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The full report is titled “Missed and Delayed Diagnoses in the Ambulatory Setting: A Study of Closed Malpractice Claims.” It is in the 3 October 2006 issue of *Annals of Internal Medicine* (volume 145, pages 488–496). The authors are T.K. Gandhi, A. Kachalia, E.J. Thomas, A.L. Puopolo, C. Yoon, T.A. Brennan, and D.M. Studdert.

Medical Errors That Lead to Missed Diagnoses in Primary Care

What is the problem and what is known about it so far?

Errors are common in medicine and are a focus of efforts to improve health care quality. Very little of the recent attention on medical errors has focused on those that occur around diagnosis. It is not uncommon for persons to discover that they have a condition that their doctor missed. Although each person with a missed diagnosis knows his or her individual story, the reasons for missed diagnoses from the perspective of the health care system have rarely been studied.

Why did the researchers do this particular study?

To understand the reasons for missed diagnoses so that they might be prevented.

Who was studied?

181 patients who filed malpractice claims alleging injury from a missed or delayed diagnosis.

How was the study done?

The researchers characterized diagnosis as a series of processes, such as ordering a test or acting on its results. They reviewed the malpractice claims to find those in which an error led to a missed or delayed diagnosis. They then tried to discover the reasons for the error and where and why the diagnostic process broke down.

What did the researchers find?

Cancer was the most commonly missed diagnosis. Most errors occurred at 4 main “breakdown” points in the diagnostic process. In over half of the cases, a proper diagnostic test was not performed. Sometimes test results were not followed up adequately, or the provider did not obtain adequate information from the patient or perform an adequate physical examination. Also, providers often incorrectly interpreted results. In most cases, more than 1 breakdown and more than 1 provider contributed to a missed diagnosis. Patients also contributed to the errors in a substantial number of cases, by, for example, not providing complete information about their health or not keeping an appointment.

What were the limitations of the study?

The study relied on malpractice claims, which do not represent the full range or nature of diagnostic errors. The study involved judgments about errors and their causes, and sometimes people disagreed in those judgments. The study focused on errors made in primary care settings and does not apply to emergency departments or other settings.

What are the implications of the study?

Errors in diagnosis are not often caused by the failures of a single doctor. Instead, they usually have several sources and involve several providers. These findings highlight the challenge of finding effective ways to reduce diagnostic errors as a component of improving health care quality.

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