

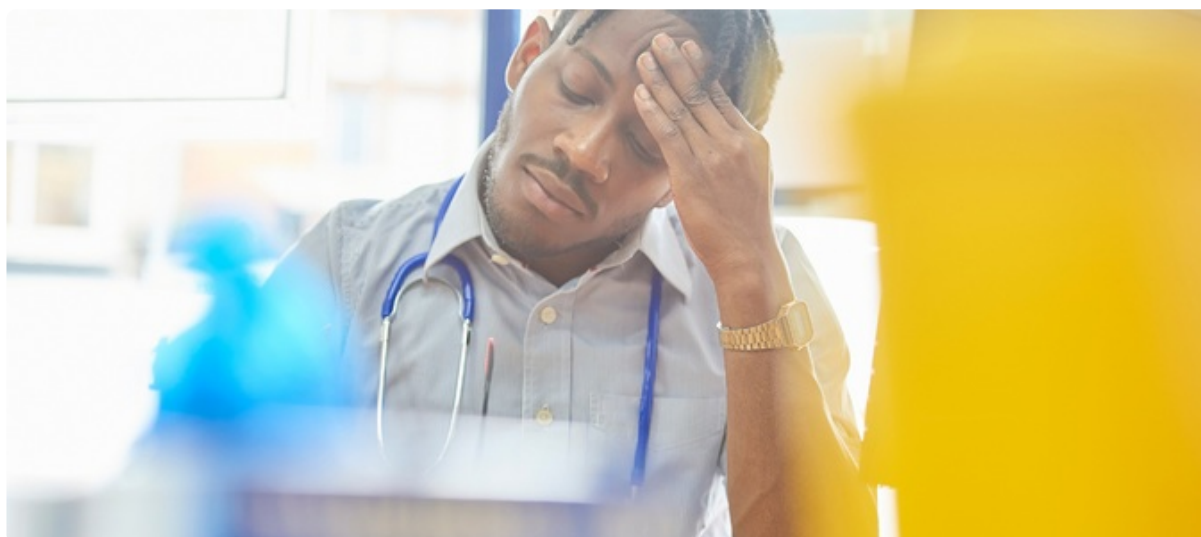
# Managing Errors & Perfectionism in Healthcare

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A healthcare error's emotional toll can be significant and include several negative emotions, including guilt, shame, anxiety, fear, and in extreme cases, depression. The pervasive culture among healthcare professionals to strive for perfection and the burden of blame in medicine are significant contributing factors to these harmful effects. In the face of adverse patient outcomes, a sense of isolation and a lack of peer and organisational support can also be responsible and impact wellbeing, burnout, and decreased job satisfaction.

Healthcare environments can be busy, noisy, or simply chaotic, thus becoming fertile grounds for diagnostic, procedural or medication errors that may place patient care at risk<sup>1</sup>. These complex conditions inherently lend themselves to potential situations which may put clinicians at risk of receiving a complaint resulting in a civil claim, investigation and/or regulatory action by AHPRA, the Medical Board or one of the State-based Health Care Complaint Commissions.

The first step to decreasing clinical errors is to understand how and when they are more likely to occur. The literature asserts there are cognitive and non-cognitive (system based) factors are at play, which synergistically combine to make a healthcare practitioner more prone to medical or dental errors<sup>2</sup> (Table 1). The inherently fast and unpredictable nature of emergencies, technical failures and equipment problems, frequent interruptions, policies, and procedure that may actively create error-prone situations or unnecessary delays, as well as failed oversight of system related issues are all potential scenarios where things can go wrong.

At the same time, cognitive errors due to flaws in critical thinking, clinical reasoning and decision-making can be at play<sup>3</sup>.

System related factors		Example
	Policy and procedures	Policies that fail to account for certain conditions
	Inefficient processes	Absence of expedited pathways
	Teamwork or communications	Failure to share needed information or skills
	Management	Failed oversight of system issues.
	Expertise unavailable	Required specialist not available in a timely manner

	Training and orientation	Clinicians not made aware of correct procedures or policies
<b>Cognitive related factors</b>		
	Faulty knowledge	Knowledge o diagnostic skills for certain conditions
	Faulty data gathering	Ineffective or incomplete history taking and physical information, failure to screen.
	Faulty synthesis & information processing	Lack of awareness or consideration of relevant factors in a patient's situation, under or overestimating the salience of a finding, failed heuristics, misidentification of a symptom or sign, faulty interpretation of a test result
	Faulty verification	Premature closure (failure to consider other possibilities once a diagnosis has been made), failure to order or follow up a test, failure to gather other useful information to verify diagnosis.

