Workshop on Patients Safety: Diagnostic Errors

18 July 2023

“Together we have the unique opportunity to improve the lives of patients around the globe.”

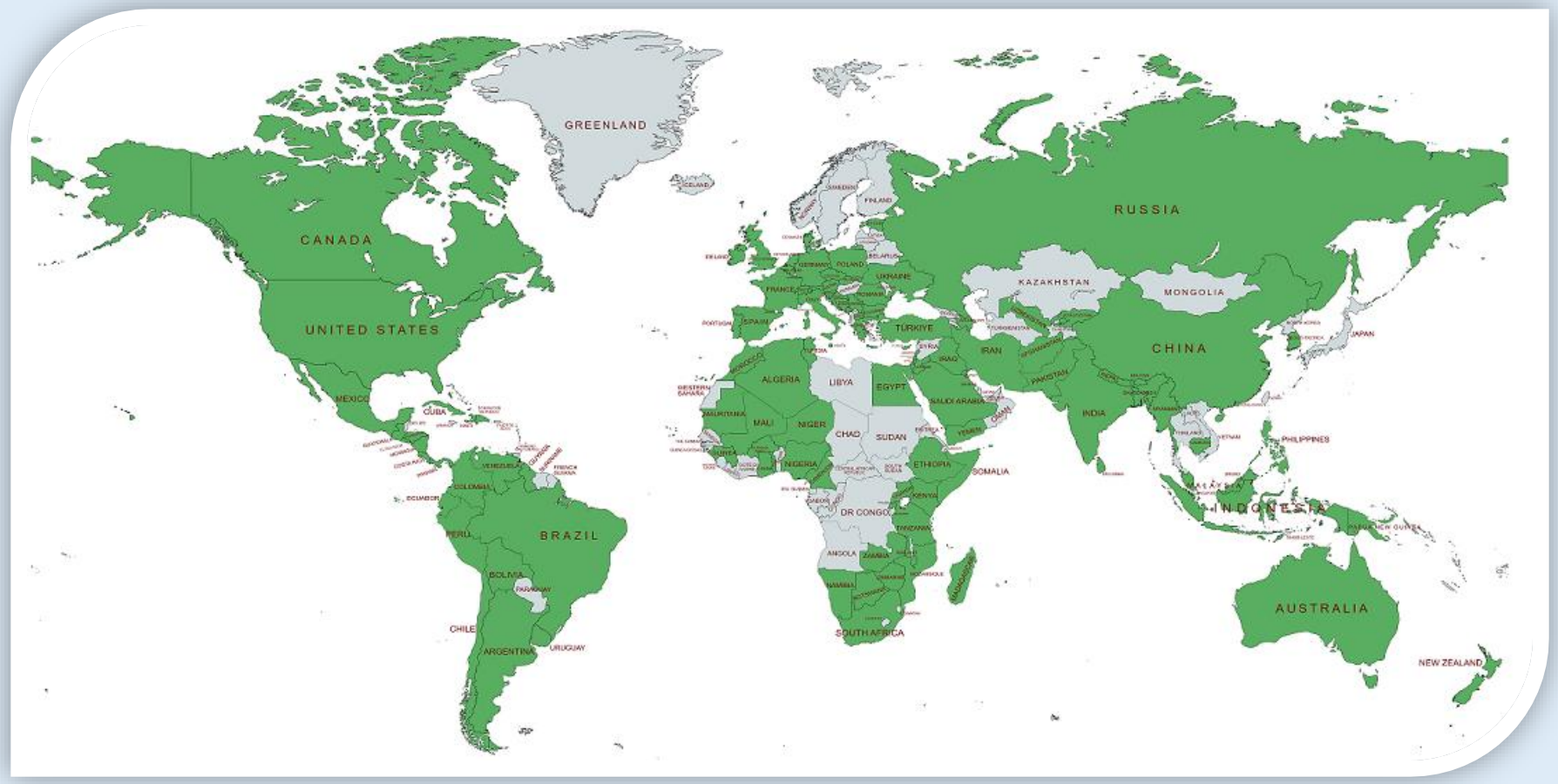
World Patients Alliance

WPA: Who We Are & What We Do

World Patients Alliance (WPA) is the umbrella organization of patients and patients-organizations around the globe. The WPA provides the platform to empower and raise the patients' voice for the provision and access to safe, quality and affordable healthcare. We represent patients from all world regions and across all disease areas.

427
Member Organizations

117
Countries



Workshop on Patients Safety: Diagnostic Errors
18 July 2023

World Patients Alliance

Patient Safety & Quality Council

Helen Haskell (USA)

Jolanta Bilinska (Poland)

Regina Kamoga (Uganda)

Hussain Jafri (Pakistan)

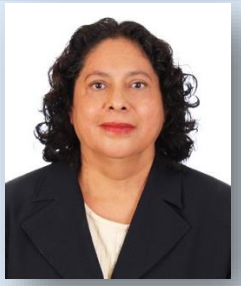
J S Arora (India)

Carole Bennet (Australia)

Anna Silivinska (Poland)

Melissa Sheldrick (Canada)

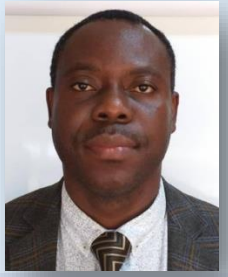
Stephanie Newell (Australia)



Evangelina Vazquez

Alex Adusei (Ghana)

Janek Kapper (Estonia)



Dr. Ernest Konadu Asiedu (Ghana)

Randall Madrigal (Costa Rica)

Nagwa Metwally (Egypt)

Frankie Fombong, Cameroon

Ruth Nankanja, Uganda

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Workshop Intro

The global burden of Diagnostic Errors is significant and has far-reaching implications for patients, healthcare systems, and society as a whole. Patient engagement plays a vital role in mitigating diagnostic errors.

World leading patient advocates and experts in patient safety will share their thoughts on the following:

Diagnostic Safety
Patient Engagement in Diagnosis
Case Studies

Topics and Speakers

Agenda

1. Welcome & Introductions
Helen Haskell, USA
President Mothers against Medical Errors
Chair WPA Patient Safety & Quality Committee

2. Introduction to Diagnostic Safety
Hardeep Singh, MD, MPH, USA
Chief, Health Policy, Quality and Informatics Program,
Center for Innovations in Quality, Effectiveness and Safety, Houston TX

3. Patient Engagement in Diagnosis
Helen Haskell, USA

4. Presentation of case studies by patient advocates
Patient 1: Nagwa Metwally, Egypt
Patient 2: Margaret Murphy, Ireland

5. Panel Discussion

6. Closing Remarks
Hussain Jafri, Pakistan
Founding Director WPA

Our Speakers

Helen Haskell
Chair WPA Patient Safety & Quality Council, USA

Hussain Jafri
Founding Director WPA, Pakistan

Hardeep Singh, MD MPH,
Chief Health Policy, Center of Innovations in Quality, USA

Nagwa Metwally
Patient for Patient Safety, Egypt

Margaret Murphy
Patient for Patient Safety, Ireland

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Helen Haskell, MA

President Mothers Against Medical Error
Chair WPA Patient Safety & Quality Council
United States

Since the medical error death of her young son Lewis in 2000, Helen Haskell has worked to bring the patient voice to healthcare safety and quality. Helen is president of the American nonprofit patient organizations Mothers Against Medical Error and Consumers Advancing Patient Safety and is an Institute for Healthcare Improvement senior fellow. She is Chair of WPA Patient Safety and Quality Council and former co-chair of the WHO Patients for Patient Safety Advisory Group and a recently retired board member of the Accreditation Council for Graduate Medical Education and the Institute for Healthcare Improvement. She is a member of the board of directors of the International Society for Rapid Response Systems, the Patient Safety Action Network and is on the steering committee of Consumers United for Evidence-Based Medicine. She serves on many other boards and committees, including quality and safety committees at the National Quality Forum, AHRQ, and the Center for Medicare and Medicaid Services. She was a winner of Consumer Reports' first National Excellence in Advocacy award in 2011 and was named by Modern Healthcare magazine as one of the "100 Most Powerful People in Healthcare" in 2009 and by Becker's Hospital Review as one of 50 leaders in patient safety in 2015, 2016, and 2017. She has written numerous journal articles and patient educational materials on patient safety and patient engagement and is co-editor of an interprofessional textbook using patient narrative to teach patient safety and professional competencies. She has been featured in dozens of articles and videos on patient safety, including Transparent Health's *Lewis Blackman Story,* shown in hospitals and medical and nursing schools across the world.

Hussain Jafri

Founding Director, World Patients Alliance

Hussain Jafri is the Founding Director of World Patients' Alliance. He is also the Secretary General of Alzheimer's Pakistan, the national association of Alzheimer's disease and related dementias that Hussain founded in 1999 as a result of his experiences as a care giver for his grandfather with Alzheimer's Disease. He has been very active in the field of patient safety and has remined the Vice Chair of Advisory Group of WHO's Patients for Patients Safety Program (PFPS). Hussain has also founded Pakistan Patient Safety Initiative and has been working towards several patient safety initiatives. The Government of the Punjab has also nominated him the Provincial Focal Person on Patients Safety & Quality and given the responsibility of developing patients safety and quality services in the health sector of the Punjab province.

He has remarkable experience of working as a volunteer in the social sector and has had an opportunity of working with government, national and international non-profit organizations. Hussain is also a member of the Person and Family Centered Advisory Council (PFCAC) of International Society for Quality in Health Care (ISQua). Moreover, he is also a taskforce member of Global Alliance of Partners for Pain Advocacy (GAPPA). He is an experienced speaker and a resource person and has been presenting nationally and internationally on different issues like patient safety, patients centered healthcare, care giving, advocacy, partnership in health, organizational development, etc. Hussain is a PhD from University of Leeds, UK on prevention of genetic disorders. He is currently working as the Deputy Project Director of Punjab Thalassemia Prevention Program and has published several publications in international indexed journals.

