What is the main cause of avoidable harm to patients?

PERSONAL VIEW Gordon Caldwell

As a hospital consultant I lead a team that helps patients to recover from illnesses such as myocardial infarction, pulmonary embolism, and gastrointestinal haemorrhage. I do not want to harm patients, make their illnesses worse, or unnecessarily prolong their stays in hospital.

Since attending the International Forum on Quality and Safety in Healthcare in Berlin in March 2009 I have been thinking and working hard to improve the care that my team of doctors and nurses give to inpatients. We have used a “considerative checklist” to ensure that we do everything we can to reduce the chances of pulmonary embolism, sepsis from meticillin resistant Staphylococcus aureus, and diarrhoea from Clostridium difficile, among several other types of avoidable harm. We have greatly improved our attention to detail and safety in writing prescription charts. All this has helped us to be more careful to avoid harming patients during treatment.

However, I believe that there is an even more important avoidable harm, one generally unacknowledged: incorrect diagnosis. When an obviously ill patient is admitted to hospital the medical team formulates a “working diagnosis.” At this point the diagnosis is uncertain, but the patient is treated as if the working diagnosis is correct. Over the next days the patient gets better and the working diagnosis is confirmed and becomes the diagnosis. But if the patient doesn’t improve we think again and consider whether the working diagnosis was wrong.

Bronchopneumonia can easily be confused with pulmonary embolism or cardiac failure, and the treatments are quite different. Treating all three conditions at once is suboptimal and potentially dangerous, so we try to limit the treatments. The consequences can be significant. A patient treated according to a working diagnosis of pulmonary embolism who actually has pneumonia may die of untreated pneumonia.

The time taken to reach the correct diagnosis may be crucial for the patient’s chance of survival. Over my career I have seen many errors in the working diagnosis causing harm to patients and even death.

Little consideration seems to have been given to how doctors make and refine a patient’s working diagnosis and treatment plan. The working diagnosis is reached by deliberating on information from interviewing and examining the patient, old notes, referral letters, drugs lists and test results, and the time course of the illness. Even if the principal working diagnosis is straightforward, the patient may have multiple pathologies. The main working diagnosis may be a fractured hip, but the patient may also have atrial fibrillation, be taking warfarin, have hyperglycaemia, and be known to have mild dementia and to have been treated for breast cancer.

How do we balance all these factors and swiftly get the patient to theatre for hip surgery?

I believe that we have not thought about the best places, the physical and psychological environments, in which doctors should do this complex clinical thinking. Often it occurs in small hot rooms subject to constant interruption or even in ward corridors without easy access to laboratory results.

Serious errors in working diagnoses made among patients under my care occurred because the old medical notes were unavailable or very disorganised; it was difficult to see important blood test results at the same time as hearing the history from the junior doctor; an old electrocardiograph was not easy to find; or there was too much pressure to get the round done and to get patients out of hospital. I have seen myself on video miss vital information in what a doctor was saying during a post take ward round because I was interrupted by another doctor asking a trivial question.

Through fear of litigation and losing face and simply because of the difficulty of explaining the complexity of what we do every day, we have failed to let our patients and society know about this very important problem. We must design our working spaces and information systems to maximise doctors’ ability to see, understand, and deliberate on the information needed for more precise diagnosis. We must allow clinicians enough time to be careful in diagnosis, treatment planning, and treatment review. We must urgently consider how to provide rooms, time, and information for doctors to do the most difficult part of their job and the part most prone to error: the clinical thinking in making the working diagnosis and treatment plan.

Perhaps we need to be like pilots and have a “diagnostic cockpit.” Our work is more dangerous than theirs.

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French martyrs

Considering how trivial are the withdrawal symptoms from opiates (by comparison with those from, say, alcohol), they have given rise to a large literature. Indeed, it may be thought that this literature is itself partly responsible for the suffering caused by withdrawal, because by dramatising that suffering it increases the anticipatory anxiety that is so large a proportion of the pain of opiate withdrawal.

Two French authors of somewhat mixed reputation, Jean Cocteau and Françoise Sagan, wrote accounts of their withdrawal from opiates undertaken in specialised clinics. By the mere fact of doing so they were investing the process with a significance well above the ordinary. No one, after all, would write a book entitled My Head Cold: The Story of a Recovery.

Cocteau published his Opium: The Diary of a Detoxification in 1930; in it he claimed, on very dubious grounds, that smoking opium was on a completely different aesthetic and philosophical plane from the vulgar habit of injecting synthetic derivatives of opium. Everyone, I suppose, is inclined to see higher purposes in the role of doctors in society. The work under review does not seem an adequate or even plausible statement of other circumstances, this does not seem an adequate or even plausible statement of her case.

