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‘Would You Have Done Something Differently?’ a Novel Marker to Identify Error in Emergency Medicine

Kiersten L. Gurley MD, Richard E. Wolfe MD, Shamai A. Grossman MD

BIDMC

Introduction/Problem

- Chart review to assess physician decision making is widely used
- One needs to distinguish between error (failure to follow the standard of care) vs medical judgement.
- Errors require that a particular or general rule be broken whereas medical judgement allows for differences in how two physicians may reasonably approach a situation.
- Attribution and self serving bias may impair reviewers’ ability to distinguish between error and medical judgement.

Aim/Goal

To compare error classification based on the question ”did an error occur” to “would you have done something differently (even if the reviewer would not classify the care as an error) ” as a marker for identifying consensus committee classified error.

The Team

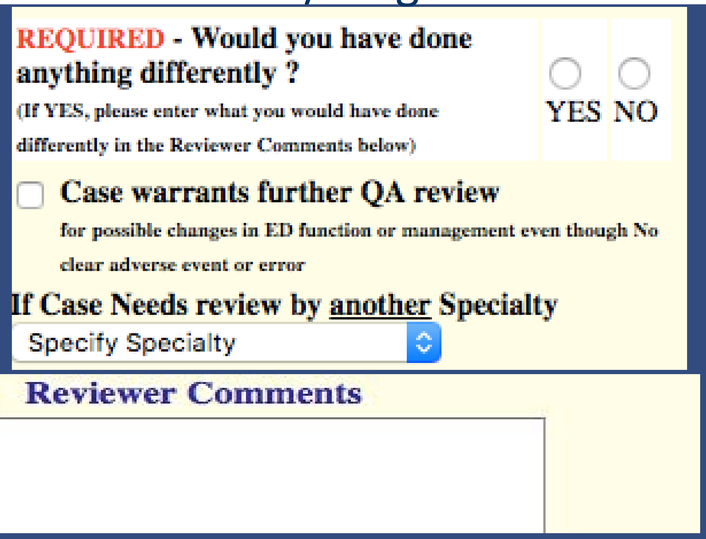
- Kiersten L Gurley MD QA Fellow, Attending physician BIDMC Boston and at Mount Auburn Hospital Cambridge
- Richard E Wolfe MD Chief Emergency Medicine BIDMC Boston
- Shamai A Grossman MD MS Vice Chair for Health Care Quality, Attending physician

The Interventions

Study Design

- Prospective, observation cohort study of consecutive patients presenting to an urban, tertiary care academic medical center, annual volume 57,000 between 1/2008 and 11/2017
- Cases are identified via either automatic identification by the QA dashboard or via a physician concern or patient complaint;
- Cases are assigned randomly with load balancing to a trained physician reviewer that was not involved in the care of the patient
- After reviewing the case documentation, reviewers then answer seven standardized questions according to an 8pt Likert scale; to asses for the possibility of error and adverse events score ≥4
- Reviwer were asked 2 questions of all reviewers in an anonymous fashion
  - Question 1” Did an error occur?”
  - Question 2 ”Would you have done something differently?”.
- The 20 member QA committee makes a final determination about whether error or adverse events occurred based on consensus. (gold standard outcome) blinded to results of question #2

Results/Progress to Date



Example of Questionairre required of all reviewers

For more information, contact:

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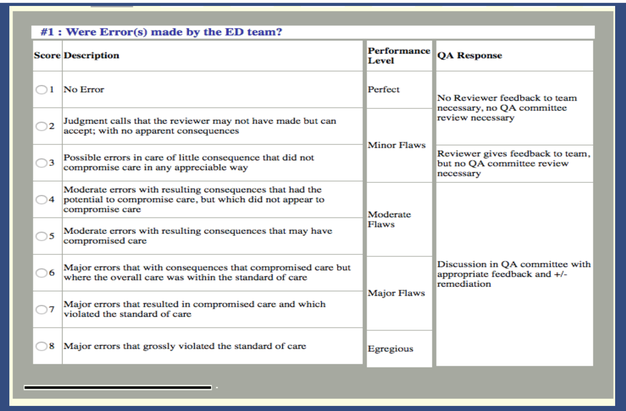
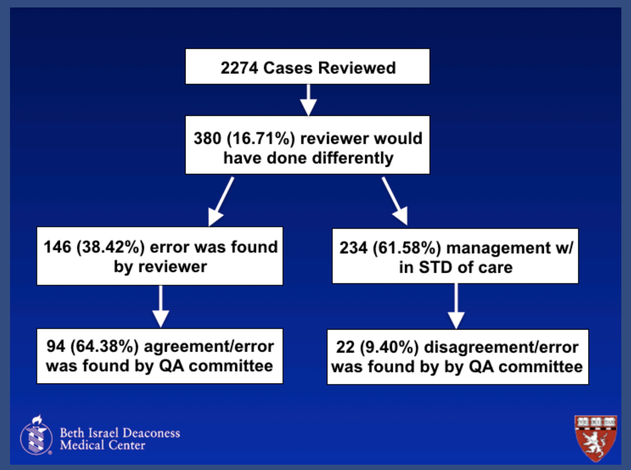
More Results/Progress to Date



#1 : Were Error(s) made by the ED team?

Score	Description	Performance Level	QA Response
1	No Error	Perfect	No Reviewer feedback to team necessary, no QA committee review necessary
2	Judgment calls that the reviewer may not have made but can accept; with no apparent consequences	Minor Flaws	
3	Possible errors in care of little consequence that did not compromise care in any appreciable way		Reviewer gives feedback to team, but no QA committee review necessary
4	Moderate errors with resulting consequences that had the potential to compromise care, but which did not appear to compromise care	Moderate Flaws	
5	Moderate errors with resulting consequences that may have compromised care		
6	Major errors that with consequences that compromised care but where the overall care was within the standard of care	Major Flaws	Discussion in QA committee with appropriate feedback and +/- remediation
7	Major errors that resulted in compromised care and which violated the standard of care		
8	Major errors that grossly violated the standard of care	Egregious	

Likert Scale as an example of #1 of 8 questions asked of all reviewers related to each case



Total Error rate found by QA Committee was 5.10% (116/2274)

- Asking the question ‘Would you have done something differently?’ of EM trained QA case reviewers is a novel marker to identify error in EM.
- This may be an underutilized QA tool, reducing the risk of attribution bias in single reviewers assessment of physician performance.
- Physicians may be more likely to say they would do something differently then assign error to a colleagues case.

Lessons Learned

- Small sample size
- Single institution test site
- Need for internal and external validation
- Lack of long term follow up

Next Steps

- **Future Directions**
- **To compare adverse event/outcome rates**
- To look for patterns in types of error found
- To validate committee peer review as the gold standard

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