Hardeep Singh, MD MPH

Professor of Medicine | Chief Health Policy,
Center for Innovations in Quality, Effectiveness and Safety (IQuEst)
Michael E. DeBakey Veterans Affairs Medical Center
Baylor College of Medicine, United States

Hardeep Singh, MD MPH is a Professor of Medicine at the Center for Innovations in Quality, Effectiveness and Safety (IQuESt) based at the Michael E. DeBakey VA Medical Center and Baylor College of Medicine, Houston. He leads a portfolio of multidisciplinary patient safety research related to measurement and reduction of diagnostic errors in health care and improving the use health information technology. His research has informed several national and international patient safety initiatives and policy reports, including those by the US National Academy of Medicine, AHRQ, AMA, ACP, CDC, OECD and the WHO. He serves as a nominated member of National Academies' Board of Health Care Services and is an elected Fellow of the American College of Medical Informatics for significant and sustained contributions to the field of biomedical informatics. His contributions include co-developing the "ONC SAFER Guides" which provide national recommendations for safe electronic health record use, co-chairing or participating on several national panels and workgroups on measuring and improving safety and developing pragmatic resources and tools to promote patient safety and diagnostic excellence in clinical practice. He has received several prestigious awards for his pioneering work, including the Academy Health Alice S. Hersh New Investigator Award in 2012, the Presidential Early Career Award for Scientists and Engineers (PECASE) from President Obama in 2014, the VA Health System Impact Award in 2016 and the 2021 John M. Eisenberg Patient Safety and Quality Award for Individual Lifetime Achievement.

Nagwa Metwally

Patient for Patient Safety Egypt

Nagwa Metwally is a seasoned health professional with decades of experience in the public health sphere on both national and international levels. She was a founding partner of the Patient Safety Alliance in Egypt in 2005 and has been a WHO patient safety champion since the same year. She has a long history of active leadership in women's organizations and was an elected president of African Women in the United Nations. She is a former member of the Supreme Council of the Egyptian Red Crescent and was Chairman of the Red Crescent Committee in Ain Shams hospitals tasked with overseeing and improving the quality of medical services across the facilities. She is currently the Red Crescent representative to the Economic, Social & Cultural Council of the African Union. She is a member of the WHO Patients for Patient Safety Advisory Group and serves on the steering committee for preparation for the 2023 World Patient Safety Day. She holds a BA in Journalism from Cairo University and a MA in Mass Communication from the International Institute of Journalism India.

Margaret Murphy

Patient for Patient Safety Ireland

Following the death of her son as a result of medical error, Margaret Murphy has been actively involved as a patient safety advocate. Margaret is former External Lead Advisor for the World Health Organization's Patients for Patient Safety, a network of 400 patient safety champions from 52 countries with 19 collaborating organizations. The focus of her work relates to seeing adverse events as having the potential to be catalysts for change as well as being opportunities for learning, identifying areas for improvement and preventing recurrence. She promotes this viewpoint at local, national and international levels as an invited presenter to conferences, hospital staffs and students. Her area of particular interest is education as a vehicle to achieve sustainable culture change. She holds three honorary doctorates, awarded by Queens University in Ontario, Queens University in Belfast and University College Cork.

Viewed as a resource for including the patient perspective in a variety of initiatives and a range of fora, Margaret has been invited to partner and collaborate in the areas of:

- Policy-making (Commission on Patient Safety & Quality Assurance and implementation steering group; member HSE National Risk Committee)
- Standard-setting (HIQA working group)
- Regulation (lay member, Irish Medical Council and serving on a number of committees),
- Education (Lectures to students – medical, nursing, radiation therapy, pharmacy, etc.)
- Research (Collaborator on EU Research Projects; Assessor final stage applications for NIHR funding)
- Conference speaker – often keynote (conferences, healthcare staffs, seminars, learning sets)
- Team member critical incident reviews
- Designated as one of seventy ISQua Experts in 2012.
- Invited by Prof. the Lord Darzi of Denham to join an advisory group to scope, research and develop a paper on the subject of patient empowerment and make recommendations to senior policy makers for presentation at the Global Health Policy Summit, Doha, 2013 and again in 2015.

Hardeep Singh
MD, MPH

Chief Health Policy, Center for Innovations in Quality,
Effectiveness and Safety (IQuESt),
Michael DeBakey Veterans Affairs Medical Center
Baylor College of Medicine, USA

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Diagnostic Errors: The Problem, the Progress and the Opportunities

Hardeep Singh, MD, MPH

CENTER FOR INNOVATIONS IN QUALITY, EFFECTIVENESS & SAFETY (IQUEST)

MICHAEL E. DEBAKEY VA MEDICAL CENTER

BAYLOR COLLEGE OF MEDICINE

TWITTER: @HardeepSinghMD

IQUEST CENTER FOR INNOVATIONS IN QUALITY, EFFECTIVENESS & SAFETY

Baylor College of Medicine

VA HEALTH CARE Defining EXCELLENCE in the 21st Century

ABOUT NEW YORK

An Infection, Unnoticed, Turns Unstoppable

By JIM DWYER Published: July 11, 2012

For a moment, an emergency room doctor stepped away from the scrum of people working on Rory Staunton, 12, and spoke to his parents.

“Your son is seriously ill,” the doctor said.

“How seriously?” Rory’s mother, Orlaith Staunton, asked.

The doctor paused.

“Gravely ill,” he said.

How could that be?

Two days earlier, diving for a basketball at his school gym, Rory had cut his arm. He arrived at his pediatrician’
next day, Thursday, March 29, vomiting, feverish and with pain in his leg. He was sent to the emergency room
Langone Medical Center. The doctors agreed: He was suffering from an upset stomach and dehydration. He w
fluids, told to take Tylenol, and sent home.

Partially camouflaged by ordinary childhood woes, Rory’s condition was, in fact, already dire. Bacteria had gotten into his blood, probably through the cut on his arm. He was sliding into a septic crisis, an avalanche of immune responses to infection from which he would not escape. On April 1, three nights after he was sent home from the emergency room, he died in the intensive care unit. The cause was severe septic shock brought on by the infection, hospital records say.

ORIGINAL RESEARCH

The frequency of diagnostic errors in outpatient care: estimations from three large observational studies involving US adult populations

BMJ Quality & Safety Online First, 17 April 2014, 10.1136/bmjqs-2013-002627

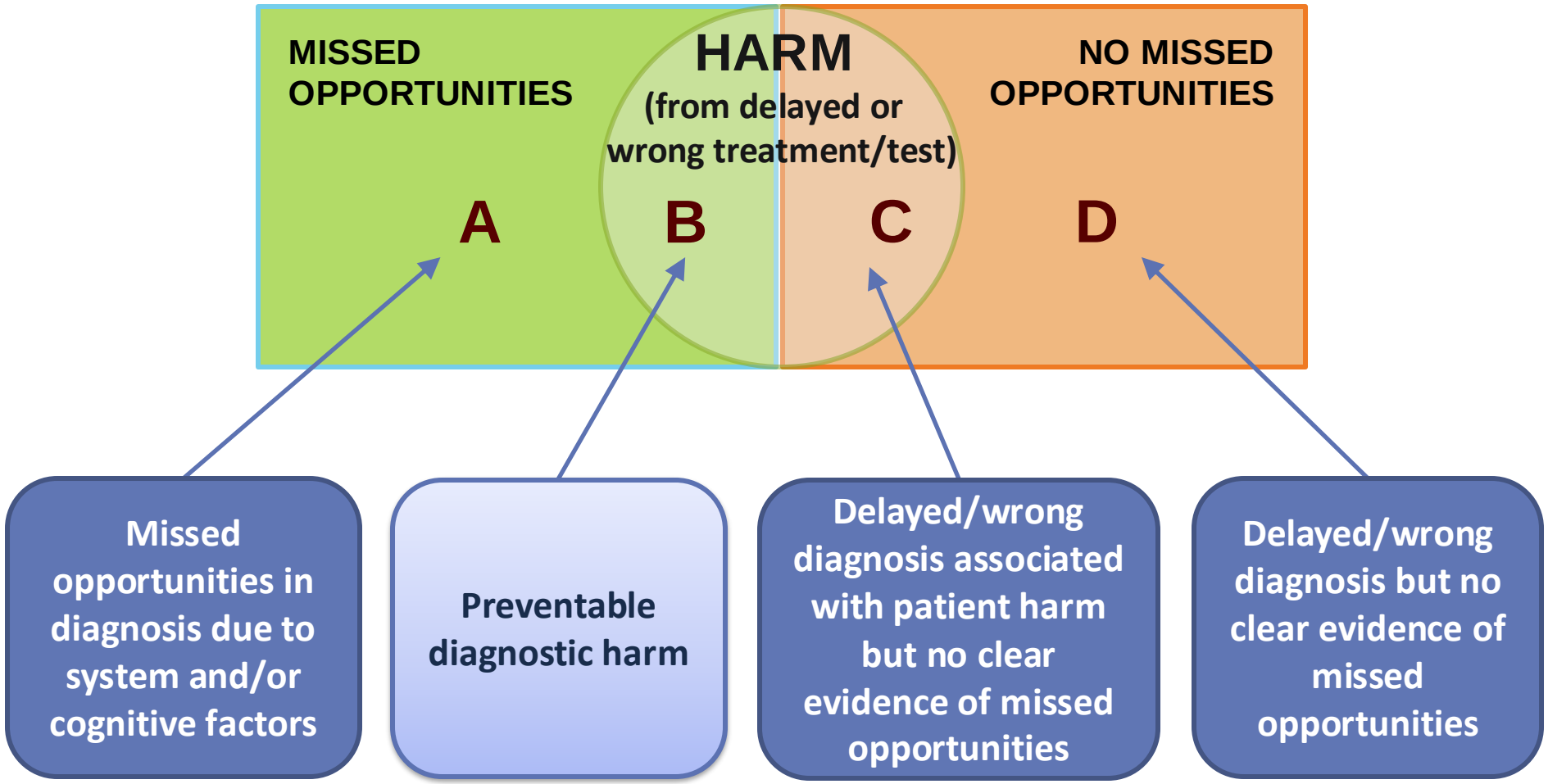
Hardeep Singh,[1] Ashley N D Meyer,[1] Eric J Thomas[2]

National Academies Definition of Diagnostic Error

- The failure to:
  a) Establish an accurate and timely explanation of the patient's health problem(s) or
  b) Communicate that explanation to the patient

