



Medical Error or Predictable Outcome

PRESIDENT'S MESSAGE



By Robert C. Midgley, MD

We need to own up to mistakes. But there is a big difference between a medical error and a predictable bad outcome.

THIS FALL MY HOSPITAL WILL undergo a JCAHO inspection. Once every three years we pay inspectors to go over all of our inpatient and some of our outpatient operations, to look for deficiencies to criticize.

This year one of the hot topics is Patient Safety and, to be more specific, Medical Errors. The Institute of Medicine Report "To Err is Human: Building a Safer Health Care System" estimated tens of thousands of lives are lost in the U.S. annually due to simple errors that could be prevented.

This has prompted a thorough look at all functions of health care, in an effort to save lives by focusing on the "simple mistakes" that can be devastating. However noble this sounds, it is not helping public perception of the medical field. Once again, medicine is being painted with a brush that overgeneralizes and oversimplifies our pitfalls.

There is no doubt that mistakes do occur. Doctors need to realize this and need to be able to admit that they or a member of their team made a mistake. But what I fear is that in the rush to admit that a mistake has occurred, we will say "mistake" simply because a patient had a "predictable bad outcome."

Is there a difference between the two terms? Absolutely. There are sometimes adverse incidents in medical and surgical care. But that does not mean a mistake was made. Nor is a small, insignificant error in patient care necessarily responsible for a bad outcome.

Let me give an example:

A mistake has occurred if a nurse gives 2.5 mg of digoxin to a patient when the doctor wrote an order for 0.25 mg.

Did the doctor or the nurse make the mistake? Perhaps the doctor is at fault for illegible handwriting, or neglecting to insert the decimal point. Perhaps the nurse is at fault for misreading a legible order.

Perhaps a pharmacist should have intervened when the order was filled. This is an example of a mistake that is easy to identify.

The patient then develops chest pain and has a cardiac arrest. Is the arrest the result of 10 times the prescribed dose of digoxin, or did the patient sustain a myocardial infarction unrelated to the dose given? It is a fact that 2.5 mg of digoxin could be tolerated with no ill effects in many clinical circumstances.

A predictable bad outcome is different from a mistake. For example, a patient suffers a perforation following a colonoscopy. The risk of such a perforation is known to be one in 500 cases. This was communicated with the patient prior to signing consent.

Analysis of the case shows no evidence of wrongdoing. The cautery settings were appropriate. All equipment functioned perfectly. But the polyp was large and a lot of cautery current had to be applied to remove it. This is a predictable bad outcome. There was no mistake.

So, in an effort to comply with JCAHO's recommendations, the hospital's risk management and quality teams thoroughly investigate both incidents. These evaluations are difficult - the doctors, nurses, pharmacists and others involved in the incidents are busy people, with varying schedules and responsibilities.

If they all can come to the same room at the same time and talk about the incidents in a free-flowing, confidential discussion, then both future errors and even predictable bad outcomes will be less likely to occur. Medical care will have improved in the process.

But then the question comes: "What do we tell the patient and family?" The malpractice attorney for the hospital wants nothing to be said that will incriminate the hospital or its staff, as does the physician's attorney.

The family will be skeptical that either the hospital or the physician will tell the truth, for newspapers and other media information sources constantly suggest that health care workers should not be trusted. The family believes the only goal of the health care field is to save money by spending less on patient care. So the patient and family get their own attorney, and a malpractice claim is filed in both cases.

A second Institute of Medicine report published recently stated that if we could analyze mistakes in a blame-free environment, we could design new processes to improve medical care. However lofty a goal that is, we are not, by any stretch of the imagination, in a blame-free environment at present.

We are at an impasse, if you will, of being hampered in improving medical care. We all know mistakes are made, we know that health care providers are human like everyone else. But unlike many other professions, we are held to a standard in which mistakes are not only intolerable but also punishable by malpractice claims.

What do we tell the patients and their family? Well, we try to tell the truth, as difficult as that might be to ascertain. Once a thorough evaluation has been performed, certain conclusions may become evident. Those evident conclusions should then be discussed with the patient and family.

If there truly was an error, it should be admitted. This approach is mandated by JCAHO, and encouraged by the AMA's Council on Ethical and Judicial Affairs. If this was a predictable bad outcome, it should be presented as such. Unfortunately, the patient and family are working under the impression that mistakes and bad outcomes should never occur in medicine; they may sue, and this cannot be avoided under the current medical-legal system.

Is there a solution to this mess? How do health care teams gain back the trust of their patients?

Until legislators are truly convinced that the best approach is to allow us to continue to confidentially, under 1157 protection, analyze errors and improve systems, we must be very circumspect in saying "mea culpa" too quickly.

I believe we should analyze each case carefully, and only then admit to a true mistake - but not to a bad outcome. If patients or their families expect perfection, they will be disappointed.

If, however, we continue to work at improving systems under current limitations, admitting only true errors, and presenting bad outcomes for what they are and nothing more, then medical care can, albeit slowly, improve.

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