Conflict in Fiduciary Duty Involving Health Care Error Reporting

Fiduciary duty is the responsibility to act in the best interest of a person or organization. Health care professionals, as well as managers in other industries, struggle continuously with the dilemma of whether or not to admit potentially harmful mistakes to unsuspecting customers and patients. Limited public disclosure of medical errors will benefit health care staff, organizational executives, and patients if specific policies are enacted to improve error prevention.

Since its beginning, the purpose of organized medical care has been to help people, if possible, recover from illness or infirmity. Included in this mission is the obligation owed to the patient and the organization, or fiduciary duty. Fiduciary duty is an obligation to act in the best interest of a person or organization. This can place health care administrators and staff in a position of ethical conflict because, in general, managers are trained to believe that their chief duty is to represent the interests of their health care organizations. In doing so, they then further patient and community interests (Nowicki, 1998).

Health care professionals, as well as managers in other industries, struggle continuously with the dilemma of whether or not to admit potentially harmful mistakes to unsuspecting customers and patients. This situation is the subject of intense debate as a result of the Institute of Medicine’s (IOM) study finding that between 40,000 to 98,000 hospital deaths are caused each year by medical errors (Asch-Goodkin, 2000). Furthermore, the IOM reported that an extra $17 to $19 billion are spent annually on nonlethal medical mistakes (Rovner, 2000). This report resulted in an immediate reaction by health professionals, the public, government agencies, and health care organizations. In an effort to reduce medical errors, several proposals have called for the mandatory reporting and public disclosure of all medical mistakes (IOM, 2000; Isenstein, 2000).

Health care professionals and medical ethicists agree that the problem of medical mistakes requires immediate attention. The public deserves to feel confident that when individuals enter the health care system, they will benefit from the care received. At issue is the best way to accomplish this mission while balancing fiduciary duties to patients and health care organizations.

The quest to provide quality patient care has never been questioned by health care providers nor by the general public. Numerous studies and expert reviews affirm that people believe that quality care is a right of every person entering the health care system. How to assure medical safety is the problem. Can health care system professionals honor their duty to patients and the organization when public disclosure of medical errors is involved?

Arguments Against Disclosure

There are inherent problems with public disclosure of medical mis-
takes because it can result in compromising an administrator's duty to the organization with little or no benefit to the patient. Health care staff have responsibility for protecting the organization from harmful situations. If public disclosure of medical mistakes places the organization at risk for financial and legal consequences but does not insure patient safety, the staff has compromised both without good cause. In this review, the advantages and disadvantages of medical error disclosure are debated relative to the concepts of risk management, confidentiality, and organizational learning. By understanding the complexity of this issue, nurses will be prepared to implement and evaluate more effectively policies and standards proposed to address the dilemma of reporting medical errors.

Risk management. One of the objections to public disclosure of medical mistakes is related to potential litigation. Historically, peer review and certain risk management documents have been restricted from review by lawyers and other outside individuals and agencies. Nowicki (1998) contends that attorneys argue that lawsuits are not only a function of mistakes made, but also of those of which the patients are aware. Therefore, if public disclosure of these documents is instituted, physicians and health care organizations will place themselves at increased risk for litigation.

Another concern is that by admitting mistakes, defense attorneys are hindered in their efforts to defend or settle patient lawsuits (Nowicki, 1998). When medical mistakes are made, patients and/or their families can become highly emotional and often wish to punish the perceived responsible parties. If organizations or practitioners admit, through disclosure of risk management documents, that they are guilty, the costs to the organization and/or the medical professional can be astronomical. Disclosure of these documents takes away the ability of the defendant's attorney to properly defend the client. In other words, the defendant becomes a witness for the plaintiff. This would not serve organizations well. Further, it fails to meet an ethical duty to patients, because there is nothing inherent in the practice that guarantees improved patient safety.

Confidentiality. According to Brennan (1999), the publication of the IOM report has resulted in an increased interest in developing a database of errors and near misses. This could serve as the foundation for developing a new science of health care error prevention. However, ensuring the confidentiality of patients and providers has not been addressed. In order for a factual basis for analysis, extremely accurate and detailed descriptions of critical incidents are required. Merely deleting patients' and providers' names may not change information to the degree that the identities of organizations and other involved parties cannot be detected. Public disclosure of this information would make the information available to attorneys and to the media, who could publicize and even sensationalize events (Brennan, 1999). This would not foster efforts to improve patient safety, because it would increase the propensity for individuals not to report these mistakes to anyone. Thus, in an effort to satisfy the duty to the organization, the duty to the patient is undermined. Additionally, this proposal fosters the problem of compromising the ethical principle of confidentiality.

Organizational learning. Currently, many organizations collect, but do not make public, medical mistake information for use by organizations and practitioners within the health care system in quality improvement (QI) initiatives. However, given the number of medical errors, these QI efforts are inadequate in ensuring patient safety. The American College of Physicians has recommended compiling a database with dissemination of alerts when trends are detected. One suggestion has been to compile a database with dissemination of alerts when trends are detected, thereby offering a template for physicians to use to improve care nationwide (Prager, 1998). In this case, health care professionals can honor fiduciary duties to both patients and organizations. Patients can gain confidence that care is rendered in a safe manner and organizations will not increase their risk for litigation and financial liability.

