

Review Analysis: Legal and Ethical Issues of a Medical Error Case

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The objective of this article review is to investigate a medical error case study focusing on legal and ethical implications and proposing strategies and policy recommendations that may help healthcare administrators to prevent this type of error from occurring. The scenario selected for the article review is based on the Smoltz case of the nurse negligence article, “Rosenthal, K. (2004). Where did this patient's I.V. therapy go awry? *Nursing*, 34(5), 56–57.”

Legal Aspects

In the Smoltz case, there are some of legal aspects that are paramount for identifying, which are as follows (Rosenthal, 2004):

- Failure to comply with the guidelines and standards of practice concerning the Intravenous (I.V.) Therapy skills.
- Ineffective communications regarding failure to inform someone in authority about an ‘emergency’ practice.
- Failure to keep clear and accurate records and documentations.
- Failure to comply with the hospital’s policy on the prohibition of nurses inserting the I.V. therapy treatments within the feet.

Overall, the hospital, physicians in addition to the nurses on duty that first night are the ones who are liable for the medical error of negligence.

Ethical Standards

The hospitals that provide the IV fluid therapy are considered to be an integral part of the care for many patients (Mahan & Escott-Stump, 2004). In the Smoltz case, it was paramount to administer the fluids and medication treatments through the fastest and most efficient method intravenously. The Emergency Department staff responded rapidly to the patient admitted on the evening of November 14, to ensure that the measures of hydration and administration of medications were done efficiently (Rosenthal, 2004). Therefore, there were some ethical standards. However, on the other hand, the Nurse Scott failed to prepare document and conduct a thorough patient assessment in terms of asking the patient if the catheter was pulled out or got caught; measuring the length of the external portion of the catheter at each nurse's visit and ensuring to maintain the same length and also documenting this further (Royal College of Nursing, 2010). There was the lack of patient probing by the nurse Scott, to seek more vital information. There were different records of the gauge intermittent; in one case, it was a 20-gauge, intermittent and the other was an 18-gauge (Rosenthal, 2004). The nurses also failed to document the observations of the swelling and discoloration of the patient's right leg (Rosenthal, 2004). The nurse Scott also breached the hospital's protocol when administering the catheter in the lower extremities due to the risk of phlebitis (Rosenthal, 2004).

Pros and Cons

From both an ethical and legal standpoint, it is a sound idea, in theory, to have the provider disclose and apologize for the medical error to the patient's family soon after the occurrence. In general, it is important to highlight the issues contributing to medical errors occurring within the hospital setting. These issues would include the lack of top management

commitment, lack of manpower (staffing), lack of incentives, fear of taking decisions, lack of knowledge/understanding, lack of a legal environment in terms of malpractice laws, the public relations on the errors' coverage, and the pressures from insurance companies (McFadden, Stock & Gowen, 2006). Furthermore, the key challenges can be classified into two major streams, internal and external (McFadden, Stock & Gowen, 2006, p. 127). The internal challenges of quality and patient safety (QPS) in primary care would include first, inadequate human resources development and management; second, lack of planning; third, lack of leadership and commitment; fourth, insufficient resources and facilities; and finally, lack of patient focus (JCIA, 2010; Sebastainelli & Tamini, 2003). The external challenges of QPS in primary care would include the threat of malpractice suits and media coverage of medical errors (McFadden, Stock & Gowen, 2006).

Taking into consideration the above, on the ethical implications of disclosure would show an expression of empathy and help in establishing a rapport with the family (Mahan & Escott-Stump, 2004). It is paramount to ensure to learn about all the facts of the scenario before meeting with the family members in a quiet private place. The downsides of disclosure is that it can lead to more distress to the family members. The pros of the legal implications are that the provider has made an explicit statement that the medical error took place, in addition to providing a straightforward outline of the scenario and highlighting what occurred exactly and also offering an apology to the family (Weiss & Koch, 2012). The healthcare professionals attending the disclosure meeting should ensure to have a summary of the meeting regarding the synopsis of the dialogues occurred, including any misinterpretations, record the names of all attendees, including the date and time (Amori, 2006). The cons of the legal implications would be that the family

members would want to press charges upon the provider and may further lead to a legal proceeding that may have an impact on the future of the physicians, nurses, and provider involved (Charles & Frisch, 2005).

Healthcare Administrators Roles

It has been reported that as many as 98,000 deaths annually in the U.S. of which 58 percent is as a result of medical errors and custodian events (Longo, Hewitt, Ge, & Schubert, 2007, p. 189; McFadden, Stock & Gowen, 2006, p. 124). A medical error can be referred as the “failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim” (McFadden, Stock & Gowen, 2006, p. 124). Whereas, a sentinel event is an anticipated occurrence involving death or major permanent loss of function unrelated to the natural course of the patient’s illness or underlying condition (JCIA, 2010, p. 27). QPS helps hospitals to be safer, reduce medical errors, be more effective, patient-centered, timeliness, more efficient and also equitable (JCIA, 2010; Laureate Education, Inc., 2008; Longo, et al., 2007, p. 189). QPS helps healthcare organizations such as hospitals, for instance, the Capital Medical Center in Olympia, WA identified and corrected medical errors and problems and improved the quality of care and services (JCIA, 2010, p. 12; Rivara & Floersheim, 2004). One critic of a research article stated that “Patient safety must be an integral part of the mission of every hospital in the US” (Longo et al., 2007, p. 205).

The first strategy is to encourage hospital leaders to collaborate to carry out the Quality and Patient Safety (QPS) program (JCIA, 2010). This strategy helps to shape the hospital’s culture and thus makes an impact on every aspect of its operations, especially for the coordination of the clinical laboratory quality control program, the risk-management program and patient safety office

(JCIA, 2010, p.148). This recommendation tends to result in improving the patients' outcomes because they receive care from many operations of various departments and services and types of clinical staff (JCIA, 2010).

Usually, participating in data collection and analysis and planning and implementing QPS require knowledge and skills that most staff did not have or do not use regularly (JCIA, 2010). Therefore, the second strategy is to train staff for them to participate in the QPS program (JCIA, 2010; McFadden, Stock & Gowen, 2006). The medical staff should also receive training consistent with their roles in the QPS (JCIA, 2010). Furthermore, health care administrators should strive for the development and implementation of trust policies and procedures and mechanisms for reporting errors and procedural announcements clearly defining the delivery methods regularly (Ballinger & Patchett, 2007).

The third strategy is to communicate regularly the QPS information to hospital staff (JCIA, 2010; McFadden, Stock & Gowen, 2006). Communication can be through notice boards, staff meetings, human-resource processes, newsletters and even electronic mails. It would be a great idea to have the hospital leaders to communicate QPS messages from time to time. These communications can be about new or recently completed QPS initiatives, progress on QPS program, recognition of best practices by staff and even outcomes of the analysis of sentinel events and medical errors (JCIA, 2010; McFadden, Stock & Gowen, 2006).

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