MedPro Group claims data show that diagnostic errors — including failure to diagnose, delay in diagnosis, and misdiagnosis — are the most common cause of emergency medicine malpractice claims. Analysis of 10 years of claims reveals that almost two-thirds of all emergency medicine claims involve diagnosis-related allegations. Further, these allegations account for 82 percent of total dollars paid for defense and indemnity costs.

Diagnosis is a complex process, which is further complicated by the fast-paced nature of the emergency department setting. To offset these issues, emergency medicine practitioners can implement risk 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 within the emergency department setting.

- Obtain information from the patient, family, or caretaker about the patient’s history of the present illness, past medical history, and family and personal/social history.
- Screen patients for risk factors, atypical presentations, and associated symptoms to avoid a narrow diagnostic focus.
- Review the patient’s records for any previous inpatient, emergency department, and outpatient visits.
- Document the medical evaluation and differential diagnoses (including why certain diagnoses were considered, dismissed, or ruled out).
- Utilize evidence-based guidelines and standardized approaches for myocardial infarctions, cerebrovascular accidents, intracranial bleeds, etc. Consider the use of clinical decision support aids and group decision-making to support clinical reasoning.
- Consider the organization’s access to and utilization of evidence-based decision support system tools to assist in determining diagnoses and treatment.
Ensure timely ordering of tests and consultations to prevent problems associated with ruling out or documenting abnormal findings.

Make sure your organization has comprehensive test tracking and referral tracking procedures that include protocols for complete review of imaging studies, patient follow-up, and documentation.

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

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

Adhere to processes for following up on radiology discrepancies and communicating test results received after discharge.

Reconsider differential diagnoses of returning patients, patients who show no signs of improvement, and patients who are intoxicated or seeking drugs.

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

This document should not be construed as medical or legal advice. Because the facts applicable to your situation may vary, or the laws applicable in your jurisdiction may differ, please contact your attorney or other professional advisors if you have any questions related to your legal or medical obligations or rights, state or federal laws, contract interpretation, or other legal questions.

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