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COMMON MEDICAL ERRORS: LEGAL, ETHICAL, ORGANIZATIONAL AND METHODOLOGICAL ASPECTS OF THE PROBLEM AND THEIR SOLUTIONS

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ABOUT ARTICLE

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Abstract: Summary The most important and conceptually significant aspects of disclosure of information about medical negligence are considered, It is methodological, organizational and practical in nature. Based on the analysis of scientific literature, the general features of the problem are presented, including in the Republic of Belarus, and the prospects for its solution are presented.

INTRODUCTION

Solving the problem of meeting the demand of the population for high-quality medical care, modern healthcare systems operate in conditions of severe resource scarcity, as well as in difficult demographic, socio-political and socio-economic conditions. One of the most serious problems facing global health systems is that the risk of harm to the patient's health in providing medical care is higher than ever before compared to other areas of human activity. According to experts from the World Health Organization (WHO), currently one in ten patients in the world suffers from adverse events or the consequences of medical errors [1]. The ancient commandment "Primum non nocere" ("First of all, do no harm") remains relevant in the XXI century, warning about the fine line between useful and dangerous consequences of medical measures in diagnosis and treatment. The current state of the problem is characterized by a rapidly changing situation in the field of threats to medical safety. In the context of the constant complication of medical technologies, the constant improvement of forms and methods of care, the rapid introduction of the latest achievements of science and technology into medical practice, new, previously unknown security threats arise. About 40% of patients in the USA and Russia consider themselves victims of medical errors, while in Canada this figure is 30%, in Australia -

27%, in Germany - 23%, in the UK - 22% [2-5]. Medical errors and adverse events cause significant emotional and material damage to patients, form a negative attitude towards the healthcare system as a social institution and entail huge economic losses. Funds are spent on minimizing the consequences of mistakes, which are withdrawn from allocations for strengthening the material and technical base, training personnel and the development of scientific and medical technologies. In addition, adverse events negatively affect the psychological state of medical workers, forcing them to "fall into a rut" and lose concentration on performing their professional duties, which creates a new risk of error. Despite the seriousness and urgency of the problem, efforts to reduce the risk of harm to the health of patients in only some countries are more or less adequate to the scale of the threat to patient safety. There is a complete lack of basic information about the prevalence, types and nature of medical errors, causes and circumstances of adverse events. Unfortunately, in the Republic of Belarus, the study of threats to patient safety has not yet acquired a systemic character and is limited to the analysis of individual risks in specific types of medical care. The excellent resources, structural capabilities and scientific potential of the healthcare system of the Republic of Belarus are practically not used to obtain comprehensive information about adverse events, analyze risks at the systemic level and implement large-scale measures to prevent medical errors. It is obvious that if there are good intentions to address medical safety issues, efforts to strengthen them could significantly improve the quality of medical care, prevent harm to the health of patients and significantly reduce the economic costs of healthcare. The lack of objective information about security threats is due to the fact that very few medical professionals make mistakes and report them to their colleagues and patients. The reasons for this are closely related to the persistent notion that medical errors are a legitimate manifestation of ignorance, negligence and unprofessionalism. It is believed that the cause of adverse events are "weak links", that is, employees who make mistakes due to negative personal qualities. The traditional way to eliminate shortcomings in the work of medical organizations remains to censure and punish doctors who make mistakes. The number of errors in medical practice does not decrease, because measures to prevent adverse events are ineffective. Medical professionals who make mistakes are reluctant to report them, because they understand that telling about them is likely to cause only a negative reaction. Information about errors becomes "closed" and inaccessible for learning lessons from negative experiences and developing measures to improve security. According to the results of sociological surveys, more than 90% of medical professionals support the idea of full disclosure of information about errors that occur in the process of providing medical care [6]. On the other hand, in daily practice, only a small proportion of errors are discussed with colleagues, and only 3.8% of all adverse events are reported to patients [7-9]. As a rule, doctors are stopped by the possible negative consequences of disclosing information,