The National Academies of SCIENCES ENGINEERING MEDICINE

Defining Preventable Diagnostic Harm



Adapted from Singh, Jt Comm J Qual Pat Saf 2014

Table 1. Most Frequently Missed Diagnoses Among 583 Physician-Reported Cases of Diagnostic Error

Diagnosis	No. (%)
Pulmonary embolism	26 (4.5)
Drug reaction or overdose	26 (4.5)
Lung cancer	23 (3.9)
Colorectal cancer	19 (3.3)
Acute coronary syndrome	18 (3.1)
Breast cancer	18 (3.1)
Stroke, including hemorrhage	15 (2.6)
Congestive heart failure	13 (2.2)
Fracture, various types	13 (2.2)
Abscess, various locations	11 (1.9)
Pneumonia, including type	10 (1.7)
Aortic aneurysm/dissection	9 (1.5)
Appendicitis	9 (1.5)
Depression	9 (1.5)
Diabetes mellitus	8 (1.4)
Tuberculosis	8 (1.4)
Anemia	6 (1.0)
Bacteremia	6 (1.0)
Metastatic cancer	6 (1.0)
Spinal cord compression	6 (1.0)

Table 2
List of the most frequent delayed or missed diagnoses

Delayed or missed diagnosis	Number of cases (n,
Any cancer diagnosis	15 (11%)
Colorectal cancer	5 (3.7%)
Pulmonary embolism	13 (9.6%)
Aortic aneurism	5 (3.7%)
Congestive heart failure	5 (3.7%)
Urinary tract infection	5 (3.7%)
Gastrointestinal perforation	5 (3.7%)

Schiff JAMA IM 2009
Gunderson BMJQS 2020

Themes from Research Studies

Common diseases missed

Missed opportunities to elicit or act upon key clinical findings (history/exam)

Overlooking information in medical record

Singh et al JAMA IM 2012; Singh et al Arch IM 2009

Contributing Factors

Premature closure

Affective bias

Faulty synthesis

Overconfidence

Process failure

Unintended consequence of policy

Sample mix-up

Faulty data gathering

Failure to detect physical finding

Perception error

Misinterpretation of test

Wrong estimate of pretest probability

Inadequate follow-up

Failure to follow up abnormal test

Failed heuristic

Limited access

Communication failure

Knowledge deficit

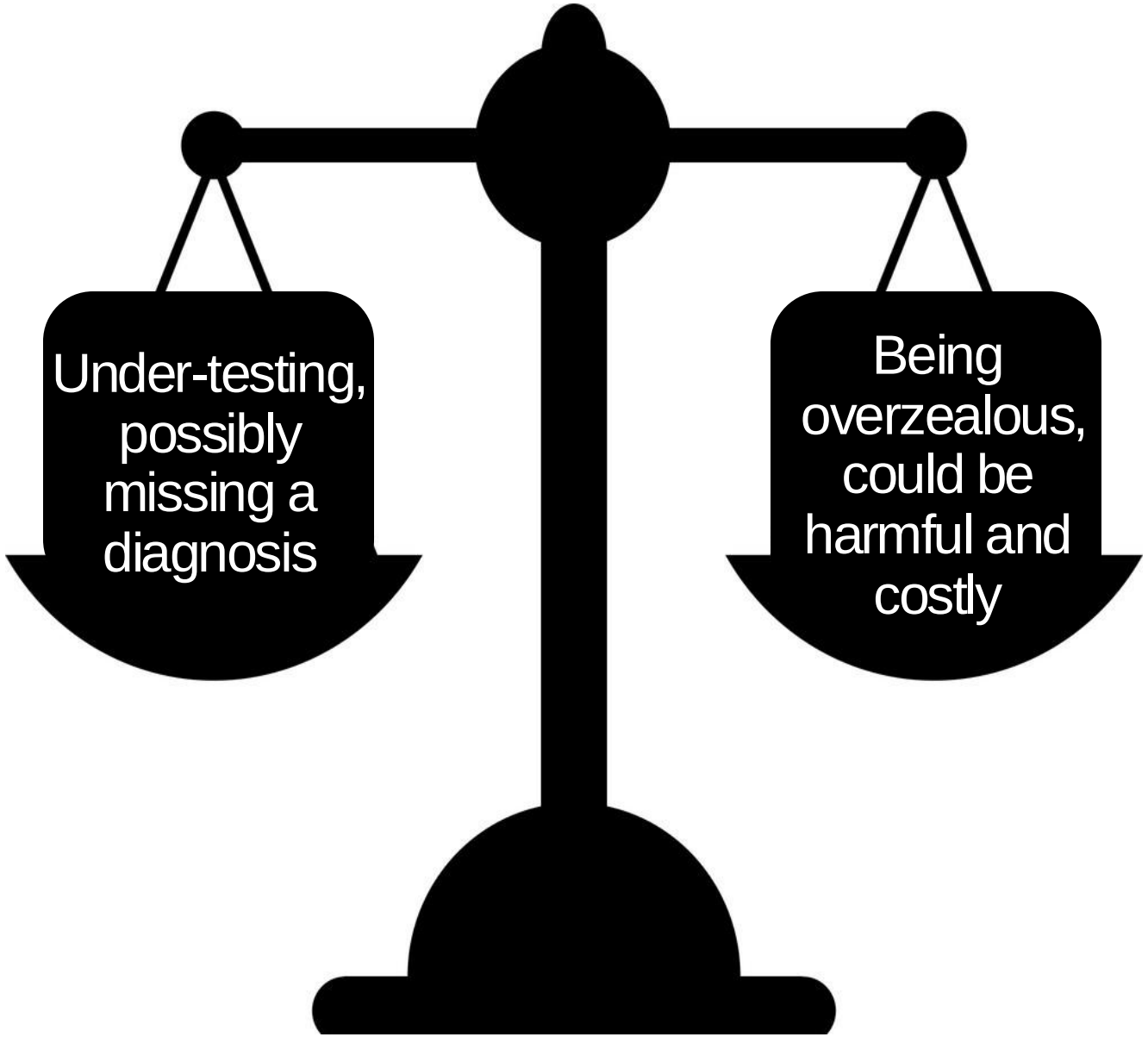
Language barrier

Faulty triggering

Uninformed patient

Thanks to Karen Cosby, MD

Testing Challenges Facing Clinicians



Diagnostic Excellence

- Use **fewest** resources
- Maximize **patient experiences**
- Manage and **communicate uncertainty** to patients
- Tolerates **watchful waiting** when unfocused treatment may be harmful

Meyer AND, Singh H. The Path to Diagnostic Excellence Includes Feedback to Calibrate How Clinicians Think. *JAMA.* 2019;321(8):737–738.

Seek feedback on diagnostic decisions

Make diagnosis a team sport

"Byte" sized practice

Foster critical thinking

Consider biases

PRACTICE POINTER

Five strategies for clinicians to advance diagnostic excellence

Hardeep Singh,[1] Denise M Connor,[2,3] Gurpreet Dhaliwal[2,3]

Learning from Patient Narratives

- Problems related to patient-physician interactions are major contributors
- Behavioral and interpersonal factors
- Patients' perspectives = comprehensive understanding of why diagnostic errors occur and help develop strategies for mitigation

Health Affairs VOL. 37, NO. 11: PATIENT SAFETY

Learning From Patients' Experiences Related To Diagnostic Errors Is Essential For Progress In Patient Safety

Traber Davis Giardina[1], Helen Haskell[2], Shailaja Menon[3], Julia Hallisy[4], Frederick S. Southwick[5], Urmimala Sarkar[6], Kathryn E. Royse[7], and Hardeep Singh[8]See fewer authors

Patients Priorities for Research

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.journals.elsevier.com/patient-education-and-counseling

Short communication

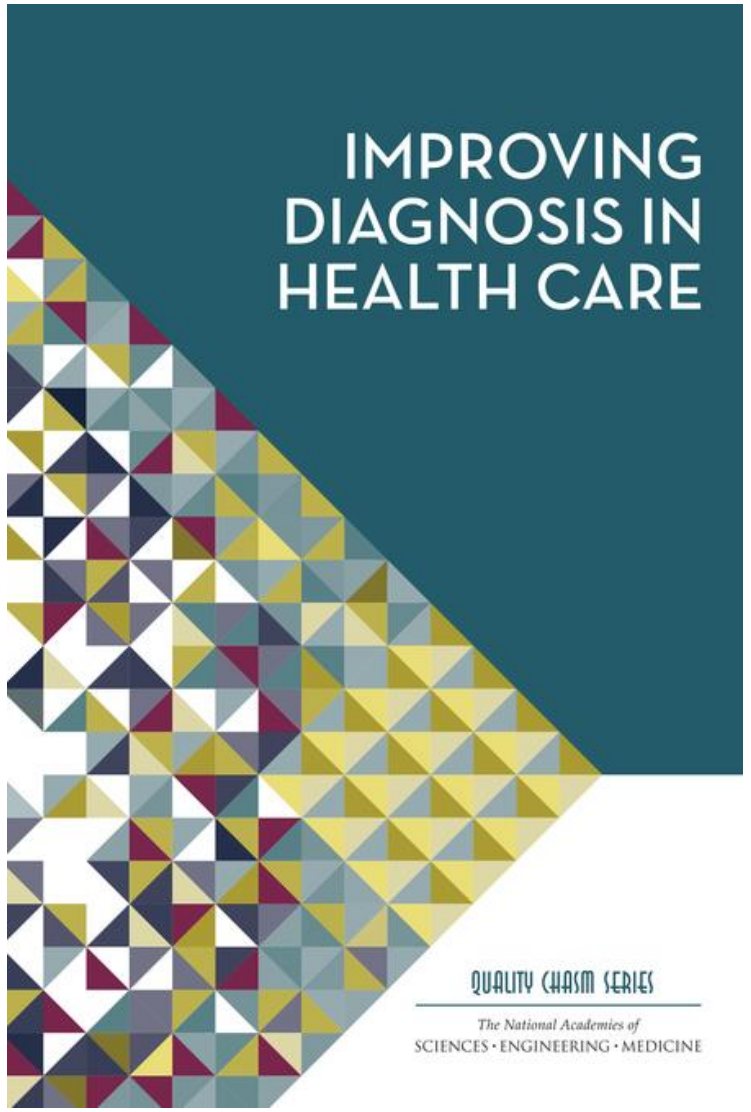
Patient generated research priorities to improve diagnostic safety: A systematic prioritization exercise

