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Admit Mistakes to Curb Medical Errors

Research suggests that medical errors cause over 250,000 fatalities each year. While the medical community has made efforts to encourage error disclosure for physicians and medical trainees to improve patient safety and outcomes, the guidelines fall short when addressing the social psychology of how errors are disclosed and how physicians and medical trainees manage the consequences of those errors.

A paper published in Medical Education calls for better education and training that focuses on the psychological challenges coinciding with errors and error disclosure.

Author Neha Vapiwala, MD, an associate professor of Radiation Oncology and vice chair of Education in the Perelman School of Medicine at the University of Pennsylvania talks about how there is a need to transform the culture of error disclosure from one that is punitive to one that is both restorative and supportive. She also highlights the importance of tending to the psychological challenges that medical professionals face when there is a need to disclose an error.

The Disclosure, Apology and Offer initiative has made some gains in creating a culture of transparency in healthcare but most of the efforts in this model focus on the legal and financial aspects of a medical error and disclosure. They do not address other possible barriers such as fear, shame and guilt. As Dr. Vapiwala points out, these psychological factors are more difficult to overcome, especially today when the social media can be used to review and scrutinise healthcare providers in public forums. Any slip-up could potentially damage someone's career.

Study authors identified two main cognitive biases that tend to hinder error disclosure. These include the Fundamental Attribution Error (FAE) which refers to overestimating one's role in a given situation and Forecasting Error (FE) which refers to overestimating the impact and duration of negative consequences.

"Overcoming these biases is akin to suppressing a reflex. It requires self-awareness, practice, and most importantly, education and training," said Dr. Vapiwala.

Learning from the examples of the airline industry, the authors suggest strategies that could help overcome these patterns of thoughts and would help utilise elements of social psychology to transform the culture of error disclosure. These strategies include incorporating standardised patients (SPs) who can simulate as patients and help practice difficult patient encounters and model interactions with family members, peers and administrators. SPs can mimic the psychosocial elements of error disclosure such as guilt, feelings of ineptitude and a fear of repercussions.

Another useful tool could be virtual reality as it offers immersive and realistic technology to supplement traditional curricula. Virtual reality is also much more cost-effective than SPs.

It is important to note that both SP and VR are simulations and while they can provide an excellent foundation, they are still not a substitute for a real-world situation when healthcare providers are forced to confront their mistake and face potential consequences.

The authors highlight the need to implement a professional standard for trainees that would include a formal evaluation of the skills that are needed to disclose and cope with medical errors. They also believe that there needs to be a cultural change, not just among trainees but at every level of medical practice.

"Administrators must make a shift from asking 'who is at fault' to asking 'why' and 'how' did a situation occur, creating a culture that embraces error disclosure and seeks to solve the many systematic factors that lead to an error in the first place. This approach will not only normalise error disclosures but also help us better understand why they happen so we can prevent more of them in the future," said Dr. Vapiwala.

Source: University of Pennsylvania School of Medicine
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