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Advances in Medical Ethics

Opinion Article

Enhancing Clinical Skill Training to Prevent Medical Errors in Emergency Departments

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DESCRIPTION

The most frequent reasons for medical errors are communication problems. These issues might arise verbally or in writing in a medical office or healthcare system between a doctor, nurse, staff member, or patient. Physicians must make difficult judgments on whether or not exposing medical errors to patients and families is an appropriate course of action due to the demand for transparency in healthcare, which is strongly advocated by patient safety campaigns, as well as the worry of unfavorable consequences and liability threats. Medical errors continue to happen despite the increased efforts hospitals and healthcare professionals undertake to prevent them and other negative outcomes. An essential technique for preventing and reducing error occurrence is effective error reporting. Medical ethics is concerned with moral concepts that should direct medical professionals in their interactions with one another, their patients, and the government. In India, patient safety and healthcare quality have significantly improved, although errors and unfavorable outcomes are still common in clinical practice. The first step in diagnosing an issue with medical malpractice in a healthcare organization is to assess the situation. The ethical ramifications of handling medical errors are constantly being studied. We lack the instruments necessary to assess the caliber of instruction, practical competence, depth of theoretical understanding of diverse topics, and the use of evidence-based medicine during residency.

A medical error is a mistake made by a medical expert that causes the patient harm. Wrong diagnosis, incorrect medicine administration, incorrect surgical technique, incorrect equipment use, and incorrect interpretation of lab results are all examples of medical errors. The most frequent conundrum doctors have when a medical error occurs is whether to tell the patient about it. Because they are worried about the repercussions, doctors frequently conceal the blunder. If medical error disclosures are handled properly, patient confidence in doctors may rise. They can also be used to enhance patient safety measures and prevent hospital lawsuits. In the past two decades, a patient safety movement has grown in the US, the UK, and other countries.

The American Medical Association (AMA) has also amended the Code of Ethics to address the doctors' duty to tell the truth when mistakes are made. New patient safety regulations that mandate the implementation of disclosure policies by medical practitioners have been implemented by US hospital and health systems. This is a result of patients and their families feeling more empowered regarding medical care and treatment. Patients regularly use the Internet as consumers of medical care and services to research medical topics, rate their doctors, or join patient advocacy groups, among other things.

Furthermore, because of their susceptibility, it can be difficult to tell pediatric cancer patients about medical mistakes. This is because they may have diagnostic delays due to the nature of the disease in children, mistakes with chemotherapy infusions, and unpleasant effects that occur outside of the hospital. In the short case scenarios, participants were split into pairs and instructed to practice the short cases before revealing the event in front of the audience and getting comments from the instructors. Furthermore, given that they would receive feedback from the organization, doctors who attended the training were more likely to report medical errors.

The term "disclosure risk" in the context of statistical disclosure control refers to the possibility that a user or an invader may utilize the protected dataset to extract private information about a specific person from the original dataset. Some of the most frequent types of medical errors include failure to act on test results, failure to take the necessary precautions, medication errors, anesthesia errors, hospital acquired infections, missed or delayed diagnoses, avoidable delays in treatment, inadequate follow-up after treatment, inadequate monitoring after a procedure, and technical medical errors.

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