Making the case for the qualitative study of medical errors in primary care

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Part one: The larger enterprise of attention to patient safety – where does qualitative inquiry fit in?
Definition

• What is an error?
• What kinds of errors are out there? (viewpoint?)
• What are the associated harms, and who is affected?
Epidemiology

- Surveillance systems
- Descriptive epidemiology
Targeting

• Which errors should we work on?
• Who should decide?
Causal analysis / Design of interventions

- Root Cause Analysis
- Failure Mode and Effects Analysis
- Crew Resource Management
- Complex Adaptive Systems
These have elements of classic qualitative traditions

• Grounded Theory
• Ethnography
• Participatory Action Research
Evaluation of impact

- Intended and unintended consequences
- Interaction with individual, team
Implementing an Electronic Medical Record in a Family Medicine Practice: Communication, Decision Making, and Conflict

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Purpose: Electronic medical record systems offer substantial opportunities to organize and manage care, with the ability to provide patients with a medical home model of care that includes high-quality, comprehensive primary care. This improves care delivery across multiple specialties. This study evaluated the impact on communication, decision making, and conflict in an outpatient family practice setting.

Methods: The study was conducted in a 10-physician outpatient family practice. The practice had previously used an electronic medical record system (EMR). The EMR was replaced with a new system (EMR2) that included a comprehensive electronic prescribing system (EPR). A survey was administered to assess the impact of the new system on communication, decision making, and conflict.

Results: The survey was administered to 437 patients, of whom 257 (59%) completed it. The results showed a significant improvement in communication and decision making, with a decrease in reported conflict. The results also showed that the new system was more user-friendly and easier to use.

Conclusion: The study demonstrated that the new EMR2 system improved communication, decision making, and decreased conflict in an outpatient family practice setting. The results suggest that electronic medical record systems can improve patient care by enhancing communication, decision making, and reducing conflict.
Contributions to measures

- Structure measure
- Process measure
- Outcome measure

Structure measures

- Environment design (eg, ward layout)
- Staffing (eg, number of floor nurses)
- Decision support system (eg, computerized prescribing, bar coding)
- Safety culture
Process measures

• Medical error, medication error
• Inappropriate drug prescription
• Near miss
Outcome measures

- Medical injury
- Adverse event, adverse drug event
- Iatrogenic illness, nosocomial infection
- Complication
Part two: A Humanistic perspective
Personal experiences, effects, coping strategies of those involved

• Patients – kinds of harms, effects on self and relationship with provider, consequences of being asked to play a role in prevention

• Providers – perceptions of patient harm, causal models, personal meaning and responses

• How can we work to bring meaning to this suffering? (Frankl, 2000)

• Power of apology (Woods and Star, 2004)
Advising patients about patient safety: current initiatives risk shifting responsibility.

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BACKGROUND: Many health care providers now disseminate advisories telling patients what they can do to avoid errors and harms in their care. METHODS: The content of five leading safety advisories for patients was analyzed and a critique of their development, content, and impact was developed, drawing on published literature and 40 interviews with a diverse sample of 50 key informants. FINDINGS: Very little is known about the effects of the distribution of safety advisories to patients, but several grounds for concern were identified. There was a lack of attention to patients’ perspectives during the development of advisory messages, and the advisories say little about what health care providers should do to ensure patient safety. Patients are given little practical support to carry out the recommended actions, and health professionals’ responses may render their attempts to act to secure their own safety ineffective. Some messages suggest an inappropriate shifting of responsibility onto patients. Advice that involves checking on or challenging health professionals’ actions appears to be particularly problematic for patients. Such behaviors conflict with the expectations many people have—and think health professionals have—of patients’ roles. DISCUSSION: A serious commitment to optimizing patients’ contributions to safe care requires a research-based understanding of patients’ perspectives and more practical facilitation of patient involvement.

