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Disregard of Patients' Preferences Is a Medical Error: Comment on "Failure to Engage Hospitalized Elderly Patients and Their Families in Advance Care Planning"

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INVITED COMMENTARY

Disregard of Patients' Preferences Is a Medical Error

To physicians, what is encompassed by the term *medical error* may seem self-evident. It is the surgery performed on the wrong limb, the medication given to the wrong patient, or the medical test that falls through the cracks. Medical errors involve acts of omission as well as commission. During the past decade, we have attempted to systematically address diagnostic, treatment, and equipment-related errors and improve patient safety in medicine. Public awareness of the health care system's efforts to improve patient safety has been raised through the groundbreaking Institute of Medicine report calling for system-level change,¹ a physician-authored *New York Times* bestseller on patient safeguards through checklists,² and a privately instigated campaign to save 100 000 lives by reducing medical errors across 3000 American hospitals.³ However, do we, as clinicians, recognize the full scope of what may constitute medical errors in practice?

Despite our recognition and understanding of the importance of patient safety for surgical treatment, procedures, and medications, the health care system has appeared to ignore a central safety issue that involves life-or-death decisions: the code status discussion and order during hospital admission for patients with serious or terminal illness. In this issue, Heyland and colleagues⁴ offer strong evidence for why we should view knowledge and documentation of patients' preferences for medical treatment through the lens of patient safety. The authors present a multi-site research study across 12 Canadian hospitals involving 278 patients and 255 family members. Patients either were aged 80 years or older or had a high risk of dying within the next 6 months; all patients were hospitalized for serious illness. Through validated survey measurements, Heyland et al found that more than 76% of patients had thought about their wishes for medical care, and nearly half reported completing a written advance directive or proxy docu-

ment before hospitalization. However, less than one-third of patients had spoken to their outpatient family physician about their preferences before hospitalization, and only one-fourth recalled being asked about their preferences or advanced directives during the current admission. As a result of this breakdown in communication, more than two-thirds of patients' preferences were either not documented at all or documented incorrectly in the medical record. In other words, close to 70% of the physician orders concerning intensity of treatment (such as cardiopulmonary resuscitation and intubation) were discordant with current patient wishes. In any other area of medicine, this would be viewed as an egregious "failure of communication" error.³

Despite evidence of a lapse in patient safety, there is some good news. The findings reported by Heyland et al⁴ demonstrate that engagement in advance care planning has increased dramatically during the 2 decades since the SUPPORT study.⁵ A shift in attitudes about advance care planning in the community seems to have occurred, possibly through public health campaigns and the media.⁶ Advance care planning involves many separate behaviors, such as identifying and asking someone to be a surrogate decision maker, identifying individual goals, communicating those goals, and preparing for medical decision making.⁷ Deciding about specific treatment preferences, such as cardiopulmonary resuscitation and code status, is one aspect of the advance care planning process that may directly affect the care received in the hospital. Because patients change their minds during the trajectory of their illness, advance care planning has also begun to be thought of as a process rather than a one-time event.^{7,8} Major strengths of the current study include its implicit recognition of this fact and the authors' demonstrated ability to ask questions about real-time end-of-life treatment preferences. The authors did not rely solely on old advance directive forms from prior

hospital admissions but rather asked patients about their preferences for care during the current hospitalization and compared those preferences with the code status orders in the concurrent medical record.

What is alarming about this study, however, is that it demonstrated the disconnect between what patients and families discuss with one another during an acute illness at the end of life and what information is translated into the medical record during hospitalization. As with all medical errors, there is likely a complex interplay of factors leading to this disconnect of documented patients' preferences, factors involving patients, families, clinicians, and the health care system. However, the study findings do suggest one possible factor: our current safety procedures and checklists have not yet overcome the reluctance of clinicians to ask difficult questions about treatment wishes when confronted with patients who are seriously or terminally ill.

This study raises multiple questions. How frequently are providers asking about end-of-life treatment preferences both before and during a hospital admission? How often do patients remember these conversations? How clearly are clinicians hearing patients and their loved ones? To what extent are these discussions actually taking place but not being documented or being documented incorrectly? To what degree are providers relying on past orders or old advance directives for code status information, an unacceptable shortcut in the care of patients near the end of their lives? Because patients do seem to be engaging in advance care planning and making decisions about treatment preferences in the absence of discussions with physicians, how can we be sure that patients and their surrogate decision makers understand their individual prognoses and the consequences of their treatment preferences?

Discussions about goals of care and code status constitute a medical procedure every bit as important to patient safety as a central line placement or a surgical procedure. Much as we have developed systems to improve patient safety in surgical procedures, we need to develop systematic approaches to discussing patient values and goals of care. The miscommunication of patients' end-of-life preferences demonstrated by Heyland et al⁴ implies that goals-of-care discussions are not occurring regularly. In a recent study of patient-physician communication at hospital admission, Anderson et al⁹ observed that some physicians appear uncomfortable with these discussions. They also identified reproducible communication techniques and behaviors (acknowledging the possibility of death and facilitating discussion of patient

concerns) that may lead to a better standard of practice. Although several aspects of the health care system will need to be addressed to fix this common and consequential medical error, standardizing both the content of clinicians' discussions and the documentation of patient preferences may be an important first step. If we are truly committed to improving patient safety and reducing medical errors, then we have found a worthy new target: the inpatient code status discussion and accurate medical documentation of real-time patient preferences.

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