Errors in breast radiology

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- Error
- What goes wrong
- Dealing with error
- How are radiologists affected
- Minimising the damage
- Communication

Error

- ‘The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.’

Kohn et al Errors in healthcare: A leading cause of death and injury Nat Academy Press 2000

Error – Inevitable? Absolutely

- ‘To err is human’ - 1999 USA reported 49-98,000 deaths annually due to patient safety incidents
- NHS – adverse events occur during 10.8% hospital admissions in UK, 1/3 resulting in death or severe morbidity
- Radiology – 2-20% imaging reports show clinically significant errors (most frequent missed fractures and cancer)

Goddard et al BJR Vol 74 886

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What goes wrong?
The individual error…

Breast imaging errors – by the individual

- Failure to perceive
- Failure to interpret
- Failure to assess adequately (investigation and biopsy)
- Failure to communicate

What goes wrong – Errors involving communication

- ‘23% of American radiologists have been sued for failing to communicate a finding*

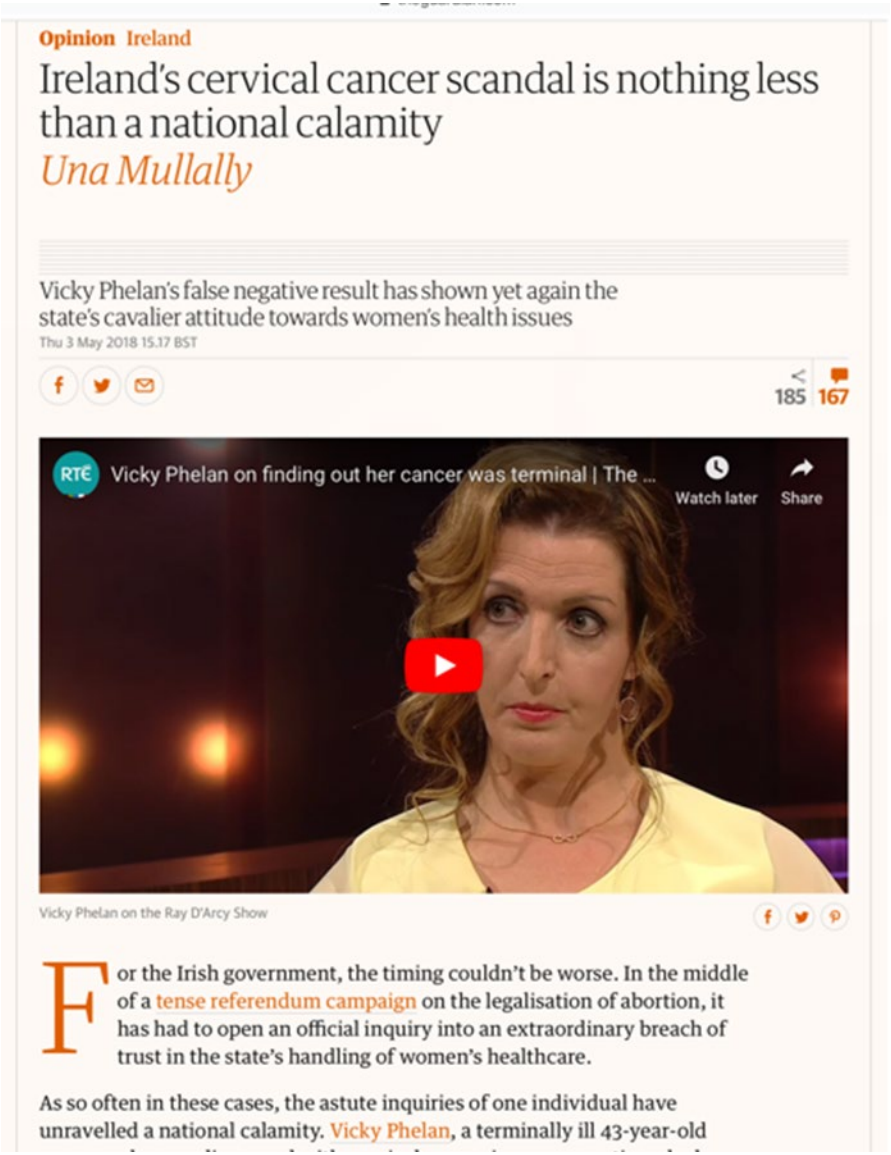
Issues:

