Error and medicine at defensive: medical ethics and patient's safety

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Abstract

Based on the ethical imperative of Medicine's, *primun non nocere*, this article presents consideration of medical ethics focusing on error and the practice of defensive medicine, whose main purpose seems often to be linked to the protection of professional to the detriment of the patient's interest. It is developed, from studies undertaken in the United States, a reflection on such linkage and the so-called "pacts of silence", which end by generating uncertainties and mistrust regarding physician-patient relationship in society at large. In consonance to the above mention research, I concluded by considering that hiding a medical error does not solve this complex problematic, and it may have mean consequences to medical practices related to increasing exams requests that produce increase in health costs as well as hampers access to services. It considers, additionally, that the State cannot be absent in this crucial discussion.

Key words: Ethics. Medical errors. Evidence-based medicine. Medicine at defensive.

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Medicine is not an infallible practice, despite the paradigm of Medicine Based in Evidence (MBE), harm to patients associated to medical errors are high and they entail a high load of suffering. Deaths associated to medical errors in the United States (US) surpass those produced by traffic accidents, breast cancer, and aids [1].

Bioethics, until now, does not have considered error in Medicine in its real dimensions as a problem that affects patients' integrity and life, where a basic value of medical ethics is at stake: *The principle of non-maleficence*. The duty to do no harm is a universal guiding principle, both for Bioethics and for Law, as happens with the legal precets *naeminem laedere* or *alterum non laedere*, comoas with ethical imperatives, *primun non nocere* or *do no harm*. In this article one reflects about these issues presenting the outcomes of new researches carried out by American studies considering the pertinence of

these practices also within our professional realm.

The bioethical criticism in historical bases

The first mention of the generic duty of do no harm is found in one the oldest Hippocrates' text[2], delas well as in the stage of the *Ius Gentium* of the Roman Right (723 to 988 =of Roma or 201 B.C. and 235 A.C.). Ulpiano, the compiler, described in them the three basic precepts of Law: *honeste vivere, alterum non laedere, suum cuique tribuere*, that is, live honestly, do no harm, and give to each one its own[3].

EnIn the transition of the traditional legal paradigm of civil responsibility to the new theory of the Harm Law, the "*nocere*", the harm, becomes the most important premise of responsibility and around which orbit the others: the anti-legality, the causality relation and the attribution factors[4], as warns Alberto Bueres, when quoting Vázquez Ferreyra. The medieval system of responsibility relied on the idea of guilt, understood as guilt-punishment, one could not think in responsibility without guilt, "*pas de responsabilité sans faute*" repeated the French liberal from past century [5].

The new theories linked to responsibility for harm are based in the necessity to repair an unfair loss, where disapproval is not necessarily in the behavior causing harm, that could be given as justification[6]. The traditional premises of responsibility and of culpability, currently, sustains that *from a unfair harm, we state that it is anti-legal not repairing It*[6]. In medical-care practice, often, "errors without guilt" are done, inclusively in the premises where the harming event, despite foreseeable, results inevitable; typical case is framed, for example, in some premises of nosocomial infections.

The most frequent errors in some medical specializations may be grouped as follows: in Surgery, laparoscopic complications, infections, death, place error; in Obstetrics, shoulder dystocia, puerperal sepsis, and guarding services, fractures diagnosis errors, in myocardial infarction, acute abdomen, among others. The way to approach error in medicine, up to present and in majority of cases, consists in hiding, in lack of interest, in lack of information to patients, and sometimes in the punishment of presumed responsible.

The lack of critical view toward inside medicine itself on the frequency of harms due to errors prevents undertaking suitable harm prevention and management activities. The uncritical attachment to evidence based medicine models (MBE) cloud clinical opinion, under-estimate experience and dehumanize physician-patient relationship; MBE inductive fallacy does not attend assisted population anthropological and social contexts.

Lack of reflection about connection between medical errors and the silence pacts weaved around this relationship, generates uncertainty, and it feeds suspicion. Truthfulness, traditional ethical rules, models professional responsibility, and solidifies clinical relations; every physician should state the truth to each patient; non-compliance of the duty generates discomfort, mistrust, and it is the first cause of legal suits.

In a study where replies from 127 mothers whose newly born children underwent harm due to obstetric errors and who had started legal suits were analyzed, it was established that the discomfort in face of suffered loss was accrued by lack of warning of complications, the mistake that they were submitted by physicians, and lack of dialogue and answers to their questionings [7]. In other work that studied the link between physician-patient relationship and medical malpractice claims, the following causes as triggering legal claim were established: limited availability of caring physician, lack of information and consideration toward the values and perspectives of patients and their families [8].

La The limited capability of listening to patients is closely linked with the occurrence of errors and harms; one forgets and high balsamic and therapeutic capability of the listening habit; nothing is new in this, it suffices remembering that Hippocrates aphorism that sentenced: *Many patients heal just with the satisfaction that a physician who listens to them causes* [9]. Therefore, it is necessary to boost a medicine based in narrative where symptoms are not just objectiveness, but rather the sick person's subjectivities [10]. It is a practice where the respect for truthfulness should allow the sincere expression of pardon, in addition to the acknowledgement of error and its integral repairing.

Recent experiment have shown that when physicians accept errors, communicate them to patients, ask for forgiveness, and offer suitable compensations, not just diminish litigation, but basically one begins to learn from the error to generate safety strategies for patients' care [11,12]. There is evidence in which humanized clinical relationship, based in reciprocal trust and respect, although there are errors, there is not legal claim. Physicians, who did not have claims, better guided their patients, showed good humor, facilitated patient's participation, estimulated questioning, and made more time available in consultation [13].

