CME Program to Enable Physician Self-Assessment of Accountability for Medical Errors

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OBJECTIVES

After viewing this poster, participants will be able to: 1) recognize the need for physician self-assessment in determining individuals' and practice settings' preparedness for managing clinical errors that adversely affect patient outcomes, and 2) recognize the value of continuing medical education (CME) in countering "blame and fear" based individual- and practice-level responses to medical errors.

BACKGROUND

The 1999 Institute of Medicine (IOM) report, *To Err Is Human: Building a Safer Health Care System,* heightened awareness of preventable medical errors as a leading cause of mortality in the United States. Such errors, noted the report, were responsible for 44,000 to 98,000 preventable deaths each year, with associated costs of $17 to $29 billion.[1] In calling for radical improvements in health care safety and quality, the report placed culpability on the entire health care system (rather than on individual clinicians) and called for a four-tiered strategy for reducing errors which would include: 1) instituting a Center for Patient Safety within the Agency for Healthcare Research and Quality (AHRQ), 2) the development of both mandatory and voluntary reporting systems whereby the health care system could examine and learn from errors and "near-misses," 3) the development of explicit performance standards for licensed health care professionals, and 4) the need for safety systems within health care delivery institutions as well as leadership among individual clinicians as well as heightened responsibility on the part of patients themselves.[1]

In the decade since the publication of the IOM report, research reveals that clinicians are disclosing medical errors more consistently than in the past, but that significant clinician-level barriers to disclosure do exist.[2] Specifically, litigation-related fears, lack of institutional/staff support, providers' concern about reputation damage, fear of damaging the provider-patient relationship, and lack of training regarding how to disclose an error have been cited as barriers to effective disclosure of medical errors, particularly in hospital settings.[2,3,4]

Activity Development

pmiCME plans and implements the CME for Pri-Med live and digital activities across the country. One of our live activities is entitled, *Pri-Med Access with ACP,* which is a two-day CME-certified educational program series developed in collaboration with and co-supported by the American College of Physicians. pmiCME worked in collaboration with hand surgeon Dr David C. Ring, Hand and Upper Extremity Orthopaedic Surgeon at Massachusetts General Hospital (MGH) and Associate Professor of Orthopaedic Surgery at Harvard Medical School, to develop a 60-minute "featured session" entitled, "About My Error." The session was conducted at four (4) live meetings in 2011 and was based upon a case report that Dr Ring had published in the November 11, 2010, edition of the *New England Journal of Medicine,* in which he described his having performed a wrong-site hand surgery on a patient.[5]

The session was designed to examine three central clinical practice concepts: that participating in the educational activity would: 1) challenge learners' assumptions about the inevitability of medical errors and lead them to examine their own readiness to confront errors within their specific practice settings, and 2) that Dr Ring's personal account of disclosure could serve as a "roadmap" for clinician learners, thereby facilitating their own readiness to disclose errors when they do occur.

In the educational session, Dr Ring first described his long-list of credentials, qualifications and experience. He described the MGH surgical facilities and the high-performance team that runs the surgical program there. He then went to detail how none of this made him immune to the medical error that impacted his patient, his surgical team members and himself. He described how he discovered his surgical error and recounted the steps that he took in disclosing the error to his supervisors, colleagues, patient and patient's family. He provided explicit descriptions of his dialogues with his patient as well as his colleagues about the error and discussed practice- and department-level process changes that MGH implemented after careful analysis of the error in order to reduce the likelihood of future preventable errors; he also extrapolated these steps into global, evidence-supported measures that can be implemented in an effort to reduce errors. Dr Ring recounted the emotional toll that the error and the process of disclosing it took on him, his family and his patient and endorsed the use of system-based checklists and practice level procedures as a means of preventing errors in the clinical setting. Finally, Dr Ring presented the "clinical pearls" to enable learners to anticipate medical errors as an unfortunate but inevitable part of health care and to honestly assess their own readiness to identify, confront and disclose medical errors when they do occur. He advocated against the culture of "blame and fear" that dominates many clinical practice settings, calling for honesty on the part of individual clinicians as well as unwavering support from colleagues, institutions and institutional leaders in addressing clinical errors.

