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Profiles in Patient Safety: A “Perfect Storm” in the Emergency Department

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Abstract

Correct and rapid diagnosis is pivotal to the practice of emergency medicine, yet the chaotic and ill-structured emergency department environment is fertile ground for the commission of diagnostic error. Errors may result from specific error-producing conditions (EPCs) or, more frequently, from an interaction between such conditions. These EPCs are often expedient and serve to shorten the decision making process in a high-pressure environment. Recognizing that they will inevitably exist, it is important for clinicians to understand and manage their dangers. The authors present a case of delayed diagnosis resulting from the interaction of a number of EPCs that produced a “perfect” situation to produce a missed or delayed diagnosis. They offer practical suggestions whereby clinicians may decrease their chances of becoming victims of these influences.

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Cognitive factors have been demonstrated to contribute in up to 74% and system-related factors in up to 65% of diagnostic errors in internal medicine.¹ Emergency medicine may be even more prone to high-consequence diagnostic error,² given that it is practiced in a chaotic environment and ill-structured domain.³ The emergency department (ED) is in a sense a “natural laboratory for the study of medical error.”⁴

Error-producing conditions (EPCs) abound,^{5,6} with cognitive failures in clinical decision making arguably presenting one of the major threats to patient safety. These EPCs are usually expedient, serving to shorten the decision making process in a high-pressure environment, and exist often by necessity. It is important to recognize the hazardous potential of many of these EPCs, and in particular the interactions between them, on clinical decision making. Many of these vulnerabilities in decision making have been recently reviewed.³ To mitigate the dangers of these conditions, clinicians first need to be aware of them and have a practical approach that minimizes the risks they present. The educational approach here warns of dangers in the areas of data acquisition,

problem representation, hypothesis generation, and cognitive feedback, all of which have been suggested as educational focal points.⁷ The development of both an understanding of cognitive error and exemplars of cognitive error⁸ are critical to any avoidance strategy.

In *The Perfect Storm*, Sebastian Junger describes a situation where a variety of unfavorable weather situations collide at a specific place and time to create as dangerous conditions at sea as can possibly be imagined.⁹ Here, we present a case in which a seemingly obvious diagnosis was missed as a result of a collision of circumstances. Clearly there are system factors that contributed to the case, but there are also cognitive issues. Emergency physicians (EPs) need to think beyond the immediate cognitive pull of a situation, a process referred to as metacognition. One of the goals of this article is to present the clinicians’ cognitive dispositions to respond (CDRs) in a framework that will make them accessible to the practicing clinician. Our hope is that just as an expert emergency medicine clinician may call up the list of life-threatening causes of chest pain, he or she might also call up the six major categories of CDRs in an attempt to improve his or her metacognition or “thinking about one’s thinking.”¹⁰

CASE PRESENTATION

A 51-year-old patient (Ms. S) with chronic renal failure as a result of diabetes mellitus experienced a grand mal seizure in the dialysis clinic. On assessment, she was found to be in rapid atrial fibrillation. The clinic contacted the ED and arranged transfer of the patient, with a referral note to cardiology and neurology.

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On arrival, she was assessed by a clinical clerk. Her heart rate was 170 beats/min, and she complained of severe pain “everywhere.” The clerk recorded that the patient could not move her legs because of the pain. The attending emergency physician (EP1) ordered a total of 15 mg metoprolol to slow her heart rate. She converted to normal sinus rhythm. She was seen by the cardiology service, which prescribed metoprolol 25 mg twice daily, and referred her to the neurology service.

Four hours after the patient’s arrival in the ED, EP1’s shift ended. At handover rounds, EP1 transferred the care of several patients to another physician (EP2), including three patients for whom disposition had yet to be finalized. EP1 reported that Ms. S was being “sorted out” by the neurology service. She mentioned that a computed tomography (CT) scan of her lower back and head ordered by the neurology resident had been delayed because of technical problems with the CT scanner. EP2 continued with his shift. Ten minutes before the end of his shift, EP2 was approached by the neurology resident, who said that the patient was refusing to be examined because of severe pain. EP2 asked about the CT scans and was told that they had been read “by radiology” as normal.

