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The challenges of providing feedback to referring physicians after discovering their medical errors

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ABSTRACT

Background: Physicians are encouraged through formalized systems to discuss their own errors with peers for the purposes of quality improvement. However, no clear professional norms exist regarding peer review when physicians discover errors that occurred at other institutions before referral. Our objective was to determine specialist physicians' attitudes and practices regarding providing feedback to referring physicians when prereferral errors are discovered.

Methods: We conducted semistructured interviews of specialists from two National Cancer Institute–designated Cancer Centers. Thematic analysis of transcripts was performed to determine physicians' attitudes toward the delivery of negative feedback regarding prereferral errors, whether and how they communicate these errors to referring physicians, and perceived barriers to doing so.

Results: We purposively sampled specialists by discipline, gender, and experience level, who described greater than 50% reliance on external referrals ($n = 30$). Specialists believed regular, explicit feedback was ideal, but the majority of participants reported practices that did not meet this standard. While there were some structural barriers to providing feedback (lack of time or contact information), the majority of barriers were internal psychological concerns (general discomfort with providing negative feedback, fear of conflict, or defensive reactions) or fears about implications for future referrals or medicolegal risk.

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Conclusions: Policies and interventions that structure the approach to this sometimes difficult, yet critically important, opportunity for reducing medical errors warrant investigation as potential mechanisms by which to improve consistency and quality of care while maintaining positive professional relationships.

Introduction

Preventable medical errors represent a major public health problem.[1] To prevent future errors, improve disclosure, and mitigate malpractice risks, organizations have adopted strategies for early transparent communication and emphasized quality improvement through peer review. These principles are incorporated into the Agency for Healthcare Quality Research Communication and Optimal Resolution (CANDOR) process, which facilitates 1) transparent communication, 2) learning to prevent errors, and 3) achieving optimal financial or other resolution with patients and families.[2,3]

Incident reporting systems, root cause analyses, and Morbidity and Mortality (M and M) conferences are mechanisms by which institutions can investigate errors and identify areas for system, process, or provider improvement.[4] M and M conferences are considered critical to provider education and have been mandated by the Accreditation Council for Graduate Medical Education since 1983.[5] In an increasingly fragmented health care system, providers may discover other physician's errors that are previously unknown to the patient and responsible provider. Application of the CANDOR principle "learning to prevent errors" may be particularly complex when the discovering and responsible physicians' practice in different facilities. What physicians should do in this scenario is unclear. There are no guidelines or clear professional norms to guide physician practice or mechanisms by which discovering physicians can ensure responsible physicians or institutions learn from these errors. Further, some believe discussing other physicians' errors is unfairly judgmental and unprofessional.[6,7] Concerns for medicolegal implications and referral relationships, as well as fairness to physicians who work in different environments may also complicate the discovering providers' willingness to communicate with responsible providers and institutions.

This work focuses on specialist communication with referring physicians to provide constructive feedback regarding prereferral errors. To understand whether and how specialist physicians provide feedback and their rationales for doing so, we conducted interviews of cancer specialists from National Cancer Institute–designated centers. Our specific research questions in this study were (1) What are specialists' attitudes and practice patterns regarding feedback to referring physicians about prereferral errors?; and (2) What barriers do specialists face in providing negative feedback? We selected a qualitative interview approach to broadly explore these research questions for which few data exist to date.

Methods

We conducted semistructured interviews with cancer specialists from two National Cancer Institute–designated cancer centers between July 2015 and August 2016. The interviews sought to obtain an understanding of specialists' experience with prereferral error discovery and included their attitudes and practice patterns regarding providing feedback to referring physicians about these errors, as well as barriers they encountered in providing each (see Interview Guide in Supplementary Material). Institutional Review Boards of participating centers approved the study. All participants verbally consented before the interviews were conducted.

We recruited participants using purposive sampling (gender, specialty, and experience level) based on flyers distributed by email, word of mouth, and professional contacts. Participants were eligible if they were cancer specialists (medical oncology, radiation oncology, surgical oncology, or surgical subspecialty with advanced oncologic training) with at least 50% of their practice volumes dependent on external referrals. We continued interviews beyond the attainment of thematic saturation (i.e., no new information was forthcoming).[8]

Concepts of feedback were discussed among investigators and a preliminary interview guide was constructed. Several iterations were generated based on content validity, face validity, presentation of information, ability of participants to interpret essential information, and ability to complete the interview within the anticipated time. Three pilot interviews were completed and the interview guide was slightly modified to its final form.

Interviews began by defining for study participants the terms medical errors, adverse events, and feedback. Definitions of medical errors and adverse events developed by the Federal Quality Interagency Coordination Task Force were presented.[9] An error was defined as "failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim." An adverse event was defined as an injury that was "caused by medical management and resulted in measurable disability." Participants were encouraged to discuss unambiguous errors or significant deviations from consensus guidelines, rather than situations where clinical uncertainty allowed for practice variation. Examples of these errors have been previously reported and included missed diagnosis leading to tumor progression, curative intent major abdominal surgery without staging in a patient with metastatic disease, improperly oriented excisional biopsies necessitating complex closures at the time of definitive resection and incorrect chemotherapy doses based on dose miscalculations.[10] Feedback was defined as discussing the error with the error and its implications with the responsible (referring) physician.

Audiotapes were transcribed verbatim. Coding for major themes was conducted independently by two investigators (L.A.D. and J.M.) and discussed to consensus iteratively using thematic analysis.[11] Some potential codes were anticipated (a priori); most were emergent. In a few instances, we compared and counted cases (participants) to provide transparency regarding preferences of various dimensions of a theme.[12]