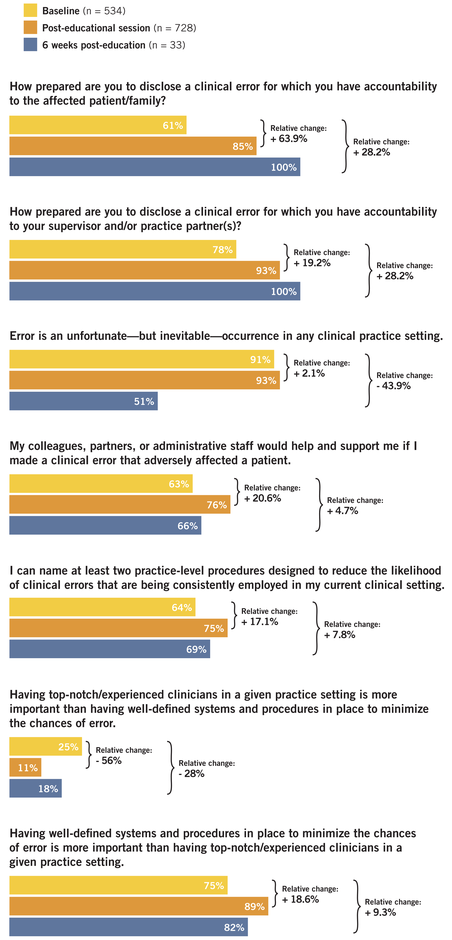
METHODS

The "About My Error" session included a learner self-assessment survey, administered by Dr Ring using the audience response system (ARS). The six-question survey was administered at the start of each educational session (in order to capture baseline responses) as well as immediately after Dr Ring's 60-minute presentation (immediate post-education). An email follow-up survey comprised of the same six questions was administered by pmiCME approximately six weeks after each activity to attendees of the live sessions (6-weeks post-education) in order to gauge retention of key learning as well as the extent to which learners' attitudes and perceptions around clinical errors were changed (and the extent to which these changes were sustained) after having attended the activity.

Outcomes surveys indicate changes in physicians' self-reported attitudes regarding medical errors

Physician responses gathered via faculty-led survey administered using an audience response system (ARS) before and immediately after the educational session* were compared analytically against responses gathered via email survey six weeks after the educational activity. Results revealed consistent changes across numerous attitudinal measures related to learners' sense of preparedness in addressing a medical error.

Reported responses indicate the percentage of learners who AGREED or who STRONGLY AGREED with the indicated statement.



RESULTS

Number of Participants

Approximately 530 physicians responded to the baseline ARS survey conducted at the (4) live meetings and approximately 730 physicians participated in the post-session ARS survey. The 6-week post-education, conducted via email, garnered responses from 33 learners (a 6% response rate).

Geographic locations included in the survey

The live educational surveys were conducted in the following four US cities: New York, NY, Hartford, CT, Houston, TX, and Philadelphia, PA.

DISCUSSION

In this poster, we presented our design and implementation of a CME-certified educational session and associated learner survey focused on the theme of physician self-assessment and accountability for medical errors.

Results of this survey support that certified continuing medical education – particularly in the format presented here (faculty leader championing medical error self-reporting) – is a valid means of engaging physicians in self-assessment around the topic of medical errors, as well as in improving physicians' readiness to confront medical errors that do occur. Learners reported both immediate and sustained increases in their own preparedness to disclose a clinical error for which they are accountable -- to the affected patient and his/her family as well as to colleagues, practice partners and/or supervisors.

These survey results also suggest that changing physicians' broader attitudes relative to the inevitability of medical errors is more difficult to accomplish with such an educational intervention. Most notably, an immediate increase in the acceptance of the inevitability of medical errors (a message underscored in the educational content) was not sustained at 6-weeks post-education and, in fact, displayed a relative decrease from baseline levels. A separate concept imparted in the session was the premise that cohesive and integrated practice settings with defined systems and procedures for addressing medical errors was a far more effective means of preventing errors than reliance on the expertise and experience of clinicians themselves. This resonated better with learners – although this measure had greater support at baseline, modest relative change was seen immediately and 6 weeks after the educational session.

Finally, survey responses to two measures designed to assess physicians' perspectives of their own practice settings indicate that physicians' perceptions of practice-level support (in terms of having defined process/procedures for preventing clinical errors in place as well as a clinical, supervisory and administrative staff that would support an accountable clinician in the event of medical error) may have been bolstered by the educational intervention (perhaps after hearing the first-hand account of the faculty's experience). This increased confidence, however, was not sustained at 6 weeks post-session, when responses returned to near-baseline levels, suggesting that barriers exist in practice-specific in-settings that do not readily support the preparation for and discussion of medical error reporting. Additional skills-based education and usable tools, including those that involve support staff, are crucial elements to enable physicians to properly report and manage medical errors.

FUTURE DIRECTIONS

Based on our findings, it is clear that CME activities can play a role in affecting physicians' readiness to address medical errors with patients and colleagues alike. For CME providers, designing educational activities that provide specific demonstrations of error disclosure and follow-up management may yield particularly effective educational outcomes. Moreover, educational activities that engage institutional leadership and well as ancillary and support staff to address the subject of preventable medical errors within specific clinical practice settings may best most effective in improving physician confidence and security in disclosing errors, thereby increasing the rate of clinical error disclosure and accountable management.

References

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