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.

Listen to the other parts here:

- Diagnostic Error (Part 1) - An overview
- Diagnostic Error (Part 2) - Decision-making and bias
- Diagnostic Error (Part 3) - Preventing Diagnostic Error
- Diagnostic Error (Part 5) - Learning and teaching about Diagnostic Error

About Dr Mark Graber

Dr Mark Graber is a Senior Fellow at RTI International and Professor Emeritus of Medicine at the State University of New York at Stony Brook. He has an extensive background in biomedical and health services research, with over 70 peer-reviewed publications. Mark is a national leader in the field of patient safety and originated Patient Safety Awareness Week in 2002, an event now recognised internationally. Mark has also been a pioneer in efforts to address diagnostic errors in medicine, and his research in this area has been supported by the National Patient Safety Foundation and the Agency for Healthcare Research and Quality. In 2008, he convened and chaired the first Diagnostic Error in Medicine conference. In 2011, Mark founded the new Society to Improve Diagnosis in Medicine and serves as President of SIDM.

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 Chair of the Patient Review Panel and Chair of the Law Institute of Victoria’s Health Law Committee.
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 a clinician respond if they have made a diagnostic error?

- Open disclosure with patients
  - Patients understand that we are human; medicine is complicated and diagnosis is not a certainty
  - Discussion should be early, honest and forthright
  - Tell them what happened and why
  - Communicate that we still have their interests foremost
  - Explain that we will try and understand what went wrong so that we can fix it
  - Seek advice from your Medical Indemnity Insurance Provider (e.g. Avant’s 24/7 medicolegal advisory service), your hospital’s Open Disclosure Response Team and/or a colleague who has previously undertaken open disclosure
  - Have a support person present for the doctor

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

Reference


Related Podcasts

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Tags: #Avant,#diagnosis,#diagnostic error,#medicolegal,#Open Disclosure,#patient safety,#responding to diagnostic error,#Root Cause Analysis