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How Resolved Malpractice Claims Might Help Reduce Misdiagnosis in the E.R.

By Laura Landro | May 10, 2011

Given the growing cost of malpractice suits from missed or delayed diagnoses in the emergency department, hospitals and their liability insurers are mining resolved claims for lessons on how to reduce such errors, today's Informed Patient column reports.
http://online.wsj.com/article/SB10001424052748703859304576307060330715004.html
In one of the more ambitious efforts, Crico/RMF, which insures Harvard-affiliated hospitals, last year convened an emergency medicine leadership summit with insured hospitals and clients of its risk-management strategies business to identify the key factors contributing to missed or delayed diagnoses in the ER.

Their main finding: physician-nurse communication breakdowns often happen at a critical juncture in care. The participating hospitals field-tested strategies to improve communication, and compiled a list of best practices that hospitals can use to prevent such snafus.
http://www.rmf.harvard.edu/files/documents/ed_white_paper_min_diagnosis_errors.pdf

To be sure, doctors do simply make diagnostic mistakes, and they can get stuck on the idea that their initial assessment has to be the correct one (a process known as "anchoring"). But Dana Siegal, program director of Crico/RMF's Risk Management Services, tells the Health Blog that in analyzing diagnostic errors, "we discovered more mundane routine breakdowns in gathering information that would have shored up the thought process."

One problem is that hospitals have become more dependent on electronic communication. In interviews, "doctors and nurses would say 'I took the vital signs and put them in the record and assumed they were looked at' … or 'It didn't dawn on me to ask whether you were aware that the patient's blood pressure had dropped sharply in the last two hours,'" Siegal says. "It seems we have forgotten the most basic art of face-to-face communication."

In one case Crico analyzed, for example, a 18-year old showed up in the ER with fever and chills, and a nurse made a note that his skin was mottled — often a sign of a dangerous blood infection. But the doctor never read the note, and discharged the patient with some Tylenol; the next day, he was back in the ER and was admitted to the intensive-care ward, but died of shock and sepsis.

Emergency physicians say that while examining resolved claims is useful for preventing future errors and developing standards of care, retroactive analysis doesn't take into account the chaotic and intense atmosphere of increasingly overcrowded emergency departments, where situations change rapidly and doctors may have to see five or six patients at a time.

"Every one of these malpractice cases sounds fairly egregious when you look at it after the fact, but the real-time environment in which we have to make decisions can be a completely different scenario," says Roger Band, an emergency physician at the Hospital of the University of Pennsylvania. "There are tangible things we can fix, like making sure we get the call back from radiology on time, but we've outstripped the capacity of the emergency-medicine system in a lot of ways, and we are asked to do a job where it's oftentimes not realistic to be 100% perfect."