Accountability for Medical Error: Is There a Way to Prevent It?

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Disclosures
No Relevant Financial Relationships

Objectives
• Review Medical Error Accountability from CHEST Article
• Present a Recommendation of Focus on Provision of Patient Care
• Discuss Potential "Stumbling Blocks" and Possible Interventions
• Review of CHEST Article's Handling of Error
• Provide a new perspective on Patient Care
1. Patient safety experts emphasize that most medical errors are caused by:
   a) Nursing
   b) Individual providers
   c) Resident physicians
   d) System breakdown
   e) Electronic Health Records

2. According to Dr. John Ball, chairman on Diagnostic Errors in Medicine, what is the chance of an individual experiencing a meaningful error in their lifetime?
   a) 5%
   b) 10%
   c) 25%
   d) 50%
   e) 100%

3. In a given week, a PCP might need to review how many chemistry or hematology results?
   a) 50
   b) 250
   c) 500
   d) 800
   e) Over 1000
Accountability for Medical Error
Moving Beyond Blame to Advocacy

Accountability for Medical Error

- Accountability in medicine, once assigned primarily to individual doctors, is today increasingly shared by groups of health-care providers.
- Patient safety experts emphasize that most errors are caused not by individual providers, but rather by system breakdowns in complex health-care teams.

Accountability for Medical Error

- This leaves individual doctors to wonder where their accountability lies.
- Increasingly, teams deliver care.
- Patients and doctors alike still think of accountability in individual terms, and the law often measures it that way.
Example Case Presentation

- We will review an example of delayed lung cancer diagnosis
- Attempt to show the mismatch between how we view errors (systems) and how we apportion blame (individuals).
- We will discuss "collective accountability"

You are the office pulmonologist and primary care physician for a 71 year old patient.

- Hospitalized on a Friday afternoon for an acute exacerbation of COPD
- Receives 3 days of IV steroids, antibiotics, bronchodilators, supplemental oxygen, and supportive measures
- The admission chest film reports "high suspicion of left upper lobe suprahilar nodule. Recommend CT scan with contrast to evaluate"
- This critical test result is called to the attention of the resident managing the patient, and documents this finding in a progress note in the electronic health record

On Monday morning, the patient goes home, scheduled to see the PCP in follow-up

- In the body of the discharge summary, the suspicious lesion is noted, but the PCP receives no direct communication about the abnormal findings, and the discharge instructions do not indicate the need for follow-up CT scan.
- No one tells the patient or his family about the finding.
- Much improved a month later, the patient comes to see you, the PCP.
- You review the discharge summary conclusions and recommendations, but miss the reference to the pulmonary lesion in the body of the document
Six months later, the patient arrives dyspneic in the ED

- The chest film shows enlargement of the left upper lobe density, and CT scan suggests a malignancy.
- Biopsy results yield squamous cell carcinoma.
- The patient undergoes surgical excision and a course of radiation therapy.
- Upon learning of the patient’s delayed diagnosis, you review the chest film from the prior hospitalization and learn for the first time of the suspicious lesion.
- You return to the discharge summary and confirm the absence of any mention of the radiology results or follow-up recommendations in the summary section.
- Torn between the desire to keep an open and trusting relationship with the patient and the fear of being sued, you wonder if and how to tell the patient about this earlier result?
- You also wonder what else (if anything) you should do to keep errors like this happening again?

Case Accountability

- When a patient experiences a harmful medical error, such as a delayed diagnosis of cancer, questions of accountability naturally arise.
- Did this patient suffer from “bad apples”, “bad systems”, or some combination?
- How should the PCP/pulmonologist view his individual accountability for the delayed cancer diagnosis and what responsibilities does he hold?
- What are the institutions responsibilities in this case and how do they complement the doctor’s role?

Who’s Accountable?

POTENTIAL BAD APPLES
- Resident Physician
- Attending Hospitalist Physician
- Radiologist
- Office Pulmonologist

POTENTIAL BAD SYSTEM
- Registration
- Medical Records
- Nursing
- Discharge Planning
- Others

Combination of These?
Accountability for Medical Error

- Is there a way to prevent most of these events from happening?
- Let me suggest how each of us may help prevent these events from happening

A conceptual leap to collective accountability may help overcome longstanding professional and societal norms that not only reinforce individual blame and impede patient safety but may also leave the patient and family without a true advocate.

