Enlisting Patients to Reduce Medical Errors

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INTRODUCTION

Two recent reports on patient safety reinforce a compelling yet fairly obvious claim: doctors can reduce medical error by enlisting patients as participants in that process. Such a participation would mean more frank, proactive disclosure by healthcare professionals of the risks of medical error to patients, but by doing so, patients themselves may improve the chances of error-free care.

ANALYSIS

Medical error made headlines this summer when a team at Johns Hopkins University claimed that 250,000 deaths per year are attributable to medical error.[1] If this claim is true,[2] medical error would be the third leading cause of death in the United States, surpassed only by heart disease and cancer. A recent piece in JAMA explained that it is difficult to measure the magnitude of this issue because "there is no comprehensive, nationwide system for reporting or capturing all types of medical errors."[3] Even defining what constitutes medical errors is controversial. A 2006 report by the Institute of Medicine (IOM) concluded that "there are at least 1.5 million preventable [adverse drug events] that occur in the United States each year."[4] Should these events be counted as "errors"? Although there is still debate regarding how to define, quantify, and regulate this problem, all stakeholders agree that medical errors need to be reduced.

Much of the literature surrounding disclosure of error to patients, including the AMA's Code of Ethics, is premised on three concerns: the ethical duty related to the patient's autonomy, i.e., full disclosure of an error allows a patient "to make informed decisions regarding future medical care,"[5] the maintenance of trust in the doctor-patient relationship, and the reduction of legal liability. While these are all important goals, can this patient disclosure requirement intersect with the goal of reducing errors themselves?

In 2009, President Obama asked the Department of Health and Human Services (HHS) to conduct research into projects that would put "patient safety first" by reducing preventable injuries, i.e. medical errors. Seven programs were put in place focusing on, among other areas, improving communication with patients in order to enhance patient safety, specifically with respect to acknowledging medical errors. In May of 2016 the Agency for Healthcare Research and Quality (AHRQ) submitted a report evaluating the various initiatives.

One of the programs at the University of Texas (UT) focused primarily on how hospitals could better their practices by utilizing patients' experience with medical error. Unlike many programs that focus on disclosure of medical error in light of conflict resolution and litigation prevention, the program at UT also aimed at "incorporating patient and family input into efforts to understand why errors occur."[6] To that end the program undertook two initiatives, (1) questioning the medical staff to assess UT hospitals' 'disclosure culture' and (2) using a structured interview guide for gathering information from patients and family members after an adverse event.[7] The authors noted that healthcare professionals that underwent training in how to disclose errors "had significantly more positive attitudes about error disclosure and perceived disclosure as less damaging to patient and peer trust."[8] By speaking to 72 patients and family members who had experienced harm after an adverse event, the authors learned that most "would like to participate in the hospital's adverse event analysis process."[9] Though many had no intention of pursuing litigation, they reported that they had considered litigation in order to receive information about what happened, and to get assurance that someone

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was addressing the problem.[10] This finding is promising, as it strongly suggests that patients' concerns over the investigation of medical errors can be utilized by healthcare professionals to make progress toward reducing errors. In addition, the program seemed to show that training medical staff on how to disclose errors was highly effective in changing attitudes and fears toward disclosure. Presumably, the more that healthcare professionals can be encouraged and trained to honestly and proactively disclose the risk of medical errors to patients, the more the patient can be enlisted to prevent them.

So-called "patient identification error" was the subject of a recent report by ECRI Institute PSO, an independent non-profit focused on patient care. The report looked at data from more than 180 healthcare organizations from January 2013 through August 2015 and determined that at least 7,000 "wrong patient errors" had occurred and that most, if not all, of them were preventable.[11] The ECRI report's recommendations made it clear that patient education and engagement is a critical component of reducing "patient misidentification." They recommended that healthcare providers engage patients and their family to take an active role in their safety by speaking up to staff if patient identification procedures are not followed, questioning unexpected tests, and requesting to see their registration forms and charts.[12]

CONCLUSION

The AMA requires that errors be disclosed after an adverse event if harm occurs. Perhaps if the ethical obligation to disclose the risks of common medical errors was extended to include all interactions with patients regardless of harm, patients could then be on notice for those mistakes. These two reports suggest that medical staff who forthrightly disclose the risks of medical errors to patients may find themselves with powerful allies—the patients themselves.

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[1] Martin A. Markary and Michael Daniel, "Medical Error – the third leading cause of death in the US," BMJ. 2016;353:i239.

[2] Many articles dispute the claim. See, e.g. Gerard J. Gianoli, M.D., "Medical Error Epidemic Hysteria," *The American Journal of Medicine*, DOI: http://dx.doi.org/10.1016/j.amjmed.2016.06.037, and David Gorski, "Are Medical Errors Really the Third Most Common Cause of Death in the U.S.?" Science-Based Medicine, last modified May 9, 2016. https://www.sciencebasedmedicine.org/are-medical-errors-really-the-third-most-common-cause-of-death-in-the-u-s/

[3] Jennifer Abbasi, "Headline-Grabbing Study Brings Attention Back to Medical Errors," *JAMA* 316, no. 7 (2016): 699.

[4] Philip Aspden, et al., *Institute of Medicine Report Brief*: *Preventing Medical Errors*(Washington, D.C.: Institute of Medicine, National Academy of Sciences, 2006) 1. Accessed October 12, 2016. http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2006/Preventing-Medication-Errors-Quality-Chasm-Series/medicationerrorsnew.ashx

[5] The AMA Code of Medical Ethics' Opinions on Patient Safety, Opinion 8.12 – Patient Information *Virtual Mentor* 13, No. 9: 626-628. . Accessed October 11, 2016. http://journalofethics.ama-assn.org/2011/09/coet1-1109.html

[6] Michelle Pillen, et al., Longitudinal Evaluation of the Patient Safety and Medical Liability Reform Demonstration Project: Demonstration Grants Final Evaluation Report. (Rockville, MD: Agency for Healthcare Research and Quality,2016.) 16. Accessed October 13, 2016. http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-safety-resources/resources/candor/psml-demo-grants-final-report.pdf.

[7] AHRQ, 16.

[8] AHRQ, 16.

[9] AHRQ, 17.

[10] AHRQ, 17.

[11] Jason Adelman, et al, *ECRI Institute PSO Deep Dive: Patient Identification Executive Summary*, (Pennsylvania: ECRI Institute PSO, 2016) 5. Accessed October 12, 2016. https://www.ecri.org/Resources/Whitepapers_and_reports/PSO%20Deep%20Dives/Deep%20Dive_PT_ID_2016_exec%20summary.pdf

[12] ECRI, 11.