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:

- Establish an accurate explanation to the patient’s health problem(s)
- Establish a timely explanation to the patient’s health problem(s)
- Effectively communicate the explanation to the patient

Diagnostic errors may contribute to 10% of patient deaths.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)
- Determine patients’ preferred methods for communicating healthcare information.
- Investigate strategies to allow care providers adequate time with patients

METHODS

- 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%)

PERCENTAGE OF PATIENTS REPORTING DIAGNOSTIC ERRORS

<table>
<thead>
<tr>
<th>Types of Reported Errors</th>
<th>No 60%</th>
<th>Yes 39%</th>
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</thead>
<tbody>
<tr>
<td>Clinical Assessment</td>
<td></td>
<td></td>
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<tr>
<td>Communication between clinicians</td>
<td></td>
<td></td>
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<tr>
<td>I don’t know</td>
<td></td>
<td></td>
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<tr>
<td>Systems</td>
<td></td>
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<tr>
<td>Explanation to patients</td>
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<tr>
<td>Listening to patients</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

COMMUNICATION PREFERENCES

<table>
<thead>
<tr>
<th>Patient PERSPECTIVES</th>
<th>Why did it happen?</th>
<th>How could it have been prevented?</th>
<th>How has it affected you?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinical Assessment</td>
<td>Clinical Management</td>
<td>Emotional distress</td>
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RESULTS

Communication Preferences

| Mean | Talk to your doctor | 8.4 | Talk to your nurse | 8.1 | Discharge summary | 7.5 | Phone call | 7.2 | Poster | 6.6 | Admission paperwork | 6.6 | Talk to a patient advocate | 6.6 | Pamphlet | 6.2 | Mail | 6.1 | MyHealthOnline | 5.1 | Email | 4.8 | Text message | 4.5 |

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

DISCUSSION

- Based on the IOM definition of diagnostic medical error, 39% of interviewed patients experienced an error in the past five years.
- Elicit patient perspectives on the causes and impacts of diagnostic errors.
- Develop patient-centered strategies to prevent diagnostic errors.
- Determine patients’ preferred methods for communicating healthcare information.
- Investigate strategies to allow care providers adequate time with patients

REFERENCES