Teamwork in Healthcare Diagnostics

Reading time:
Jayson Nagpiing
Date created: 01/07/2023

Tags: Case Studies | Medical Practitioner | Communication Skills | Risk Education

A nurse colleague of mine, Kelly was presented with a patient when she was a young nurse who came in feeling quite sick, but as the day progressed, he got worse and his vital signs got a little abnormal.

He specifically mentioned to her he felt like his belly was expanding and not too long after that his vital signs considerably deteriorated. While the medical team descended on the patient to try to resuscitate him, Kelly second-guessed herself as to whether to share the information the patient had imparted to her earlier. She left the medical team to their jobs and never spoke up. Unfortunately, the patient didn't survive, and Kelly has since wondered if she had said something if the patient would've survived.

This is an important lesson in team diagnosis. It is no longer a single's tennis game – the whole team matters! Everyone's input is equally valued. "We have to acknowledge the strength, capabilities and knowledge of everyone in the team to help get the patient the best possible diagnosis." Dr David E. Newman-Toker - Professor, Neurology and Emergency Medicine, John Hopkins University School of Medicine.

What is diagnostic error?

The failure to:

1. establish an accurate and timely explanation of the patient's health problem(s) or
2. communicate that explanation to the patient

From a patient's perspective, if they have not received correct diagnosis in time to treat their condition promptly then that is classified as a diagnostic error. Two other definitions that elaborate on the first is:

1. **Missed opportunity**
   ...a failure to make a correct or timely diagnosis resulting from a preventable process failure (omission or commission), given the evolving context at the time, linked to the sociotechnical work system (adapted from Singh, 2014)
2. **Misdiagnosis-related harm**
   ...harm resulting from the delay or failure to treat a condition actually present (when the working diagnosis was wrong or unknown) or from treatment provided for a condition not actually present. (adapted from Newman-Toker, 2009)

Burden and impact

Diagnostic errors can occur in every area of healthcare including medicine, dentistry and family practice with every disease in every clinical setting. They are the most common, most catastrophic and most costly and truly represent the bottom of the iceberg of patient safety.

According to the National Academy of Medicine (IOM) Report 22 Sept 2015,

“The delivery of healthcare has proceeded for decades with a blind spot: Diagnostic errors…”

“…most people will experience at least one diagnostic error in their lifetime, sometimes with devastating consequences.”

“Improving the diagnostic process is not only possible, but it also represents a moral, professional, and public health imperative.”

“Early efforts could focus on identifying the most common diagnostic errors, don’t miss health conditions that may result in patient harm, or diagnostic errors that are relatively easy to address.” [1]

The three main causes for serious harm are vascular, infection and cancer disease categories. These account for 75% of all the serious harms from diagnostic error and 15 diseases or so, five in each category account for half of all the serious harm from diagnostic error.

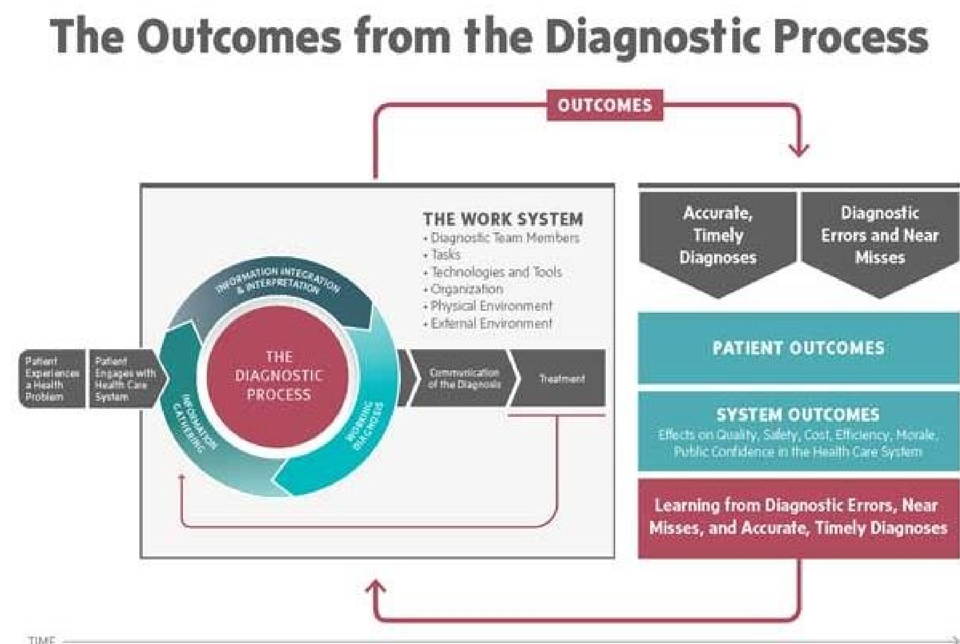
Weak links in the diagnostics process[2]

Traditional/historical errors

- Specimen handling
- Reporting
- Follow up

Bedside errors

- Eliciting history
- Eliciting exam
- Ordering test
- Reading or interpreting test
- Considering or weighting diagnosis



This diagram reflects the notion of the ideal work system and learning health system structure around diagnosis. The patient initiates an encounter with the healthcare system after experiencing a symptom or problem that leads to an iterative cycle of

information gathering and integration that is referred to as the diagnostic process. That in turn, we hope leads to a diagnosis that is effectively communicated and treated and the product of the work system gets monitored for the product of the diagnostic encounters to measure when we have accurate and timely diagnoses, diagnostic errors and near misses and patient outcomes[3]

Diagnostic team members/Clinical teamwork

Facilitate more effective teamwork in the diagnostic process among healthcare professionals, patients, and their families.
Multidisciplinary
People from different disciplines working together, each drawing on their disciplinary knowledge
Interdisciplinary
Integrating knowledge and methods from different disciplines, using a real synthesis of approaches
Transdisciplinary
Creating a unity of intellectual frameworks beyond the disciplinary perspectives
Physician teams

Physician to physician collaboration is familiar to most clinicians. You may encounter informal consultations or curbside consultations where information is shared among peers on de-identified cases to garner opinion. Formal consultations, tests involving other clinicians or getting information from other colleagues, multidisciplinary teams such as cancer teams, diagnostic management teams such as coag labs and by obtaining information by enlisting the services of other clinicians known as crowdsourcing.

It is imperative to remember that diagnostics is a collaborative and patient-centred process that can be most effective through conversation and dialogue. It is a complex area as there could be a number of differentials on a particular diagnosis with a number of tests for individual diseases that need to be performed with the involvement of a number of departments making decisions.

We can help our patients by offering translation and being more culturally sensitive, build relationships and rapport, exchange information, respond to their emotions, share decision making and empower the patient to manage their symptoms.

And in turn our patients can be encouraged to come prepared, feel comfortable to ask questions and learn to stay vigilant.

[1, 3] NAM (IOM), Improving Diagnosis in Healthcare, 2015

[2] Schiff et al., Arch Intern Med 2009

Medical Indemnity Protection Society ABN 64 007 067 281 | AFSL 301912

All information on this page is of a general nature only and is not intended to be relied upon as, nor to be a substitute for, specific legal or other professional advice. No responsibility for the loss occasioned to any person acting on or refraining from action as a result of any material published can or will be accepted by MIPS.

You should seek legal or other professional advice before relying on any content, and practise proper clinical decision making with regard to the individual circumstances.

Information is only current at the date initially published.

If in doubt, contact our claims and 24-hour medico-legal advice and support team on 1300 698 573.

You should consider the appropriateness of the information and read the Member Handbook Combined PDS and FSG before making a decision on whether to join MIPS.