Reducing Medical Errors by Improving the Diagnostic Process

By Marshaleen King, MD

November 16, 2017

Introduction

Medical errors remain a major cause of morbidity and mortality. Recent estimates indicate that medical error is likely the third leading cause of death in the US, [1] with some sources reporting an incidence of 210,000 to 400,000 deaths annually due to medical errors among hospitalized patients.[2] Although diagnostic errors have received less attention over the past decade compared to medication errors and procedural errors, diagnostic errors account for a significant number of preventable medical errors. The Institute of Medicine (IOM) report published in 2015, titled, “Improving Diagnosis in Health Care,” placed a spotlight on diagnostic errors and emphasized the fact that diagnostic errors serve as a major source of avoidable medical errors. The IOM attributes the failure to recognize diagnostic errors as a significant cause of medical harm, due in part to the fact that diagnostic errors are often recognized in hindsight.[3]

Factors Contributing to Diagnostic Errors

Several aspects of the diagnostic process are vulnerable to mistakes, thus addressing diagnostic errors warrants a multifaceted approach. Analysis of medical errors over the years has revealed that medical errors are often the result of cognitive factors and/or system-related factors. Due to the numerous factors contributing to diagnostic errors, many institutions have had difficulty in developing tools to reduce these errors and improve the diagnostic process. A recent publication by investigators from Houston, Texas, outlined a multifaceted framework for improving the measurement of
diagnostic errors in order to enhance system-wide safety measurement and monitoring and to reduce diagnostic errors. The authors proposed that systematically studying diagnostic errors and paying closer attention to the factors contributing to these errors will enable us to devise strategies to prevent diagnostic errors and improve the diagnostic process.

Sources of diagnostic errors include:

- Breakdown in physician-patient communication; including taking an incomplete patient history and/or obtaining necessary tests
- Failure to utilize cognitive support tools such as information resources, risk-assessment tools and consultations
- Failure to properly use the chart/EHR to review and document data
- Failure to clearly designate the patient responsibility to follow up on test results
- Lack of a reminder system to ensure follow-up on test results

Enhancing the Diagnostic Process

Mechanisms for avoiding diagnostic errors may be categorized based on the primary area of focus. Strategies targeting both cognitive and system-based errors are necessary to effectively reduce diagnostic errors.

Recommendations for improving the diagnostic process include:

- Implementing a teamwork approach in the diagnostic process and employing methods that enhance communication between patients and medical professionals in order to improve on the quality of information gathered in making a diagnosis
- Keeping an open mind when investigating a problem, (instead of narrowing down the differential too soon), in order to avoid anchoring bias
- Ensuring healthcare professionals receive high-quality education and training in the diagnostic process
- Paying attention when things don’t add up, such as when test results don’t coincide with a suspected diagnosis: an alternative diagnosis should also be considered
- Following up on tests and ensuring that the responsibility to act on test results has been clearly designated in order to avoid delays in making an accurate diagnosis
- Consulting specialists when appropriate/necessary in order to guide the diagnostic process particularly for complex or uncommon conditions
- Involving patients and their family members in their care in order to ensure that follow-up tests/procedures occur as planned and changes in the patient’s condition are not missed
- Developing a system that permits near misses and errors to be identified and reported without fear of retaliation, then utilizing the information to improve on the system in order to avoid future repetition of errors

Reducing the healthcare burden caused by diagnostic errors warrants a team approach with participation from physicians, patients and other members of the healthcare team. Although it is unlikely that diagnostic errors will ever be totally prevented, implementing the strategies and recommendations outlined above will likely lead to improvements in the diagnostic process and lesson the likelihood of diagnostic errors.


The information provided in this resource does not constitute legal, medical or any other professional advice, nor does it establish a standard of care. This resource has been created as an aid to you in your practice. The ultimate decision on how to use the information provided rests solely with you, the PolicyOwner.

Source URL: https://www.magmutual.com/learning/article/reducing-medical-errors-improving-diagnostic-process