

## Diagnostic Errors—Why They Happen and How to Avoid Them

**W**hat drives ophthalmic malpractice claims related to diagnostic errors? While it's tempting to presume that rare conditions or unusual complications are involved, that often isn't the case.

**OMIC reviews claims of alleged malpractice.** A recent study conducted by the Ophthalmic Mutual Insurance Company (OMIC) evaluated 1,613 claims that were closed or resolved during a 7-year period ending in 2014. Of these, 223 (14%) involved allegations of diagnostic error.<sup>1</sup> And here's the surprising part: Retinal detachments (RDs) accounted for 65 (29%) of those 223 claims, said Anne M. Menke, RN, PhD, OMIC's risk manager, who conducted the study.

There were an additional 19 retina claims that didn't involve RD. Beyond retina, other common categories of alleged diagnostic error included glaucoma (27 claims), oncology (27 claims), cornea (26 claims), and endophthalmitis (17 claims). There also were 27 claims where a systemic illness presented with ophthalmic signs and symptoms.<sup>1</sup>

**Claims involve some common culprits.** *When you hear hoofbeats, think horses not zebras*—this is an adage that is drilled into residents, and with good reason, said oculoplastic surgeon Tamara R. Fountain, MD, at Rush University in Chicago. “The diagnoses that we miss are absolutely not

for some exotic disease.” Instead, she said, diagnostic errors typically occur with “common, common, common” conditions in which “either the patient is presenting in an abnormal fashion, or we are locked into another diagnosis and don't take a step back and reconsider why the patient isn't improving.”

Dr. Fountain added, “If you miss a ‘zebra,’ a jury might be sympathetic, thinking that it's a one-in-a-million possibility. Instead, you're missing something that's as clear as the nose on your face. You're just not looking for it.”

### Parsing the Problem

Although diagnostic errors are affected by myriad factors, they tend to fall into the following categories.

**Systemic failures in testing and communication.** “Systemic issues like test tracking—say, ordering a test without following up and scanning the results into the record—can come back to haunt us,” said Dr. Fountain. “Make sure you have systems, and don't allow things to fall through the cracks.” In her group practice in Deerfield, Ill., she said, “Everything is logged weekly, so that we're sure we got results back.” As a safety cross-check, “We tell patients, ‘We'll call you within 5 days; if you don't hear from us, call!’”

**Failure to ask the right questions.** Physicians may “miss diagnoses because we don't get the right information, particularly if the patient isn't right there

in front of us,” Dr. Fountain said. “Say it's the weekend, and you get a call from the ER, and you don't ask the right questions of the ER doc. As an ophthalmologist, you should have a higher index of suspicion and probe—and be willing to see the patient in person.”

**Physician-patient communication breakdown.** Communication challenges—such as a language barrier or cultural differences—can disrupt the physician's therapeutic alliance with the patient, making it more difficult to tease out the correct diagnosis. “You need to communicate with the patient or the patient's family to explain your diagnoses, your concerns, potential treatment, and any risks,” said pediatric ophthalmologist Robert S. Gold, MD, who practices in central Florida and is an OMIC committee member.

**Patients' unusual presentation.** Unusual disease signs and symptoms may confound the diagnosis. “Residents are typically taught the common presentations of common diseases,” said Dr. Menke, “If the disease presents atypically, they might miss it.”

**Physicians' faulty reasoning and decision-making processes.** OMIC's initial analysis of the 223 diagnostic error claims indicates that physician factors were primarily responsible.

“Some of these claims were notable in that the physician didn't correctly interpret a visual field or an optical coherence tomography image,” Dr. Gold said. “It comes back to the basics. It's making sure that you do an accurate history and examination, that you order the appropriate tests, that you

interpret the tests correctly, and that you follow up in the appropriate time frame. And then, if you get a process or a condition that you're not comfortable with, that you refer the patient to a specialist."

## Solving the Problem

What can physicians do to improve their diagnostic accuracy?

**Keep an open mind.** "We lock ourselves into a diagnosis, whether it is our own, from a previous examination, or is one proffered to us by someone else, and then we end up signing someone up for surgery after a cursory look," Dr. Fountain said. Instead, she said, "Get your own history, and do a full exam with an open mind. Start at the top on the differential diagnosis."