Arguments for Disclosure

Many consumer advocates, attorneys, and other experts contend that the public disclosure of medical mistakes is in the best interest of the health care system and the public and that it does not compromise the fiduciary duties to patients or organizations. According to IOM committee member Mary Wakefield, PhD, RN, FAAN, those taking this position argue that public disclosure of medical mistakes helps hold health care systems accountable for their actions and omissions (Gardner & Hallam, 1999). How can holding health care systems accountable for their actions, including public disclosure of mistake information, compromise fiduciary duties? It enables patients to be more active participants in their health care and encourages organizations to practice more safely. Theoretically, this should be the goal of all parties in health care. This position can be analyzed with respect to risk management, confidentiality, and organizational learning.

Risk management. Lawsuits for mistakes made by the health care organization's employees and physicians are common. However, research indicates that while 98% of patients want to know about all medical mistakes involving them, they were less likely to consider legal action if the mistakes were disclosed (Nowicki, 1998). Furthermore, if litigation is pursued, punitive damages are often reduced or rejected when professionals or organizations have made disclosure to patients or their families. When mistakes are discovered by other means, organizations and practitioners are subject to direct liability and punitive damages. Thus, admitting errors openly can benefit organizations as well as patients.

Confidentiality. The confidentiality of individual's involved in medical mistakes (those not resulting in serious injury) is a concern. Even though the IOM has
recommended reporting serious medical errors to governmental agencies, it also recognizes the
concern for confidentiality. The IOM report recommended maintaining confidentiality when errors are
considered near misses or result in lesser injury (IOM, 2000).

The confidentiality of patients, organizations, and providers involved in the nonserious inci-
dences could be maintained through technology that can provide limited access to data. Some argue that even if confidentiality cannot be guaranteed, the safety of the public outweighs individual confidentiality. If managers take the position of greater public good, they are no longer forced to choose between duty to patients and their organizations.

Organizational learning. Wakefield contends that medical mistake data must be available in
order for error reduction to occur (Frieden, 2000). Several organizations, including the Veterans’
Administration and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO),
have instituted measures to capture medical mistakes, but there is no universal mechanism in place currently. JCAHO leadership felt so strongly about supporting patient safety and reducing medical errors that the organization revised its standards, which became effective July 1, 2001 (JCAHO, 2001). The revised standard requires hospitals not only to initiate policies and procedures to prevent errors, it also requires that patients be informed when they are harmed during their course of treatment. Specifically, this standard requires prospective analysis and redesign of patient care systems that are vulnerable to medical error commission (Hill, 2001). Even with these changes, nationwide communication between facilities and providers has not been established satisfactorily. This is very problematic because the entire health care system is unable to benefit from the information. Public disclosure of the data to organizations and patients could accelerate initiatives directed towards problems. This approach would relieve health care man-
agers from deciding which fiduciary duty was greater, duty to the patient or duty to the organiza-
tion.

Proposed Solutions

Many experts assert that using a standardized system for reporting all medical mistakes is the best solution to this problem. Instituting a system that ensures confidentiality of information, immunity (as appropriate), and anonymity in reporting, will be critical to its success. When reporting incidents to consumers is necessary, penalizing practitioners should be avoided. Limiting public access to raw data is seen as a way to prevent an increase in litigation, penalizing practitioners and organizations for human mistakes, and reporting of those mistakes. This caveat is recommended, because if organization managers and other individuals believe they will be harmed (legally or economically) by reporting mistakes, especially those that did not result in serious harm, mistakes are likely to remain unreported. This proposed solution upholds administrators’ and other health care professionals’ responsibilities to their organizations and patients. It permits individuals to protect their organizations appropriately while protecting patients from harm. Ultimately, patients would benefit from this proposal because of improved safety and quality. The negative effects on organizations would be limited. Staff would fulfill duties to patients and organizations without having to decide which takes precedence over the other.

Implications

Preventing medical errors from occurring is the best solution to this dilemma. Then, health care professionals are not placed in the difficult position of choosing between their fiduciary duty to their organization or patients. The following measures have been suggested to reduce these conflicts.

Administrative practice. The redesign of many health care delivery systems will reduce signifi-
cantly the likelihood of error, according to Leape (1997). One source of error is the reliance on clinicians’ short-term memory, which is known to be fallible, for decision making activities. By nature, human decision making is subject to lapses and errors. Certain clinical conditions increase the likelihood of mistakes. Morris (2000) contends that excess information in complex situ-
tions can exceed clinicians’ abilities for decision making and therefore increases the probability of clinical errors. The instillation and use of a computer-based decision-support system has been used successfully to decrease medical errors (Morris, 2000). Such systems combine patient data with crucial diagnosis and management information to produce protocols for patient care. Such a mechanism can protect patients from clinicians’ mental lapses and inadequate knowledge. However, in urgent and emergency situations, practical limitations exist.

