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Risk Tips

Reducing Diagnostic Errors in Emergency Medicine

Diagnostic errors are a critical patient safety concern, and they account for the largest percentage of malpractice claims and the most severe clinical and financial outcomes.[1]

Diagnostic errors are particularly problematic in emergency medicine. MedPro Group claims data show that 70 percent of all emergency medicine claims involve diagnosis-related allegations (e.g., failure to diagnose, delay in diagnosis, or misdiagnosis). Further, these allegations account for 76 percent of total dollars paid for defense and indemnity costs.[2] In comparison, an analysis of claims across all specialties showed that diagnosis-related allegations account for 24 percent of claims and 32 percent of total dollars paid.[3]

Diagnosis is a complex process, and the fast-paced and chaotic nature of the emergency department (ED) setting further complicates it. To offset these issues, emergency medicine providers can proactively implement strategies that address common weaknesses in the diagnostic process, such as cognitive biases, system deficiencies, and documentation errors. The following list offers suggestions for managing diagnostic risks in the ED setting.

1. Gather thorough information from the patient, family, and/or significant others about the patient's history of the present illness/condition, past medical history, family medical history, and personal/social history.

2. Review the patient's available health records for details about any previous inpatient, ED, and outpatient visits.

3

Screen patients for potential risk factors, atypical presentations, and associated symptoms to avoid a narrow diagnostic focus. Reconsider differential diagnoses of returning patients, patients who show no signs of improvement, and patients who are intoxicated or seeking drugs.

4

Document the physical evaluation and differential diagnoses (including why certain diagnoses were considered, dismissed, or ruled out). Verify that documentation supports the clinical rationale for the diagnosis and treatment plan.

5

Utilize evidence-based guidelines, clinical pathways, and standardized approaches for cardiac conditions, strokes, intracranial bleeds, gastrointestinal issues, etc. Consider adopting the diagnostic team framework to support clinical reasoning and decision-making.

6

Be aware of common cognitive and affective biases and how they might negatively affect clinical judgment. Learn about various techniques to address biases, such as situational awareness, metacognition, perspective-taking, emotional regulation, and partnership-building.

7

Evaluate how clinical decision support systems and other technologies, such as electronic health record alerts, can support the diagnostic process and team communication when correctly implemented.

8

Ensure timely ordering of tests and consultations to prevent problems associated with ruling out or documenting abnormal findings.

9

Ensure your organization has comprehensive test-tracking and referral-tracking procedures that include protocols for thoroughly reviewing imaging studies, signing off on studies, and following up with patients.

10

When receiving direct verbal reports from radiologists and other specialists, take brief notes and/or repeat back any findings requiring prompt follow up.

11

Ensure prompt communication and documentation of relevant findings from consultations and referrals. Communication mechanisms should take into account patients' location (e.g., in the ED, admitted to the hospital, transferred to another facility, or discharged).

12

Adhere to organizational protocols for patient handoffs and signouts, including expectations for verbal and written communication. Using standardized handoff checklists can remind healthcare providers about important patient information to communicate.

13

Thoroughly review the health record at each patient encounter to stay informed of the most recent clinical information.

14

Prior to discharge, reevaluate patients who have abnormal vital signs and/or lab results.

15

Adhere to organizational processes for following up on radiology discrepancies and communicating test results received after patients are discharged.

16

Use team drills and situational simulations to improve teamwork and communication between all providers in the ED.

Endnotes

[1] Society to Improve Diagnosis in Medicine. (n.d.). *What is diagnostic error?* Retrieved from www.improvediagnosis.org/what-is-diagnostic-error/

[2] MedPro Group. (2023). *Emergency medicine: Claims data snapshot.* Retrieved from www.medpro.com/documents/10502/5086243/Emergency+Medicine.pdf

[3] MedPro Group. (2022). Diagnostic errors: Overview, analysis, and emerging Risks — A 10-year claims analysis. Retrieved from www.medpro.com/diagnostic-errors-overview-analysis-od