**Know when to switch from "fast" to "slow" thinking.** Dr. Menke cites 2 types of clinical reasoning: fast and slow thinking. Fast thinking, which is intuitive and automatic, is honed by years of training and experience. In contrast, slow thinking is deliberative and rational. "Fast thinking works well if it's a common disease that is presenting in a common way. And you can't be deliberative on every diagnosis, or you'd only be able to see 3 patients each day," she said. "But physicians often don't recognize when they need to go slowly; they think they're safe when they aren't."

If you're puzzled, or something doesn't add up, it's time to switch to slow thinking, Dr. Menke said. "Does your diagnosis explain all the findings and symptoms? If it doesn't, then you need to rethink it." She added, "The goal isn't absolute certainty; instead, it's arriving at a working diagnosis that will move the process forward, either to more testing or to treatment."

**Get your own second opinion.** For Dr. Fountain, this is the primary take-home message from the OMIC study. She offered an example: "If a patient has had cataract surgery and is not improving over a prolonged period after surgery, think, 'What's my differential diagnosis again? What do I not want to miss?'"

Do your own risk stratification, Dr. Menke suggested. "Ask yourself, is it

vision- or life-threatening? If so, refer right away to a specialist. If you're a specialist, but the patient isn't responding as you expected, you may need to refer to an academic ophthalmologist. You have to ask yourself pretty early on, 'Is it safe for me to keep following this patient, or do I need help?'"

**Don't be too proud.** This is a critical component of diagnostic accuracy, Dr. Gold said. "We're not perfect; we don't know every bit of information about every disease process," he said. "Don't be too proud. Ask yourself, What happens if I'm not right? If you have that kind of ability to question yourself, you'll be in a better position. And ask for help from your colleagues. I've been in practice 30 years, and I still ask my partners to see patients of mine—or I might refer to a university setting, where the patient can get tests that I can't do. Getting that help can make all the difference."

**If you have doubts, be ready to share them with the patient.** Based on a recent report from the Institute of Medicine, which cites the patient as key to the diagnostic process,<sup>2</sup> Dr. Menke recommends sharing your uncertainty with your patients. "You really can say to patients, 'I've done your exam, and here's what I think, but I'm not absolutely certain. I can't figure out what's causing the vision loss. So here's when I want you to call me, and here's when I want you to come back.'"

**Stay alert.** "You can't afford to have even 1 patient get lost in the shuffle," said Dr. Gold. "Whether it's the first or the last patient of the day, you have to be diligent. You've got to deal with the problem and not just run out of the office at the end of the day."

If you go back to Dr. Fountain's hypothetical example of the cataract surgery patient who is not improving, the top 3 potential adverse outcomes are endophthalmitis, glaucoma, and RD. "If you showed that case to an audience, 9 out of 10 would say, 'That patient is still on steroids; it may be glaucoma,'" said Dr. Menke. But back at their practice, they might not be so alert for that possibility. "You're in a busy clinic, looking at the electronic health record, and it keeps pulling you away from thinking about the diagno-

sis, and you just don't take that time to step back and reconsider."

## RD Review

A final note with regard to the puzzlingly high percentage of RD claims: Dr. Menke is in the process of further investigating them. It's possible that some of the cases may have involved atypical presentations, she said. "It's also entirely possible that a physician didn't find an RD, and then, literally hours later, a detachment occurred. OMIC has seen that even in claims against retinal specialists. That's why you always have to tell a patient what to look for and when to call back."

But based on her initial assessment, she said the odds are that the physicians involved simply didn't do a dilated eye exam. "If you don't look at the retina, you're not going to see the RD." And while there is such a thing as overdiagnosis, with attendant risks from invasive testing, that doesn't come into play in this instance. "A dilated eye exam is a fairly low-risk, high-yield test. Since you could have done this exam, why didn't you?," said Dr. Menke.

1 Menke AM. Diagnostic error: Types and causes. *The Ophthalmic Risk Management Digest*. 2016; 26(1).

2 Balogh EP et al. *Improving Diagnosis in Health Care*. Washington, DC: The National Academies Press, 2015. [www.nap.edu/21794](http://www.nap.edu/21794). Accessed April 8, 2016.

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Dr. Gold is in practice in Maitland, Fla., and is chairman of OMIC's Retinopathy of Prematurity Task Force. Relevant financial disclosures: None.

Dr. Menke is OMIC's risk manager. Relevant financial disclosures: None.

## Further Reading

OMIC will publish an analysis of the study's oncology claims in the second 2016 issue of *The Ophthalmic Risk Management Digest*, a free quarterly publication that is online at [www.omic.com/news-2/publications](http://www.omic.com/news-2/publications).