Laura Zwaan [a,*], Kelly M. Smith [b,c], Traber D. Giardina [d,e], Jacky Hooftman [a,f], Hardeep Singh [d,e]

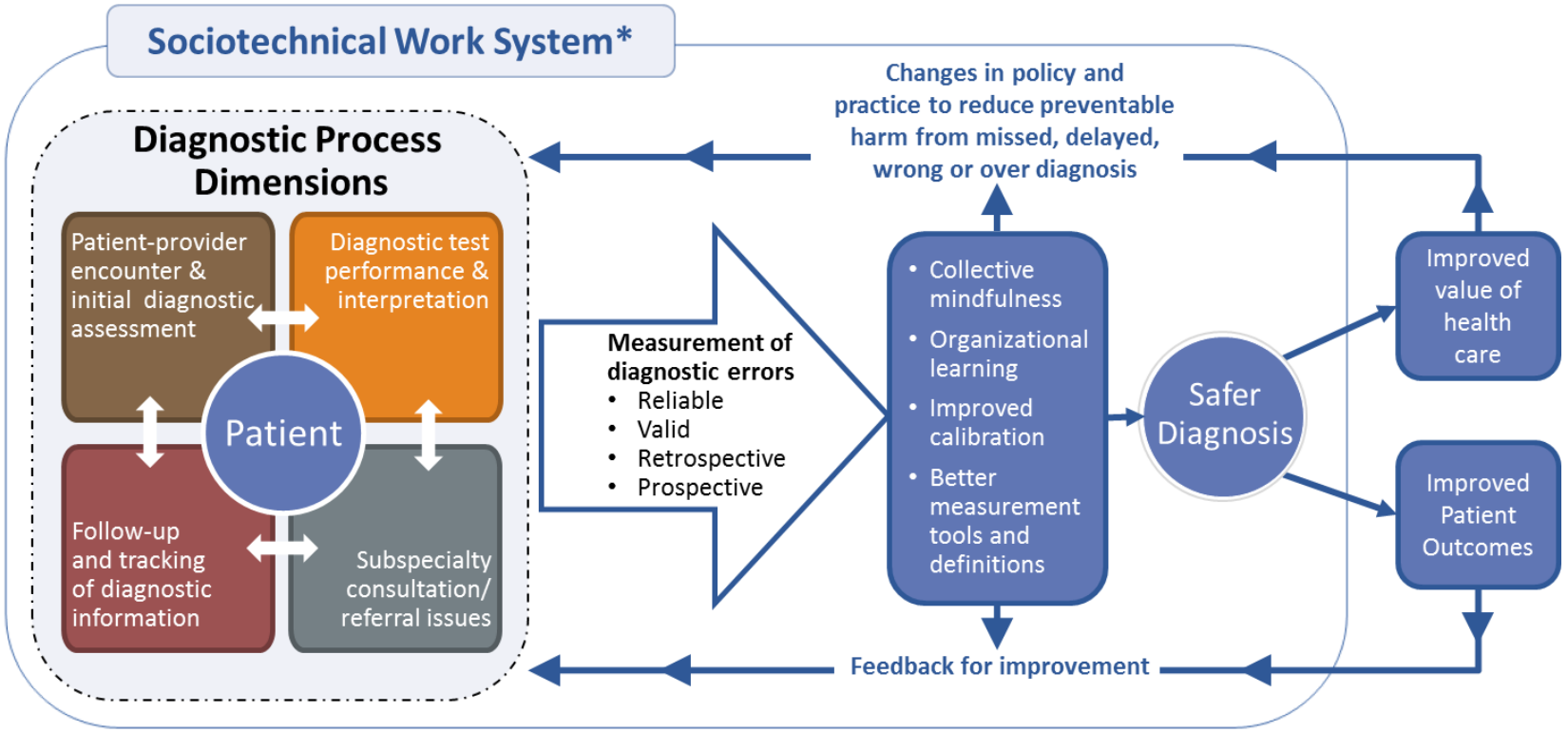
Rank	Research priorities
1	How do we implement better integration, coordination, and communication between clinical teams and patients/caregivers to improve the accuracy and efficiency of the diagnostic continuum?
2	How to accurately track and report diagnostic errors at a health system level?
3	How do clinician documentation requirements affect the diagnostic process and outcomes?
4	What specific solutions would address the common contributing factors that affect the diagnostic process for at risk patients such as rural and low health literacy.
5	How do we identify and decrease gaps in diagnostic care across care transitions?

Accrediting organizations and Medicare

"require that healthcare organizations have programs in place to monitor the diagnostic process and identify, learn from, and reduce diagnostic errors and near misses in a timely fashion."



Safer Dx Framework for Diagnosis

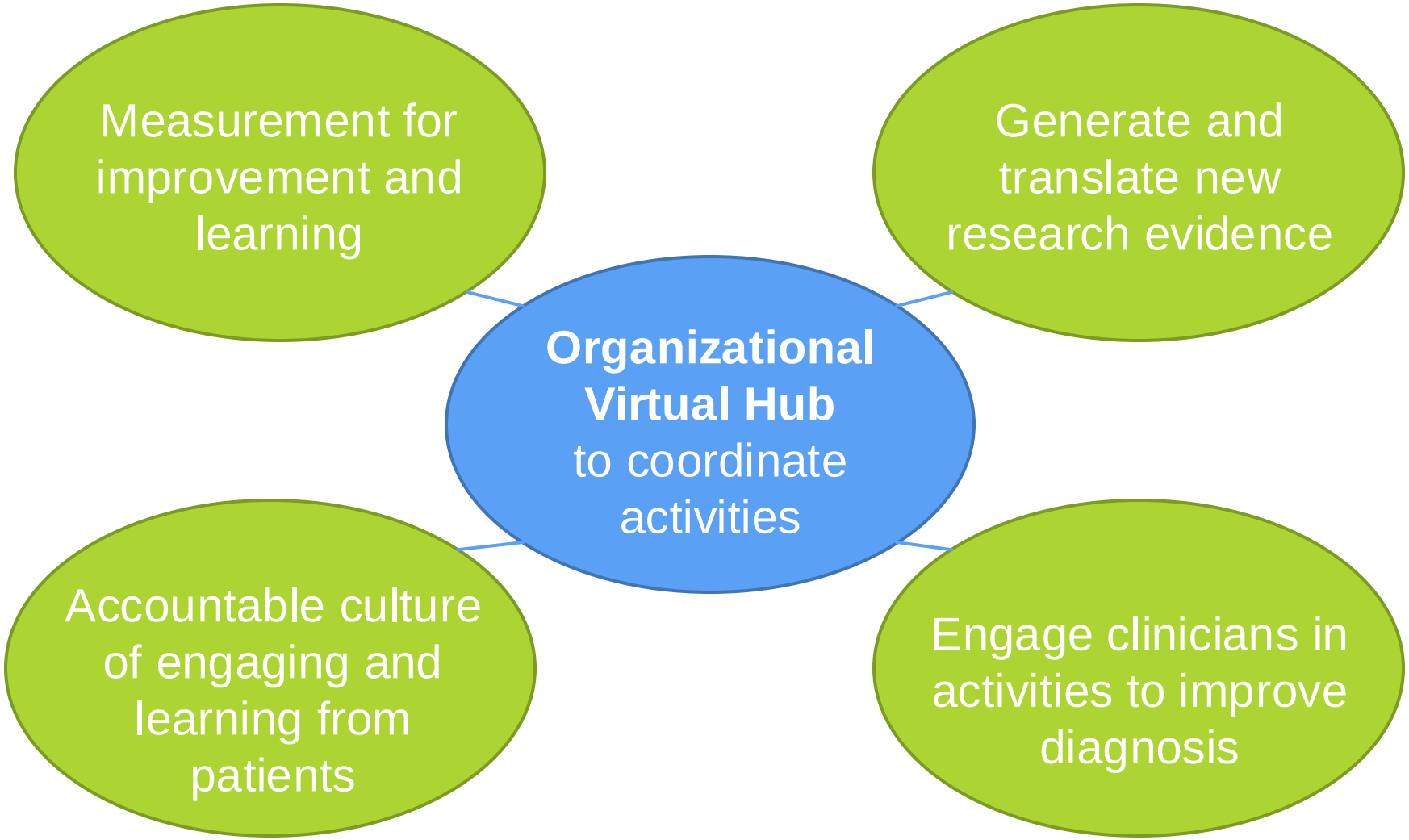


* Includes 8 technological and non-technological dimensions

Singh and Sittig, BMJ Qual Saf 2015

New Care Models: "LEDE" Organizations

LEDE = Learning & Exploration of Diagnostic Excellence



Singh H, Upadhyay DK, & Torretti D. Developing health care organizations that pursue learning and exploration of diagnostic excellence: An action plan. *Acad Med*.

Leveraging Patient Reported Data

ORIGINAL RESEARCH

Use of patient complaints to identify diagnosis-related safety concerns: a mixed-method evaluation

Traber D Giardina [1,2] Saritha Korukonda,[3] Umber Shahid,[1,2] Viralkumar Vaghani,[1,2] Divvy K Upadhyay,[4] Greg F Burke,[4,5] Hardeep Singh [1,2]

Journal of the American Medical Informatics Association, 29(6), 2022, 1091–1100
https://doi.org/10.1093/jamia/ocac036
Advance Access Publication Date: 29 March 2022
Research and Applications

Research and Applications

Inviting patients to identify diagnostic concerns through structured evaluation of their online visit notes

Traber D. Giardina[1], Debra T. Choi[1], Divvy K. Upadhyay[2], Saritha Korukonda[2], Taylor M. Scott[1], Christiane Spitzmueller[3], Conrad Schuerch[2], Dennis Torretti[2], and Hardeep Singh [1]

OpenNotes®

Patients Can Play A Role in Every Step

The Safer Dx Checklist

10 High-Priority Practices for Diagnostic Excellence

PREPARED BY:

Center for Innovation in Quality, Effectiveness, and Safety (IQuESt),
Michael E. DeBakey Veterans Affairs Medical Center and
Baylor College of Medicine, Houston, TX

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Geisinger, Danville, PA

- Divvy Kant Upadhyay, MD, MPH

Institute for Healthcare Improvement, Boston, MA

- Joellen Huebner, BA
- Patricia McGaffigan, RN, MS, CPPS

http://www.ihi.org/resources/Pages/Tools/safer-diagnostic-checklist.aspx

Checklist Example Items

Health care organization actively seeks patient and family feedback to identify and understand diagnostic safety concerns and addresses concerns by codesigning solutions.