At that time, EP2 was trying to organize dispositions for several complicated cases before he could go home. He hurriedly took a history from Ms. S, including that of pain in her back that had been getting steadily worse since her seizure. The pain had initially radiated from her left shoulder down her left leg but was now going from her back down her leg, resolving if she lay still and returning in spasms with any movement. EP2 passively raised each leg to about 75°, resulting in exacerbation of the pain, more so on the left. A superficial check of sensation in her legs revealed numbness, which she said had been present for years and attributed to diabetic neuropathy. She resisted log rolling, refusing to be moved because of the pain. EP2 continued to be very busy with several patients, but eventually, with the aid of a paramedic, was able to perform a log roll under titrated intravenous fentanyl (200 µg); she was found on palpation to have mild lower lumbar spinal tenderness. He reviewed her large clinical chart briefly and noticed many admissions and presentations involving chronic pain, although he noted that she was not currently taking analgesics at home. He diagnosed mechanical back pain, and realizing that she would not be able to go home, consulted the nephrology service requesting an admission for pain management and ongoing dialysis.

The nephrologist was reluctant to admit her to a nephrology bed. He made it clear that she had been a “difficult” patient in the past, noting a history of severe and unexplained pain. He suggested a medicine consult, which EP2 requested. EP2 arranged the disposition of his other patients and went home.

The following morning, EP2 was called at home by a staff neurologist to say that his resident had assessed the patient in the ED and that she was unable to move her legs. He asked about the report of the patient being able to lift her legs 70° bilaterally, because his resident had told him that EP2 had facilitated this with analgesia. EP2 indicated that the straight leg raising had been a passive test for sciatica and not active on the part of the

patient. The neurologist asked if EP2 was aware that the patient was on warfarin for prophylaxis of previous deep vein thrombosis. EP2 was not. The neurologist said he suspected that the patient had suffered a spinal epidural hematoma following her seizure, a condition that might have been surgically correctable had the diagnosis been made early enough. A magnetic resonance imaging scan performed 24 hours after the seizure showed a fracture of T12 with spinal compression. The neurosurgery service admitted the patient with traumatic paraplegia.

DISCUSSION

Following an injury actually sustained in a hospital setting, an important diagnosis was delayed for more than 24 hours. In hindsight, the causes of the diagnostic failure can be attributed to an interplay of EPCs, including many of a cognitive nature. These are not uncommon in the special milieu of the ED yet seldom recognized as impediments to patient safety. CDRs represent situations that steer a physician’s cognitive process in a particular way that can predispose to error, and more than 30 CDRs have been described as relevant to emergency medicine practice.¹¹ Although each CDR has its own discrete properties, there is considerable overlap and interaction. The clustering of CDRs is shown in Table 1. Several interacting and overlapping CDRs and other EPCs are detailed in the following discussion.

Errors Involving Patient Characteristics or Presentation Context

On the patient’s chart, the triage “presenting complaint” was written as “tachycardia-atrial fibrillation” instead of the less specific “tachycardia.” Tachycardia-atrial fibrillation is a diagnosis rather than a complaint and may cue caregivers in a particular direction. This may lead to the CDR of triage cueing.⁵ The presenting complaint should be restricted to what the patient is complaining of, preferably in his or her own words. The triage nurse can effectively change the presentation context for the receiving nurses and physicians with these seemingly innocuous labels. Triage labels may strongly direct the course of subsequent management, what has been referred to as “geography is destiny.”¹²

For example, if a patient presenting with leg swelling is labeled “ankle sprain,” then hopefully her deep vein thrombosis or necrotizing fasciitis will be caught in the express care or minor care area, because that is where she is likely to receive initial care. A trauma patient with an open fracture may earn the diagnosis label of “open femur fracture,” potentially distracting the EP from more pressing, yet clinically less obvious, life-threatening issues such as intra-abdominal injury.

In a discussion with the nephrologist, EP2 was informed that the patient was “difficult” and had a history of “chronic unexplained pain.” Furthermore, EP2 attributed the patient’s inability to move her legs to an unwillingness owing to her hyperalgesia and did not pursue this further. This is a manifestation of fundamental attribution error, the tendency to assume that what a patient is experiencing is due to dispositional qualities of the patient rather than to situational circumstances.^{5,13}

