“Why don’t you call the primary team back and tell them our recs?” my attending suggested.

“So 1 milligram of Haldol BID for the patient, right?” I asked my attending.

We had just finished rounding on my patient. As a third year medical student, I was still new to the process of delivering recommendations and worried I might make a mistake.

“Yes that’s right,” she replied as I picked up the phone to call the team.

“Hi, this is the med student on the psych consult service. So we saw Ms. H and our recommendations are to start 1 mg of Haldol BID,” I said to the hospitalist.

I heard clicks and typing in the background.

“Alright, I just put it in, thanks.” replied the hospitalist.

Leaning back in my chair, I finished up my notes, logged out of the EHR and headed home for the weekend.

When I came in on Monday morning, my resident gently asked, “Hey, did you see Ms. H on Friday?”

“Yup, what’s up?” I asked.

“Well, she may have developed neuroleptic malignant syndrome. She was put on ten milligrams of Haldol BID.” my resident replied.

My resident must have seen the panic develop in my eyes.

“It’s not your fault. I checked our consult notes, yours and the attending’s both said 1 mg BID,” she reassured me.

I checked my note anyways.

Communication errors are at the heart of many patient safety events in the hospital. In any system as complex as healthcare, accurate transmission of information is key. As the child’s game of telephone beautifully illustrates, each time a message is relayed it has the potential to be misheard or misinterpreted. Indeed multiple organizations, including the National Coordinating Council for Medication Error Reporting and Prevention, and the Joint Commission, have recognized that critical information is often misheard or misunderstood[i], and studies indicate that physicians are often the worst offenders.[ii] Unfortunately, neither my team nor I recognized the root cause of the error in this case. The patient ultimately recovered without lasting sequelae and the error was dismissed, at least by our service, as the fault of a typo on the part of the primary team. It would take my own error, committed a few months later, to force me to recognize how common and deeply rooted this incident was.

During my medicine rotation, we had consulted psychiatry about a patient’s anxiety, and I was following up with the psych consult service about their recommendations. Over the phone, I was

told that the recommendation was to start 0.5 mg of clonidine BID. I relayed this information to my intern who, by sheer luck, was in the psychiatry residency program. He was surprised by the order and asked me if the team didn't mean Klonopin. I called the psych service back and found that they indeed had wanted Klonopin, not clonidine. Whether I had misheard the name or the name was misspoken, the same error nearly occurred again. It was at this moment I realized that the Haldol dosing error was not an isolated instance of carelessness, but rather a predictable, yet preventable consequence of the way information is currently conveyed between providers in the hospital.

At the Academy for Emerging Leaders in Patient Safety retreat, I learned about a number of structured communication strategies to ensure information is properly understood. Speaking with nurses at the retreat, I learned a simple strategy could have prevented these potentially deadly errors. Read back confirmation has long been emphasized in nursing and pharmacy for critical results and while taking verbal orders. Read back is distinct from repeat back. To meet the read back standard, the information, whether a lab result or an order, must first be inputted into the system or written down and then read back out loud to the person on the phone.[iii] As compared to repeat back, where a person may automatically repeat what was told to them without consciously registering the information, read back's higher standard decreases the likelihood of an error occurring.

Reflecting back, my first patient's overdose would have been prevented by this technique as the provider would have read back *ten* milligrams from the ordering screen, which would have been identified as the incorrect dose. Meanwhile, my mistake of hearing the incorrect medication name would have been detected had I sought confirmation.

Fortunately, neither patient suffered lasting consequences from these errors. However, these incidents provide a valuable opportunity to improve the transmission of critical results and recommendations. Taking a page from our nursing colleagues, physicians – whether an attending giving orders over the phone to a resident or a consulting service providing recs to a primary team – should use a read back system. The receiving provider should write down or input the information and then subsequently read back what they have copied down. This is a strategy I have personally adopted when receiving recommendations from consulting services and one I will share with colleagues and trainees as I continue with my training.

These patients taught me to recognize that an error is rarely just a "careless" mistake, but often a symptom of an underlying flaw in the system that must be addressed. More fundamentally, I learned that a mistake made by one of us can be made by any of us.

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[i] National Coordinating Council for Medication Error Reporting and Prevention. Recommendations to reduce medication errors associated with verbal medication orders and prescriptions: adopted February 20, 2001. Available at: http://www.nccmerp.org/council/ council2001-02-20.html. Accessed March 29, 2004

[ii] Barenfanger J, Sautter R, Lang D, Collins S, Hacek D, Peterson L. Improving Patient Safety by Repeating (Read-Back) Telephone Reports of Critical Information. *American Journal of Clinical Pathology*. 2004;121(6):801-803. doi:10.1309/9dym6r0tm830u95q.

[iii] Uselton J, Kienle P, Murdaugh L, Coe C. *Assuring Continuous Compliance With Joint Commission Standards*. Bethesda, Md.: American Society of Health-System Pharmacists; 2010.