didn't get paid properly, Dr. Bangasser said. There were some concerns about increased utilization and cost of services for groups participating in the program, and what the long-term returns on investment would be.

It was also determined that groups serving large Hispanic or Native American populations should get "extra credit" for having to deal with more diverse, culturally different populations.

Applying the right types of incentives is key, he said. "If a physician thinks the measure is a good idea, putting a little money behind it will speed quality improvement. However, if the physician thinks the measure is not going to improve quality, $1 million will not change behavior."

Sometimes, the simplest incentives can produce good results.

Dr. Bangasser mentioned a particularly bad influenza season in 1998, when patients had to wait in long lines to see physicians in his group practice. "I asked all of the doctors if they'd take on two more patients a day. That's a long day, but I gave them two tickets to a movie theater for Christmas."

All but two physicians took on the extra patients. "This meant that over 60 physicians saw an extra 120 patients per day," he said. ■

Physician Disclosure of Errors Is Still a Mixed Bag

BY KATHLEEN LOUDEN

Contributing Writer

CHICAGO — Four percent of primary care physicians and third-year medical students surveyed in a regional study reported that they made errors resulting in a patient's death but did not disclose them to their institution, Lauris C. Kaldjian, M.D., said at the combined annual meeting of the Central Society for Clinical Research and the Midwestern section of the American Federation for Medical Research.

Dr. Kaldjian surveyed faculty, residents, and third-year medical students in the departments of internal medicine, family medicine, and pediatrics at two medical schools and three hospitals in the Midwest and Northeast. The 538 responses were weighted more heavily toward residents and students than faculty members.

Of respondents, 17% did not disclose to their institution medical errors that prolonged the course of treatment or caused discomfort, and 12% did not disclose to the patient. Still, more primary care physicians and students voluntarily disclosed medical errors than those who did not, said Dr. Kaldjian, a bioethicist at the University of Iowa. Of the respondents, 27% revealed to the patient a medical error that prolonged therapy, and 18% disclosed such a mistake to their institutions.

The study was designed to develop a comprehensive taxonomy of the factors that influence voluntary disclosure of errors by physicians and to use the taxonomy in a cross-sectional survey of primary care physicians. The survey asked about factors that facilitate voluntary disclosure in four domains: a sense of responsibility to the patient, oneself, the medical profession, and the community. It also solicited reasons that impede disclosure of errors in four domains: attitudinal barriers, uncertainties, helplessness, and fears and anxiety.

These eight domains included 59 factors that either facilitate disclosure, such as the belief that telling patients about mistakes increases their trust in the physician, or hinder disclosure—for example, fear of legal liability.

"This study is trying to get at the deepest motivations and barriers that come into our minds and even our hearts when it comes to talking to patients about medical errors," said Dr. Kaldjian, whose work was funded by the Robert Wood Johnson Foundation. "The issue of disclosure of errors has come to the fore in recent years because of the patient safety movement."

Among fears, the most common reason survey respondents did not disclose a medical error was fear of a negative reaction from the patient or family (88%).

"You hear certain experts in the field saying the more candid we are, the less likely we'll get sued," he said. "Among the people we surveyed, it certainly is not the consensus of what would happen."

Women in the study were more inclined than men to disclose their errors to patients. Faculty members appeared more willing than trainees to disclose errors to their patients but not as willing to disclose to their colleagues.

Dr. Kaldjian did not break down medical errors other than those that prolonged therapy or caused discomfort and those that caused death, he told this newspaper. He is continuing to interpret the data.

The taxonomy he developed may assist in the design of systems for reporting medical errors and might be helpful for educational interventions. ■

Mucopolysaccharidosis I (MPS I) – a lysosomal storage disorder

Jarrett was diagnosed with MPS I, a relatively uncommon yet rapidly progressive and often life-threatening lysosomal storage disorder. Now, with early detection, an urgent referral, and treatment options, children like Jarrett may have a more positive prognosis, and may avoid serious problems associated with disease progression.

Signs and symptoms of MPS I — identifiable, but not always obvious

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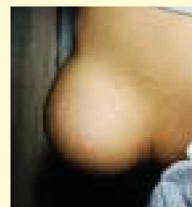
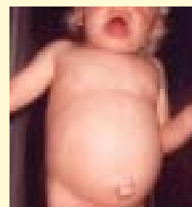
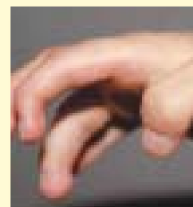
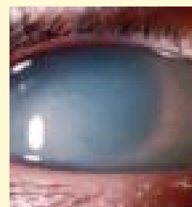

- Macrosomia (in infancy)
- Recurrent otitis media
- Hepatosplenomegaly
- Hearing loss
- Hernia (inguinal/umbilical)
- Facial dysmorphisms (coarse features)
- Corneal clouding
- Chronic rhinitis
- Communicating hydrocephalus (severe form)
- Joint stiffness and skeletal deformities
- Developmental delay (severe form)
- Valvular heart disease
- Obstructive airway disease

Learn more about identifying signs and symptoms of MPS I by visiting **www.MPSIDISEASE.com** or by contacting Genzyme Corporation at **800-745-4447, option 2.**

Make the call

Make the urgent referral that may make the difference for children with MPS I

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