Study Views Medical Errors Through Different Lenses

BY PATRICE WENDLING
Chicago Bureau

QUEBEC CITY — Clinicians, staff, and patients report medical errors in distinctly different ways, Robert L. Phillips Jr., M.D., said at the annual meeting of the North American Primary Care Research Group.

Patients tend to file fewer reports, while clinicians and staff are far more likely to report errors of process rather than errors of knowledge and skill.

Such variances are important to consider as error reporting becomes mandatory. The Patient Safety and Quality Improvement Act of 2005 (S. 544), signed into law this summer, establishes a voluntary system to report errors and near misses.

TALK BACK

What has been your experience with medical error reporting?

Share your thoughts!
Send e-mail to imnews@elsevier.com; write to Internal Medicine News, 12230 Wilkins Ave., Rockville, MD 20852; fax to 301-816-8738; or click on the Talk Back box at www.internalmedicinenews.com.

Dr. Phillips presented a study in which 10 family medicine clinics were asked to routinely report errors over a 10-week period. Additionally, on 5 intensive days, they were asked to report every error. Errors could be of omission or commission.

The reports were anonymous and could be filed by mail, phone, or the Internet. Reporting took about 3-5 minutes.

Of the eligible reporting population, 401 (86%) clinicians and staff signed consent forms.

A total of 726 events were reported, of which 717 had at least one error. There were a total of 935 errors.

Just over half of the reports came from staff (384), a little over one-third from physicians (278), and relatively few from residents (46) and nurse practitioners and physician assistants (18).

The majority of reports came over the Internet (546), while 180 were mailed.

Although most of the reports were filed on routine versus intensive-reporting days (440 vs. 265), there was a disproportionate amount filed on the 5 intensive-reporting days.

"Routine reporting does not approximate volume," said Dr. Phillips, director of the Robert Graham Center: Policy Studies in Family Medicine and Primary Care, Washington. "There has to be some other mechanism than routine reporting if you want to get at [errors], especially the common, less harmful mistakes."

The top errors were chart completeness and availability (176), medication (127), appointments (111), filing (84), laboratory work (82), and communication with patients (65).

Analysis revealed that 96% of the errors reported were process errors, suggesting that clinicians and staff either recognize more process errors or are reluctant to report errors of knowledge and skill, he said.

Clinicians were significantly more likely to report errors concerning medications, laboratory investigations, and diagnostic imaging, while staff members were more likely to report errors related to patient communication and appointments.

One of the more striking findings was that patients filed only 126 reports, of which 18 were actual errors. Of these, 6 were related to waiting too long, 2 were mistaken identity, and 10 cited a variety of issues, including credit card theft and even clinician-induced fear. Most patient reports were sent by mail.

While such insights are important, it's not clear if the overall lack of patient reporting is due to patients not seeing errors or if another tool is needed to collect the data, he said.

The audience suggested that patients may report less often because acknowledging an error might make them feel more at risk.

The analysis revealed that 706 reports indicated errors that caused health consequences or harm. There were no deaths, but nearly a quarter of the patients involved experienced some health consequence.

Reports from both staff and clinicians suggest that patients with complex health issues are vulnerable to more serious harm.

Of the reports that had multiple errors, 4 reports had four errors, 33 had three errors, and 183 had two. In 93 of these cases, a cascade of errors occurred as a result of an initial error, which usually involved an incomplete or unavailable chart.

The Robert Graham Center is a division of the American Academy of Family Physicians. ■

Electronic Record Interfaces Can Contribute to Errors

BY PATRICE WENDLING
Chicago Bureau

LOS ANGELES — Electronic health records have been proposed as a way to reduce medical errors, but their design can contribute to errors as well, Melonie Nance, M.D., said at the annual meeting of the American Academy of Otolaryngology–Head and Neck Surgery Foundation.

"The way doctors work, and the way we think about patient problems and diseases is often completely mismatched with the way things are presented in electronic records," Dr. Nance, a resident, said in an interview.