including accusations of unprofessionalism, negligence and negligence, loss of respect and authority from patients and colleagues, delayed career growth, litigation and related time, financial and emotional costs. Thus, even if medical professionals have a desire to talk about mistakes, there are many obstacles to realizing these intentions. Obviously, this problem can only be solved by changing the psychological attitude towards mistakes and shifting the focus from finding the perpetrators to investigating the causes of incidents. Consideration of the full context of adverse events creates conditions for an open discussion of errors and the "disclosure" of medical safety issues [10-11]. Today, most medical professionals do not have a clear idea of what, to what extent, how and to whom errors should be reported. In this regard, a very important task in the context of improving patient safety is to develop a methodology for the process of disclosing information about errors and create effective organizational mechanisms that allow this process to be organically integrated into the quality management system of medical care and the doctor-patient relationship. First of all, it is necessary to distinguish between two types of informing about medical errors, which differ in goals and objectives, as well as in forms and methods of information disclosure. The first type of reporting relates to the healthcare quality management system, which transmits information about errors through reporting systems to departmental or non-departmental organizations dealing with safety issues in healthcare. Reporting systems are designed to collect information, analyze it, identify risks, and develop tools to counter threats to patient well-being [12-13]. Another type of reporting is an admission of error directed at the affected patient. This type of information disclosure is emotionally and psychologically complex, difficult to subordinate to clear rules or fit into a rigid methodological framework. Despite the fact that there are different and sometimes very contradictory opinions among researchers regarding the form and method of recognition, everyone agrees that reporting errors to patients should be a mandatory action of a medical professional. According to many authors, disclosure of information about errors is the starting point for organizational measures to normalize the relationship between doctor and patient and improve health care safety [14-16]. An analysis of the scientific literature on various aspects of disclosure of information about medical errors indicates that the need for this action is determined by the requirements of ethical standards, the provisions of legal documents and recommendations for continuous improvement of the quality of medical care. This review is devoted to the most important and conceptually significant aspects of disclosure of information about errors, characterizes the current state of the issue and presents prospects for its solution. The moral and ethical aspects of disclosing information about mistakes are based on the basic principles of human relationships in healthcare: trust, mutual respect and responsibility for decisions made. When seeking medical help, patients entrust their health to doctors and expect that their knowledge, skills, professionalism and means of

applying modern medicine will help them overcome the disease and accelerate recovery. At the same time, an unfavorable situation in the provision of medical care can significantly worsen the patient's condition and even lead to death. Doctors inevitably face a dilemma when they direct all efforts to minimize the negative consequences of mistakes. From an ethical point of view, not informing patients about adverse events is tantamount to hiding vital information about life and health from them, which are key human values. Hiding mistakes leads to loss of trust and disruption of therapeutic cooperation, which is perceived by patients as a sign of indifference and disrespect and is accompanied by a number of negative emotions, from disappointment and resentment to anger and resentment. The ethical duty of doctors to disclose their mistakes was discussed by many outstanding doctors who left a mark on the history of medicine with their outstanding professional and moral qualities. I sincerely admire a doctor who makes only minor mistakes." A deep heart strives to avoid trouble, and a deep heart is ready to admit the mistakes it has made," wrote the ancient Roman physician Celsus N.I. Pirogov believes that "conscientious people, especially teachers, need to disclose their mistakes as soon as possible in order to warn others less knowledgeable." Ethical standards governing the need to admit mistakes are set out in a number of codes that take into account the moral and ethical aspects of the professional behavior of medical workers. The Code of Ethics of the American Medical Association states: "If a mistake made during treatment is harmful to the patient's health, he should be informed about it. Mistakes are not necessarily the result of unprofessional or unethical behavior, but hiding mistakes from patients is certainly such behavior."[17] The Code of Ethics of the Canadian Medical Association defines the problem of recognition as follows: "... All necessary steps should be taken to prevent harm to the patient's health, and any adverse events should be reported to the patient or his representative" [18]. The Principles of Medical Ethics of the American Medical Association states that "... Doctors are required to adhere to the high moral and ethical standards of the medical profession, be honest in their relationships with colleagues and patients, and disclose information about deviations from medical standards" [19]. The Code of Medical Ethics adopted in the Republic of Uzbekistan does not contain separate provisions on the publication of medical errors. Nevertheless, the high moral and ethical guidelines laid down in this document allow doctors of the Republic of Belarus, who put the well-being of patients above their personal and corporate interests, to believe that admitting a mistake should be considered by them as fulfilling their professional duty. Researchers of the problems of medical ethics have not ignored the difficult issue of disclosing mistakes made by other medical professionals. Most authors are of the opinion that it is the professional duty of doctors who have witnessed an adverse event to support the disclosure of an error and help minimize its consequences. If the doctor who made the mistake hides the reason for it, the doctor colleague must make every effort to convince him or her