Getting It Wrong: “Everyone” Suffers An Incorrect or Late Diagnosis

From a new report: National Academy of Medicine
Getting It Wrong: “Everyone” Suffers An Incorrect or Late Diagnosis

- Solution involves getting the pathologists and radiologists more actively involved in the patient’s diagnosis (IOM recommendation)
- They are also calling for changes to medical malpractice laws so professionals aren’t afraid to own up to mistakes
- At least 5% of U.S. adults who seek outpatient care each year experience a diagnostic error
- Postmortem exams suggest diagnostic error contribute to 10% of patient deaths
- Medical records suggest diagnostic errors account for 6 to 17 percent of adverse events in hospitals
- Sometimes people suffer from more than 1 error

The report calls for guidelines & better training

- Hospitals, healthcare systems, organizations and others should develop and deploy approaches to identify, learn from, and reduce diagnostic errors and near misses in clinical practice
- Need to create a culture where hospitals and doctors feel free to admit their mistakes
- IOM called for this “Culture of Confession” in its landmark 1998 report on medical errors
- Found tens of thousands of Americans die from medical mistakes such as botched surgery or infections acquired in the hospital

Another case where initial report was the tumor was benign

- Patient told this result
- Pathologist ordered additional stains and testing
- Found significant aggressive tumor
- Pathologist faxed report to physician
- Placed in chart without physician’s review
Getting It Wrong: “Everyone” Suffers An Incorrect or Late Diagnosis

Question asked:

• Why didn’t the pathologist make sure the physician saw the tumor report?
• What if he had picked up the phone and called the doctor?

Pathologist assumed since he knew it was cancer everyone else did

System seemed to have failed

Getting It Wrong: “Everyone” Suffers An Incorrect or Late Diagnosis

• The report suggests this communication does not occur because physicians do not receive reimbursement for this and calls for this type of consultation to be paid for
• Radiologists and pathologists need to be much more involved in clinical care
• Also calls for a return to the lost art of autopsy
• Affordable Care Act’s provisions to encourage teams getting paid for patient care

Getting It Wrong: “Everyone” Suffers An Incorrect or Late Diagnosis

• Do electronic health records help?
• Still not a system that ensures one hospital’s system can talk to another’s
• Our systems prevents the doctors from talking to each other
Possible Preventive Attitude

My first question is: Who is our customer?

I would suggest that our customer is the Patient

So if that is our customer, what should that Patient expect from each of us?

IDEAL PATIENT CARE

Ideal Patient Care

How do we define Ideal Patient Care?

Dr. John Kenagy is a Physician, Healthcare Executive, Scholar, Advisor, & Patient

- He has tested his Ideal Patient Care model for at least 10 years
- It works because it sets a clear, meaningful direction for everyone that they can use everyday in their work.

Ideal Patient Care

- Exactly what the patient needs, when and where they need it
- Individually customized care
- Immediate response to problems or changes
- Safe environment: physically, emotionally, and professionally - for patients, staff, physicians, and management
- No waste of resources
Ideal Patient Care

Ideal Patient Care is powerful because it's much more than a slogan hung on a wall.

It is a functional tool for management and the front line that can be used in everyday work.

It combines inspiration and aspiration with practical qualities of a day-to-day managerial tool.

Using Ideal Patient Care, you can set a powerful, meaningful purpose for your organization that will guide you in achieving what you thought was impossible.

Ideal Patient Care

Ideal Patient Care should be the care that each of us would expect to be delivered to our family, friends, and to us personally.

So if that is what we should expect, shouldn't our customers (patients) receive that same care?

Bridging the Gap

What can help us move closer to Ideal Patient Care?
Accountability for Medical Error

So let's return to the initial presented case:

- How important is it to follow-up on abnormal results?
- Who is paying attention to these failures to follow-up?

Texas Medical Board

**Action Date:** 12/09/2005
**Description:** ON DECEMBER 9, 2005, THE BOARD AND DR. ENTERED INTO AN AGREED ORDER REQUIRING DR. TO COMPLETE 20 HOURS OF CONTINUING MEDICAL EDUCATION IN THE AREA OF MEDICAL RECORD KEEPING AND RISK MANAGEMENT. THE ACTION WAS BASED ON ALLEGATIONS THAT DR., THROUGH AN OVERSIGHT, FAILED TO ENSURE THAT A FOLLOW UP X-RAY WAS ORDERED FOR A PATIENT FOR WHOM AN X-RAY SOME NINE MONTHS LATER REVEALED ADENOCARCINOMA

Texas Medical Board

**Action Date:** 12/12/2008
**Description:** ON DECEMBER 12, 2008, THE BOARD AND DR. ENTERED INTO A TWO-YEAR AGREED ORDER REQUIRING THAT DR. PRACTICE BE MONITORED BY A PHYSICIAN MONITOR; THAT HE OBTAIN AN AUDITOR TO PROVIDE A PRACTICE REVIEW; THAT HE OBTAIN 10 HOURS OF CONTINUING MEDICAL EDUCATION IN MEDICAL RECORD KEEPING AND 10 HOURS IN RISK MANAGEMENT; AND THAT HE PAY AN ADMINISTRATIVE PENALTY OF $5,000 WITHIN 180 DAYS. THE ACTION WAS BASED ON DR.'S FAILURE TO REVIEW DOCUMENTS OF A COLONOSCOPY AND A BARIUM ENEMA OF AN ANEMIC PATIENT WHO WAS ULTIMATELY DIAGNOSED WITH METASTATIC ADENOCARCINOMA.
Diagnostic physicians at increased risk for medical malpractice claims due to communication failures