Health care organization encourages patients to review their health records and has mechanisms in place to help patients understand, interpret, and/or act on diagnostic information.

Measure DX:

A Resource to Identify, Analyze, and Learn From Diagnostic Safety Events

AHRQ
Agency for Healthcare Research and Quality

PATIENT SAFETY

Overview of Measure Dx

1

Prepare for Measurement

- Engage stakeholders
- Build a team
- Foster psychological safety

2

Conduct a Self-assessment

Inventory available resources to support this work and select a measurement strategy

3

Implement Measurement Strategies

Use one or more data sources within the organization to capture potential diagnostic safety events for further review

4

Review & Analyze Cases

Use a systematic review process to identify learning opportunities and translate findings into useful feedback

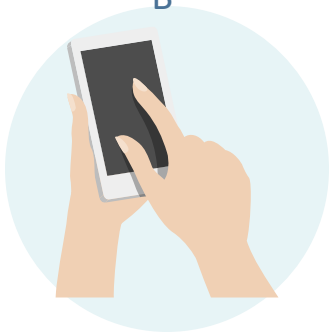
Four Strategies to Detect Diagnostic Safety Learning Opportunities

A

USE EXISTING QUALITY & SAFETY DATA

Examine previously identified safety events for diagnostic improvement opportunities

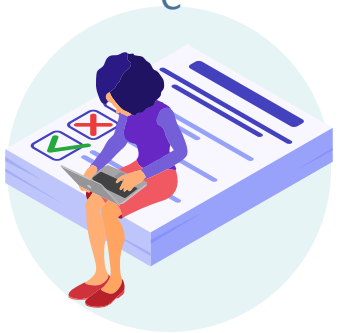
B



SOLICIT REPORTS FROM CLINCIANS

Ask clinicians to bring attention to diagnostic events within an environment of psychological safety

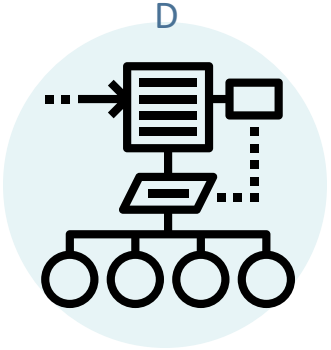
C



LEVERAGE PATIENT-REPORTED DATA

Examine patient surveys, incident reports, and complaints to identify missed opportunities

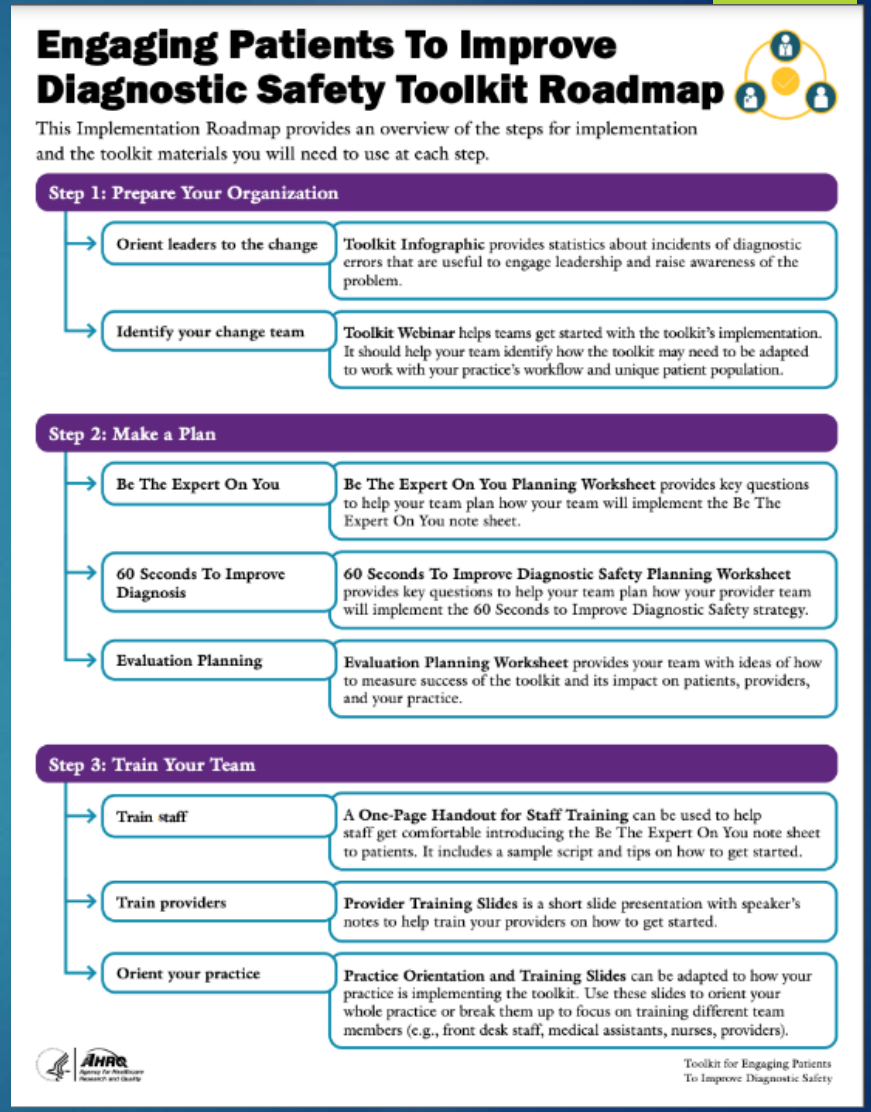
D



EHR-ENHANCED CHART REVIEW

Use EHR searches or trigger algorithms to identify high-risk diagnoses or care patterns

AHRQ Toolkit for Engaging Patients To Improve Diagnostic Safety



Engaging Patients To Improve Diagnostic Safety Toolkit Roadmap

This Implementation Roadmap provides an overview of the steps for implementation and the toolkit materials you will need to use at each step.

Step 1: Prepare Your Organization

Orient leaders to the change	**Toolkit Infographic** provides statistics about incidents of diagnostic errors that are useful to engage leadership and raise awareness of the problem.
Identify your change team	**Toolkit Webinar** helps teams get started with the toolkit's implementation. It should help your team identify how the toolkit may need to be adapted to work with your practice's workflow and unique patient population.

Step 2: Make a Plan

Be The Expert On You	**Be The Expert On You Planning Worksheet** provides key questions to help your team plan how your team will implement the Be The Expert On You note sheet.
60 Seconds To Improve Diagnosis	**60 Seconds To Improve Diagnostic Safety Planning Worksheet** provides key questions to help your team plan how your provider team will implement the 60 Seconds to Improve Diagnostic Safety strategy.
Evaluation Planning	**Evaluation Planning Worksheet** provides your team with ideas of how to measure success of the toolkit and its impact on patients, providers, and your practice.

Step 3: Train Your Team

Train staff	A **One-Page Handout for Staff Training** can be used to help staff get comfortable introducing the Be The Expert On You note sheet to patients. It includes a sample script and tips on how to get started.
Train providers	**Provider Training Slides** is a short slide presentation with speaker's notes to help train your providers on how to get started.
Orient your practice	**Practice Orientation and Training Slides** can be adapted to how your practice is implementing the toolkit. Use these slides to orient your whole practice or break them up to focus on training different team members (e.g., front desk staff, medical assistants, nurses, providers).

AHRQ Agency for Healthcare Research and Quality

Toolkit for Engaging Patients To Improve Diagnostic Safety

Next Steps and Opportunities

- Test and use novel methods to engage patients to improve diagnosis and reduce diagnostic errors
- Gather information from patients to learn about diagnostic risks and safety events
- Implement pragmatic tools and strategies to achieve goals related to 1 and 2 above

Thank You

- **Funding Agencies that make research possible:**
  - Department of Veterans Affairs
  - Agency for Healthcare Research and Quality
  - Gordon and Betty Moore Foundation
- **Our multidisciplinary team at the Center for Innovations in Quality, Effectiveness and Safety (IQuESt):**
  - Email: hardeeps@bcm.edu
  - Web: http://www.houston.hsrd.research.va.gov/bios/singh.asp and www.bcm.edu/saferdx
  - Twitter: @HardeepSinghMD

Helen Haskell, MA

President Mothers Against Medical Errors
Chair WPA Patient Safety and Quality Council, USA

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Patient Engagement in Diagnosis