Table 1
Classification Scheme for Cognitive Dispositions to Respond

Error of overattachment to a particular diagnosis	
Anchoring	The tendency to fixate on specific features of a presentation too early in the diagnostic process and subsequent failure to adjust
Confirmation bias	The tendency to look for confirming evidence to support the hypothesis, rather than to look for disconfirming evidence to refute it
Premature closure	Accepting a diagnosis before it has been fully verified
Error due to failure to consider alternative diagnoses	
Multiple alternatives bias	Irrational inertia against optimizing choice among competing alternatives
Representativeness restraint	Restraint from considering a particular diagnosis for a patient because the presentation is not sufficiently representative of the class
Search satisficing	The tendency to call off a search once something is found and not considering additional findings or diagnoses
Sutton's slip	Fixation on the most obvious answer or interpretation
Unpacking principle	Being influenced by the way in which the facts are presented
Vertical line failure	Rigidity and inflexibility in the approach to clinical problems (not thinking laterally)
Error due to inheriting someone else's thinking	
Triage cueing	A predisposition toward a particular decision as a result of a judgment made by caregivers early in the patient care process
Diagnosis momentum	The tendency for a particular diagnosis to become established in spite of other evidence
Framing effect	A decision being influenced by the way in which the scenario is presented or "framed"
Ascertainment effect	When thinking is preshaped by expectations
Errors in prevalence perception or estimation	
Availability bias	The tendency for things to be judged more frequently if they come readily to mind
Base-rate neglect	Failing to adequately take into account the prevalence of a particular disease
Gambler's fallacy	The belief that a sequence of similar diagnoses will reverse (belief that the same thing won't happen again)
Hindsight bias	Once the outcome is known, an underestimation (illusion of failure) or overestimation (illusion of control) of the calibration of the original decision
Playing the odds	Deciding that a patient does not have a particular disease on the basis of a likelihood judgment (frequency gambling)
Posterior probability error	Having a judgment unduly influenced by what is known to have been the case before
Order effects	Focusing on information given at the beginning or end of a history, to the neglect of the "stuff in the middle"
Errors involving patient characteristics or presentation context	
Fundamental attribution error	Attributing the blame for a circumstance or event to the patient's personal qualities rather than the situation
Gender bias	When the decision made is influenced unduly by the patient's gender or the gender of the decision maker
Psych out error	A variety of biases associated with the health care provider's perception of the psychiatric patient
Yin-yang out	Presumption that extensive prior investigation has ruled out any serious diagnosis
Errors associated with physician affect or personality	
Commission bias	Tendency toward action rather than inaction
Omission bias	Tendency toward inaction rather than action
Outcome bias	Choosing a course of action according to a desired outcome; avoiding possibilities that would suggest an undesired outcome
Visceral bias	Making decisions influenced by personal (positive or negative) feelings toward patients (affective bias)
Overconfidence/underconfidence	Being overconfident in (more likely) or underconfident in the efficacy of decisions that we make
Belief bias	The tendency to accept only things that fit in with our belief systems
Ego bias	In this context, a systematic overestimation of the prognosis for one's own patients
Sunk costs	Unwillingness to give up a diagnosis in which we have invested considerable effort
Zebra retreat	Reluctance to pursue a rare diagnosis for a variety of reasons

In the present case, the assumption of pain as a cause of immobility had yet to be established. Symptoms ascribed to the pain might have been more objectively evaluated after the patient had received adequate analgesia. Grand mal seizures, as demonstrated above, are well known to result in trauma, and postseizure patients should always be evaluated from this standpoint. For

example, this patient's complaint of shoulder pain might have been due to a shoulder subluxation or dislocation. It is unclear why EP1 did not address the pain noticed at the clerk's assessment and then later by her own assessment. Possibly she believed that the patient's general level of distress was being expressed as a somatic symptom (pain).

Error of Overattachment to a Particular Diagnosis

CDRs such as anchoring, confirmation bias, and premature diagnostic closure¹⁴ all result in overattachment to a diagnosis. The thought process of EP1 “anchored” to the cardiac and neurologic diagnoses that she had been offered, stopping the diagnostic process at that stage (premature diagnostic closure). Diagnostic labeling in this patient resulted in specialist consultation before a formal emergency assessment evaluation. The history of seizure triggered a neurologic consultation before the possible effects of the seizure were fully evaluated. Emergency medicine is a discipline with few physiologic or anatomic borders. Treating any event or illness as an isolated occurrence is very risky, and the diagnosis and treatment of any specific condition by an EP should always include consideration of possible indirect effects.

