial retribution or demand an explanation are absent,” Chiu wrote. “Nevertheless, finding someone to whom to disclose the error could be helpful, if not therapeutic, for the clinician directly involved, as it involves the clinician setting aside his or her pride in order to reflect on what just transpired,” as well as to mentally organize events to help identify ways to prevent errors.

**Rectification.** “What constitutes adequate rectification of an error can be an ongoing source of ethical and clinical consideration, but, for purposes of discussion here, rectification can be construed as a restorative process related to either a harmed patient (by minimizing his or her discomfort) or, in the case of a patient’s death, memories of that patient,” Chiu wrote. “Unfortunately, some errors could render a patient unresponsive or unable to clarify his or her end-of-life wishes.”

In such a situation, the physician might consider seeking advice from colleagues not directly involved in the patient’s care who have relevant expertise or from the organization’s ethics committee. Prolongation of life, Chiu noted, could result in additional harm being suffered by the patient and is only ethically acceptable when its benefits outweigh those harms.