# Reseracher pinpoints diagnostic errors as the critical blind spot of health-care providers

October 7 2015, by Beth Duff-Brown

Most Americans will get at least one faulty diagnosis in their lifetime, sometimes with devastating consequences. "Urgent change is warranted to address this challenge," according to a recent landmark report from the Institute of Medicine.

The September report, by a committee of medical experts, found that despite dramatic improvements in patient safety over the last 15 years, diagnostic errors have been the critical blind spot of health-care providers.

Kathryn McDonald, executive director of Stanford's Center for Health Policy/Center for Primary Care and Outcomes Research, is a member of the committee that wrote the report, "Improving Diagnosis in Health Care."

Recently, Beth Duff Brown, the communications manager at CHP/CPCOR, asked McDonald some questions about the report's findings and also got her suggestions for limiting one of the most overlooked health-care dilemmas today.

## Q: What surprised or enlightened you most in your findings?

McDonald: I learned a lot about the ways that the legal system sets up barriers to transparency even as it tries to protect patients. For example,

the current approach to resolving medical liability claims sets up barriers to transparency needed to learn from diagnostic errors. In the aftermath of devastating errors that arise from failures in the diagnostic process and teamwork, many patients want to help make the delivery system safer. Concerns about medical liability prevent clinicians from disclosing medical errors to patients and their families, despite calls from numerous groups that full disclosure is an ethical necessity. It is often complex to understand the multiple forces that result in a diagnostic error.

Learning is important to patients and physicians to prevent repeat problems. We made recommendations about medical malpractice reforms that might be designed to permit patients and health professionals to become allies in trying to make health care safer by encouraging transparency about such errors. We need approaches that would allow patients to be promptly and fairly compensated for injuries that were avoidable while at the same time turning errors into lessons to improve subsequent performance. It's a real shame that we are not there yet, and that evidence is lacking about exactly how to get there. We need folks with medical, law, maybe psychology, and patient safety backgrounds to work on research in this area.

**Q: What do you believe is the most significant message and mission of the report?**

McDonald: The report is packed with reasons and directions for action from all, in ways that support what patients deserve from the health-care system: freedom from worry about inattention to diagnostic errors. That's been the status quo for too long.

What is particularly critical is the huge gap in methods to identify diagnostic errors and near misses, measure their frequency and severity, and figure out a systematic way to make those involved aware of them. As a researcher who has spent most of my life developing patient-safety

and quality measures, I know we can do better in this area. At the same time, the challenge is significant. Diagnosis occurs over time and involves varying levels of uncertainty. Real research funding, with an applied focus, is needed. The report calls for this. It includes a carefully crafted definition that is patient-focused in order to set us on a new path for measuring what matters to patients. There is a chapter devoted to measurement: Chapter 3, worth reading if you want a sense of the scope of both diagnostic errors and the challenge of measuring them well enough to help those who want to improve diagnosis.

Part of the challenge is figuring out where to direct energies for the biggest payoff from a public health perspective, while also fostering the culture change needed to focus on learning and improving, sooner rather than later. Definition and measurement are central to this work.

## Q: How did the committee define a "diagnostic error" and how might this differ from previous definitions?

McDonald: We defined diagnostic error from a patient's perspective, and brought together the research so far that clearly shows the opportunity and grave need to improve the current situation. The definition has two parts, both focusing on what patients want and need. Part 1 states that diagnostic error is the failure to establish an accurate and timely explanation of the patient's health problem. This part of the definition is not meant to set an unreachable bar. It is open to establishing what is known at each point in the diagnostic process, sometimes a working diagnosis as more information is collected to rule out the most pressing concerns in the physician's list of possibilities. Part 2 states that a diagnostic error is the failure to communicate that explanation to the patient. No other definitions have anything related to this part, even though it is exactly what patients are looking for, or want for their loved ones if they are not in a state where the communication can occur with

them.

Several previous definitions have arisen to accomplish different purposes—often anticipating the measurement challenge. For example, there is a solid stream of research about "missed opportunities" and "triggers" that can be found in a medical record showing that there was a sign that a patient might have a serious condition, but then it wasn't followed up with additional testing in a specific and appropriate time frame. The IOM report's definition built upon previous definitions, but with a clear orientation toward patients and their families.

## Q: You outline eight goals that physicians and health-care providers should follow in their diagnostic practice. Which do you believe are the most significant?

McDonald: They are all important. I know that isn't a satisfying answer, but this is a complex problem that requires a many-pronged, multi-level attack from education to payment system reforms. We tried to be bold and aspirational, while grounded in the existing evidence. I guess if I had to underscore a goal where I am most optimistic that it will make a difference in the short run, I'd point to the teamwork one. There is a growing evidence base that the benefits of teamwork accrue to all members of the team, so this recommendation has the potential to be a win-win for all involved. Improving diagnosis is quite challenging, partly because making a diagnosis is a collaborative effort and involves many, often iterative, steps—few simple ones. These steps can unfold over time, across different health-care settings, and usually involve diagnostic uncertainty. All the moving parts, all the different types of expertise, all the people involved, well that's a call for teamwork. This IOM report and the challenge of improving diagnosis puts health-care organizations on the hook for ensuring that health-care professionals have knowledge and

skills to engage in effective teamwork—both interprofessionally and intraprofessionally. And the goal doesn't stop there. We also recommended, as part of this first goal, that health-care professionals and organizations should partner with patients and their families as diagnostic team members, and facilitate patient and family engagement in the diagnostic process, aligned with their needs, values and preferences.

## Q: The video that was released with the report is very powerful. I think many of us don't realize how often a misdiagnosis can occur and how significant the impact can be.

McDonald: The video has two patients for whom things went poorly and one who had a first-class diagnostic experience because of excellent teamwork. And this is one of the key messages of the report. We need less of the old model of diagnosis from one expert to more of a teamwork approach to the diagnostic process. It is well worth watching the video to understand the human side, and the unique patient perspective on this important issue.

**More information:** "Improving Diagnosis in Health Care": iom.nationalacademies.org/Repo … s-in-Healthcare.aspx

Provided by Stanford University Medical Center