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IOM Report: Teamwork Critical for Improved Diagnosis

Data on diagnostic errors are sparse, few reliable measures exist and errors are often found in retrospect, an independent research committee has found with poor teamwork a chief cause. “Diagnostic errors stem from collaboration and communication among clinicians, patients, and their families, a health care work system ill-designed to support the diagnostic process limited feedback to clinicians about the accuracy of diagnoses and a culture that discourages transparency and disclosure of diagnostic errors, which impedes attempts to learn and improve,” the Institute of Medicine of the National Academies of Sciences, Engineering, and Medicine (IOM) said in its report *Improving Diagnosis in Health Care* released today.

“This latest report is a serious wake-up call that we still have a long way to go,” said Victor J. Dzau, president of the National Academy of Medicine. “Diagnostic errors are a significant contributor to patient harm that has received far too little attention until now.”

The committee, comprised of medical and science professionals from around North America, said that most people would experience at least one diagnostic error in their lifetime, sometimes with devastating consequences.

Efforts to improve diagnosis and reduce diagnostic errors had been quite limited, the committee said.
“Diagnosis is a collective effort that often involves a team of health care professionals -- from primary care physicians, to nurses, to pathologists and radiologists,” said John R. Ball, chair of the committee and executive vice-president emeritus, American College of Physicians. “Therefore, to make the changes necessary to reduce diagnostic errors in our health care system, we have to look more broadly at improving the entire process of how a diagnosis made.”

To improve diagnosis and reduce errors, the committee called for more effective teamwork among health care professionals, patients, and families, enhanced training for health care professionals and more emphasis on identifying and learning from diagnostic errors and near misses in clinical practice. It also stressed the need for a payment and care delivery environment that supported the diagnostic process and a dedicated focus on new research.

The report also pointed to the need for reforms to the medical liability system to make health care safer through encouraging transparency and disclosing diagnostic errors. Furthermore, federal agencies should develop a coordinated research agenda on the diagnostic process and diagnostic errors by the end of 2016, it said.

The report is a continuation of the Institute of Medicine’s Quality Chasm Series, which includes reports such as T *o Err Is Human: Building a Safer Health System*, *Crossing the Quality Chasm: A New Health System for the 21st Century* , and *Preventing Medication Errors*.

“Diagnostic errors are a significant contributor to patient harm that has received far too little attention until now. I am confident that *Improving Diagnosis in Health Care,* like the earlier reports in the IOM series, will have a profound effect not only on the way our health care system operates but also on the lives of patients,” said J. Dzau.

Source: National Academies of Sciences, Engineering, and Medicine.
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