to disclose the error. If this fails, colleagues have the right to inform their immediate supervisor or the person responsible for quality management of medical care [20-21]. In a medical environment with strong corporate ties and a spirit of solidarity, there is not always a favorable attitude towards those who reveal other people's mistakes [22]. The reason for this attitude lies in the traditional perception of mistakes as personal failures, and not as a result of systemic deficiencies in healthcare organizations. On the contrary, a "safety culture" prevents disputes based on published errors. This is because in an atmosphere where mistakes can be freely discussed, it becomes less important who exactly reported the adverse event. The ethical aspect of error disclosure is often associated with hierarchical issues between medical professionals. The most serious disagreements about admitting mistakes usually arise between nurses and doctors. On the one hand, nurses are more likely to make technical and administrative mistakes than other medical professionals, but on the other hand, they are more likely to admit mistakes. Researchers of medical ethics problems believe that, given these features, nurses who make mistakes are obliged to immediately report them to the attending physician. Such recognition is absolutely necessary not only to protect the moral and ethical aspects, but also due to the importance of timely notification to the doctor to adjust the treatment plan. This is due to the fact that, according to many authors, it is desirable that a confession be made by a doctor who can answer the patient's questions about how the error affected his health and what measures are planned to be taken to eliminate adverse consequences. If a nurse discovers a doctor's mistake, she is obliged to inform the immediate nurse about it. The responsibility for further actions rests with the doctor, and the nurse cannot be considered an accomplice in concealing the error, unless the doctor recognizes it [23]. Legal aspects of disclosure of information about errors From a legal point of view, the need to report errors that occur in the provision of medical care is due to the requirement of the law to inform patients about their health status, treatment methods and prognosis of the disease. The patient's right to informed consent is enshrined in almost all countries of the world and is prescribed in legislation on medicine and patient rights. Consent to medical intervention is also subject to legislative approval, which stipulates that the patient must be carefully informed of the reasons for the intervention. Thus, if a mistake has been made, it is necessary to admit it in order to inform the patient in a timely manner about any changes in his state of health and obtain consent for further treatment. A number of international documents, such as the Declaration on the Development of Patients' Rights in Europe (WHO, 1994), the Convention on the Protection of Human Rights in Biomedical Research (Council of Europe, 1999) and the European Charter of Patients' Rights (European Civil Initiative, 2002), consider the right to information as one of the most important principles. The right to information is considered as a fundamental principle determining the integrity and legitimacy of the doctor-patient relationship.

