Focusing on Missed or Delayed Diagnosis

Dr. David Troxel’s examination of internal medicine claims in “An Analysis of Internal Medicine Malpractice Claims” provides valuable information about medical errors, system failures, and high-risk clinical events that contribute to adverse patient outcomes.

We reviewed the same data set but focused on specific patient safety/risk management issues. We identified 659 patient issues in the following categories:

- 29% Patient Assessment
- 11% Selection and Management of Therapy (57% were medication-related)
- 11% Communication with Patient/Family
- 10% Patient Factors
- 9% Communication Among Providers
- 9% Documentation/Medical Record
- 7% Patient Monitoring
- 6% Failure/Delay in Obtaining Consult/Referral
- 8% Other

More than half of the patient safety/risk management issues in the Patient Assessment category were linked to allegations of missed or delayed diagnosis—specifically, failure or delay in ordering a diagnostic test, failure to establish a differential diagnosis, and a missing or inadequate clinical information assessment.

The following two scenarios demonstrate the types of claims seen in the allegation of missed or delayed diagnosis.

Scenario I—Patient Assessment: Missed or Delayed Diagnosis

When this 45-year-old patient was admitted to the neurosurgery service, she was unresponsive, hypotensive, and bradycardic. A CT scan and MRI revealed a large intracerebral hematoma and an arteriovenous malformation (AVM).

On the second day, the patient had stabilized, with the medical and nursing notes describing her as alert and oriented, so surgery was scheduled to take place within the next week. A nursing protocol and checklist for neurological assessments had recently been implemented on the unit. The protocol called for neuro checks every hour.

On the fourth day, the patient complained of headache and nausea. When the nurse contacted the neurosurgeon, he told her to call the hospitalist. When the hospitalist arrived on the unit, she could not find the nursing flow sheet with documentation of the patient’s vital signs or neuro checks. The hospitalist ordered an analgesic for pain and the continuation of neuro checks.

Within five hours, the patient’s pupils were fixed and dilated. She was taken to surgery, where the hematoma and AVM were removed. The patient never regained consciousness and died four days later. The cause of death was determined to be brain-stem herniation.

What Were the Diagnostic Failures?

The neuro checks, although completed, did not occur at the intervals required by the nursing protocol. Because the hospitalist was unable to find the neuro check documentation, she relied on what she had been told about the patient. The neurosurgeon, believing that the hospitalist was handling the pre-surgery care, did not inquire about the neuro checks. The hospitalist believed that the neurosurgeon was aware of the neuro checks, so she did not address the checks with the nurses.

What Human Factors May Have Impacted the Delay in Diagnosis?

From a review of the nursing documentation, it was evident that neuro checks had not been accomplished per the protocol. This may have been a result of fatigue, overwork, or “drift toward failure.” Drift toward failure occurs when production goals (having to do more and more) take precedence over safety goals (performing all of the required assessments). When assessments are missed and nothing bad happens, there is an assumption that missing assessments will not result in a bad outcome since nothing adverse has previously occurred. Thus, the assumption develops that it is acceptable to skip some assessments.

Scenario II—Patient Assessment: Missed or Delayed Diagnosis

This 45-year-old patient was seen in the emergency department (ED) complaining of shoulder and back pain and was diagnosed with thoracic strain and spasm post-injury. He was administered morphine IV and Phenergan and was discharged.

Three days later, the patient returned to the ED confused, febrile, and complaining of back pain and lack of sensation in his legs. The diagnosis was determined to be pyelonephritis, urinary retention, and urosepsis. Admission orders were written, and he was taken to the patient care unit. The complete ED record was not received by the unit. When it arrived two hours later, the hospitalist came to examine the patient.
At that point, the patient was uncooperative and complaining of leg weakness, neck and back pain, and a distended bladder. The hospitalist’s note said that motor power could not be examined because the patient was uncooperative. An MRI was completed and revealed minor disc herniation with degenerative changes from C1-C7.