Hiding error also relates increasing with the practice of medicine at defensive in which the main purpose consists in protecting own responsibility, rejecting patient's best interests. A striking example of medicine at the defensive is the over indication of highly complex diagnosis measures. In this sense, a publication reports that in the USA the request for computerized tomography increase at yearly rate of 10%, and actually 75 million of such exams are carried out annually[14].

The outcomes of a survey undertaken among physicians in Massachusetts indicate: *28% of the derivations of images exams only represent defensive practice and physician's precaution;* also referring to unsuited medical education as cause of unjustified increment of these exams[15]. Despite the fact that available statistics in Argentina are still scarce, there is indication that the expenditure generated by "medicine at the defensive" meant expenditures of almost 900 million dollars in the last decade of past century [16]. It is suspected also that a considerable percentage of radiologic reports of highly complex exam did not evidence change or any pathology that could be related in any way to lack of soundly supported medical.

The major concern that this starts to generate is that the radiation produced by Computerized Emission Tomography (CET) is between 100 and 500 fold higher tan a traditional radiography plate. In some countries claims for harm associated to excessive and unjustified irradiation have been recorded already. The practice of medicine at defensive, in this case evidenced in the crowning of highly complex exams, inverts medicine's own end in which physician interests moves and it is above patient's interest, and where worship of the computerized image subordinated clinical experience and confidence.

Trust is a basic principle of companionship and social peace; without it one could not even get up from bed every morning, without it a physician sees a potential foe in each patient, and, similarly, in each mistrusting patient resides the lack of adherence and the worst prognosis of his own disease. Both when it lacks and when is abundant the possibility to request highly complex exams, it is necessary to believe again in the non-transferable experience of the physician-patient relationship based in the mutual need of trust.

For it, patient must realize that medicine is not a precise science, and that it is not the "art of healing always", and that error is inseparable, even in the best practices. It is necessary also to remind that health is not goods or service produced, rendered, or traded according to market rules, it is a basic right where patient, even if he pays for his health, it is not a user or less still a consumer.

Notwithstanding, physician should revitalize the best clinical practice that he has on hands and that, precisely, his hands, presence, and word, believe again in clinics as experience of learned knowledge through looking, touching and, above all, "listening**".** He should understand, as well, that an informed consent process for the patient does not consist in signing an incomprehensive form as intended exonerative eagerness. It is necessary also to give new meaning to therapeutic value of the work to discharge the fantastic ideas of believing that one heals best where there are more devices.

Final considerations

The State cannot be absent in face of ill consequences of the practice of medicine at defensive and of error, health costs reproduce unequally and it resents accessibility and the true sense of health. In order to change this scenario is mandatory that physician can work at ease, only thinking in do no harm and to benefit each patient. Active public policies that enhance working conditions and that dignify the task carried out by health workers should be implement.

Currently, one should struggle for an integration between evidence base medicine and that base don narrative, as well as by transmutation of medicine at defensive into a model that practices medicine in defense of better medical working conditions, and the promotion of the right of better health available to all, substantive issues that are not antagonist but rather two faces of the same coin.

Resumo

Erro e Medicina na defensiva: ética médica e a segurança do paciente

Baseando-se no imperativo ético da medicina, *primun non nocere*, este artigo apresenta considerações sobre o erro médico e a prática da medicina defensiva, cujo propósito principal parece, nuitas vezes, estar vinculado à proteção do profissional, em detrimento dos interesses do paciente. A partir de estudos realizados nos Estados Unidos se desenvolve uma reflexão sobre tal vinculação eos chamados "pactos de silêncio", que acabam gerando na sociedade, em geral, incerteza e desconfiança no que se refere à relação médico-paciente. Conforme os resultados da citada pesquisa, este artigo conclui considerando que ocultar o erro não resolve esta complexa problemática e pode trazer consequências nefastas à prática da medicina, relacionadas ao crescimento dos pedidos de exames, que produzem aumento nos custos da saúde, assim como dificultam o acesso aos serviços. Considera, ademais, que o Estado não pode estar ausente nesta discussão fundamental.

Palavras-chave: Ética. Erros médicos. Medicina baseada em evidências. Medicina defensiva.

Resumen

Error y medicina a la defensiva: ética médica y la seguridad del paciente

Basándose en el imperativo ético de la medicina, *primun non nocere*, este artículo presenta consideraciones de ética médica, enfocando el error médico y la práctica de la medicina defensiva, cuyo propósito principal parece muchas veces estar vinculado a la protección del profesional, en detrimento de los intereses del paciente. A partir de estudios realizados en los Estados Unidos se desarrolla una reflexión sobre tal vinculación y los llamados "pactos de silencio", que acaban generando incerteza y desconfianza en lo referente a la relación médico-paciente, en la sociedad en general. Conforme a los resultados de la citada pesquisa, concluye considerando que ocultar el error no resuelve esta compleja problemática y puede traer consecuencias nefastas a la práctica de la medicina relacionadas al crecimiento de los pedidos de exámenes, que producen aumento en los costes de la salud así como dificultan el acceso a los servicios. Considera, además, que el Estado no puede estar ausente en esta discusión fundamental.

Palabras-clave: Ética. Errores médicos. Medicina basada en evidencia. Medicina defensiva.

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