Urgent change needed to improve diagnosis in health care or diagnostic errors will likely worsen

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Most people will experience at least one diagnostic error—an inaccurate or delayed diagnosis—in their lifetime, sometimes with devastating consequences, says a new report from the Institute of Medicine of the National Academies of Sciences, Engineering, and Medicine. The committee that conducted the study and wrote the report found that although getting the right diagnosis is a key aspect of health care, efforts to improve diagnosis and reduce diagnostic errors have been quite limited. Improving diagnosis is a complex challenge, partly because making a diagnosis is a collaborative and inherently inexact process that may unfold over time and across different health care settings. To improve diagnosis and reduce errors, the committee called for more effective teamwork among health care professionals, patients, and families; enhanced training for health care professionals; more emphasis on identifying and learning from diagnostic errors and near misses in clinical practice; a payment and care delivery environment that supports the diagnostic process; and a dedicated focus on new research.

This report is a continuation of the Institute of Medicine's Quality Chasm Series, which includes reports such as To Err Is Human: Building a Safer Health System, Crossing the Quality Chasm: A New Health System for the 21st Century, and Preventing Medication Errors.

"These landmark IOM reports reverberated throughout the health care community and were the impetus for system-wide improvements in

patient safety and quality care," said Victor J. Dzau, president of the National Academy of Medicine. "But this latest report is a serious wake-up call that we still have a long way to go. Diagnostic errors are a significant contributor to patient harm that has received far too little attention until now. I am confident that Improving Diagnosis in Health Care, like the earlier reports in the IOM series, will have a profound effect not only on the way our health care system operates but also on the lives of patients."

Data on diagnostic errors are sparse, few reliable measures exist, and errors are often found in retrospect, the committee found. However, from the available evidence, the committee determined that diagnostic errors stem from a wide variety of causes that include inadequate collaboration and communication among clinicians, patients, and their families; a health care work system ill-designed to support the diagnostic process; limited feedback to clinicians about the accuracy of diagnoses; and a culture that discourages transparency and disclosure of diagnostic errors, which impedes attempts to learn and improve. Errors will likely worsen as the delivery of health care and the diagnostic process continue to increase in complexity, the committee concluded. To improve diagnosis, a significant re-envisioning of the diagnostic process and a widespread commitment to change from a variety of stakeholders will be required.

"Diagnosis is a collective effort that often involves a team of health care professionals—from primary care physicians, to nurses, to pathologists and radiologists," said John R. Ball, chair of the committee and executive vice president emeritus, American College of Physicians. "The stereotype of a single physician contemplating a patient case and discerning a diagnosis is not always accurate, and a diagnostic error is not always due to human error. Therefore, to make the changes necessary to reduce diagnostic errors in our health care system, we have to look more broadly at improving the entire process of how a diagnosis

made."

Critical partners in improving the diagnostic process are patients and their families, because they contribute valuable input that informs diagnosis and decisions about their care. To help them actively engage in the process, the committee recommended that health care organizations and professionals provide patients with opportunities to learn about diagnosis, as well as improved access to electronic health records, including clinical notes and test results. In addition, health care organizations and professionals should create environments in which patients and families are comfortable sharing feedback and concerns about possible diagnostic errors.

Few health care organizations have processes in place to identify diagnostic errors and near misses in clinical practice. However, collecting this information, learning from these experiences, and implementing changes are critical for achieving progress. The culture of health care organizations can also discourage identification and learning. Therefore, the committee called for these institutions to promote a non-punitive culture that values open discussions and feedback on diagnostic performance.

Reforms to the medical liability system are needed to make health care safer by encouraging transparency and disclosure of diagnostic errors. States, in collaboration with other stakeholders, should promote a legal environment that facilitates the timely identification, disclosure, and learning from diagnostic errors. Voluntary reporting efforts should also be encouraged and evaluated for their effectiveness.

Payment and care delivery models also likely influence the diagnostic process and the occurrence of diagnostic errors, but information about their impact is limited and this is an important area for research, the committee said. It recommended changes to fee-for-service payment to

improve collaboration and emphasize important tasks in the diagnostic process. For example, the Centers for Medicare & Medicaid Services and other payers should create codes and provide coverage for evaluation and management activities, such as time spent by pathologists and radiologists in advising treating physicians on testing for specific patients. Moreover, payers should reduce distortions in the fee schedule that place greater emphasis on procedure-oriented care than on cognitive-oriented care, because they may be diverting attention from important tasks in diagnosis, such as preforming a thorough clinical history, interview, and physical exam, or decision making in the diagnostic process.

Additionally, the committee recommended that health care professional education and training emphasize clinical reasoning, teamwork, communication, and diagnostic testing. The committee also urged better alignment of health information technology with the diagnostic process. Furthermore, federal agencies should develop a coordinated research agenda on the diagnostic process and diagnostic errors by the end of 2016.

The report presents resources to help patients better engage in the diagnostic process. One resource, a checklist for getting the right diagnosis, advises patients about how to effectively tell their story, be a good historian, keep good records, be an informed consumer, take charge of managing their health care, follow up with their clinicians, and encourage clinicians to think about other potential explanations for their illness.

More information: www.nap.edu/catalog/21794/impr … nosis-in-health-care

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