- Clarity of the report
- Transmission and receipt of the report
- Communication when errors Duty of Candour

* Berlin Radiology vol 277 Nov 2015

Communication Ireland 2018

- Vicky Phelan had a normal cervical screen in 2011 and was diagnosed with cervical cancer in 2014.
- An audit (interval cancer review) found the original result to be incorrect but she was not informed and found out (from her notes) in 2017
- She sued the HSE (Irish NHS) and the lab (USA) and received 2.5 million euro



Opinion Ireland

Ireland's cervical cancer scandal is nothing less than a national calamity

Una Mullally

Vicky Phelan's false negative result has shown yet again the state's cavalier attitude towards women's health issues

Thu 3 May 2018 15.17 BST

185 167

Vicky Phelan on the Ray D'Arcy Show

For the Irish government, the timing couldn't be worse. In the middle of a tense referendum campaign on the legalisation of abortion, it has had to open an official inquiry into an extraordinary breach of trust in the state's handling of women's healthcare.

As so often in these cases, the astute inquiries of one individual have unravelled a national calamity. Vicky Phelan, a terminally ill 43-year-old

Communication Ireland 2018

- HSE confirmed audit had shown 206 women had developed cancer after false negative cervical screens
- 162 had not been told that the initial results were incorrect
- Although Ireland had an ‘open disclosure ‘ policy there was no agreement about who should tell these women the results so they were filed
- The clinical director of Cervical Check and the Director general of HSE resigned
- An independent report into the controversy , the Scally report described “ whole system failure” and widespread practice of non disclosure
- It recommended that open disclosure in the **Irish breast screening programme be considered …….**

What goes wrong? System errors

How common? How far reaching ?

Faulty systems – a case study ,our dependence on robust systems….

National incident England 2018
What happened?

- The BSS specification : women are eligible for breast screening from 50 **until they reach their 71st birthday**

- In Jan 2018 it became apparent that **not all women** received an invitation to their final screen in the three years before their 71st birthday.

- PHE identified a number of **complex issues** that had led to this, including national and local IT problems :
  - Incorrect specification of batches
  - Incorrect specification of failsafe some of which clashed with the invitations for the AgeX trial

- Thought to be 122,000 women affected

Incident 2018 :What was done?

- Immediate: **IT fixes**

- The benefits and harms of screening over age 70 are uncertain, which is why the Age X trial is being conducted, so NHSBSP did not simply invited all these women (age 71-80) for a screen, they were **written to** and offered:
  - Up to 72 : re invitation for catch up screen with information about harms and benefits
  - 72 to 80th birthday: information re harms and benefits and option of self referral (about 15% requested screening)

- Helpline also **supported** women connected to the incident who had developed breast cancer.

Next steps

- Estimate of women who may have had **lives shortened** by the missed invitation are less than 75

- A **review process** to look at cases of women who have missed their invitation and developed breast cancer to asses if the missed invitation worsened their outcome

- Women or their next of kin will be **offered the outcome** of the review,

- An **independent review** to investigate the incident and learn from it : by Prof Sir Mike Richards

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Dealing with error - Recognise

- ‘I don’t make errors’
- Recognition - Individuals –
  - Review – intervals, MDT outcomes, single reader cancers, feedback, complaints
- Recognition – Departments-
  - Audit
  - Data monitoring
  - Incident reporting
  - Complaints and concerns

Dealing with error - investigate

- Root cause analysis : The process of identifying contributing factors that led to adverse events to decrease the likelihood of future occurrence.

- Avoid individual blame, focus on systems.

