

Diagnostic Errors: Why Do They Matter, and What Can You Do?

Why They Need Attention Now

Diagnostic errors are difficult to measure. But what is known points to a significant problem.

Deaths



Diagnostic errors that may have contributed to death have been found in **10%** of autopsies

Source: Shojania et al.



This extrapolates to **40,000 to 80,000** deaths annually

Source: Leape et al. "Counting Deaths."

Adverse Events



7% to 17% of adverse events in hospitals result from diagnostic errors, per record reviews

Sources: Leape et al. "The Nature of Adverse Events"; Thomas et al.

Liability

Most Common Allegation



29% of claims

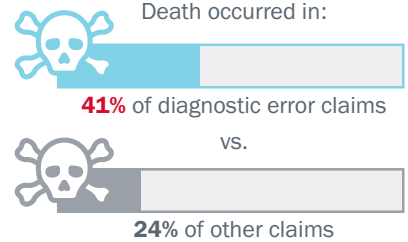
Most Costly Allegation



35% of payments

\$390,000 mean payout

Most Deadly Allegation



Death occurred in:

41% of diagnostic error claims

vs.

24% of other claims

Source: Saber Tehrani et al.

Frequency



At least **1 in 20** adults experiences a diagnostic error annually, based on outpatient studies

Source: Singh et al.



12% of adults said they or someone close to them had experienced a misdiagnosis in the past 5 years, according to a phone survey

Source: Betsy Lehman Center.

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

— Institute of Medicine (IOM) report on improving diagnosis

Source: NAS.

What You Can Do

The IOM report offers recommendations across 8 broad goals for a variety of stakeholders (NAS).



Teamwork among healthcare professionals, patients, and families



Education and training regarding the diagnostic process



Identification of errors and near misses and efforts to learn from and reduce them



Supportive health information technology systems



Learning-focused reporting and medical liability systems



A supportive culture and work system



Supportive payment and care delivery environments



Research funding

Learn how to reduce diagnostic errors.

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Sources

Betsy Lehman Center for Patient Safety and Medical Error Reduction, Harvard School of Public Health. The public's views on medical error in Massachusetts. 2014 Dec [cited 2019 May 31].

<https://cdn1.sph.harvard.edu/wp-content/uploads/sites/94/2014/12/MA-Patient-Safety-Report-HORP.pdf>

Leape LL, Berwick DM, Bates DW. Counting deaths due to medical errors—reply. JAMA 2002 Nov 20;288(19):2405.

Leape LL, Brennan TA, Laird N, et al. The nature of adverse events in hospitalized patients. Results of the Harvard Medical Practice Study II. N Engl J Med 1991 Feb 7;324(6):377-84.

National Academies of Sciences, Engineering, and Medicine (NAS). Improving diagnosis in health care. Washington (DC): National Academies Press; 2015.

<http://www.nationalacademies.org/hmd/Reports/2015/Improving-Diagnosis-in-Healthcare.aspx>

Saber Tehrani AS, Lee H, Mathews SC, et al. 25-Year summary of US malpractice claims for diagnostic errors 1986-2010: an analysis from the National Practitioner Data Bank. BMJ Qual Saf 2013 Aug;22(8):672-80.

Shojania KG, Burton EC, McDonald KM, et al. The autopsy as an outcome and performance measure. Evidence report/technology assessment no. 58. Rockville (MD): Agency for Healthcare Research and Quality. 2002 Oct [cited 2019 May 31].

<http://archive.ahrq.gov/downloads/pub/evidence/pdf/autopsy/autopsy.pdf>

Singh H, Meyer AN, Thomas EJ. The frequency of diagnostic errors in outpatient care: estimations from three large observational studies involving US adult populations. BMJ Qual Saf 2014 Sep;23(9):727-31.

Thomas EJ, Studdert DM, Burstin HR, et al. Incidence and types of adverse events and negligent care in Utah and Colorado. Med Care 2000 Mar;38(3):261-71.

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