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Diagnostic Medical Errors: Patient's Perspectives on a Pervasive Problem

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Diagnostic Medical Error: Patients' Perspectives on a Pervasive Problem

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INTRODUCTION

♦The Institute of Medicine (IOM) defines diagnostic error as the failure to[3]:
- Establish an **accurate** explanation to the patient's health problem(s) OR
- Establish a **timely** explanation to the patient's health problem(s) OR
- Effectively **communicate** the explanation to the patient

♦Diagnostic errors may contribute to 10% of patients deaths.[1]
♦More than 11% of patients have experienced misdiagnosis in their lifetime.[1]
♦To our knowledge there are no studies characterizing diagnostic error from a patient perspective using the IOM definition.

OBJECTIVES

- Determine frequency and categorize diagnostic error experienced by patients.
- Elicit patient perspectives on the causes and impacts of diagnostic error(s) that they experienced.
- Identify patient-generated strategies to prevent diagnostic error.
- Determine patients' preferred methods for communicating healthcare information.

METHODS

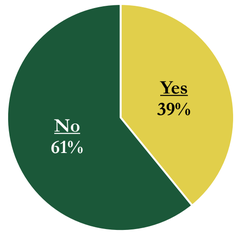
- Screened adult inpatients at University of Vermont Medical Center for experiences with diagnostic error in the past 5 years.
- Conducted structured interviews with patients who experienced diagnostic error.
- Performed qualitative analysis using Grounded Theory.
- Performed Fisher Exact Tests investigating correlations between demographics and patient reports

DEMOGRAPHICS

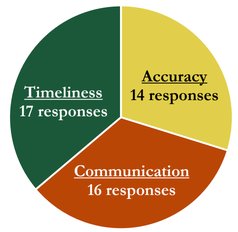
Number of patients approached	102
Number of patients consented / screened	77
Number of patients excluded from final data pool	8
Total number of patients included in final data pool	69
Median age (decade)	60-70
Number of (%) male	40 (58%)
Number of (%) female	29 (42%)

RESULTS

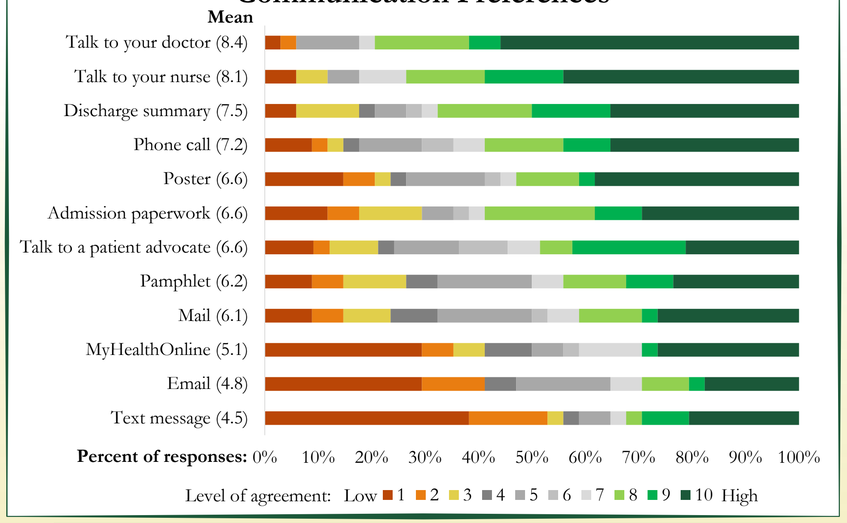
Percentage of Patients Reporting Diagnostic Errors



Types of Reported Errors



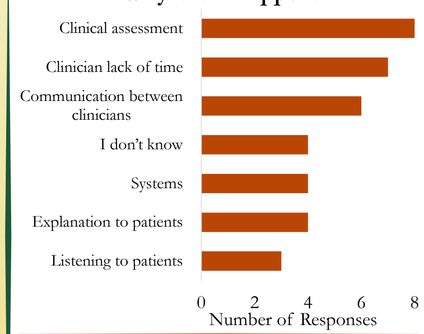
Communication Preferences



Fisher exact tests detected no significant associations between demographics and patient reports.

PATIENT PERSPECTIVES

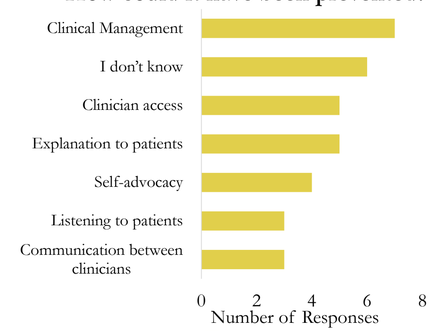
Why did it happen?



"They're rushed, tired, understaffed... People get stretched past the point where they can take all the time they would like to find what's going on."

"[T]hey were like a bloodhound, finding an answer. Now you go in for any little problem, they have an excuse for you."

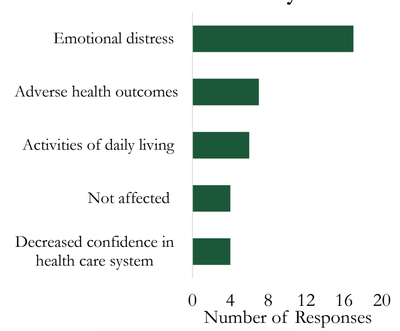
How could it have been prevented?



"If you want something solved, you have to get into it yourself."

"Better communication between doctors…"

How has it affected you?



"It made me feel like they thought I was crazy or didn't know what I was talking about."

"mentally, spiritually, physically, psychologically"

DISCUSSION

♦Based on the IOM definition of diagnostic medical error, **39%** of interviewed patients experienced an error in the **past five years**.

♦Errors in accuracy, communication, and timeliness were **evenly** represented.

♦Patients highlighted **inadequate clinical assessment**, **lack of time with doctors** and **poor communication** as causes of errors.

♦Patients pointed to **improvement in clinical management**, **increased access to doctors** and **improved communication** as ways to prevent errors.

♦**Emotional distress** was the most frequently reported outcome of diagnostic medical error. **Adverse health outcomes** and **impaired activities of daily living** were also reported.

♦Communication preferences varied greatly among patients. Overall, patients preferred **talking to care providers** and **detailed paper instructions** over **digital communication**.

RECOMMENDATIONS

- Implement a systematic approach to improve communication and prevent diagnostic medical error.
- Medical errors are common and go largely unrecognized. Routinely survey patients to identify errors and provide emotional support to patients who desire it.
- Use patient and provider "checklists" for communication at transitions of care[2]:
  - •New diagnoses and explanation of new diagnoses
  - •Patient read-back to assess understanding of diagnoses
  - •Timeline for outstanding test results and next steps
  - •Discharge summary highlighting items added to the problem list during visit.
- Investigate strategies to allow care providers adequate time with patients

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