Avant factsheet:
Missed or delayed diagnosis

Quick guide

- Genuine care, concern and communication is important if a patient has a missed or delayed diagnosis, particularly if they suffer an adverse outcome
- If an error is identified follow the open disclosure process and keep the patient well informed
- Reflect on your practice and consider what modifications you can make to minimise the chances of an error happening again

Frequency of diagnostic errors

Avant claims data indicates that 1 in 5 claims were primarily about diagnosis. 75% of those claims related to missed or delayed diagnosis. These events may not necessarily be as the result of an error you have made; however, the ongoing patient care and management may become your responsibility.

Managing the situation

1. **Personally, tell the patient** – Depending on the urgency of the diagnosis, contact the patient to inform them of the unexpected finding and its implications as soon as possible. A personal telephone call to set up a face-to-face conversation generally works better, rather than delegation to another member of the practice.
2. **Obtain advice** – If necessary, before you meet with the patient contact a specialist for advice on the likely treatment required and the impact of the delayed diagnosis so you are prepared to answer the patient's questions when you meet with them.
3. **Explain the situation** – Have a face-to-face discussion with your patient about the new findings. When doing this follow an open disclosure process and acknowledge what has occurred. You can express regret and say how sorry you are about the unexpected news. The apology is not about blame or liability, but rather about expressing empathy with the patient for the events that occurred. Refer to Avant's Open Disclosure factsheet for more information.
4. **Arrange ongoing management of the patient and immediate treatment** – You should then explain what treatment may be necessary. This may include a referral for additional tests and specialist treatment. We would recommend that you arrange this for the patient rather than giving the patient a standard referral letter and asking them to arrange their own follow-up consultation.
5. **Maintain contact with the patient** – Remember to enquire periodically about the patient's progress and help them cope with the feelings about the diagnosis or any possible delays.
6. **Consider the cause of the delayed diagnosis** – After an experience of a missed or delayed diagnosis, it might be tempting to respond by over investigating every patient. Critically review the decisions you made and consider what your objective criteria for the management of similar presentations in future patients.
7. **Review practice systems** – If the delay was caused or contributed to by a systems error, such as follow-up failure or misfiling of pathology or diagnostic imaging reports, review your systems to prevent a recurrence. Avant has a follow-up and recall factsheet with further information.
8. **Change and inform** –The patient may appreciate hearing about any steps that have been taken to avoid a repeat of the same situation
9. **Notify Avant about the incident** – As soon as possible after you become aware of the incident, let Avant know. If you receive a letter of complaint from the patient or their representative, obtain advice from Avant before you respond.
10. **Consider cancelling or refunding your fee** – Remember to check your routine processes to make sure you don't inadvertently inflame the situation by sending an account or fee reminder. It is better to forego a fee than risk offending the patient. Not charging is not an admission of liability.

What if another doctor is responsible for the misdiagnosis and you are now managing the case?

Diagnostic errors are not necessarily avoidable or as the direct result of an error. The situation can become clearer with hindsight. If you meet a patient who has been previously misdiagnosed the situation needs to be managed carefully. When discussing the diagnosis and its implications, stick to the facts. You only have one side of the history and as such, it is better to avoid any implied or stated criticism about the doctor(s) who may have been involved with the previous error. It is not uncommon for a legal claim or complaint to be pursued by a patient after throwaway comments by the second doctor, which were not intended to be a criticism.

Remain professional and objective during these exchanges.

If, at a later date, the patient's solicitor seeks a report in the investigation of a compensation claim, keep the report objective and avoid criticism. You do not need to offer a medicolegal opinion about the care provided by another doctor. Contact Avant if you are unsure what is required.

As a guide, do what you would expect the other doctor to do if the roles were reversed. This might include informing the other doctor of the correct diagnosis and, if the patient agrees, offering to send the patient back to that doctor so they have an opportunity to explain.

How to reduce diagnostic errors

Reflecting on the events that may have contributed to a diagnostic error or delay can assist in reducing future similar situations. Dr Mark Graber from the Society to Improve Diagnosis in Medicine suggests techniques to improve your clinical reasoning to reduce the chances of an error being made. This includes an awareness of when you 'jump to conclusions' and ultimately not relying on your intuition. In addition, being comprehensive in your assessment by considering what else the symptoms might indicate.

Practical tips to reduce some errors may include:

- seeking a second opinion
- developing a list of differential diagnosis
- ensuring follow up of all results
- being wary of overconfidence
- take a diagnostic time out – pause to reflect
- utilising checklists and mnemonics so you are less likely to miss something

In addition, thoroughly documenting the diagnostic discussions, investigative findings and follow-up actions you have taken in your patient records could be key to demonstrating you have met the expected standard of care, if an error was to occur. For further information watch Avant's interview with Mark Graber.

Additional resources

Webinar: Understanding diagnostic errors

Factsheet: Diagnostic related claims

Society to Improve Diagnosis in Medicine

Avant factsheet: Managing an adverse event

Avant factsheet: Open disclosure: how to say sorry

Factsheet: Follow-up and recall

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