Diagnostic errors

In the area of patient safety, recent attention has focused on diagnostic errors, including cognitive errors. Doctors often have to make rapid decisions because they need to see many patients in a limited time. To make correct decisions, doctors must first gather information on which to base their judgement. The most efficient way to do this is to ask the most appropriate questions, interpret the answers properly and to stop searching further when there is sufficient information to make a judgement. However, unconscious cognitive biases may create pitfalls throughout this process. One such bias is confirmation bias - a tendency to look for, notice and remember information that fits in with the pre-existing expectations. Information that contradicts those expectations may unconsciously be ignored or dismissed as unimportant. In taking medical histories, doctors sometimes ask questions that solicit information confirming their earlier judgements or they may stop asking questions because they reach an early conclusion and so fail to unearth key data.

Confirmation bias can lead to treatment errors and so it is important to remain constantly vigilant for information that might contradict the existing diagnosis and give such information careful consideration rather than dismissing it as irrelevant.

In a recent HDC decision 14HDC00919 (15 August 2016) a GP saw a 38-year-old man who was experiencing coughing fits, particularly at night. The man was relatively fit but was overweight, a smoker and had been diagnosed with diabetes. When the GP saw the man in September and November 2013 he thought the man might have a chest infection and prescribed antibiotics, which seemed effective, as the man's symptoms disappeared for about six weeks.

The man returned to the GP and reported another coughing fit and that he was coughing up blood and felt unwell. He reported bleeding from his nose and shortness of breath. The GP ordered an urgent chest x-ray and documented that the man might require specialist work up. The x-ray revealed nothing of concern. Subsequently, the GP noted that the man was still coughing and smoking and prescribed further antibiotics and anti-smoking medication.

By January 2014 the man was experiencing shortness of breath and further coughing fits, during which he would sometimes cough up blood. The GP sent a semi-urgent referral to the DHB respiratory service for a chest x-ray and stated the man might require specialist work up.

Expert adviser Dr David Maplesden advised that until that stage, the GP's actions were appropriate as the man's symptoms and assessment findings were primarily respiratory in nature and there had been positive response to antibiotic treatment.

Overnight on 7 February 2014, the man coughed all night and had to sit up using his inhaler. He returned to the GP who recorded that the man needed an urgent respiratory appointment but did not advise the DHB that the referral was now urgent. There is no record that the GP carried out a physical examination although blood tests were ordered.

On 14 February 2014 the man returned to the GP with bowel issues. The GP sent a further referral to the DHB for specialist gastroenterology review. Three days later the DHB informed the GP that an appointment had been booked for the man for 1 May 2014 at "the medical clinic". The GP assumed this related to the respiratory appointment but in fact it

was for the gastroenterology review. Although the Commissioner accepted that this was a reasonable assumption to make, he considered that the GP should have attempted to expedite the respiratory appointment. However, the GP appeared unaware that he was able to take steps to bring forward specialist appointments.

There are no physical assessments documented for any consultations after 28 January 2014. By mid February the man's symptoms had changed to include weight loss, anorexia and fatigue. On 25 February the GP prescribed an antibiotic without examining the man. Sadly, overnight on 25/26 February 2014, the man's condition deteriorated, he collapsed and died. His cause of death was respiratory failure due to a severe pulmonary oedema and pleural effusions. He was found to have had severe coronary artery disease, signs of an old myocardial infarction and an enlarged liver.

The GP stated that he never considered that the man's issues might be heart related. Dr Maplesden advised that there was no particular reason to suspect that someone in the man's age group with no symptom history suggestive of cardiac ischaemia could have severe ischaemic heart disease, including a previous myocardial infarction. Dr Maplesden noted that the predominant symptoms of a cough and dyspnoea were consistent with a diagnosis of COPD or perhaps adult onset asthma. However, by mid February 2014 the rapid progression of the man's symptoms and increasing symptoms of weight loss, anorexia and fatigue were less typical for COPD in a relatively young person. Dr Maplesden advised that further investigation was required, with a careful and thorough reassessment by the GP, including a physical examination.

It was held that the GP failed to advocate appropriately for the man by failing to follow up the respiratory referral or inform the DHB when the man's condition deteriorated, and failed to carry out the appropriate physical assessments of the man before prescribing an antibiotic. Accordingly, the GP failed to provide services with reasonable care and skill and breached Right 4(1) of the Code. There was also found to be a pattern of inadequate documentation in the GP's referral letter and clinical notes and so the GP also breached Right 4(2). Adverse comment was made about the DHB's communication with the GP.

It is important to be alert to changes in presentation that could indicate a reassessment of the differential diagnosis is required. In addition, when making referrals, GPs should act as advocates for their patients, by reporting changes in the patients' condition and when necessary, requesting more timely appointments.

Dr Cordelia Thomas, Associate Health and Disability Commissioner
NZ Doctor, 10 May 2017