

# Diagnostic Error (Part 4) – Responding to Diagnostic Error

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In Part 4 of a series of 5 podcasts on diagnostic error, James talks to Mark Graber and Owen Bradfield about responding to diagnostic error.

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- [Diagnostic Error \(Part 1\) - An overview](#)
- [Diagnostic Error \(Part 2\) - Decision-making and bias](#)
- [Diagnostic Error \(Part 3\) - Preventing Diagnostic Error](#)
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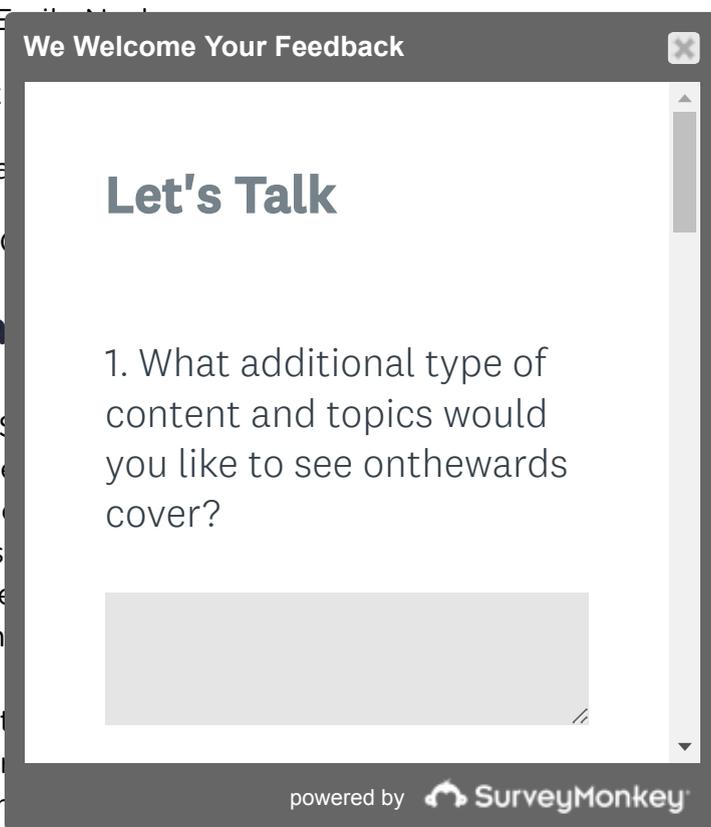
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**Editor:** Amanda Wa

**Interviewee:** Mark C

## About Dr Ma

Dr Mark Graber is a S  
Medicine at the State  
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Patient Safety Aware  
has also been a pion  
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## About Dr Owen Bradfield

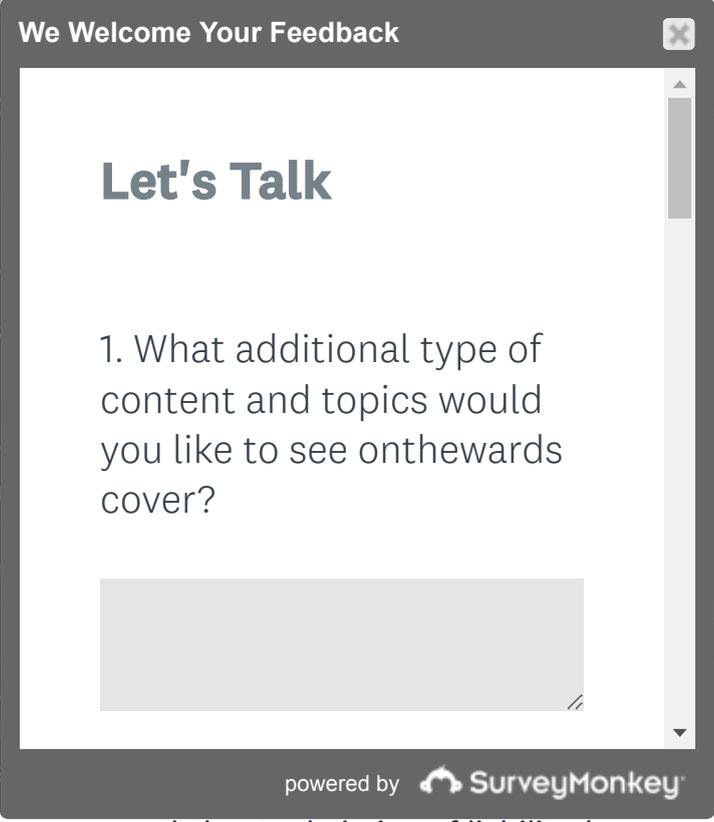
Dr Owen Bradfield is a Senior Claims Manager, Medical Advisor and Medico-Legal Advisor at [Avant](#). Owen graduated with First Class Honours in 2003 from Monash University's unique combined Bachelor of Medicine/Bachelor of Surgery and Bachelor of Laws program. He was awarded the Ebsworth & Ebsworth Prize for Medical Law and the Victorian Institute of Forensic Medicine Prize. Owen is a qualified medical practitioner and lawyer. He completed his internship at The Alfred Hospital in Melbourne and later completed his articles of clerkship at Slater & Gordon Lawyers. He also has experience in health services management and completed an MBA at Monash University, where he was awarded the prize for the top graduating student. In addition to his work at Avant, Owen also works as a part-time [General Practitioner](#), is Deputy

## Diagnostic error (Part 4) - responding to diagnostic error

With Dr Mark Graber, leader in the field of patient safety, and Dr Owen Bradfield, lawyer, doctor and Senior Claims Manager for Avant Mutual

### Introduction

This is Part 4 of a series of 5 podcasts on diagnostic error. Diagnosis is important to both patient and doctor. Diagnostic error can be defined as a failure to provide an explanation of the patient's health problem. There is a dichotomy within how clinicians think, relying on both intuition and analytical thinking. Intuitive thinking is much more heavily utilised, however it is also more prone to diagnostic error.



**1. How should clinicians respond to diagnostic errors?**

- Open disclosure
  - Patients diagnosed with a diagnostic error
  - Discuss the error with the patient
  - Tell the patient what happened
  - Communicate the error to the community
  - Explain the error and how it can be fixed
  - Seek advice from the patient's lawyer (e.g. Avant's Open Disclosure team) to undertake a disclosure
  - Have a strategy for dealing with the error
- Doctors are often concerned about admission of liability, however they can be assured that under Australian law, an apology doesn't amount to an admission of liability, and saying 'sorry' to patients amounts to an admission of facts rather than liability

**2. How should clinicians respond to colleagues making diagnostic errors?**

- Give junior staff permission to discuss errors if they observe them, to create a culture of patient safety
- Discussion with colleagues in the face of error can improve the diagnostic process

- Explain to colleagues that you want to hear feedback about yourself (both positives and negatives)

### 3. How should organisations respond to diagnostic errors?

- Have an Open Disclosure policy
- Support physicians (the second victim, who made the mistake) with provision of counselling services
- Have methods for reviewing diagnostic errors - e.g. Root Cause Analysis (RCA) is a method for identifying the cognitive, systems-based and patient-related factors that contributed to error

### Refer

- NSW Health, Op  
at:<http://www1.health.nsw.gov.au>

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**Tags:** #Avant,#c  
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## Let's Talk

1. What additional type of content and topics would you like to see onthowards cover?

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