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70 – Talking about Medical Errors: the Bigger Picture

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Healthcare professionals involved in quality improvement focus more and more on active patient participation in the care process. The point is not patient satisfaction, but to get the patient involved as the central actor to improve outcomes in all quality dimensions, especially in safety.

The patient has a key-role in hospitals and even more so in primary care: When will he call and whom? How does he express and understand his illness? Will he/she observe the prescriptions?

These questions appear essential when dealing with the risk issue. Previous studies focused on adverse events (AEs) in primary care showed that some risks can be reduced if the patient is well listened to, informed and guided by the surrounding professionals.

At the 2014 Lisbon conference, we presented a French epidemiological study ESPRIT (1) collecting AEs in general practice and drawing up a typology. This study showed that AEs are frequent in primary care (1 every 2 days, detected by a GP in his practice), fortunately with no resulting consequence to the patient in 3/4 cases.

Some AEs' examples from this study suggest that the physician-patient interaction and the information given to the patient are important to the risk management in the outpatient health care system:

A 78 year-old patient, treated for glaucoma, consults her GP for a prescription renewal. By the end of the consultation, he proposes to substitute benzodiazepine for an anticholinergic drug. The glaucoma is listed in the patient's history but the software alarm does not work when writing the prescription.

This error resulted in no adverse consequence because the patient, being aware of frequent drug contraindications with glaucoma, read the notice and decided not to take it.

The key here was the patient's health literacy, her ability to draw a conclusion, and the relationship's quality enabling the patient to speak with her doctor about it.

While electronically composing a prescription, a doctor makes a slip in the alphabetical medication list and validates Temesta* instead of Temerit* just above on the list. Reading the prescription together, the patient observes she does not recognize this drug.

Joint reading of the newly-issued prescription is a secured practice and signals a good doctor-patient relationship.

Such good practices could be more widespread: a 2013 report from the WHO (2) gives the results of a Polish study exploring the knowledge and information the

patients have at hand about their treatments: only 39% of the patients with chronic diseases knew the name and dosage of the prescribed drugs, 2/3 had a talk about it during the consultation - mostly (93%) at their own initiative; only 6% reported that the physician mentioned or discussed the possible drug interactions.

Diagnostic procedures and investigations also require some information exchange at the right time with the right actors:

A 70 year-old patient consults his GP for diarrhoea associated with poor general condition. The physician orders a colonoscopy for his patient as soon as possible. An appointment is organized but two days prior to the exam, the endoscopy centre finds out that the patient had not seen the anaesthetist, and postpones the exam for a month. The patient was neither aware of the need for an anaesthetist consultation, nor that he had to make the appointment himself.

This was a near-miss: the patient informed the GP, who obtained the anaesthetist consultation in time for the initial endoscopy date.

Mr Y, 80 years old, consults for his anti-hypertensive treatment renewal. Some hours later, the pharmacist calls, wondering about the double treatment, duplicating the nephrologists', ordered two weeks before. The GP had not received any mail and the patient did not mention it.

Here, the pharmacist's mediation averted any harmful consequence. The communication between physicians is an issue; however the patient did not provide the link between them. What exactly did he know and understand about the treatment change?

Sometimes, the patient situation is awkward to explain, and tricky to understand:

A teenager, 14 years old, comes with her mother for a delayed period. In front of her mother, the girl declares she never had intercourse. The physician does not order a BHcg level. Some weeks later, the patient comes again and the diagnosis of pregnancy is made.

Communication between patient and physician is a key issue in this diagnosis delay, an incident most feared among GPs. However, one cannot assume that a face-to-face interview would have helped the teenager to speak out.

Obviously patients could significantly contribute to their own safety with better information and understanding of their disease and treatment.

The studies quoted suggest enhancing this new role for the patient, already applied in chronic disease management. However, practitioners often regret the constraints of time in training and educating their patients (3).

But patient safety, transparent communication and mutual patient-doctor trust, are not always easy to conciliate, when it comes to the inherent risks linked to care activities. A Danish qualitative study (2013) shows that in oncology, patients and physicians talk little about safety (4). Exchanges are limited to medication adherence and some drug side effects. According to the physicians, talking about risks, would add unnecessary anxiety.

With regard to the patients,, there is a large array of feedback, from the continuous demanding of information to keeping to the strictly necessary: not everybody "wants to know" ...

Threats to the doctor-patient relationship become more obvious in the case of more direct involvement of patients in safety management such as error reports. Patients do not feel comfortable challenging a professional they trust. They may fear coming across as "difficult patients" and decreased quality and outcome of care.

Today general practitioners seem open to the idea of giving a larger and more central place to the patient (5), provided that such involvement does not detract y responsibility away from doctors (6).

Building a comprehensive action to facilitate AE reporting and their analyses in quality circles or other QI programs could promote real cultural change and good practices, improving patient-physician communication regarding medical errors and risks as well as preventing harm to the patient.