- 5 Why's: eg: Mis labeled second breast biopsy sample sent to lab

  - Why was it mis labeled?
    - No second sample request form was filled in
  - Why was no form available?
    - It wasn't printed from the RIS system
  - Why was it not printed?
    - Nobody was responsible for doing it
  - Why was nobody assigned responsibility?
    - It was not discussed during the pre biopsy time-out
  - Why was this not discussed during the time-out?
    - The process and content of time out procedures varied

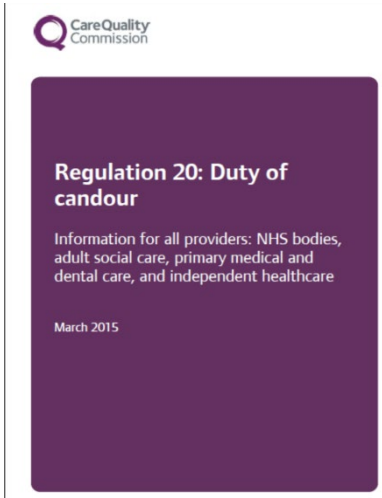
Dealing with error - Learn

- Individual feedback and learning

Dealing with error - Learn

- System design eg WHO

Dealing with error: Communicate: Duty of Candour



CQC regulation 20 : April 2015 in response to Francis report:

1 Must act in open and transparent way

2 Must tell users as soon as practicable about notifiable safety incidents (something has gone wrong and the person has been harmed) and their investigation

3 Must apologise

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How are radiologists affected : personal stress

- Communication : To patient and family : DoC
- Investigations local:
  - Incident
  - Complaint
- Legal processes: Nationally in 2017/2018 427 claims involving ALL radiology: rare for individual
- Trust performance management processes: trust HR policies: advised by NHS resolution
- GMC: anyone can make a referral to the GMC : investigation

How are radiologists judged for individual error?

Individual errors –

- Consequences for radiologist and patient
- What is the legal consequence?
  - ‘Simple error vs negligent error’
  - Negligence - Below standard of a responsible body of medical opinion (Bolam test)
  - How defined?

Individual errors usually mitigated by teamwork and safe systems

Berlin Radiology Vol 123 issue2 1977

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Minimising the damage: Sources of support

- Local team: Colleagues
- Family and friends
- Legal: Protection societies act for the individual and NHS Resolution for the NHS
- Medical :Trust occupational health / counseling / GP / NHS Practitioner health programs
- Resilience: Training and preparation for difficult conversations

Minimising the damage :Teamwork

- Traditional model – Highly autonomous and self sufficient practitioner
- Increased complexity modern medicine
- Modern need – Highly coordinated team
- Learn team behaviours eg assessment : RA and second opinion

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But is this enough?

- We need a better public understanding of limitations of screening BEFORE things go wrong….

Communication

Unfortunately, the greater understanding of error – its frequency and … inevitability - which radiologists have gained over the past two decades is not shared even by colleagues in our own profession who often seem to have unrealistic expectations of the accuracy of radiological interpretation.

Outside the profession, understanding is even less. One of the biggest problems facing radiologists now is the yawning gap between what we know to be our error rate and what our patients might believe it to be. The discovery in hindsight of an error in interpretation of a radiological image is now commonplace in our practice but is still often perceived by the patient as something shocking and exceptional, calling into question the competence of the radiologist involved..

Maskell BJR 2018

Communication

Addressing this disjunction must be one of the highest current priorities for radiologists and our professional bodies. It will not be easy. “Technical” solutions such as a process of consent prior to imaging or disclaimers on reports are unlikely to be popular or effective.

Ultimately a process of public education is required which treads a fine line, explaining the pervasive nature of radiological error as well as the measures which we take to avoid it whilst emphasising the enormous benefit which radiology – despite its inherent flaws – continues to bring to patient care

Maskell BJR 2018

Conclusion

- Error is inevitable – we are human
- It is damaging to radiologists as well as patients
- Look for it
- Benefit from it by learning –
  - ‘We cannot change the human condition but we can change the conditions under which humans work’
- **We really need to consider how we convey the imperfections of screening and diagnostic radiology to the public**