Identifying Medical Errors: An Interactive and Case-Based Workshop

Matthew Parrish, MS4

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BRODY SCHOOL OF MEDICINE

8th Annual Medical Education Day

Disclosures

- None

Collaborative Team Members

- Cassandra Bradby, MD
  - Assistant Professor, Department of Emergency Medicine, The Brody School of Medicine at East Carolina University
  - Project Mentor and Advisor
- Jennifer Stahl, MD
  - Assistant Professor, Division of Critical Care, Department of Internal Medicine, The Brody School of Medicine at East Carolina University
  - Project Mentor and Advisor

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Background

- Medical errors are unfortunately common and often go unrecognized.

- *To Err is Human*, 1999
  - Estimated 98,000 annual US healthcare deaths were reportedly due to medical errors[1]

- Annual deaths due to medical errors:
  - Upwards of 250,000 per year or approx. 10% of deaths in the US healthcare system[2]

Rationale

- Medical education often lacks experience in **identifying** and **disclosing** medical errors
  - Students are shielded from disclosing errors to patients
- With little education, physicians are forced to rely on experience and trial and error
- *"…how can we help medical student gain experience with identifying and disclosing medical errors?"*

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Project Learning Objectives

1. Identify medical errors in patient care across interprofessional settings
2. Discuss the types of communication related errors that occur in the patient care setting
3. Review strategies and systems to prevent medical errors.
4. Develop skills and practice communication of medical errors to patients, families, as well as interprofessional.
5. Practice debriefing and discussing a medical error and the aftermath.

Methods

Case-based workshop:
1. Didactics
2. Author created video simulation
3. Participant Role play

Likert Scale pre and post-surveys administered

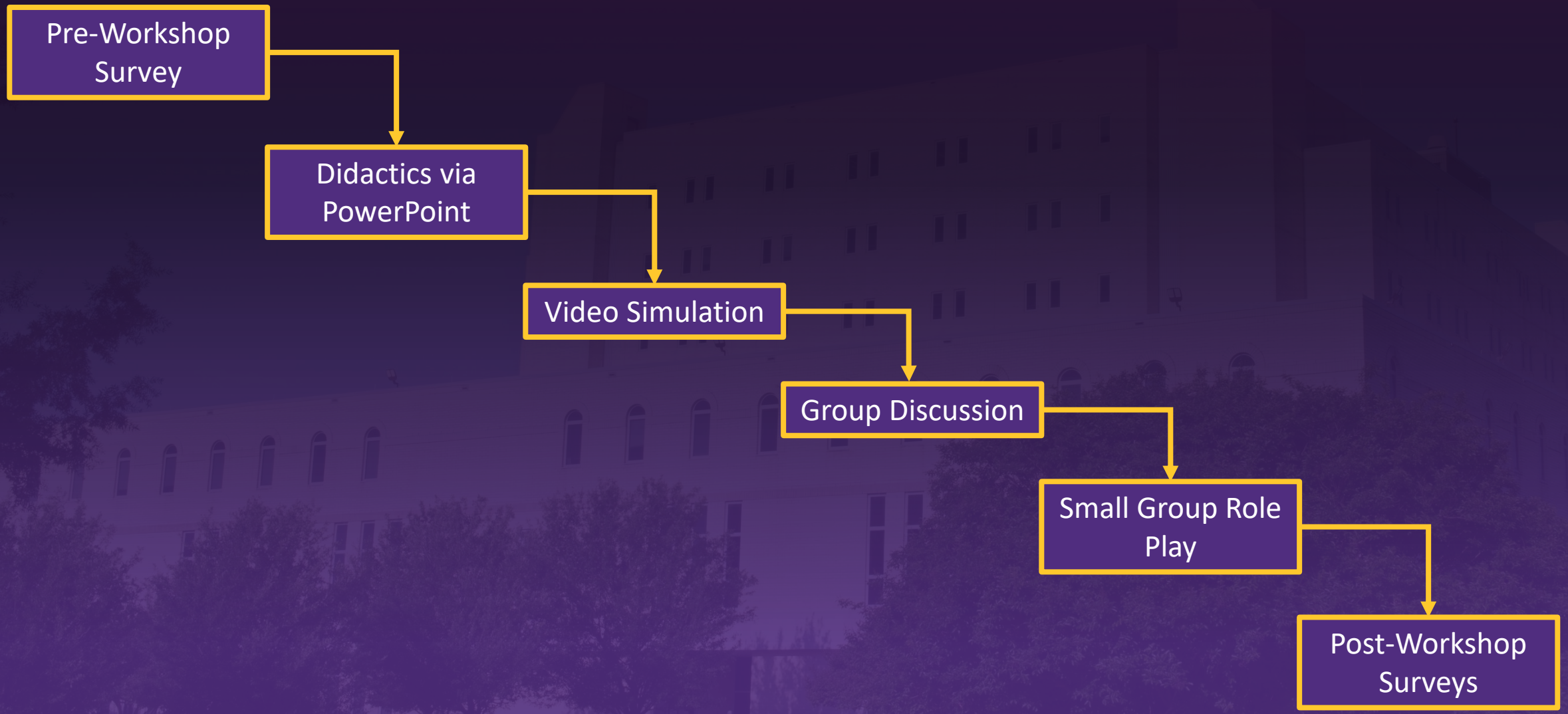
Workshop piloted to 10, M4 students to assess feasibility