- Diagnostic physicians have a responsibility to notify referring clinicians when test results reveal urgent or unexpected findings.
- The rapid growth of diagnostic testing appears to be placing physicians at greater risk for medical malpractice payments related to diagnosis increased approximately 40%.

*CME Activity of the Month in most recent edition of Journal of the American College of Radiology

- During the past decade clinicians have ordered dramatically greater numbers of diagnostic examinations.
- Between 1996 and 2003, malpractice payments related to diagnosis increased by approximately 40%.
- Contributing factors include:
  - failure of physicians and patients to receive results
  - delay in report findings
  - lengthy turnaround time
Diagnostic physicians at increased risk for medical malpractice claims due to communication failures

- JACR article suggests taking advantage of available "semi-automated critical test result management systems" could improve patient safety, shorten hospital days, and reduce risk by providing legal documentation
- When reportable test results arise, healthcare organizations need clear policies that define the responsibility of reporting and referring providers to ensure patient follow-up

Cont....

- Types of communication failures included miscommunication or noncommunication among physicians and failure of physicians to instruct or communicate with patients or families
- The authors suggest that a contributing factor is a dramatic increase in the number of diagnostic tests ordered by physicians over the past decade (defensive medicine?)
- Modern technology has raised societies expectations

Cont...

- Patient involvement is important, but the burden of following up on test results shouldn't fall on their shoulders
- Physicians however need a helping hand
- In a given week, a PCP might need to review 360 chemistry test results, 460 hematology results, 12 pathology reports, and 40 radiology reports²

²Partners Healthcare system in Boston
How Often Do Second Opinions Differ From Referral Diagnoses?

Sample of 268 patients referred to them from primary care practices during 2009 and 2010

- 12% who sought a second opinion received the same diagnosis
- 66% received a better defined/refined diagnosis
- 21% received a final diagnoses that were distinctly different from referral diagnoses

They concluded that referrals to advanced specialty care for undifferentiated problems are an essential component of patient care

Without adequate resources to handle undifferentiated diagnoses, a potential unintended consequence is misdiagnoses resulting in treatment delays and complications leading to more costly treatments.
Returning to the Delayed Diagnosis...

- The PCP initially responded with “my problem, my responsibility” individual accountability mindset.
- He agonized over the missed, embedded text about the suspicious lesion on the discharge summary.
- The PCP was a significant part of the chain of events casually connected to the unfortunately delayed cancer diagnosis.
  - But, the PCP did not cause the event in isolation.

Collective accountability of the involved doctors might look like this: The PCP discloses the delayed diagnosis openly and directly to the patient and reports the problem in communication and data transfer between inpatient and outpatient spheres in the institution.

Returning to the Delayed Diagnosis

- The inpatient attending of record and resident are notified of the downstream events in the patient’s care and together with the PCP and institutional leadership, participate directly in system fixes to prevent such a mistake from happening again.
- The PCP advocates for the patient by participating in the event analysis to uncover the root causes of the delayed diagnosis and implement prevention plans.
- He also helps advance the patient’s interests by supporting collaborative efforts between the institution and the malpractice insurer to offer appropriate compensation to the patient.
- All clinicians involved become active participants in learning, reporting near misses, improving team communication skills, and applying the mentality of shared ownership for the patient safety to daily practice.

Returning to the Delayed Diagnosis

Although these suggestions can help frame specific responsibilities for doctors and institutions involved in medical error, perhaps the more important unanswered questions about accountability, and focused work is needed to define collective accountability in each of our own areas.
**Wrap Up and Conclusions**

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**Golden Rule**

The Golden Rule or ethic of reciprocity is a maxim of ethical code, or *morality* that essentially states either of the following:

(Possible form): One should treat others as one would like others to treat oneself.

(Negative/prohibitive form, also called The Silver Rule): One should not treat others in ways that one would not like to be treated.

The Golden Rule is arguably the most essential basis for the modern concept of human rights, in which each individual has a right to just treatment, and a reciprocal responsibility to ensure justice for others.

*Wikipedia, The Free Encyclopedia*
My Recommendations

Hopefully, each of us can agree that we have a responsibility to our patients'. That each of us would desire that ourselves and our families receive Ideal Patient Care. So, why should not each of our patients' deserve the same care?

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Questions?