The Condescending Dental Hygienist

CASE FOR CHAPTERS 4, 7, 12, AND 15

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Instructions

Read the case summary below with a focus on the key management issues. Using the resources provided at the end of this case study, answer the plan development and response questions as indicated in APA format. Use a minimum of 3 scholarly references, listed in APA format. A tutorial on APA format has been uploaded to the assignment. The length of the assignment should be what is necessary to substantially respond the objectives of the assignment. Use APA format. Do not use personal opinion to complete this assignment, it is based on legal and ethical issues, use scholarly sources to find your answer.

Summary

In this case, a competent senior citizen who is still employed as a professor is given the wrong medication by Chrissy, the dental hygienist, despite clearly indicating her allergies at check in. The dental hygienist, instead of stopping what she is doing, apologizing, and ensuring that the patient is safe, continues about her tasks and argues that the patient doesn't know what she is talking about, insulting the patient by telling Dr. Rose she is confused. The patient stops the procedure, gets out of the chair, and proceeds to give herself anti-allergy interventions. The dentist, who employs Chrissy, just happens along and asks what is going on, whereupon the patient has to explain the medication error, which Chrissy continues to deny until he tells her she is wrong.

Legal and Ethical Issues Associated with Medical and Medication Errors

With respect to ethical issues, all health care professionals, including dentists and dental

hygienists, and their organizations have an obligation to prevent harm from befalling patients when they are under their care. When patients suffer from ADEs, the organization has failed to discharge its legal and ethical obligation to above all do no harm. The tort concept of **non-feasance**, or failing to act where there is a duty that a reasonably prudent person would have fulfilled, is not debatable in this case. The ethical concept of **non-maleficence** in this case means "do no harm" or "don't make it worse." Chrissy not only did harm to the patient, she made it worse by attempting to convince the patient she was confused. Health care managers and clinicians have an obligation to minimize risk to patients. Using Chapter 15, Ethics and Law, this case presents an opportunity for instructors to review the distinctions and overlaps between ethics and law, as well as the concepts of respect for persons, beneficence, non-maleficence, and justice. It also offers an opportunity to review torts and to discuss whether malpractice has occurred in this case and what legal remedies Dr. Rose or her family might pursue.

Quality improvement and patient safety are the responsibility of the health care organization, not just the clinical staff. While the majority of medical errors and health care quality problems stem from organizational processes, in this case, *Chrissy* was the problem. While it is unlikely that Chrissy went to work saying, "I'm going to kill someone today," her attitude, attribution errors, and actions could have killed Dr. Rose. This event should call into question whether Chrissy is re-trainable. She needs to understand not only the harm her actions could have caused, but also the ethical dilemma she created for her employer.

Key Management Issues

The four key areas for discussion in this case are:

- Medical errors and avoidable drug errors (ADEs); and,

- Legal and ethical issues associated with medical and medication errors.

Medical Errors and Avoidable Drug Errors (ADEs)

After reviewing this case, provide the following,

- **Summary of case:** This should include not only what was in the case, but additional research you conduct on the outcomes of the case. What happened? Who was found responsible? What were the legal ramifications?
- **Analysis and assessment:** What are the quality control problems in this case? This will come from whichever quality assessment technique you chose.
- **Performance improvement plan (PIP):** This is where you say what SHOULD be done to prevent this error from occurring again, based on your analysis.
- **Methods to incorporate or overcome local, contemporary, and corporate cultures:** List and describe a few (no more than five [5]) validated approaches to accomplish this.
- **Identify and overcome other barriers to implementation success:** Aside from culture, what else could be a barrier? Education? Training? Lack of resources, including money?
- **Develop a maintenance plan:** What will you do to be sure the organization never forgets? Will you require onboarding orientation that addresses this issue? Will you require annual refresher courses for current employees?
    - **Develop an assessment plan:** What METRICS will you use to evaluate the effects of the PIP? How will you know when you have accomplished what you set out to do?

Next, answer the following questions,

1. According to Van Den Bos and colleagues (2011), a medical error is:
2. What causes these errors? Keers and colleagues conducted an extensive literature review of qualitative and quantitative studies of causes of medication administration errors (MAEs) in hospital settings. They found:

Resources

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