Can patients identify factors that contribute to their misdiagnosis?

“Yes, patients are the single constant in the diagnostic process. Their perspective is vital to understanding some of the hidden places diagnosis can go wrong,” say Traber Davis Giardina and Hardeep Singh, patient safety researchers at the VA Center for Innovations in Quality, Effectiveness and Safety (IQuESt) and Baylor College of Medicine.

Misdiagnosis (or diagnostic error) is underreported. Patients have unique perspectives that are not well incorporated in current patient safety and adverse event reporting mechanisms. Some of the only ways to collect information about a patient’s experience with health care quality and safety are through patient complaints or narratives in patient experience surveys. But diagnostic concerns can easily be lost in the numerous types of issues that patients encounter. The authors’ study explored how patients can provide new supplemental data on diagnostic errors.

The study analyzed voluntary patient and family self-reports of diagnostic errors. The authors partnered with a patient coalition that had collected patient and family reports of adverse events since 2010. Upon reviewing 184 reported diagnostic error narratives, the authors found that almost three-fourths included a discussion of problematic clinician behaviors associated with a diagnostic error. Behaviors were categorized into four themes: ignoring patient knowledge, disrespecting patients, failing to communicate, and engaging in manipulation or deception.

Narratives revealed that certain clinician behavioral and interpersonal factors contributed to diagnostic errors. Refusing to listen to concerns about a patient’s decline is an important example. The study’s findings build on prior literature that suggests that high numbers of patient complaints can correlate with higher numbers of malpractice claims. However, despite growing interest in the role of patients and families in safety and quality, there are no current policy or practice initiatives to supplement patient safety data with information, feedback and experiences self-reported by patients. Patients and families can identify safety events not necessarily captured in incident reporting or in medical records.

The study authors recommend that health systems develop and use systematic methods to collect patient reports of safety issues, allowing identification and monitoring of contributory factors, including unprofessional clinician behaviors. In addition to developing a safety culture that encourages reporting, the authors suggest reforms in medical education that emphasize the safety impacts of such behaviors and patient-centered communication practices. Fostering clinician accountability for unprofessional behavior may be challenging and will need to be balanced with system pressures on clinicians that lead to burnout, which itself can be a contributory factor for inappropriate conduct. Policy efforts that nurture the patient-physician relationship are long overdue and would enhance patient-physician communication, provide time and space for physicians to listen to patients, and allow effective data gathering. Together, these efforts can support clinical reasoning and reduce diagnostic errors.
HEALTH POLICY research presents a summary of findings on current health policy issues. It is provided by Vivian Ho, Ph.D., James A. Baker III Institute Chair in Health Economics and director of the Center for Health and Biosciences at Rice University’s Baker Institute for Public Policy, in collaboration with Laura Petersen, M.D., MPH, chief of the Section of Health Services Research in the Department of Medicine at Baylor College of Medicine.

This publication aims to make research results accessible to regional and national health policymakers. The views expressed herein are those of the study authors and do not necessarily represent those of the Baker Institute or of Baylor College of Medicine.

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