The Law of the Republic of Belarus "On Medical Care" confirms the patient's right to information (Article 41 "Patient's rights"): the patient has the right to: ... The patient has the right to information about the state of his health, the medical method used ... ...), consent to medical intervention (Article 44 "Conditions for providing medical care to patients": ... The conditions necessary for the provision of medical care to the patient are that the adult patient... or about the purpose of the medical intervention, the expected results and possible risks ... ... who are familiar with ... ... is a prior consent ...) [24]. It follows from the content of these articles that these requirements are quite applicable to situations where medical care is provided to patients suffering from the consequences of an adverse event. There is a tendency in foreign medical legislation to adopt separate legislative acts for the purpose of highlighting medical errors. In the USA, first at the state level and then at the national level, laws were passed according to which administrators of medical institutions are required to notify patients in writing (Pennsylvania) or orally (Florida, Nevada) within seven days of the cause of an adverse event [25-28]. The Danish Patient Safety Law obliges medical professionals to report an error and its consequences if the patient's health is harmed [29]. It is important to provide patients with the opportunity to continue treatment, and this is possible only in conditions of therapeutic cooperation. In addition, the importance of such a dialogue for a doctor should not be underestimated. After such a dialogue, the doctor is freed from feelings of guilt towards the patient, the burden of anxiety is removed, psychological balance is restored, and the doctor can successfully perform his professional duties. An apology should be truly sincere, reflecting the true feelings of the doctor and conveying compassion for the patient. Insincere apologies are perceived by the patient as disrespectful to his suffering, and in some cases the effect of such apologies is even worse than hiding the error. The question of which language doctors should use to express sympathy and apologize to patients remains open. Some authors and researchers of error recognition manuals write: ..... Some people prefer a sincere confession of guilt: "I made a mistake and I apologize for the suffering I caused." Proponents of "full recognition" believe that patients value the honesty, frankness, sincerity, empathy and compassion of medical professionals, and that recognition consistent with patients' perceptions usually leads to the restoration of trust in medical professionals and the end of conflict. The experience of some medical organizations that have implemented a "full recognition" strategy has shown a significant decrease in the number of complaints and lawsuits, as well as the amount of payments if it comes to court [41-43]. As a result of the agreement reached on the issue of compensation for damage to the health of patients, these medical institutions can save significant financial resources, which can be directed to the development of programs to improve medical safety. Nevertheless, there are opinions in the scientific literature that "full authorization" carries a high risk of legal consequences for doctors due to the imperfection of legal mechanisms

regulating medical relations. Immunity" for admitting a medical error has been legally recognized only in the United States and some European countries; In other jurisdictions, admitting a medical error and repenting of it is equivalent to a full admission of guilt and is the basis for a verdict in a lawsuit. Medical researchers are generally ambivalent about the requirement for full disclosure of all details of the incident to patients and recommend further investigation of the consequences of disclosing errors. In the final part of the negotiation process with the patient, the issue of compensation for the damage caused is resolved, proposals for compensation for damage and measures to prevent similar adverse events in the future are discussed. It is very important that the patient feels fully involved in the negotiation process and that his opinion influences the final decision. Like many people who have experienced serious shocks or stressful situations, patients who have been victims of unfair practices often find that the physical and emotional consequences of a harmful event begin to shape their thinking, leading to changes in their personal attitudes and motives. In this regard, the offer of compensation for damages should be proportionate to the nature of the harm caused and the significance of the adverse event for the patient. By talking about the action plan to fix the error, patients can understand that their suffering was not in vain and that by participating in a discussion with a doctor, others will be able to avoid similar situations. It should be emphasized that at any stage of recognition, it is unacceptable to ignore patients, neglect them, charge for services until the dispute is resolved, and even more so to treat them or their relatives in a disrespectful and inappropriate manner. Studies aimed at establishing a causal relationship between errors and litigation have shown that, along with the severity of the incident, the behavior of medical professionals after making a mistake can significantly affect the condition of patients. By not admitting a mistake, not apologizing for the harm caused, not offering compensation, and not showing disrespect to patients, doctors significantly increase the likelihood of lawsuits, large fines, and severe disciplinary penalties. Unfortunately, in the healthcare sector of the Republic of Belarus, there is a clear causal relationship between doctors' failure to recognize their own mistakes and a large number of lawsuits. Most forensic medical examinations conducted based on the materials of "medical cases" contain information about gross violations of ethical and non-binding requirements by doctors, including after mistakes they made. A significant part of these violations is directly related to the patient's decision to contact law enforcement agencies. Patients claim that they learn about mistakes in the process of providing care by accident, not from doctors, but from nurses, from certificates, stories and comments from other specialists. Patients write that they are literally forced to write letters, make phone calls and go to administrators, seeking information about the causes of what happened. According to patients, they suffer twice. The first time because of a mistake made by a medical professional, and the second time because he was not

