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Authors
Allison, TA
Sudore, RL

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Disregard of Patients’ Preferences Is a Medical Error

To physicians, what is encompassed by the term medical error may seem self-evident. It is the surgery performed on the wrong limb, the medication given to the wrong patient, or the medical test that falls through the cracks. Medical errors involve acts of omission as well as commission. During the past decade, we have attempted to systematically address diagnostic, treatment, and equipment-related errors and improve patient safety in medicine. Public awareness of the health care system’s efforts to improve patient safety has been raised through the groundbreaking Institute of Medicine report calling for system-level change, a physician-authored New York Times bestseller on patient safeguards through checklists, and a privately instigated campaign to save 100,000 lives by reducing medical errors across 3000 American hospitals. However, do we, as clinicians, recognize the full scope of what may constitute medical errors in practice?

Despite evidence of a lapse in patient safety, there is some good news. The findings reported by Heyland et al demonstrate that engagement in advance care planning has increased dramatically during the 2 decades since the SUPPORT study. A shift in attitudes about advance care planning in the community seems to have occurred, possibly through public health campaigns and the media. Advance care planning involves many separate behaviors, such as identifying and asking someone to be a surrogate decision maker, identifying individual goals, communicating those goals, and preparing for medical decision making. Deciding about specific treatment preferences, such as cardiopulmonary resuscitation and intubation, were discordant with current patient wishes. In any other area of medicine, this would be viewed as an egregious “failure of communication” error.

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The current study is consistent with these findings and adds some significant contributions. First, we have attempted to systematically address diagnostic, treatment, and equipment-related errors by creating a medical error matrix that involves the wrong patient, the wrong procedure, and the medical test that falls through the cracks. Medical errors involve acts of omission as well as commission. During the past decade, we have attempted to systematically address diagnostic, treatment, and equipment-related errors and improve patient safety in medicine. Public awareness of the health care system’s efforts to improve patient safety has been raised through the groundbreaking Institute of Medicine report calling for system-level change, a physician-authored New York Times bestseller on patient safeguards through checklists, and a privately instigated campaign to save 100,000 lives by reducing medical errors across 3000 American hospitals. However, do we, as clinicians, recognize the full scope of what may constitute medical errors in practice?

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hospital admissions but rather asked patients about their preferences for care during the current hospitalization and compared those preferences with the code status orders in the concurrent medical record.

What is alarming about this study, however, is that it demonstrated the disconnect between what patients and families discuss with one another during an acute illness at the end of life and what information is translated into the medical record during hospitalization. As with all medical errors, there is likely a complex interplay of factors leading to this disconnect of documented patient preferences, factors involving patients, families, clinicians, and the health care system. However, the study findings do suggest one possible factor: our current safety procedures and checklists have not yet overcome the reluctance of clinicians to ask difficult questions about treatment wishes when confronted with patients who are seriously or terminally ill.

This study raises multiple questions. How frequently are providers asking about end-of-life treatment preferences both before and during a hospital admission? How often do patients remember these conversations? How clearly are clinicians hearing patients and their loved ones? To what extent are these discussions actually taking place but not being documented or being documented incorrectly? To what degree are providers relying on past orders or old advance directives for code status information, an unacceptable shortcut in the care of patients near the end of their lives? Because patients do seem to be engaging in advance care planning and making decisions about treatment preferences in the absence of discussions with physicians, how can we be sure that patients and their surrogate decision makers understand their individual prognoses and the consequences of their treatment preferences?

Discussions about goals of care and code status constitute a medical procedure every bit as important to patient safety as a central line placement or a surgical procedure. Much as we have developed systems to improve patient safety in surgical procedures, we need to develop systematic approaches to discussing patient values and goals of care. The miscommunication of patients’ end-of-life preferences demonstrated by Heyland et al4 implies that goals-of-care discussions are not occurring regularly. In a recent study of patient-physician communication at hospital admission, Anderson et al9 observed that some physicians appear uncomfortable with these discussions. They also identified reproducible communication techniques and behaviors (acknowledging the possibility of death and facilitating discussion of patient concerns) that may lead to a better standard of practice. Although several aspects of the health care system will need to be addressed to fix this common and consequential medical error, standardizing both the content of clinicians’ discussions and the documentation of patient preferences may be an important first step. If we are truly committed to improving patient safety and reducing medical errors, then we have found a worthy new target: the inpatient code status discussion and accurate medical documentation of real-time patient preferences.

Theresa A. Allison, MD, PhD
Rebecca L. Sudore, MD

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Author Affiliations: San Francisco VA Medical Center (Drs Allison and Sudore), and Division of Geriatrics, Departments of Medicine (Drs Allison and Sudore) and Family and Community Medicine (Dr Allison), University of California, San Francisco.

Correspondence: Dr Allison, San Francisco VA Medical Center, 4150 Clement St, PO Box 181-G, San Francisco, CA 94941 (Theresa.Allison@UCSF.edu).

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