WHY YOU WILL EXPERIENCE A DIAGNOSTIC ERROR

Cause Map

> "It will be a huge leap forward if the report could help foster a safety culture where clinicians are encouraged to discuss and learn from errors more openly and work with patients, policy makers and researchers to start solving this complex problem."
>
> - Dr. Hardeep Singh, expert reviewer on the Institute of Medicine report on Diagnostic Errors

1 Problem

What	Problem(s)	Diagnostic errors in healthcare
When	Date	Proactive
	Different, unusual, unique	Diagnostic error has received relatively little attention
Where	Facility, site	All healthcare providers/ facilities
	Task being performed	Diagnosing patients

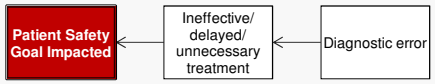
Impact to the Goals

Patient Safety	Contribute to ~10% of patient deaths
	Account for 6-17% of hospital adverse events
Compliance	Leading type of paid medical malpractice claims
Patient Services	Ineffective/delayed/unnecessary treatment
Schedule/ Operations	Additional treatment required
Labor/ Time	

Frequency	5% of US adults who seek outpatient care each year experience a diagnostic error ("conservative estimate"); the best estimates indicate everyone in the US will likely experience a meaningful diagnostic error in their lifetime

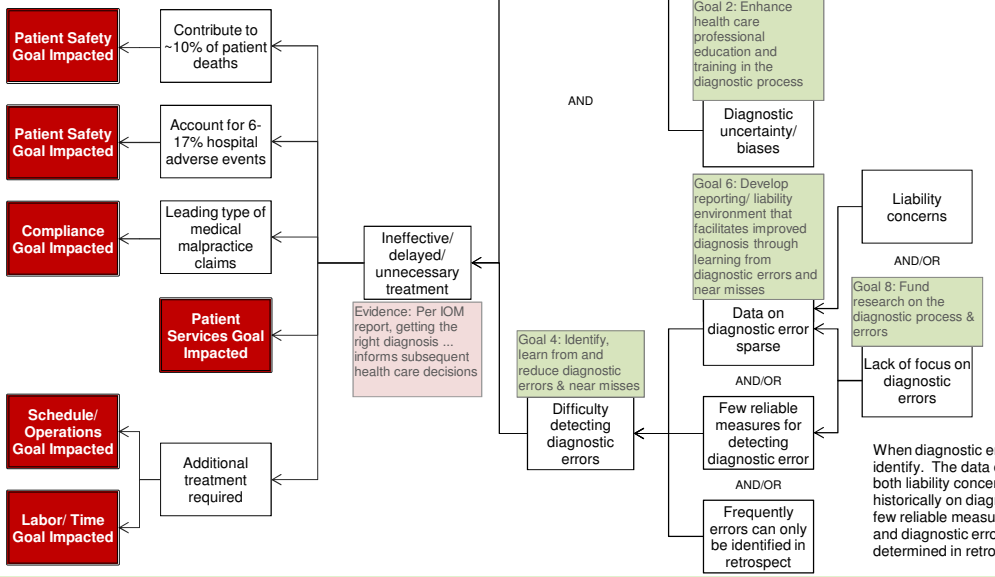
2 Analysis

Basic Level Cause Map - Start with simple Why questions.



More Detailed Cause Map - Add detail as information becomes available.

The burden of harm determined to result from diagnostic errors is significant. Diagnostic errors are estimated to contribute to about 10% of hospital deaths, and 6-17% of hospital adverse events, clearly impacting patient safety. Not only patient safety is impacted, however. Diagnostic errors are the leading type of paid malpractice claims. They also impact patient services, leading to ineffective, delayed, or unnecessary treatment. This then impacts schedule and labor as additional treatment is typically required. The report found that, in a "conservative" estimate, 5% of adults who seek outpatient care in the United States experience a diagnostic error each year and determined that it is likely that everyone in the US will likely experience a meaningful diagnostic error in their lifetime.



When diagnostic errors do occur, they can be difficult to identify. The data on diagnostic errors is sparse due to both liability concerns as well as a lack of focus historically on diagnostic errors. In addition, there are few reliable measures for measuring diagnostic errors, and diagnostic errors can frequently only be definitely determined in retrospect.

On September 22, 2015, the Institute of Medicine released a report entitled "Improving Diagnosis in Health Care". The tasking to the committee formed by the IOM matched the three step problem-solving process: first, to define the problem by examining "the burden of harm and economic costs associated with diagnostic error"; second, to analyze the issue by evaluating diagnostic error; third, to provide recommendations as "action items for key stakeholders".

The report also provided an analysis of issues within the diagnostic process that can lead to diagnostic errors. Errors that occur at any step of the diagnostic process can lead to diagnostic errors.

Why?

Effect ← Cause

NOTE: Read the Cause Map from left to right with the phrase "Was Caused By" in place of each arrow.

The report identifies eight goals that address these potential causes of diagnostic errors. These goals are presented as a call to action to health care professionals, organizations, patients and their families, as well as researchers and policy makers.

3 Solutions

Goals for Improving Diagnosis and Reducing Diagnostic Error

1) Facilitate more effective teamwork in the diagnostic process among health care professionals, patients and their families
2) Enhance health care professional education and training in the diagnostic process
3) Ensure that health information technologies support patients and health care professionals in the diagnostic process
4) Develop and deploy approaches to identify, learn from, and reduce diagnostic errors and near misses in clinical practice
5) Establish a work system and culture that supports the diagnostic process and improvements in diagnostic performance
6) Develop a reporting environment and medical liability system that facilitates improved diagnosis through learning from diagnostic errors and near misses
7) Design a payment and care delivery environment that supports the diagnostic process
8) Provide dedicated funding for research on the diagnostic process and diagnostic errors

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