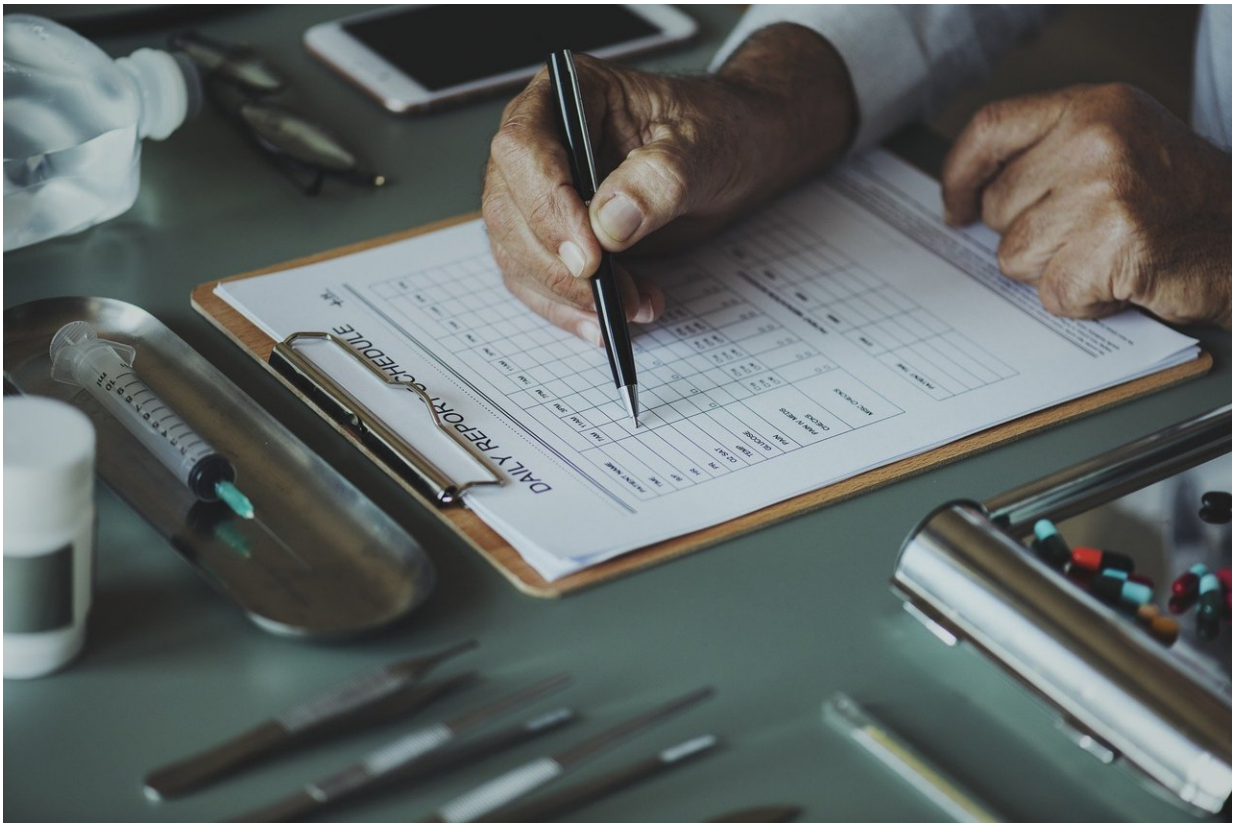
Patients' experiences with misdiagnosis inform patient safety improvement efforts

November 6 2018



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Diagnostic errors affect an estimated 12 million U.S. adult outpatients annually; however, patients' experiences of these errors are underexplored. To gain insight into the patient perspective, researchers

from Baylor College of Medicine conducted a study to identify factors that could contribute to diagnostic error, specifically those related to patient-physician interaction. The study appears in the November issue of *Health Affairs*.

"To conduct this study, we worked with the Empowered Patient Coalition, a nonprofit focused on patient advocacy and healthcare safety," said lead author Dr. Traber Giardina, assistant professor of medicine at Baylor. "Since 2010, the organization has collected patient and family reports of adverse events through their website, and a recent analysis of this database found many that involved diagnostic issues. We looked deeper within this data to explore patients' experiences and factors they identify as contributing to their diagnostic error." Giardina also is a researcher at the Houston VA Center for Innovations in Quality, Effectiveness and Safety (IQuEst).

Giardina and her team evaluated data from 465 patients or family members who reported a diagnostic error to the database between January 2010 and February 2016. They focused only on patients who included a written narrative of their diagnostic error experience. Upon reviewing 184 diagnostic error narratives, they found that approximately 75 percent included discussions about clinicians' behaviors that the patient or family members thought contributed to the error.

Researchers identified four themes of problematic behaviors, or behaviors inconsistent with patient-centered care, that patients indicated were related to the diagnostic process. These themes are:

- Ignoring patients' knowledge: Many patients felt that clinicians ignored or dismissed their reports of clinical clues such as worrisome symptoms, changes in patient status or failure to improve, which resulted in their diagnostic error. For instance, the patient might introduce a symptom and the physician might

dismiss it or downplay it.

- Disrespecting patients: The manner in which clinicians communicated with patients and families may have contributed to diagnostic error. Disrespectful behaviors included belittling, mocking, stereotyping or being rude to the patient.
- Failing to communicate: This category included a wide range of descriptions from ineffective communication styles to outright refusal to speak with patients and families. For example, some patients reported clinicians being unresponsive to questions, not responding to telephone calls or inquiries or requests, and failing to communicate directly with patients and families.
- Engaging in manipulation or deception: While this was the least frequent, patients felt their physician was using fear to influence them in a certain direction or was misleading or misinforming them. For instance, a patient said a physician told her that she was going to die if she did not have surgery even though she requested a second opinion. Ultimately, it turned out the patient never needed the surgery.

Study findings have several implications for training, clinical practice and policy efforts to improve patient safety and decrease diagnostic errors.

"One important study implication is that health systems should encourage patients to speak up in some way when there is a problem," said senior author Dr. Hardeep Singh, chief of the Health Policy, Quality and Informatics Program at the Houston VA's IQuEst and professor of medicine at Baylor. "Often, patients are not comfortable speaking up or don't know who to speak to when there is a problem, and having a system in place that allows them to do so in a way that they are comfortable is essential."

Health systems should also monitor safety-related data from patients and

analyze it for patterns suggesting the need for interventions, Singh said. Patients and families often identify problems that are harder to pin-point through traditional data sources but there are no current policy or practice initiatives to gather patient experiences related to misdiagnoses. Insights from this data can help health systems build a culture of accountability and safer diagnosis. For example, reports that identify unsafe physician behaviors—such as consistently failing to listen to patient concerns—could lead to interventions focused on improving communication.

Additionally, Singh suggested the need to emphasize patient safety-related professionalism issues when physicians are in training and on an ongoing and lifelong basis. Changes in medical education curricula and efforts to train physicians on being receptive to patients' needs and more patient-centered behaviors can help efforts to reduce diagnostic errors.

More information: Traber Davis Giardina et al. Learning From Patients' Experiences Related To Diagnostic Errors Is Essential For Progress In Patient Safety, *Health Affairs* (2018). DOI: 10.1377/hlthaff.2018.0698

Provided by Baylor College of Medicine