Understanding medical errors in primary care

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- Brief report of two studies, one representing patients' points of view, and the other that of physicians
- Funding from Agency for Healthcare Research and Quality, Commonwealth Fund
- Conducted in 2001-2002

Team for patient study:

- Kuzel, Woolf
- Valerie Gilchrist, MD
- John Engle, PhD
- Richard Frankel, PhD
- Charles Vincent, PhD
- Thomas LaVeist, PhD
- Interviewers

Aims:

- Develop patient-focused typologies of medical errors and harms in primary care settings
- Discern which errors and harms may be the most common and the most serious

Methods:

- 38 in-depth, anonymous interview of adults from Virginia and Ohio
- Range of locales; all three PC specialties
- Stories of preventable problems with primary health care that led to physical or psychological harm
- Transcripts analyzed to identify, name, and organize the stories of errors and harms

Results:

- 38 interviews yielded 221 separate reports of problematic incidents
- Most common were breakdowns in access or relationship
- Linked to 170 separate reports of harms
- 70% psychological: anger, frustration, belittlement, loss of relationship/trust
- Several reports of perceived racism

Taxonomy major categories:

- Access breakdown
- Communication breakdown
- Relationship breakdown
- Technical error
- Inefficiency of care

Selected quotes

Conclusions:

- Breakdowns in access and relationship appeared to be more common than technical errors
- These patients were more likely to be harmed psychologically and emotionally

Team for physician study:

- Woolf, Kuzel
- Susan Dovey
- Robert Phillips
- Investigators in 5 other countries (Canada, UK, Australia, New Zeland, Netherlands)

Aims:

- Test the feasibility of a web-based physician reporting system
- Develop a taxonomy of physician reported errors
- Evaluate brief reports as tool for causal analysis
- Evaluate physician sensitivity to patient harms

Methods:

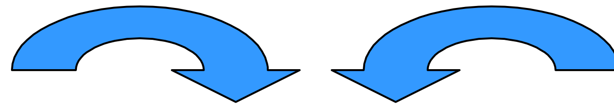
- 18 US family physicians in 5 states filing anonymous reports
- Prompt: "T*hat was a threat to patient well-being and should not happen. I don't want it to happen again*"
- Free text answers to what happened and what may have contributed
- Fixed choice response to severity of harm

Results:

- 75 error reports, 3/4 showing cascade of errors
- ”Most common” error depends on unit of analysis (proximal, distal, all) and label
- **Great majority distal errors treatment or diagnosis; 2/3 resulted from miscommunication**
- **Physicians were more likely to report physical injuries, and generally underreported harms**

Example of error "cascade"

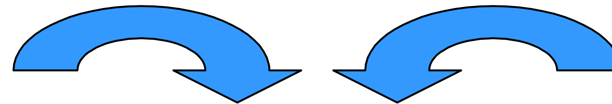
Lack of uninterrupted triage system



Message to triage nurse obscured by other papers

Failure of original practice to respond in timely fashion

Second provider fails to facilitate rapid evaluation



Delay in treatment of complication of pregnancy

Conclusions

- Distribution of errors and harms depends upon reporter, definition, reporting methods [listen for this at this conference!]
- Cascade analysis may help unmask causes and solutions
- Safety effort could well focus more on preventing miscommunication