PATIENT SAFETY AUTHORITY
An independent agency of the Commonwealth of Pennsylvania

Patient Education Regarding Diagnostic Error

Patients play an important role in preventing diagnostic error, and should be encouraged to be active participants in each and every physician encounter. Consider educating the patient population by informing them of the following strategies:[1–5]

- Tell your doctor the complete story, because even symptoms that may seem minor could be important.
- Establish a timeline. Knowing the chronological order of symptoms and complaints could be very important for your doctor.
- Keep records of all test results, discharge summaries, and whatever data might be needed by the next doctor who does not have access to information from the last doctor or healthcare organization.
- Do not minimize complaints. If you do, your doctor may follow your lead and do the same.
- Bring important information like medications, your medical history, and a list of your symptoms in writing.
- Bring a companion to help you hear and understand everything your doctor says to you.
- Understand that your doctor diagnoses your condition by considering the history of your medical problem, the results of a physical examination, and the findings of medical tests. With each step, the doctor looks for patterns that fit an illness. Help your doctor see patterns by disclosing all relevant information in a concise manner. Do not be afraid to ask if your doctor needs more information.
- Find a doctor who knows how to listen.
- If you think your doctor has overlooked something, tell him.
- Do not be afraid to ask questions like the following:

  —What else could it be?

  —Is there anything that does not fit?

  —Could it be that I have more than one problem?

- Feel free to offer your own suggestions.
- Ask about when you can expect all test results, and call your physician if you do not hear about the results. Do not think that "no news is good news."

Notes

1. Schiff GD, Kim S, Abrams R, et al. Diagnosing diagnostic error: lessons from a multi-institutional collaborative project. In: Henriksen K, Battles JB, Marks ES, et al., eds. *Advances in patient safety: from research to implementation*. Rockville (MD): Agency for Healthcare Research and Quality; AHRQ pub No. 05-0021-2. 2005:255-78.
2. Groopman J. *How doctors think*. New York (NY): Houghton Mifflin Company; 2008.
3. Graber ML. Taking steps toward a safer future: measures to promote timely and accurate medical diagnosis. *Am J Med* 2008 May;121(5 Suppl):S43-6.
4. Don't be a diagnostic error: 10 common medical mix-ups and how to avoid them. *Consum Rep Health* 2009 Sep;21(9):1-3.
5. Groopman J. How you talk to your doctor can save your life [online]. Bottom Line Health 2007 Apr [cited 2010 Aug 1]. Available from Internet: http://www.bottomlinesecrets.com/article.html?article_id=41183.

For more information, visit http://www.patientsafetyauthority.org.

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