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A LARGER SCOPE OF ISSUES

Research shows diagnosis error not only caused by individuals

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Most medical negligence cases filed in Illinois focus primarily, if not exclusively, on the actions or omissions of individual healthcare providers. Allegations against hospitals, clinics and physician practices seem to focus primarily on vicarious liability through actual or apparent agency.

Diagnostic error is a good example. A radiologist misses signs of pneumatosis on an abdominal CT in a patient with severe abdominal pain and a history of volvulus; an ER physician dismisses EKG evidence of ST segment depression and sends a heart attack patient home without appropriate laboratory tests. Both of these examples involve patients in high-risk/high-acuity settings, which is generally the focus of research into diagnostic error. Both also involve negligence that at first blush seems related to simple human error, committed by a single provider at the tip of the healthcare spear.

Recent research indicates, however, that the high prevalence of diagnosis-related patient injury is not limited to ERs and ICUs and is not solely caused by individual provider carelessness. Indeed, the provider who ultimately makes the diagnostic error may be just the tip of the causation iceberg. According to a recent study published in BMJ Quality & Safety, harmful diagnostic errors in general medicine admissions are frequent and most are preventable (Dalal AK, *et. al. BMJ Qual Saf* 2024;0:1-1). The data, based upon a retrospective cohort study among patients hospitalized in a general medicine setting, revealed that one of every 14 patients — or 7.2% — suffered a diagnostic error that caused injury. Also, the vast majority of these errors and injuries — more than 84% — were preventable.

As the authors point out, the sample utilized broadly represents typical clinical trajectories for inpatients receiving general medical care. The data illustrates that diagnostic errors are frequent, they cause substantial harm and are associated with certain process failures. Identified failures included not only individual errors in initial assessment or diagnostic test interpretation, but also coordination and communication problems including suboptimal subspecialty consultation.

In response to these types of concerns, patient safety organizations have published resources and guidelines for hospitals to use to protect patients from diagnostic errors. In 2022, the Leapfrog Group published recommended practices for hospitals to promote diagnostic excellence. Leapfrog referred to research that suggests nearly 80% of diagnostic errors can be traced back to a process breakdown. The report recommends a focus on senior administrative leadership and institutional-level remedies such as surveillance, training, and policy creation and enforcement.

In 2024, the Centers for Disease Control (CDC) published its "Core Elements of Hospital Diagnostic Excellence (DxEx)." The CDC's Core Elements outline structures and processes that hospitals should implement to improve the diagnostic process, including activities related to improving diagnostic reasoning, testing and communication around diagnosis.

Under Illinois law, a hospital may be held directly liable for its own institutional negligence or vicariously liable for the professional negligence of its employees or agents. Where the evidence supports it, a plaintiff can employ both theories as a basis for establishing a hospital's liability. *Wilcox v. Advoc. Condell Med. Ctr.,* 2024 IL App (1st) 230355. Illinois law recognizes a duty on the part of hospitals "to review and supervise the treatment of their patients." This duty is "administrative or managerial in character," and does not involve looking over the radiologist's shoulder to point out the evidence of pneumatosis he misses. Rather, the duty arises long before the patient needs the CT scan and involves an institutional commitment to minimize or eliminate diagnostic error.

The institutional tools to protect patients are no mystery. As Leapfrog pointed out, "[h]ospitals know how to do this." A survey administered by Leapfrog found that while most hospitals who responded were aware of the diagnostic error problem and institutional role in the problem, their commitment to change was limited. One of the reasons is that hospitals "don't know" why they need to start:

> [They] do not get a clear signal from the public, private payors, regulators, or accreditors that diagnostic safety and quality is a priority.

In other words, hospitals do not have the financial incentive to change. Perhaps the cause of action described in *Wilcox* can help provide that incentive. CL

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