

Primum Non Nocere



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In 1995, because of an inadvertent overdose of chemotherapy, a mother of two and beloved *Boston Globe* health reporter died.¹ In 2001, an 18-month-old daughter and sister died of dehydration and an erroneously administered narcotic.² In 2003, a father of two and award-winning producer for CBS died from a potentially deadly mix of drugs given with dangerous frequency.³

These are a mere representation of the number of medication errors that occur daily. In fact, on average, a hospitalized patient is subject to at least one medication error per day, which is a sobering statistic.¹ These events and well-documented evidence of inadequate treatments have fueled research on prevention of medication errors—but those are but one component of the ongoing issue of patient safety in health care.

Patient safety has been on the agenda of the Institute of Medicine (IOM) for decades. Since the initial publication in 2000, the focus of *To Err Is Human: Building a Safer*

ed primarily on medication-use processes, prescribing, packaging and education, and improving the “processes of care to ensure that patients are safe from accidental injury.”⁴ However, we have consistently overlooked another major problem in patient safety: diagnostic errors.

One aim of the Harvard Medical Practice Study I (1991) was developing contemporary and more reliable estimates of adverse events and negligence in hospitalized patients. The researchers defined negligence as “care that fell below the standard expected of physicians in their community.”⁵ In that study, the rate of adverse events due to negligence was 27.6%. In the subsequent Harvard Medical Practice Study II, researchers identified 1,276 adverse events and noted that 13.8% of them were the result of diagnostic errors.⁶ Further, in a systematic review of autopsy studies conducted over 40 years, data revealed that roughly 9% of subjects had a major health problem that went undetected while they were alive.⁶

The results of these studies are evidence that thousands of hospitalized patients die every year due to diagnostic errors. Despite data from autopsy and malpractice claims that identify diagnostic errors as preventable causes of morbidity and mortality, and the frequency with which misdiagnosis occurs, this matter has not received much consideration.⁷

In 2009, Newman-Toker and colleagues called attention to this oversight, recommending that diagnostic errors become the next focus of patient safety initiatives.⁷

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Health System and the subsequent Quality Chasm series has been on how health care organizations emphasize patient safety, prevent medical errors, mitigate health care-associated infections and postoperative complications, and tackle breaches in safety when they occur. All these efforts concentrat-

Sadly, in a recent report from the IOM, we read that “most Americans will encounter at least one diagnostic error in their lifetime, sometimes with severe consequences for their physical and mental health.”⁸

And so we again turn our attention to improving how we deliver health care. The latest IOM report in the Quality Chasm series, *Improving Diagnosis in Health Care*, emphasizes the grave category of medical errors: errors of diagnosis, which include inaccurate or delayed diagnoses.⁸ We all know that correct and timely diagnosis is crucial to the ability to clarify a health problem, and it provides the basis for all decisions on how to solve that problem. While cure may not be possible in every situation, at the very least, our plan of care should not result in harm. What we also know is that we are members of a team, and it is within that team that we can take up the gauntlet of improving diagnosis and reducing the incidence of diagnostic errors.

The IOM Committee members who developed this report provided the following eight goals to achieve the outcome of improved diagnosis and reduced errors:

- Facilitate more effective teamwork in the diagnostic process among health care professionals, patients, and their families
- Enhance health care professional education and

training in the diagnostic process

- Ensure that health information technologies support patients and health care professionals in the diagnostic process
- Develop and deploy approaches to identify, learn from, and reduce diagnostic errors and near misses in clinical practice
- Establish a work system and culture that supports the diagnostic process and improvements in diagnostic performance
- Develop a reporting environment and medical liability system that facilitates improved diagnosis through learning from diagnostic errors and near misses
- Design a payment and care delivery environment that supports the diagnostic process
- Provide dedicated funding for research on the diagnostic process and diagnostic errors.⁸

NPs and PAs are integral to the success of this initiative. Our responsibility, as key stakeholders in our health care system, is to identify situations that might result in these types of errors and be proactive in mitigating them. Moreover, it is our professional and moral obligation to take an active, even a leadership, role in this critical endeavor.

Read the report (available at www.nap.edu/21794) and lead the charge in your setting. I am interested in how you think this initiative will evolve, and what role you will take in advancing it as a priority in your setting; let me know by writing to NPEditor@frontlinemedcom.com. **CR**

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