Another area of practice that can result in medical errors are the staffing patterns and ratios organizations use. Hospitals are increasingly relying on overtime, extending shifts, “floating” nurses, and the use of nursing staff employed by outside agencies to provide patient care. According to the president of the American Nurses Association, 16-hour shifts are becoming increasingly common, and 24-hour work days have been reported (Foley, 2000). Nurse executives must review these practices and evaluate them in terms of patient safety as well as economics. Overtime, extending shift hours, and moving staff from their usual area of expertise may be poor staffing methods due to their risk for increasing the chance for error. Nationwide, nurse executives are trying to determine ways to decrease overtime and decrease the use of extended shift hours, despite regional nursing shortages. The military has been very successful in transferring some nursing duties to unlicensed assistive personnel. When specific programs are in place to educate and monitor the work of these unlicensed personnel, their scope
of practice can be expanded further. For example, depending on state nurse practice acts, they can be trained in venipuncture and intravenous infusion care.

When nurses are moved from their usual area of assignment to another area of the facility, they should have clear guidance on the scope of their duties and responsibilities. Experts insist that nurses floated to an unfamiliar unit should never be placed in charge of that unit. An organized plan for integrating these nurses into the unit and how to consult when questions and problems occur should be in place. Some institutions have developed fluctuation plans working with the administrators or managers in which nurses rotate only within related specialty areas. For example, nurses would only float between labor and delivery, women's health, and postpartum units.

Nurses should understand what constitutes an error and when to notify physicians and/or managers. Staff education can reinforce policies and improve decision making. In a study conducted in a 700-bed hospital in Florida, the investigators found that fear or reprisal and not allowing for nursing judgment in specifying what constitutes an error had a direct influence on reporting errors (Osborne, Blais, & Hayes, 1999). The investigators speculated that the term "medication error" hinders reporting and suggested using the term, "adverse drug event," implying that harm or potential harm resulted. However, pharmacologically, the term adverse drug event has another meaning and confusion could result. There is a need to clarify policies defining errors, specific problems that should be reported to the physicians and managers, and the circumstances in which incident reports are required. Reporting mechanisms should be changed to enhance trending and remove the implication of impending punitive action for individuals. Most experts agree that replacing punitive systems with those that enable support, education, and critical analysis of the factors that contribute to errors will reduce the incidence of errors.

Health care policy. Nationally, there is a call for developing a reasonable and viable system for error reporting. The IOM report recommends creating a Center for Patient Safety (IOM, 2000). This center would provide a national system for reporting, tracking, trending, and providing standards, policies, and actions related to reducing health care errors (Foley, 2000). This center should be non-punitive, and findings from data analysis should be available to health care systems for use in decreasing errors. This organization would analyze data for system as well as nationwide trends and note specific organizations with particular problems. The reporting system should not be directed towards identifying individual liability, as there are systems already acting in this fashion. Health care organizations would submit data for analysis with appropriate explanatory information targeting system problems and not individual problems. Additionally, one of the mandates of the center would be to examine factors that increase the probability of medical errors. That information would be published in annual reports to the executive branch along with suggestions of ways to address these issues.

At the state level, organizations mandated to license health care professionals must put more emphasis on patient safety. This action should include requirements for mandatory continuing education of health care professionals for relicensure to assure the currency of practice information. Organizations involved in the peer review process should become more aggressive in their attempts to ensure patient safety by reporting, to the appropriate bodies, professionals who are dangerous or potentially dangerous in their usual practice. The "good old boy" or "good old girl" system of peer review should end because it can endanger patients.

At the organizational level, policies should be developed and enforced, requiring all employees and physicians to report all medical mistakes that cause or have the potential to cause harm. The culture of the organization should reflect an emphasis on discovering ways to prevent errors and not on punishing the individual(s) involved. Managers should stress that by admitting mistakes when they occur, health care professionals will fulfill their duties to both patients and the organization. This behavior provides an avenue for improved patient care and protects the organizations from legal, financial, and ethical consequences (Nowicki, 1998).

Conclusion

Limited public disclosure of medical errors will benefit health care staff, organizational executives, and patients if specific policies are enacted to improve error prevention. If disclosure is required, neither patients nor organizations will be served well. Organizations will possibly be compromised and, as a result, patient care can suffer. If disclosure is not required, there is a better chance that errors will be reported and methods implemented to eliminate their recurrence. Policymakers, managers/executives, and practitioners must take steps to determine the factors that cause or contribute to medical errors, and devise and implement plans to decrease these events. It will require a coordinated effort on all fronts to adequately address this issue. While no error occurrence is the ideal, the truth of the matter is that because humans are involved and they are not perfect, errors will occur. However, the current medical error rate in the United States is unacceptable. Concern for patient safety requires that all involved parties take action immediately to correct the situation.

In orchestrating that effort, policymakers and executives must not be insensitive to the position in which health care workers may find themselves. These individuals should not be placed in a situation where they feel that they must choose between their organization and their patients. If organizations are sensitive and responsive to this issue, both patients and organizations will benefit because
the conflict for organizational staff members related to fiduciary duty will be minimized greatly.

References
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