Improving Diagnosis in Health Care
IOM Report Examines the Issue of Diagnostic Errors

The Institute of Medicine (IOM), now known as the National Academy of Medicine, has weighed in on the issue of diagnostic errors with a landmark report called Improving Diagnosis in Health Care. This report, released in September 2015, is a continuation of Institute of Medicine reports To Err is Human (1999) and Crossing the Quality Chasm (2001), studies that launched the patient safety movement.

The report calls diagnostic errors “a blind spot” in health care delivery and offered a “conservative estimate” that 5 percent of U.S. adults who seek outpatient care experience a diagnostic error. It also noted that one in every ten diagnoses is wrong, and one in every thousand ambulatory diagnostic encounters result in harm.

Getting the right diagnosis is a key aspect of health care—it provides an explanation of a patient’s health problem and informs subsequent health care decisions. The report defines a diagnostic error as “the failure to (a) establish an accurate and timely explanation of the patient’s health problem(s) or (b) communicate that explanation to the patient.” This definition is encouraging because it suggests that correct diagnosis isn’t just limited to naming the disease, but also making the patient central to that process.

“The data on diagnostic error are sparse, few reliable measures exist, and often the error is identified only in retrospect,” says John R. Ball, MD, chair of IOM’s Committee on Diagnostic Error in Health Care, in a preface to the report. “The stereotype of a single physician contemplating a patient case and discerning a diagnosis is not always true; the diagnostic process often involves intra- and interprofessional teamwork. Nor is diagnostic error always due to human error; often, it occurs because of errors in the health care system. The complexity of health and disease and the increasing complexity of health care demands, collaboration and teamwork among and between health care professionals, as well as with patients and their families.”

The report’s summary states that “Improving the diagnostic process is not only possible, but it also represents a moral, professional, and public health imperative. Achieving that goal will require a significant re-envisioning of the diagnostic process and a widespread commitment to change among health care professionals, health care organizations, patients and their families, researchers, and policymakers.”

From the available evidence, the report committee determined that diagnostic errors stem from a wide variety of causes that include:

- Inadequate 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.
- A culture that discourages transparency and disclosure of diagnostic errors, which impedes attempts to learn and improve.

The report offers several suggestions to address diagnostic errors. Related to medical liability, it suggests reforms to the current system that encourage transparency and disclosure of diagnostic errors, and a legal environment that facilitates the timely identification and learning from diagnostic errors.
Additionally, the committee recommended that health care professional education and training emphasize clinical reasoning, teamwork, communication, and diagnostic testing. The committee also urged better alignment of health information technology with the diagnostic process.

Several COPIC physicians were acknowledged for their contributions to this report. This report is available free online at https://iom.nationalacademies.org/Reports/2015/Improving-Diagnosis-in-Healthcare.aspx.