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Part three: Writing qualitative proposals that might get funded, with an illustration
Guide for evaluating qualitative proposals
(Morse, QHR, 2003)

- Relevance – the potential contribution of the product
- Rigor – the appropriateness and adequacy of the methods
- Feasibility – researcher ability, resources, access (and ethics)
Ben says:

Tell ‘em what you are going to do, and why, and avoid jargon.
A pragmatic approach to “standards” (Kuzel and Engel, 2001)

• State the presumptions that create the need for the study – what’s your basis for thinking you have a problem, and one worth solving?
• Show how the methods you’ve chosen are a fit with the “phenomenon of interest.”
• Defend your sampling strategy.
A pragmatic approach to “standards” (continued)

- Explain your analysis strategy (and, in a proposal, expand upon now accepted shorthand terms such as “editing” or “immersion-crystallization.”)
- Make explicit how democratic values inform the design of the project.
- Show how the findings expand current understanding and suggest action.
Example from proposal to AHRQ (Kuzel, Woolf, Engel, et al 2003)
The problem:

- *To Err is Human* focused on hospital setting, significant morbidity and mortality
Why this was a problem:

- 750,000,000 outpatient encounters in US each year
- Few published studies of ambulatory care used physician reports
What was needed:

- Descriptions of patient experiences
- Prioritization of error-harm dyads
Options, and our choice:

• Direct observation
• Individual interviews
• Group interviews
• Chart reviews
• QI data, malpractice claims
• Sampling of range of errors and harms, prioritization most readily accomplished by individual interviews, with group interview critique
Attention to quality, findings:

- Researcher experience; advisory team
- Sampling strategy – maximum variation; saturation of categories
- Data analysis plan – independent coding → consensus → critique (investigator and patient)
- Dissemination plan – professional publications, multiple professional audiences (STFM, NAPCRG, AcademyHealth, NPSF, VIPCS, PCRMSC)
Our study (Kuzel, Woolf, Gilchrist, et al 2004)

Funded by AHRQ
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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 interviews 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
Working definition of medical error:

• All forms of improper, delayed, or omitted care that unnecessarily injure patients by either worsening health outcomes or causing physical or emotional distress.
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
But are all of these “medical errors?”

• It’s all about harm reduction (Bagian, 2005)
• Can’t we think of some of these as “relationship mistakes?”
• Don’t these sorts of preventable problems diminish our ability to engage in empathic relationships with our patients?
Empathy

• Curiosity and emotional resonance (Halpern, 2001)
• A housecall from one human soul to another (Stone, 2005)
The importance of empathy

• Helps people tolerate intolerable feelings
• Helps people believe that the future might not be as bad as they think
• Helps people regain agency/self-efficacy (Halpern)
Patients want empathy. Empathic relationships are associated with:

- More thorough diagnoses (Suchman, Markakis, Beckman, Frankel, *JAMA*, 1997)
- (Less Burn-Out! (Roter, Stewart, Putnam, Lipkin, *JAMA*, 1997))
- (Little or no extra time! (Stewart, Brown, Weston, *Can Fam Phys*, 1989))
Do Patients Treated With Dignity Report Higher Satisfaction, Adherence, and Receipt of Preventive Care?

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ABSTRACT

BACKGROUND: Although receiving patients in their own health care setting is known to be associated with improved outcomes, the study was conducted to determine whether expecting patients more broadly, such as treating them with dignity, has additional patient benefits.

METHODS: Using data from the comprehensive rural area health care survey of 2001, this study aimed to examine the influence of receiving care in the rural setting on patient satisfaction with care, adherence to care, and receipt of preventive services. A mixed-methods approach was used to assess factors associated with patient satisfaction with care, adherence to care, and receipt of preventive services.

RESULTS: The study found that patients receiving care in their own health care setting were more satisfied with care, were more adherent to care, and were more likely to receive preventive services. The study also found that patients receiving care in their own health care setting were more likely to report higher levels of patient satisfaction, adherence to care, and receipt of preventive services.

CONCLUSIONS: Treating patients with dignity and being treated in their own health care setting are associated with improved outcomes, although receiving patients in their own health care setting is an important factor in improving patient satisfaction with care, adherence to care, and receipt of preventive services.
What’s at stake: Death by a thousand cuts – the accumulation of small insults and injuries that erodes trust.
Final thoughts: Validity and generalizability worries – can I have enough faith in the findings that they influence my beliefs and actions?
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