GETTING IT RIGHT

Diagnostic errors continue to cause unnecessary harm

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In most health care encounters, the single most important aspect is making the right diagnosis. According to the National Academy of Medicine (NAM), diagnosis provides an explanation for the problem. It informs and influences subsequent health care decisions.

In a 2015 consensus study "Improving Diagnosis in Health Care," a follow up to the 2000 landmark Institute of Medicine report "To Err Is Human," NAM examined diagnostic error as a contributor to preventable harm. It concluded these errors persisted throughout all care settings and continue to harm an "unacceptable number of patients."

A new study published by the Agency for Healthcare Research and Quality (AHRQ), an arm of the U.S. Department of Health and Human Services, provided some disturbing quantification of that "unacceptable" number in the emergency department.

The study entitled "Diagnostic Errors in the Emergency Department: A Systematic Review" was designed to answer the following questions:

1) What clinical conditions are associated with the greatest number of emergency department diagnostic errors and their associated harm?
2) How frequent are these diagnostic errors and their associated harms?
3) What are the major causes of these diagnostic errors and their associated harms?

According to the results, among 130 million American emergency department visits per year, 7.4 million patients are misdiagnosed, 2.6 million are injured and 370,000 suffer serious harm as a result of those misdiagnoses.

To put these results in context, the report notes that in an average emergency department with 25,000 annual visits and "average diagnostic performance," each year 1,400 patients would be misdiagnosed, 500 would suffer injury, and 75 would suffer serious injury, including 50 deaths. That's almost one preventable death per week, per hospital.

The five most-missed conditions are not particularly surprising: Stroke, myocardial infarction, aortic aneurysm/dissection, spinal compression/injury, and venous thromboembolism. The root causes of these preventable injuries, as attributed by AHRQ, are also not surprising and are mostly related to cognitive errors involving failures in clinical assessment, reasoning or decision-making. The strongest predictors of diagnostic error have been, and unfortunately remain, individual patient factors that "increase the cognitive challenge" of formulating the correct diagnosis, such as "nonspecific, mild, transient, or 'atypical' symptoms."

More than seven years ago, NAM stated it's likely that most people will experience at least one diagnostic error in their lifetime. The committee concluded that improving the diagnostic process is not only possible, but also represents a "moral, professional, and public health imperative." The occurrence of diagnostic errors, according to NAM, in what amounts to a clarion call, has been largely unappreciated in efforts to improve the quality and safety of health care.

"Without a dedicated focus on improving diagnosis, diagnostic errors will likely worsen as the delivery of health care and the diagnostic process continue to increase in complexity… [I]mproving diagnosis will require collaboration and a widespread commitment to change among health care professionals, health care organizations, patients and their families …The recommendations of Improving Diagnosis in Health Care contribute to the growing momentum for change in this crucial area of health care quality and safety." (NAM 2015).

NAM's prediction has been validated by AHRQ's report. Its recommendations have gone largely unheeded and preventable diagnostic errors persist, injuring and killing an "unacceptable" number of patients.

How does any of this impact the trial lawyer in the trenches? Consider this. Most emergency room negligence cases are focused on the ER physician, a clinician ostensibly not employed by the hospital and who usually has limited coverage. Attempts to hold the hospital responsible through apparent agency must navigate a legal minefield and — unjustly in our opinion — may be defeated by language in a consent form.

Perhaps an additional inquiry should focus on whether the hospital heard and responded to NAM's clarion call. What efforts has the hospital made to heed to reduce diagnostic error? What policies have been instituted? What clinical decision support tools have been implemented? What research has been conducted to reduce errors?

A hospital administration/institutional negligence expert would likely find the answers to these questions interesting. CL

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