Communication and Shared Understanding

Helen Haskell

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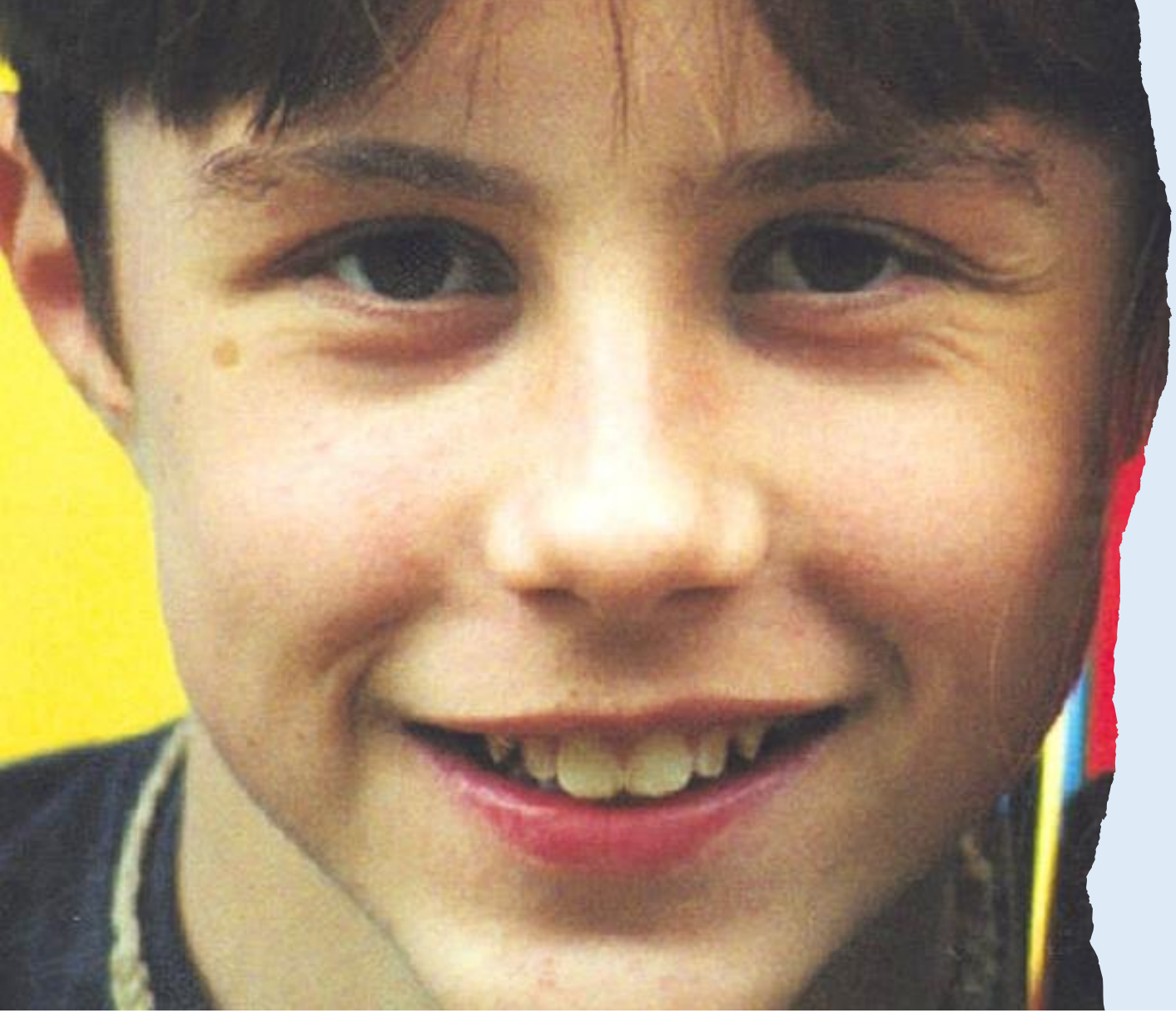

Why I’m here

Workshop on Patients Safety:
Diagnostic Errors

18 July 2023

World Patients Alliance

Common diagnostic problems from the patient point of view

- Miscommunication and lack of collaboration between providers and between providers and patients
- Preconceptions and biases, both positive and negative
- Problems with diagnostic testing: Overtesting, undertesting, poor interpretation and poor relaying of test results
- Lack of a systematic process of considering alternative diagnoses
- “Anchoring”: Not reconsidering the diagnosis when symptoms persist
- Reluctance to acknowledge and learn from mistakes

Why and how providers and patients should engage more effectively

- Patient involvement & engagement are strong safeguards against diagnostic error.
- Structured communication, careful listening, and respectful conversations are important tools.
- There are many opportunities for improved communication and continuity of care in diagnosis.
- Assumptions and premature conclusions are common pitfalls.

What we all should understand about diagnosis

- Diagnosis is a process, not an event.
- Diagnosis is often uncertain.
- Diagnosis evolves and changes.
- Time is always an issue.
- Diagnosis requires a continually open mind.
- Diagnosis is an interaction, not an edict from above.
- To be accurate, it requires your input and active participation.
- It can’t be done without you.

Help ensure an accurate diagnosis

- Be prepared
  - Do your homework
  - Have a goal
  - Be clear and concise
  - Keep written records
- Ask questions and communicate well
  - Be sure you and your diagnostician understand each other
  - Be sure your concerns are addressed
  - Be respectful and courteous, and expect the same
- Follow up
  - Understand the plan
  - Understand your diagnostician's reasoning
  - Understand the changes to watch for
  - Be open to changing diagnoses

Patient Toolkit:
Society to Improve Diagnosis in Medicine

- Questions to contemplate
  - What worries you most about your condition?
  - What do you hope to get from the appointment?
- Questions to Ask
  - What else could it be?
  - Do all my symptoms match your diagnosis?
  - Could there be more than one thing going on?

http://www.improvediagnosis.org/

Thank You!

Nagwa Metwally

Patient for Patient Safety
Egypt

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18 July 2023

World Patients Alliance

Diagnostic errors:
PATIENT PERSPECTIVE

Workshop on Patients Safety:
Diagnostic Errors

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When I attended Mrs S.H. in the ER, she was holding the side of her head and said:

I have a severe headache ...
I feel my head will explode right now into pieces.

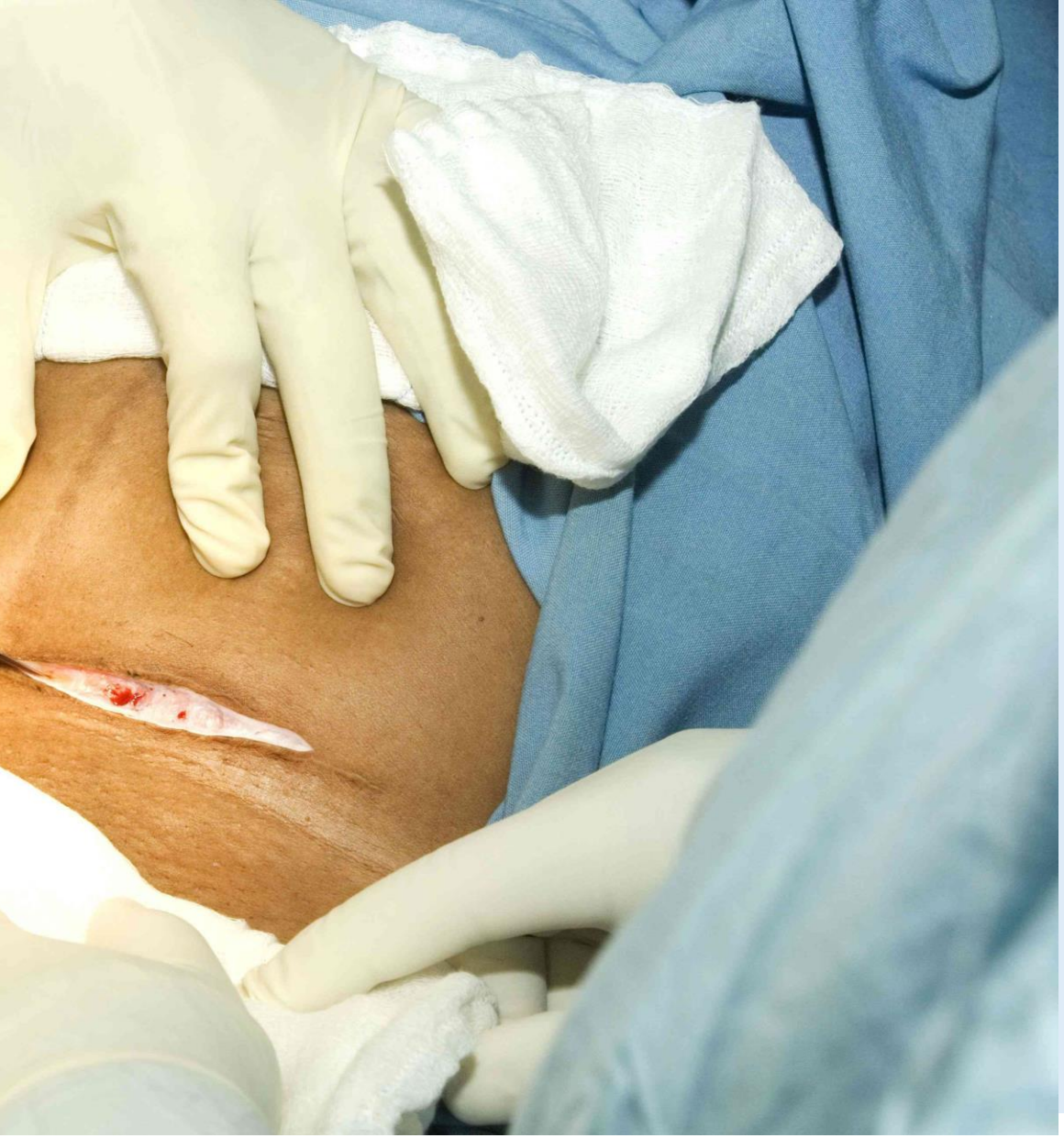
I asked the ER nurse about her vital data. Her blood pressure was shooting as high as 180/100 mmHg.
It was clear that Mrs S.H. condition has progressed to **SEVERE PREECLAMPSIA**.

The severe headache she is experiencing is worrisome, as it might indicate an impending life-threatening eclampsia.