Premature diagnostic closure is perpetuated by confirmation bias, where the clinician “selects” clinical details that support the initial diagnosis, disregarding those that make his or her diagnosis less probable. This is even more likely when achieving diagnostic closure presents other advantages to the physician. EP2 anchored on the diagnosis that would allow him to go home—that of “mechanical back pain”—confirming it with a “negative” spinal examination on log roll but ignoring the fact that he had given her a large dose of narcotic analgesia. He ascribed the severity of the symptoms to the patient’s tendency toward hyperalgesia, even after noticing that she had not been on maintenance analgesics. Further, he failed to test her motor function after he had treated the pain presumed to be preventing movement.

Failure to Consider Alternative Diagnoses

This case also demonstrated the distracting effect of comorbidities. Without the distracting influence of the cardiac problem, the connection between the complaint of severe back pain and a recent seizure might more readily have been made. It can be difficult for busy clinicians to consider that a patient may have more than two different systemic pathologies. Had the cardiac and neurologic symptoms presented in isolation, each might have received more thorough individual assessment. One must always ask the question “Does the diagnosis I am assigning account for all of the clinical features found?” and probably more importantly “What else might this be?” EP2, on finding pain with sciatic stretch and lumbar spinal tenderness, and combining these with a history of chronic pain, was satisfied that he had enough to make a diagnosis of mechanical back pain and called off the search for other problems. This distraction from the pursuit of alternative diagnoses results from the reassurance of having made a “reasonable” search and has been described as “search satisficing.”¹¹

Error Due to Inheriting Someone Else’s Thinking

Diagnostic momentum refers to the tendency for a particular diagnosis to become established without adequate evidence and involves several intermediaries that may include the patient. The process typically starts with an opinion of what the source of the patient’s symptoms might be, and as this is passed from person to person, the diagnosis gathers momentum without necessarily gathering evidence. Attaching a diagnostic label is a con-

venient shorthand way of communicating but invariably means that someone else’s thinking has been inherited.¹¹ Diagnostic momentum in this case began in the dialysis clinic with a referral note to cardiology and neurology by the nephrologist, and EP1 continued this line of workup. Because these two other services were already involved with the patient by the time he took over her care, EP2 did not consider a diagnosis outside of those covered by those disciplines, again reflecting both diagnostic momentum and premature diagnostic closure. In turn, the consultants both deferred to the “triage” function of the EP, failing to consider that patients referred to them might have conditions other than those normally managed by their disciplines. This is another form of “geography is destiny” in the ED,¹² where geography now refers to the particular discipline. Specialists tend to see clinical problems within their own field and frame of reference.

EP2 had been reassured by the verbal report of a normal lumbar spine CT scan. In fact, the report had been read by the radiology resident only and proved to be erroneous. The following day, the staff radiologist noticed fractures of the transverse processes of L2 on plain films. The CT scan had begun below the level of the fracture, another reason for false reassurance. EP2 did not read the lumbar spine CT himself. Had he done so, he might have noticed that the patient had significant osteoporosis, raising the likelihood of, and suspicion for, fracture. Reviewing the imaging study, or ascertaining definitive results, should be part of the EP’s assessment in assuming responsibility for patients. This was another example of inheriting someone else’s, in this case erroneous, thinking.

Errors of Prevalence Estimation or Biases in Prevalence Perception

Ms. S complained of numbness in her legs. EP2 conducted a sensory examination and found decreased sensation, but on learning that this had been a problem in the past, he did not attach significance to it and did not proceed to look for a new cause. This is an example of posterior probability error,¹¹ where what has gone before unduly influences current interpretations. It is also another example of search satisficing,¹¹ the tendency to call off a search for a diagnosis once something can be found that provides a ready explanation. EPs should endeavor to ensure that complaints attributable to a chronic cause are, in fact, exacerbations and not a similar manifestation of a new illness.

Errors Associated with an Affective (Emotional) Component or Involving Physician Personality Type

EP2 had called his wife to tell her that he would be late, and she had expressed irritation that he would not be home in time to spend time with her to discuss some domestic issues before she went to bed. This added to his sense of frustration and urgency to complete his shift. He felt that this frustration, and having several other stress precipitators, lowered his threshold of satisfaction with his clinical decision. The same situation at the beginning of a shift, or in a less stressful state, would undoubtedly have been handled very differently. There has been little direct work on the impact of affective state and

stress levels of EPs on their clinical decision making, although some sources of affective biases have been described.¹⁵

In any setting, acute changes in mood and stress level will be unavoidable. The practice of metacognition, stepping back and reflecting on the decision making process, can be helpful in ameliorating the impact of these adverse influences.¹⁰

Downstream Effects of Systemic Failures

The delay of CT imaging due to mechanical failure is an example of the contribution of systemic conditions in the ED to adverse events, the EPCs referred to previously. In this case, the delay postponed a more thorough evaluation by EP1 until it was too late and her shift had ended. EP1's intent might have been to assess the patient more thoroughly after the scan, similar to the practice of not examining an elder patient with hip pain until after the x-ray; if it is fractured, a hip examination is neither necessary nor compassionate.