Table 1: Cognitive and non-cognitive factors associated with medical errors. Adapted from Graber & Franklin (2005)<sup>4</sup> .

## Strategies to minimize cognitive and non-cognitive errors and mitigate your clinico-legal risk<sup>5,6</sup>

- Firstly, remember that mistakes happen. We are only human; errors will inevitably occur.
- Use checklists, Guidelines and Algorithms. Cognitive function is affected by levels of stress and fatigue. Checklists reduce the reliance on memory and thus minimise cognitive errors. They can assist with:
  - Diagnosis
  - Ensure standardisation
  - Provide reminders of evidence-based practice.
- Obtain additional expertise through consultation. Consulting and learning from more senior clinicians give you access to the collective wisdom gained through group decision-making.
- Develop a reflective practice. Also known as a diagnostic “time out,” this strategy aims to foster metacognition, whereby a practitioner re-evaluates an experience and considers alternatives to produce insights that may lead to change in behaviours in future practice.
- Develop an understanding of the clinical reasoning process and its inherent flaws. This strategy involves knowing the major heuristics and biases and how they may lead to cognitive error.
- Adopt Heuristic-based strategies. Also known as ‘cognitive forcing strategy’, this debiasing techniques encourages you to deliberately choose analytic reasoning in situations where an intuitive approach may lead to error.
- Avoid counterproductive responses. Circular thinking, emotional repression and avoiding a patient that has suffered an adverse event are unhelpful and do not change what happened. Recognize what is happening and take action to break the cycle.
- Take positive steps. Accept responsibility, talk to trusted peers, avoid blaming others or the environment. Recognizing your part in the mishap is the first step to move forward.
- Maintain contemporaneous patient health records. This includes updating a patient’s medical and family history to assist with the communication of information among multiple clinicians.
- Contact your medical defense organisation (MDO) early with any issues. Note that MDO advisers are exempt from mandatory reporting to AHPRA.

## Relevant MIPS resources

## Webinars

- [Diagnostic Error in Medicine](#)
- [The Evolution of a Dental Complaint](#)
- [Anatomy of a notification: Why patients raise complaint](#)
- [Diagnostics: Improvements in healthcare](#)
- [Diagnostics: A team sport](#)
- [Safety, Quality, and improvements in Diagnosis](#)
- [COVID-19 – Diagnosis and pathology](#)

## Articles

- [Working under pressure and avoiding legal hazards](#)
- [Diagnostic errors in medicine](#)
- [Diagnostics - A Team Sport](#)
- [How to avoid diagnostic errors in the ED](#)
- [Dental - Express yourself clearly!](#)
- [Medical Administration: Understanding the implications for individuals and organisations](#)

<sup>1</sup>Westbrook, J. I., Raban, M. Z., Walter, S. R., & Douglas, H. (2018). Task errors by emergency physicians are associated with interruptions, multitasking, fatigue and working memory capacity: a prospective, direct observation study. *BMJ quality & safety*, 27(8), 655-663.

<sup>2</sup>Croskerry, P., & Sinclair, D. (2001). Emergency medicine: a practice prone to error?. *Canadian Journal of Emergency Medicine*, 3(4), 271-276.

<sup>3</sup>Hartigan, S., Brooks, M., Hartley, S., Miller, R. E., Santen, S. A., & Hemphill, R. R. (2020). Review of the basics of cognitive error in emergency medicine: Still no easy answers. *Western Journal of Emergency Medicine*, 21(6), 125.

<sup>4</sup>Graber ML, Franklin N, Gordon R. Diagnostic Error in Internal Medicine. *Arch Intern Med*. 2005;165(13):1493-1499. doi:10.1001/archinte.165.13.1493

<sup>5</sup>Ibid 4

<sup>6</sup>Tessa Davis (2017). Coping with errors, Don't Forget the Bubbles. Available at: <https://doi.org/10.31440/DFTB.11227>

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