Oddly enough, these pains did not reappear once the Palfium was withdrawn. She wrote: “Artificial paradise of no-suffering. I will never know you again. I will never again see [the nurses] Fifi or Felix cleverly decapitate those little ampoules with blue writing, that seem so wise, but which are not.” It is obvious that the suffering of which she speaks here is not physical, caused by injury, but existential.

The use of the passive voice is another giveaway: “I was sufficiently intoxicated that a stay in a specialised clinic was necessary.” Not: “I intoxicated myself sufficiently that I decided to stay in a specialised clinic.”

Sagan was hooked by Palfium in the same way as a blue marlin was by Ernest Hemingway.

At least she didn’t use the trope of chains and slavery that has been current ever since De Quincey and Coleridge. On the other hand, she considered herself some kind of martyr to her own suffering: “I don’t want to be martyred in this way.”

In what way did her martyrdom manifest itself? According to what she wrote, by her own childish behaviour, caused by withdrawal.

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Bad medicine: specialisation

“You're too good to be a general practitioner,” someone once told me. I never knew whether this statement was a slight or a compliment. In truth general practice chose me, because of particular personality traits (faults), not the other way round. But generalism is in decline, with the assent of the specialists. Gone is the widely experienced general physician, and general surgeons are replaced by an ever expanding list of “ologists” who now seem to be almost single cell specialists.

This drive to specialism is mirrored across all the allied medical professions. In the past district nurses dealt with everything, and all referrals simply went through them. But we have seen the expansion of specialist community nurses in palliative care, diabetes, and learning difficulties and tissue viability nurses and a raft of liaison nurses. In the hospital the number of specialist nurses seems to be rising exponentially. Why has this happened? The primary driver has been the attempt to improve the technical aspects of medical care; most of medicine, however, is not technical. There are secondary drivers too: generalism has a low status, there is more money in specialising, and modern society has come to venerate the specialist, a proxy for “better.”

We are passing the tipping point: increasing specialisation is harming care. Specialism is breaking down continuity, promoting the “not my clinical area” that fuels endless internal specialist referrals and wasting time and resources. Add to this the churning “ching ching” that characterises private medical practice around the world. Many health professionals are now unwilling to make even basic decisions outside their specialty, leading to a creeping paralysis of medical systems.

Specialist “opinion” now dominates guideline development, which often has just a token representation of generalism, leading to the blinkered extrapolation of unrepresentative trial data into general populations. Specialisation is promoting yet more medical tribalism, the gangs aggressively defending their clinical turf and unwilling to accept criticism. Specialist opinion has become law. We have lost perspective, and the obvious solutions to health problems have become obscured.

The greatest threat is the decline in generalism in the developing world, with its “big health” problems. These countries desperately need public health initiatives and small teams of local generalists: doctors, surgeons, and nurses. The temptation has been to mimic the specialisation fad of the developed world, distorting priorities and wasting scarce medical resources. The time has come for an international moratorium and non-proliferation of medical specialisation. We are undermining the confidence and position of the generalist, and soon there will be no one left good enough to call a generalist.

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Being loved

After observing my chairing skills at a conference on international health recently, a colleague from New Zealand told me that I came across as “being loved.” This surprising assessment stopped me in my tracks: I was hoping she would notice that I had deftly fielded the difficult questions, kept the meeting to time, and interjected amusing comments to lessen the pain of endless PowerPoint presentations. Pink faced, I asked her to explain.

“You seem to be confident in who you are and so were engaged in the debate and not yourself. And this can only happen when you are secure and loved.”

I was fortunate with my parents and siblings and generally, though not always, successful in my friendships; and my children and spouse are forgiving and generous. But explaining, justifying, and codifying why we are loved is pointless. We are not loved because we deserve it. Mostly we are loved regardless; we are loved for who we are.

A child who is not touched will probably die. Lack of love permanently damages many children who have been institutionalised. They gather around any available person like heat seeking missiles, their every fibre grasping for emotional or indeed any attention. Or they hang back with empty eyes and shut down in desolation and despair. Such a child will go into the world as an adult forever and disastrously seeking what they have lost.

Adults who have not been loved in childhood or who are lacking in love now also seek to fill their gaps.

We miss love when it is gone. Pining long for those we have lost is common. Dying of a broken heart is rarely recorded on a death certificate, yet we all know it happens. Every person fears that they will die alone and unnoticed, that regardless of worldly assets no one will be there at the end to bury them and to shed tears. The urge to pass on a legacy of love to the next generation is strong.

It is surprising, even embarrassing, when our being loved comes up in professional settings, yet we know deep down that it is our bedrock. Not shy on our CVs about degrees, positions held, committees chaired, and papers written, we extirpate love from our bedrock. Not shy on our CVs about degrees, positions held, committees chaired, and papers written, we extirpate love from our personal records. Our track record in love will be kept professionally private till the very end: a subtle, emotionally bleached reference in a BMJ obituary, perhaps a few words on a gravestone. “Deeply missed. Much loved.”

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