Within two minutes,

Mrs S.H. had **GENERALIZED FITS.**

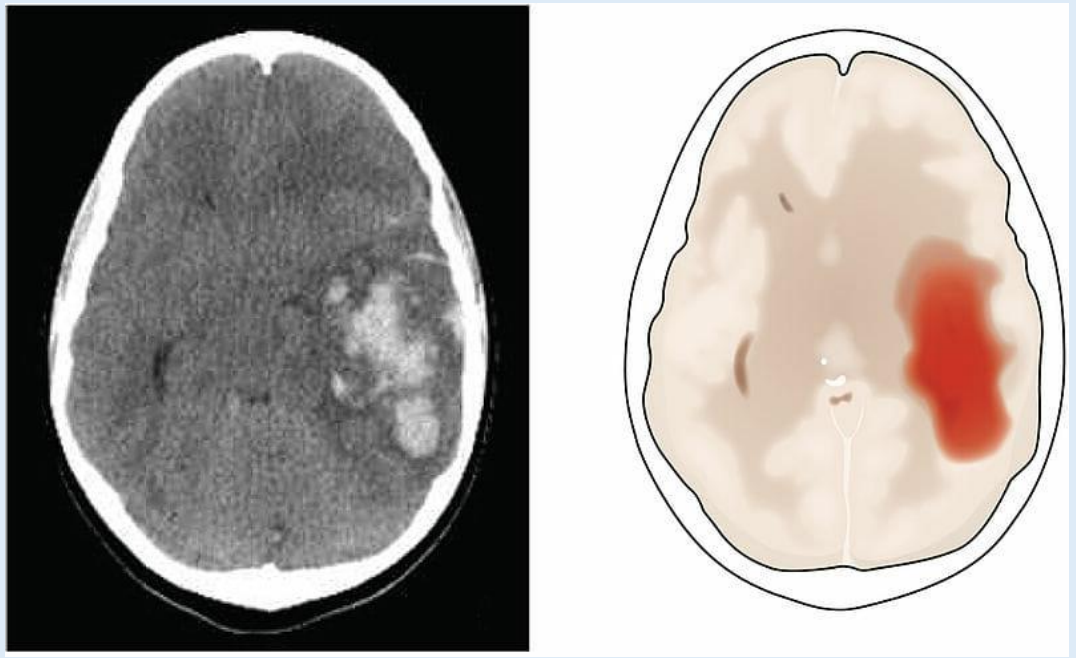
Her body was shaking and her back was arching for a whole one minute. She was then unresponsive and lost consciousness.



In view of her condition, an urgent cesarean delivery was done.

She gave birth to a 1500 gm baby that needed NICU admission

However, she remained unconscious for the next three days



The CT showed signs of brain hemorrhage

NOT ECLAMPSIA

and this was missed for four days

So, a CT brain was requested

Despite having an urgent brain surgery,

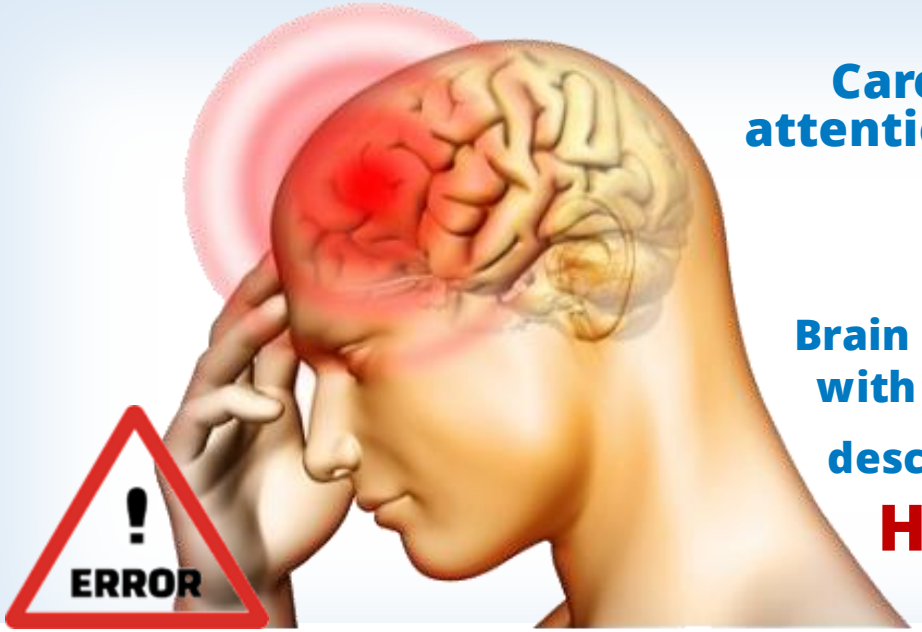
Mrs S.H. died after one week

and her baby died in the NICU after two days

WHAT WERE THE PITFALLS IN THIS CASE ?

When I attended Mrs S.H. in the ER, she was holding the side of her head and said:

I have a severe headache …
I feel my head will explode right now into pieces.



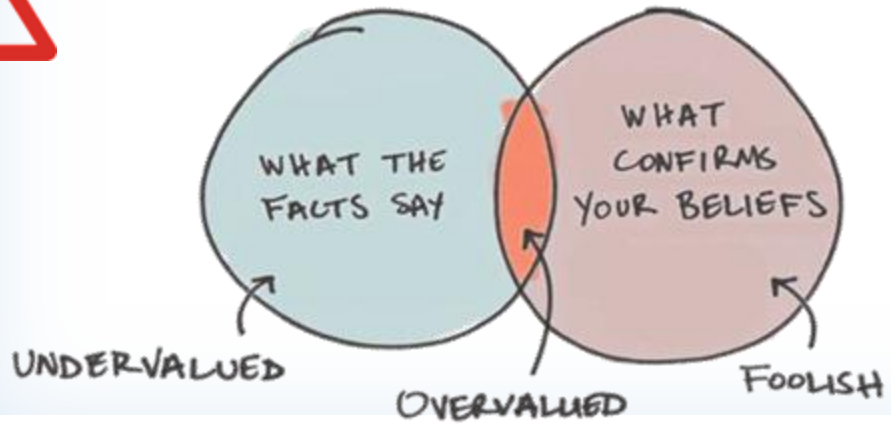
Careful attention NOT given to the patient complaint

Brain hemorrhage TYPICALLY presents with headache that the patient describes as "THE WORST HEADACHE SHE HAD IN HER LIFE"

"I asked the ER nurse about her vital data. Her blood pressure was shooting as high as 180/100 mmHg.
It was clear that Mrs S.H. condition has progressed to **SEVERE PREECLAMPSIA**.

The severe headache she is experiencing is worrisome, as it might indicate an impending life-threatening eclampsia."

CONFIRMATION BIAS



To keep the case fitting his assumed diagnosis, the doctor

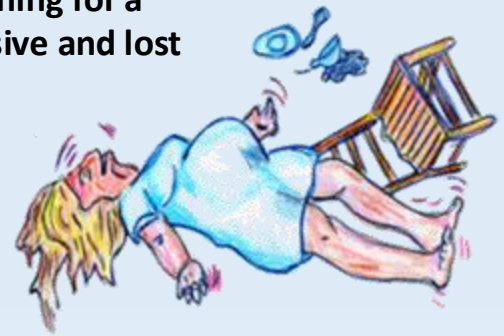
IGNORED some signs → **Character of headache**

Did NOT search for others → **Neurological examination wasn't done**

Within two minutes,

Mrs S.H. had **GENERALIZED FITS.**

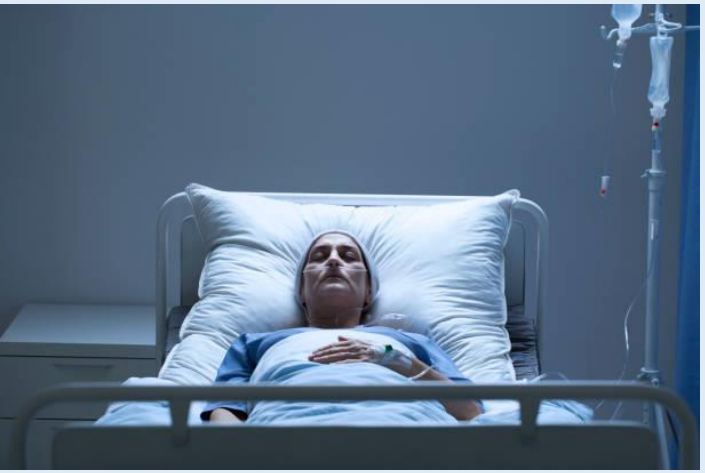
Her body was shaking and her back was arching for a whole one minute. She was then unresponsive and lost consciousness.



Lack of effective communication

The patient lost consciousness after two minutes and thus became silent

No effective communication was done with HER RELATIVES. This might have drawn more attention that the patient's main complaint was UNBEARABLE HEADACHE



However, she remained unconscious for the next three days

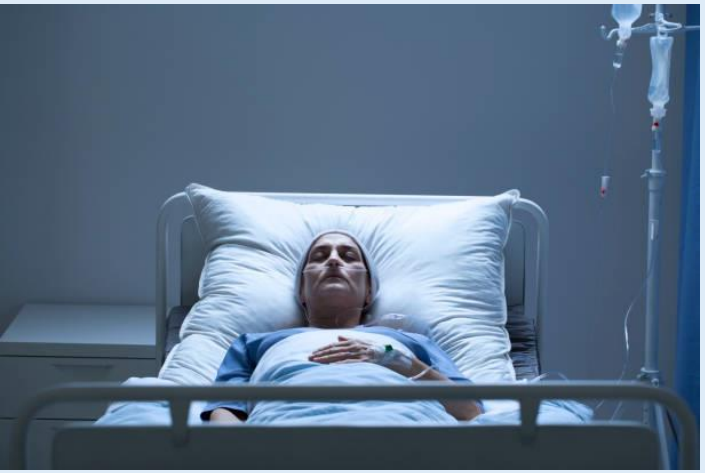
So, a CT brain was requested

Defective problem solving skills

It is **UNCOMMON** for eclamptic patient to remain in coma for days

The doctors **NEGLECTED** to go back and **RETHINK** their own diagnosis even when the signs begin to point in a different direction.