The next day, a urology consult showed hydronephrosis. The patient was moaning and complaining of increased pain. Blood cultures showed gram-positive cocci, so antibiotics were ordered. The patient’s condition continued to worsen over the next few hours. A second MRI revealed an epidural abscess with spinal cord compression from T3-T10.

Postoperatively, the patient had no motor function or sensation in his lower extremities. He was discharged to a rehab facility.

What Were the Diagnostic Failures?
This case showed a lack of timely and thorough assessments. When the patient was admitted, the delays in obtaining his medical records and in the hospitalist completing his examination resulted in a delay in the initial MRI, which, in turn, probably delayed the second MRI. In addition, the patient was uncooperative, which hampered the hospitalist’s ability to perform a detailed examination. Only when the patient’s condition did not improve and he underwent a second MRI was the diagnosis of epidural abscess confirmed.

What Human Factors May Have Led to the Delay in Diagnosis?
The hospitalist settled on one diagnosis without considering the possibility of epidural abscess. This type of error commonly occurs when physicians are busy, and they base their assessments on limited data. Cognitive diligence (taking time to think) and cognitive skill (knowledge) are both required to minimize errors in judgment.

In How Doctors Think, Dr. Jerome Groopman clarifies the complex interaction between thinking and knowledge. Dr. Groopman defines several types of cognitive mistakes that lead to medical errors. He dramatically illustrates these types of errors, using real cases from his personal experience as a medical oncologist. For example, Dr. Groopman defines an availability error as a cognitive mistake resulting in a faulty decision that has been made based upon the ease with which a relevant example comes to mind. If it looks like a duck, walks like a duck, and quacks like a duck, it must be a duck. Similarly, if it looks like pyelonephritis, urinary retention, and urosepsis, that must be the diagnosis. These types of errors are made in haste and then the search for additional supportive or conflicting information stops.

The patient was also perceived as being uncooperative or difficult. Dr. Groopman discusses the tendency of allowing our emotions to interfere with our cognitive skills. In the case presented here, the tendency was to avoid the patient. Steps must be taken by the physician to quickly address the issues or transfer the patient to another physician if rapport cannot be established.

Tips to Avoid Missed or Delayed Diagnosis
- Identify the physician (hospitalist or specialist) who is in charge of the care of the patient, and make sure everyone is informed.
- Familiarize yourself with hospital policies and protocols governing the roles and responsibilities of all physicians, including specialists, consultants, and hospitalists.
- Make sure there is verbal communication between physicians when the care of a patient is being handed off so they can determine each physician’s responsibilities. The staff should have a clear understanding of which physician is in charge of the patient’s care.
- Utilize a standardized communication process such as SBAR (Situation Background Assessment Recommendation) during patient handoffs. Find out if your hospital has such a policy.
- Make sure all clinicians caring for the patient review the patient’s histories and physicals, daily physician notes, and nursing assessments. The physician in charge of the patient’s care is responsible for reviewing the medical record and for ensuring that appropriate orders are written and carried out.
- Take action when you perceive there is a delay in implementing an order.
- Take steps to transfer the patient to another physician if you are concerned that he or she is not communicating with you or the staff and, therefore, is not involved in or is not capable of being involved in treatment.

Conclusion
Closed-claim analysis has traditionally been used to retrospectively determine the frequency and severity of a group of claims with emphasis on the defendant physician, hospital, or other health care provider. However, the analysis in this article identified processes or failures within a health care system that have led to patient injury. This approach focuses on improvements
that can be made in the environment in which our physicians, nurses, and other health care providers work to reduce claims and improve quality and patient safety. This analysis made it clear that multiple failures—including lack of coordination of care, ineffective communication, and missing or inadequate assessments during the care of those patients—led to the delay and missed diagnoses.

If you would like to read our analysis of the selection and management of therapy with the focus on medication—the second most frequent patient safety/risk management issue identified in our study—please go to www.thedoctors.com/2Q10part2.

Reference:

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