recognized and apologized for it. The patient's statement emphasized that if he had confessed to the mistake in good faith and in a timely manner, he would have refused to take the case to court and agreed to the proposed compensation. Organizational and practical aspects of disclosure of information about errors Disclosure of information about medical errors is a complex and time-consuming process that requires taking into account both external aspects of the situation and internal factors related to the direct participants in a particular case. The external aspects are determined by a set of ethical, legal and methodological requirements for the recognition of errors, and the internal ones are determined by the conditions in which the recognition process takes place. These conditions vary from case to case, but their scope and general outlines can be regulated through certain organizational mechanisms. The following three measures can be taken: to ensure that medical professionals have the skills to conduct complex negotiations; to improve coordination between participants in the error disclosure process; to strengthen control over compliance with ethical standards and requirements for the quality of staff service. Doctors, who often have to tell patients and their relatives bad news about the course of the disease and the prognosis, often find themselves not in the best shape when discussing the quality of medical care. Since doctors usually play a leading role in talking to patients, they are not used to feeling like participants in a dialogue. In situations of error disclosure, such an attitude can lead to the exact opposite result. If the patient is unable to express his point of view, the conflict may flare up with renewed vigor. Listening to patients is necessary not only to establish a psychological understanding with them, but also to obtain information about the threats to the safety of treatment that can be identified during the conversation. Researchers believe that serious attention should be paid to training medical professionals to report errors to patients. However, medical professionals do not make mistakes often enough to require regular practice of this skill. It is advisable to familiarize staff with the general principles of error disclosure and focus negotiation training on those employees who already have conflict resolution skills. Such specialists can act as consultants and contact persons in the event of adverse events. An important recommendation is the creation of a permanent expert group on patient safety in each medical institution, whose responsibilities include investigating the causes of adverse events, assisting in the process of disclosing information about errors to affected patients and negotiating compensation for damages. The expert group should include representatives of the administration, the most reputable and experienced doctors, staff responsible for quality management of medical care, consultants with negotiation skills, and contact persons who should be contacted immediately after the occurrence of an adverse event. The creation of such an expert group could significantly accelerate the process of strengthening patient safety in the Republic of Belarus, since the issue of medical safety is also very relevant for the national health system. This is due to the fact that

the necessary conditions for this have already been created. Ethics committees operate in medical institutions, and psychologists support them. Ethics committees have the ability to investigate adverse events, take measures to prevent such incidents, and organize a process for disclosing errors. The help of psychologists may include assessing the patient's emotional state, preparing the patient for the error message, participating in the admission process and minimizing the negative impact of the message on the patient. The advantages of a team of specialists are mobility and the ability to perform several functions simultaneously. As soon as an adverse event is signaled, one expert begins investigating the causes and circumstances of the incident, while others begin checking the patient's health status and preparing for an error message. The functions of the expert team include providing feedback to the patient: reporting on the progress of the incident investigation, answering the patient's questions, drawing up a convenient schedule for him, discussing further rehabilitation measures and resolving compensation issues.

CONCLUSION

Thus, the problem of publicizing medical errors and adverse events that patients and doctors suffer from all over the world is also relevant for domestic healthcare. Based on the information provided on the ethical, legal, methodological and organizational aspects of recognition, it is possible to draw conclusions about the versatility and complexity of this phenomenon. Mistakes and adverse events in medicine remain a "closed" topic, and their disclosure is impossible without radically changing attitudes towards doctors who make mistakes and creating a situation in which adverse events can be openly discussed. Only further study of this issue, the search for promising solutions and the adaptation of best practices will improve the safety of care and reduce the risk of harm to the health of patients.

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