This seems simple, but it is difficult for most people to do

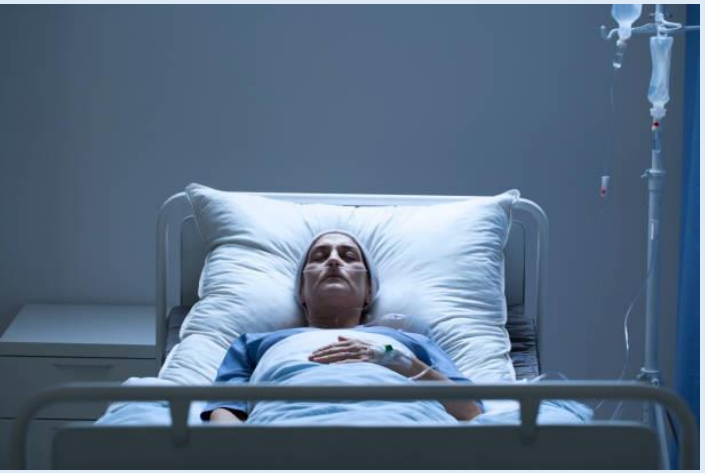


However, she remained unconscious for the next three days

So, a CT brain was requested

Delay in neurological consultation

There was delay of 2 days in neuro-logical consultation. The cause of the delay couldn't be traced due to lack of proper digital registration



However, she remained unconscious for the next three days

So, a CT brain was requested

Lack of equipment

Due to the rarity of the condition, CT scan facilities is NOT available in many maternity hospitals

Thank You!

Margaret Murphy

Patient for Patient Safety
Ireland

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A Preventable Loss of A Young Life

- Delayed diagnosis making rescue impossible -

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The 3-year back Story

Repeated engagement with healthcare individuals and system

For most of year 1, tools, e.g. blood tests, consultant referrals not used to assist understanding and inform treatment.

Concerns of parent not taken seriously despite worrying symptoms -
YOU IGNORE AT YOUR PERIL THE CONCERNS OF A MOTHER

The Swiss Cheese Model

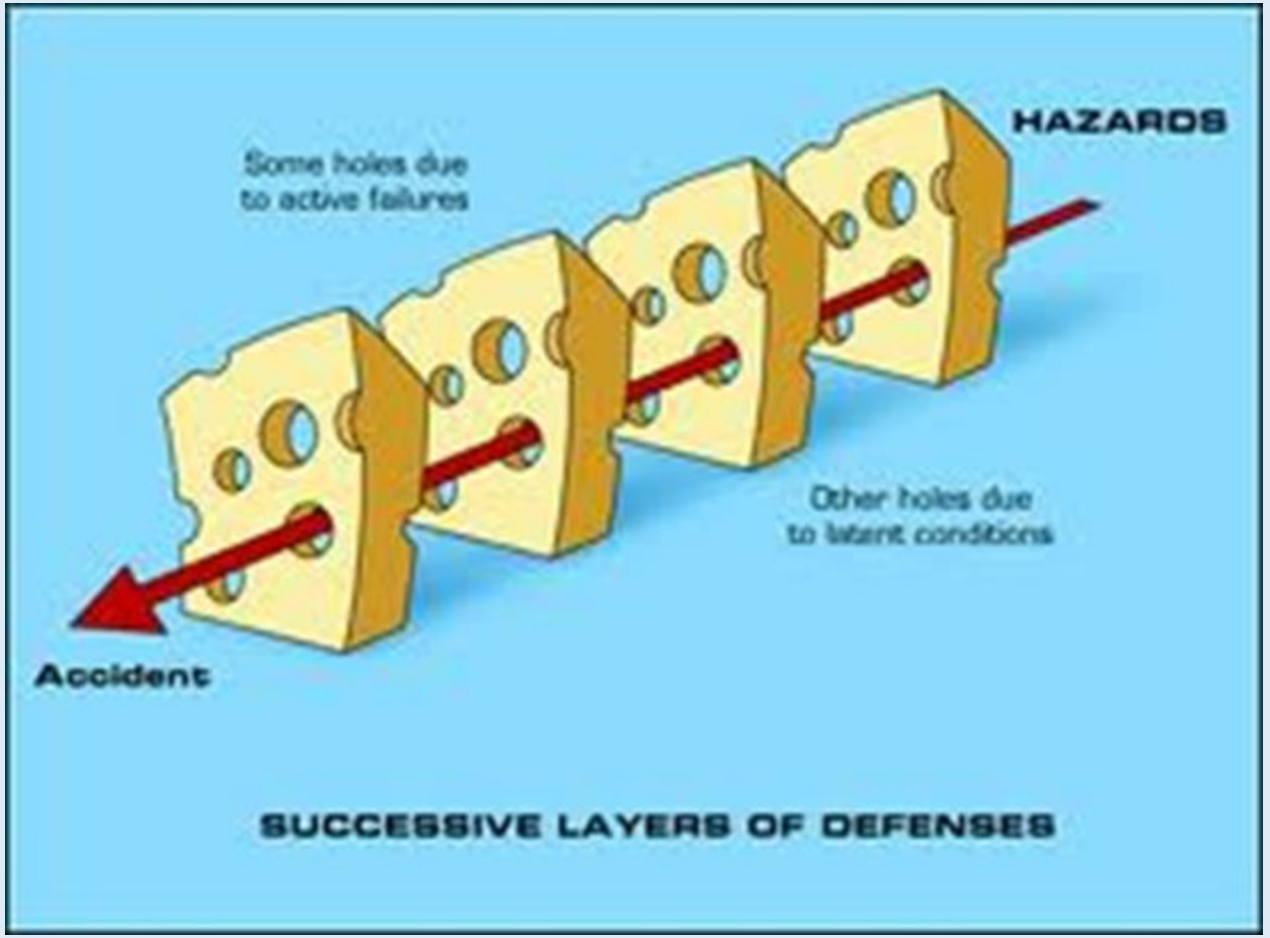
A litany

of missed opportunities

to intervene

and save a life

while every point of contact failed him

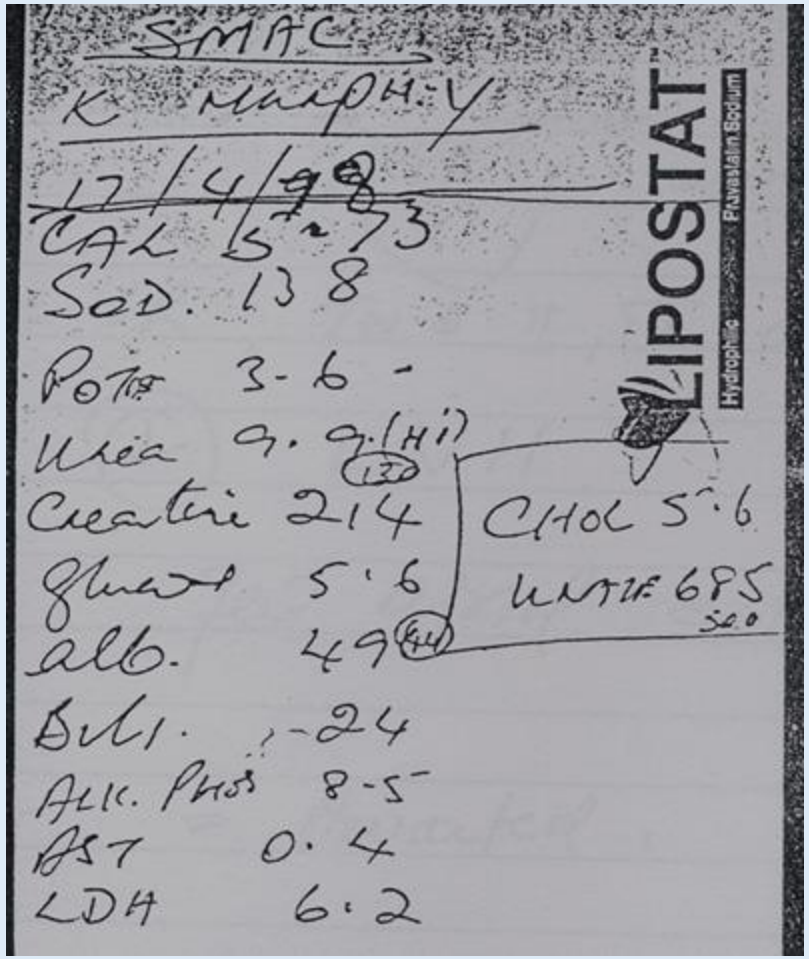


Peer Review

- “The combination of bone pain, renal failure and hypercalcemia in a young patient points either to a diagnosis of primary hyperparathyroidism or metastatic malignancy and these ominous results should have been investigated as a matter of urgency”.
- Kevin would have had surgery to remove the over-active parathyroid gland. He would have been cured and would still have been alive today.”
- All the evidence indicates that the patient was suffering from a solitary parathyroid adenoma at the time, removal would have been curative with a normal life expectancy”

A Final Opportunity to Rescue

- Doctor succumbing to confirmation bias to the detriment of patient care and safety
- Filtering of test results by only partially transmitting test results
- Further escalation in calcium levels
- Attempt to preserve vital post-it further impeded diagnosis
- Consequent incorrect diagnosis of nephritis - symptom not underlying cause



The Final Scenes in the Debacle

Further escalation of symptoms - muscle pain and neurological problems - patient quote: 'I have crazy thoughts coming into my head'

Because of incorrect diagnosis of nephritis patient transferred to renal unit rather than endocrinology unit of tertiary training hospital

Levels of calcium now at 6.1mmol/L later described as 'inconsistent with life'.

Treatment and management solely by Resident without input of senior personnel

Failure to appraise senior 'on call' consultant of deteriorating condition and attempt to 'hold' patient over the weekend.

Wisdom From Atul Gawande

More than anything,
what distinguishes
the great from the mediocre,
is not that they fail less,
it is that they rescue more.

- Atul Gawande

To ERR is HUMAN
To COVER UP is UNFORGIVEABLE
To REFUSE TO LEARN is INEXCUSABLE

-Sir Liam Donaldson, Chair, World alliance for Patient safety

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To Summarize

- Inability to recognize the seriousness of Kevin's condition
- Discounting family concerns and absence of direct communication with patient and family
- Appropriate and timely interventions not taken. No tracking of deterioration.
- Selective and incomplete transmission of information - seriously flawed handover
- Absence of an integrated care pathway
- Link between reported uncharacteristic behavior and test results not made
- Developing neurological problems ignored
- His treatment solely at resident level without consultant input or alerting consultant to the true nature of his condition
- Serious damage to the trust and confidence in the healthcare system and in particular individuals.

Thank You!

Panel Discussion | Questions & Answers

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Hussain Jafri

Founding Director
World Patients Alliance

Workshop on Patients Safety: Diagnostic Errors

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Closing Remarks

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