

## Improving Diagnosis

By Robert Trowbridge, MD

“It is likely that most of us will experience at least one diagnostic error in our lifetime, sometimes with devastating consequences.”

-Institute of Medicine, 2015

Providing patients with an accurate and timely diagnosis is central to the provision of quality health care. Without the correct diagnosis, it is difficult, if not impossible to determine the best treatment or the prognosis for return to health. Despite the importance of diagnosis, we don't have a safe and reliable diagnostic system. Approximately 10 percent of “established” diagnoses are either wrong or were unnecessarily delayed. This lack of diagnostic reliability holds true no matter the patient population or care setting, including adults and children, inpatient and outpatient, medical and surgical.

These diagnostic errors cause extraordinary harm to patients. The financial implications are also remarkable secondary to costs associated with unnecessary testing, treatments incurred by delayed diagnoses, and litigation. Diagnostic errors can also have a profound effect on clinician well-being....missing the diagnosis of an early-stage and curable cancer can result in tremendous self-doubt and contribute to burn-out.

Although there is much to learn about how to improve the diagnostic system, there are many steps we can take now. The Institute of Medicine has published a [series of eight recommendations available here](#).

Many of the IOM suggestions relate to what needs to change at a systems level, but there are many steps the individual clinician can start with now. The top three are:

- 1) **Reflect on the diagnostic process** in their specialty and identify what causes diagnostic delays and misses and then advocate for change. Is communication lacking or are hand-offs poorly done? Is the necessary testing available? Do workloads interfere with the diagnostic process?
- 2) **Be a skeptic.** Many diagnostic errors occur because a diagnosis was assigned too early in the diagnostic process. Expert clinicians “know when to slow down” and question an “established diagnosis.”
- 3) **Seek and provide diagnostic feedback.** Many of us do not hear about our mistakes. If you see a diagnostic mistake, let the clinician know, and then be open to hearing about your own mistakes (every clinician makes them). We can't improve what we don't know we need to improve.

To learn more:

- The *Society to Improve Diagnosis in Medicine* has a great website with resources and information on improving diagnostic reliability: [improvediagnosis.org](http://improvediagnosis.org)
- A good [introductory podcast](#) (with an Australian perspective)