Delays or technical difficulties in the sequence of investigations are common. When any step in a process is interrupted unexpectedly, any downstream effect of this disruption should be considered. It should have been communicated clearly to EP2 that the assessment had not been adequately completed by the time of hand-over. That the receiving physician could receive the impression that the patient was being managed safely through the neurology consult should have been anticipated.

Transition of Care Error

EP2 made an assumption that the patient had been fully assessed by EP1, but this was clearly not the case. Transitions of care represent discontinuities in patient management and are known to be vulnerable to error. It is a dangerous time when various cognitive biases may exert themselves and significantly influence the judgment of the receiving physician and nurses.^{16,17} The signing-off physician or nurse generates the contextual background of the patient, which may be a powerful modifier of the thinking and actions of the oncoming team.

At changeover rounds, EP1 had not mentioned to EP2 that the patient was anticoagulated. This is a significant omission in a patient who has experienced a generalized seizure with its associated potential for trauma. Data must be prioritized and high-priority data transmitted in a consistent fashion during shift sign-out. For safe and effective transitions in the ED, there should be clear protocols in place in each department.¹⁶ An example of recommendations for handovers is offered in Table 2.

Authority Gradient Effect

The medical student, who was first to see the patient, recorded that the patient "could not move her legs." This note was not read by EP1, EP2, the cardiology resident, or the neurology resident. We do not know the verbal communication that may have transpired from the medical student to these various clinicians. Commonly, EPs and residents do not read clinical clerks' notes because of their length, overinclusiveness, and presumed limitations in clinical judgment. The failure to attach credence

Table 2

Recommendations for Changeover Rounds

1. Oncoming and offgoing physicians should round with the nursing leader and nurse caring for each patient to introduce the new physician, reexamine the patient if appropriate, and review the care plan. If "bedside" rounds are not practical, then the oncoming physician, early in the shift, should endeavor to get to the bedside of each patient for each patient who has been accepted in transfer.*
2. Data transferred to the oncoming physician should be as objective as possible. Opinions or clinical impressions should be given and received very guardedly, if at all.
3. In all but the most straightforward of cases, diagnostic closure should not be attempted; do not inherit someone else's thinking.
4. Attributional (judgmental) comments are absolutely to be avoided. They breach professional codes of conduct and may significantly influence the management of the patient by the oncoming team. Labeling (e.g., "IV drug user") should be used only when medically relevant to the case. Clinical information that may be construed as negative should be balanced with an overt statement of the risk of false attribution.
5. The new physician should provide feedback to the offgoing physician if further workup changes the diagnosis or plan.

* A clear hospital policy regarding the responsibility for admitted patients in the ED should exist.

to the opinion of someone in training or someone lower in the hierarchy is a manifestation of authority gradient effect.¹⁸

Those higher up the gradient would not see reading the detailed notes of trainees as a good investment of their time and might find them distracting. In this case, however, the note would have led to a straightforward examination that would probably have yielded the correct diagnosis. This is a complex problem that is rooted in the culture of the ED and the health care sector, in general. Ideally, all team members should feel empowered to question a course of action or give input when they feel patient safety is at stake. This type of empowerment can be fostered through team training using simulation.^{19,20} Even when pressed for time, the physician should value all information that could assist with a decision, including the observations of other members of the health care team.

Gender Bias

The neurology resident was female, of diminutive stature, and nonassertive. EP2 gained the impression that she had not been firm enough in her assessment of a "difficult" patient, an example of gender bias.²¹ Had the resident been an assertive man, EP2 felt, in retrospect, that he might have placed a different interpretation on the reported difficulty in assessing the patient. Like attribution of clinical features to a patient's dispositional qualities, we should be careful to avoid attribution biases in interpreting information from coworkers. EPs should periodically engage in introspection and personal reflection to assess their own vulnerability to sociocultural and medical prejudices that may adversely affect clinical reasoning.

