

Reducing Diagnostic Error | Patients and Families

Ten Things I Could Do Tomorrow

Background

Diagnosis is the first step in addressing any new patient complaint or concern, and typically the diagnostic process is completed efficiently and accurately. Diagnostic errors, when they occur, derive from the complexity of the diagnostic process itself — from minor flaws in our health care systems, and from the inherent limitations of clinical reasoning.

Although we now have a basic understanding of how diagnostic errors arise, we know very little about how to prevent them. A wide range of interventions have been proposed, but very few have been formally evaluated.¹⁻⁷ Until the science of error prevention catches up with the need that exists, the best we can do is adopt common-sense steps that address the most common and important factors known to contribute to diagnostic error and harm. The list that follows presents initial suggestions, acknowledging that diagnosis involves not just the patient and the physician, but other members of the health care team and the practice environment.

1. Be a good historian and trust your own judgment. Keep records of your symptoms, when they started, how they have responded (or not) to treatment.
2. Take advantage of cancer screenings recommended by the United States Preventive Services Task Force (USPSTF).
3. Make sure you know your test results and keep accurate records of them.
4. Don't assume no news is good news. Follow up if you don't receive copies or results of tests and consults.
5. Speak up and ask:
 - a. What else could it be?
 - b. What should I expect?
 - c. When and how should I follow up if symptoms persist or worsen?
 - d. What resources can I use to learn more?
 - e. Is this test worthwhile? Can we wait? (More testing does not always mean better care.)
6. Don't assume the health care system will adequately coordinate your care. Be proactive, keep your own records, and help coordinate your own care.
7. Provide feedback about diagnostic errors to providers and organizations.
8. Understand that diagnosis always involves some element of uncertainty.
9. Get a second opinion regarding serious diagnoses or unresolved symptoms.
10. Take advantage of help and support such as support groups, patient safety staff, patient advocates, and online forums.

References

- 1 Graber M, Kissam S, Payne V, Meyer A, Sorensen A, Lenfestey N, et al. Cognitive interventions to reduce diagnostic error: A narrative review. *BMJ Quality and Safety*. 2012;21:535-57.
- 2 Graber ML. Reducing diagnostic error in medicine — There's a job for everyone. *NPSF Focus on Patient Safety*. 2009;12(2): 6-7.
- 3 Singh H, Graber M, Kissam S, et al. System-related interventions to reduce diagnostic errors: A narrative review. *BMJ Quality and Safety*. 2012;21:160-70.
- 4 McDonald K, Matesic B, Contopoulos-Iannidis D, Lonhart J, Schmidt E, Pineda N, et al. Patient Safety Strategies Targeted at Diagnostic Errors — A Systematic Review. *Ann Int Med*. 2013;158(5):381-9.
- 5 Croskerry P, Singhal G, Mamede S. Cognitive debiasing 2: impediments to and strategies for change. *BMJ Quality and Safety*. 2013;22ii:65-72.
- 6 Croskerry P, Singhal G, Mamede S. Cognitive debiasing 1: Origins of bias and theory of debiasing. *BMJ Quality and Safety*. 2013;22 Suppl 2:ii58-64.
- 7 Mamede S, Schmidt HG, Rikers R. Diagnostic errors and reflective practice in medicine. *J Eval Clin Pract*. 2007;13(1):138-45.