Feedback solicited:
1. Increase to 90 mins
2. Trim PowerPoint
3. More time for role play

Workshop administered during Transitions to Residency course

18 graduating M4 students completed the workshop

Workshop Format



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Results

Table 1 Average Likert Scale Responses

Prior to this Workshop (N=28):	Average response out of 5[a]	After completion of this workshop (N=26):	Average response out of 5[a]	P-Value[b]
How knowledgeable are you about the different types of medical errors?	2.89	How knowledgeable are you about the different types of medical errors?	4.19	<0.001
How comfortable are you in disclosing medical errors to patients and their families?	2.46	How comfortable are you in disclosing medical errors to patients and their families?	4	<0.001
After completing this workshop, I hope to be more knowledgeable and comfortable about identifying and disclosing medical errors.	4.57	After completing this workshop, I am more knowledgeable and comfortable about identifying and disclosing medical errors.	4.42	<0.001

[a]5-point Likert Scale with 1 indicating not comfortable/no prior knowledge and 5 indicating extremely comfortable/Very knowledgeable

[b]Two-sample T-Test use as N of pre-workshop survey is different from post-workshop survey.

Results

Table 2 Post-workshop Feedback Responses

Survey Question (N=26)	Average Response out of 5[a]	Percent scoring 4 or 5
After this session, are you more comfortable in identifying patient errors?	4.42	96.15
Did this session increase your ability to disclose medical errors to patients?	4.35	92.31
Will you make changes to your practice based off of this Patient Safety session?	4.42	92.31
Do you feel more sessions centered around patient safety, identifying medical errors, and disclosing errors to patients should be incorporated into medical education?	4.65	96.15
How beneficial was this session to your role as a physician in the future?	4.54	96.15

[a]5-point Likert Scale with 1 indicating strongly disagree and 5 indicating strongly agree

Discussion

- Workshop was developed out of the need for more patient safety and quality improvement related medical education
  - Mandated by the LCME and ACGME
- Student knowledge and comfort with disclosing a patient error improved
  - Practice disclosing errors was best benefit
- Participants generally felt that the workshop was relevant to their role as future physicians
- Participants noted that they would make a change to their practice after this workshop.

Lessons Learned

- Students are eager to practice!
- Using multiple learning modalities is key.
- Disclosing medical errors takes practice.
- Apologizing effectively is a skill to be **learned** and **practiced**.
- Four components of an effective apology include:
  1. Acknowledgment
  2. Explanation
  3. Expression of remorse, shame, and humility
  4. Reparation

Next Steps

- Boost numbers
- Expansion to include to residents
- Curriculum implementation needs assessment?

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Citations

1. Institute of Medicine (US) Committee on Quality of Health Care in America, Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err is Human: Building a Safer Health System*. Washington (DC): National Academies Press (US); 2000.
2. Makary MA, Daniel M. *Medical error-the third leading cause of death in the US*. BMJ. 2016;353:i2139. Published 2016 May 3. doi:10.1136/bmj.i2139

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