Resource Availability Continuous Quality Improvement Trade-off

Conditions in the ED were approaching “resource availability continuous quality improvement trade-off” (RACQITO),¹⁰ the tipping point at which the quality of care in the ED begins to be compromised by resource limitations. A shortage of beds in the hospital results in a greater proportion of ED beds being occupied by admitted patients, creating a throughput problem. Wait times to be seen go up, placing additional stress on ED personnel, and inevitably lead to error and compromised care. Rather than a disposition to respond, RACQITO is a state in which achieving patient flow by additional effort is, by definition, not possible. Attempts to compensate for RACQITO will compromise proper care, and patients will inevitably be managed inappropriately, as physicians and nurses are pushed into risk-taking behavior. When a “logjam” occurs, a good strategy is to reevaluate each patient briefly to ascertain who can safely (and appropriately) be moved out of a bed. EPs should be acutely aware of how close to RACQITO the department is at all times and need to always remain the “real-time advocate” for patients under their care. This may require adamantly holding to a safe course of management and, in some cases, insisting on admission for “marginal” patients with uncertain diagnoses. Insisting on admission, however, may also mean continuing “bed blockage” by that patient, conflicting the EP’s concern for this patient’s well-being with his concern for potentially unstable patients in the waiting room “blocked” from entering the ED. The role of real-time patient advocate comprises a large share of the responsibility burden of the EP and requires special attention. Effective patient advocacy requires the development of credibility with consultants, the making of good and appropriate referrals, and frequently the calm, unapologetic, and firm insistence that patients are not managed inappropriately because of resource limitations.²²

EP2 was trying to deal with several delicate and complicated cases at once, specifically in getting “marginal” patients home, holding discussions with patients’ family members, and arranging early follow-up. Aware of the shortage of inpatient beds, his course of least resistance was to discharge patients to their homes. Generally, at late stages in a shift there is an emphasis on finalizing dispositions on patients who have completed their ED evaluation, and Ms. S may have been seen in this category. She had been in the ED a long time, had seen several consultant services, and had had more imaging than most patients with back pain typically receive. One solution might be for physicians to stop seeing new patients in the last hour of their shift, so that disposition arrangements are less hurried.

Failure to Implement Cognitive Forcing Strategies

Finally, none of the physicians involved in this patient’s care had examined her for anal sphincter tone. No clues would be forthcoming from urinary retention or incontinence, because the patient was anuric. In the context of severe back pain, a cognitive forcing strategy²³ should have been applied to ensure the completion of a rectal examination that would evaluate sphincter tone and sensation. Other examples of cognitive forcing strategies

include the assurance that an older patient with renal colic does not have a leaking aortic aneurysm or that a patient with a “sprained ankle” does not have a proximal fibular Maisonneuve fracture.

CONCLUSIONS

This case illustrates a number of typical errors that occur in the ED. The disposition toward cognitive errors is frequently based on innate and learned cognitive processes that are usually unconscious and unrecognized as risks to patients.²¹ Perhaps the most important approach for EPs is to continually force themselves to examine their thought processes to seek out cognitive pitfalls (and how process variances contribute to these), both at the bedside and at morbidity and mortality reviews; such metacognition may eventually become second nature.

There is often a complex interplay between CDRs and prevailing process-related error-producing conditions. In the ED environment, errors are frequently detected through various barriers, allowing recovery to occur. Each barrier, however, has defects or holes through which the error may pass undetected.²⁴

In isolation, it is unlikely that any particular error described above would have led to the delayed diagnosis of as obvious a condition as acute traumatic spinal paraplegia. Acting together, however, they produced the “perfect diagnostic storm” in the ED.

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REFLECTIONS

Abdominal Pain, EU (Educated, Uptight)

After an atypical history for concern
 I said to the anxious little man,
 “I won’t hurt ya; climb on up,
 N’ put yer feet up this here way.”
 At three, he hesitantly ascended.
 HEENT negative, I asked for big breaths.
 He did, but with a quiver to the bottom lip.
 “You’re doin’ great, and we’re almost done,
 Remember, I won’t do anything ta hurt.
 Jest lay down, so I can feel
 What’s botherin’ your tummy.”
 Before his shoulders repositioned,
 We heard, “You lay down an object,
 Whereas lie is reserved for people.”
 “Thanks,” I said, “That’s been confusing.”
 Mom and I, principal culprits in conflict
 Failed to concur on a diagnosis and a dialect.

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