Dr. Nance and her colleagues at the University of Pittsburgh analyzed two cases of preventable medical errors that occurred in part because of computer interface design. In neither case did the error lead to patient injury, so both were "near misses."

In the first case, a resident reviewed the pathology report of an operative biopsy prior to a composite resection, noting that the diagnosis was squamous cell carcinoma, but failed to recognize that the date of the biopsy was from the previous year.

In the electronic record used, multiple pathology reports were displayed on one screen. Also, pathology and operative reports were stored in separate categories and were not linked, even though both reports resulted from the same procedure. The problem consisted of both time-line and data-fragmentation errors. Rather than presenting critical data in a way that links related information, the electronic record had recreated a problem seen with traditional paper files where information is stored by data type, Dr. Nance said.

Standardized time lines, unambiguous links between related information, and data organized by problem are all potential solutions. For example, pathology reports of a head and neck cancer should be displayed with other information about the specific cancer, while reports on a liver biopsy should be linked to other information about the patient's liver disease.

In the second case, a patient was discharged in acute renal failure 30 minutes after the renal failure had been noted and documented by the critical care fellow. The fellow had entered the diagnosis into the electronic record at the end of a lengthy note but had not communicated the information to the otolaryngology resident who discharged the patient. The error was discovered quickly and the patient was readmitted 2 hours later.

The primary problem in this case was that data entry was mistaken for thorough communication. Critical patient information was hidden from the discharging physician and the record contained excessive information.

Dr. Nance and her colleagues suggested that a severity scale could be used to bring attention to important information such as abnormal lab data. Copied-and-pasted notes, a strategy often used to generate complete documentation, could be marked with color coding, time stamps, or a notation similar to the "track changes" function on word processors.

Such communication failures could be reduced by an automated warning system triggered by attempts to discharge patients with worsening conditions. Electronic medical records also could be equipped with a message system similar to e-mail that notifies parties when a message has been retrieved.

"There were human errors in both cases, but electronic records should be designed better to reduce the risk of error," Dr. Nance said. ■

FDA Considers Changing Nutrition Label to Help Fight Obesity

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

WASHINGTON — The federal government is looking hard at whether to make changes to the "Nutrition Facts" label found on packaged foods, Barbara O. Schneeman, Ph.D., said at a meeting on obesity sponsored by Business Access.

In April, the Food and Drug Administration published two different "advance notices of proposed rulemaking" in the Federal Register outlining the issues it was considering, explained Dr. Schneeman, who is director of the agency's Office of Nutritional Products, Labeling, and Dietary Supplements. "Estimates indicate that more than 70% of consumers will use the panel in their first-time food purchase, and 50% said they have changed a food purchase because of what they saw on the Nutrition Facts panel," she said. "So it's a very valuable tool."

One question the FDA is considering is how to make calorie information more prominent on the food label. "Some of the questions we were asking were, 'What are ways to give [calorie information] more prominence? Bold typeface? Larger font size? Should we consider including a daily value of calories?' " Dr. Schneeman said. "Would that create an incentive to change the number of calories in a product?"

Serving size is another issue, she said. Under current law, food packages must provide nutrition information for the "reference amount customarily consumed" (RACC) of a product. The RACC, or serving size, is currently derived from the U.S. Department of Agriculture's Food Consumption Survey, which was taken in the late 1970s and late 1980s. "Do we need to update the RACCs? What database would we use to do that update?" she asked.

In fact, there are several issues concerning serving size, Dr. Schneeman said. "There's a lot of concern about confusion when consumers buy that 20-ounce soda or 4-ounce bag of chips. Do they realize that the labeling is for a single serving and that the container actually has more than one serving?

Dr. Schneeman said she was pleased that some manufacturers have already started including the nutrition information for the entire package of their products, even if the package contains more than one serving.

The comment period for both Federal Register notices has closed, and "I think we received far more comments on serving size than we did on calories," she noted, adding that the agency was currently analyzing those comments. ■