Comparing SIDM Efforts to Improve Medical Diagnosis to the Long Needless Hospital Deaths Track Record of Failure

Society to Improve Diagnosis in Medicine (SIDM) is one of the most recent patient safety organizations seeking to improve the quality of patient care. Dr. Mark Graber founded SIDM in 2011, and he is a longtime VA physician and a fellow at the nonprofit research group RTI International. I too am a member of SIDM.

The Biggest Mistake Doctors Make (WSJ Nov. 18, 2013) Laura Landro, Asst. Managing Editor, and writes its Informed Patient column. (Selected excerpts)

Such devastating errors lead to permanent damage or death for as many as 160,000 patients each year, according to researchers at Johns Hopkins University. Not only are diagnostic problems more common then other medical mistakes – and more likely to harm patients – but they're also the leading cause of malpractice claims, accounting for 35% of nearly $39 billion in payouts in the U.S. from 1986 to 2010, measured in 2011 dollars, according to Johns Hopkins.

The good news is that diagnostic arrows are more likely to be preventable than other medical mistakes. And now healthcare providers are turning to a number of innovative strategies to fix the complex web of errors, biases and oversights that stymie the quest for the right diagnosis.

Part of the solution is automation - using computers to sift through medical records to look for potential bad calls or to prompt doctors to follow up on red flag test results. Another component is devices and tests that help doctors identify diseases and conditions more accurately, and online services that give doctors suggestions when they aren't sure what they're dealing with.

Finally, there is a push to change the very culture of medicine. Doctors are being trained not to latch onto one diagnosis and stick with it no matter what. Instead, they're being talked to keep an open mind when confronted with conflicting evidence and opinion.

“Diagnostic error is probably the biggest patient-safety issue we face in health care, and it is finally getting on the radar of the patient quality and safety movement,” said Mark Graber, a longtime Veterans Administration physician and a fellow at the nonprofit research group RTI International.”

The effort will get a big boost under the new health-care law, which requires multiple providers to coordinate care – and help prevent key information like test results from slipping through the cracks and make sure that patients follow through with referrals to specialists.

There are other large-scale efforts in the works. The Institute of Medicine, a federal advisory body, has agreed to undertake a $1 million study of the impact of diagnostic errors on health care in the U.S.

In addition, the Society to Improve Diagnosis in Medicine, which Dr. Graber founded two years ago, is working with health-care accreditation groups and safety organizations to develop methods to identify and measure diagnostic errors, which often aren't revealed unless there is a lawsuit. In addition, it's developing a medical-school curriculum to help trainees improve diagnostic skills and assess their competency.

Robert Wachter, associate chairman of the department of medicine at the University of California, San Francisco, says defining and measuring diagnostic errors is an important step. “Right now, none of the incentive's for improvement in health care are based on whether the doctor made the correct diagnosis,” Dr. Walker says. But equally important, he adds, “we need to nurture bottom-up innovation.”

What Patients Can Do | Steps you can take to prevent or detect diagnostic errors
TELL YOUR STORY WELL Communicate symptoms and timing carefully
KEEP ACCURATE RECORDS of symptoms and when they started
MAKE SURE YOU KNOW your test results
DON’T ASSUME no news is good news. Follow up if you don’t hear back after a test or appointment
ENCOURAGE your doctor to think broadly
KNOW that there may be uncertainty and that the initial diagnosis is only a working diagnosis
Ask Your Doctor these questions
Can you review my primary concerns and symptoms?
How confident are you of the diagnosis?
What further tests might be helpful to make you more confident?
Will the test you are proposing change the treatment plan?
Are there findings or symptoms that don't fit your diagnosis?
What else could it be?
Can you facilitate a second opinion by providing me with my medical records?
When should I expect to see my test results?
What resources can you recommend for me to learn more about the diagnosis?

As a SIDM member I strongly support their efforts, and every other positive effort to improve the quality of health care and patient safety. That said, I judge their efforts as presented in BMJ Quality & Safety Journal, multiple email messages sent throughout their membership, and their periodic Online Webinars to be theoretical hair-splitting. Their passion to improve diagnosis in medicine is clearly evident, but there is no evidence of any ability to make medical diagnoses far better throughout the current system, and there are, in my judgment, clearly evident reasons why.

The current health care delivery system members of SIDM wish to “change the very culture” (in their words) is composed of approximately 5,0000 acute care hospitals, a similar number of surgery centers, and between 800,000 and 1 million practicing physicians, all licensed by their respective state. In addition, most patient care takes place

in community hospitals, and not medical centers or teaching hospitals. Therefore SIDM, like all other well-intended patient safety efforts during the past several decades have tried, or are continuing to try to "change the culture" of a health care delivery system while continuing to ignore each state's responsibility to actively participate in those efforts.

Example: South Carolina has 68 acute care hospitals and 65 surgery centers (such numbers are fluid). How do SIDM members get their current positive measures, and any anticipated future positive diagnostic measures throughout that system? They can't unfortunately for all concerned, both doctors and patients. But some of my more specific thoughts regarding Ms. Landro's WSJ article are:

Ask Your Doctor these questions:
Most Important Question When Seeking Diagnosis of an Obscure Medical Condition:
Doctor, what is your Differential Diagnosis and are they listed in my medical record?
Medical students, just prior to beginning to see live patients, for decades were assigned a course typically called Physical Diagnosis, and early in that course those students were taught the critical importance of creating a list of their differential diagnoses that may be indicated by that specific patient's clinical, and laboratory findings. Furthermore, the legal admonition, "Doctor, if it's not in the patient's medical record, it did not happen" supported the understanding that such lists were required to be written. Yet the term Differential Diagnosis rarely appears in their literature.

Most Important Question When More Than One Doctor is Involved in a Patient's Care:
Doctor, who is the Captain of my Ship, and will I be informed should that responsibility be transferred to another doctor?
Far too many patients forced to endure lengthy periods of hospitalization, and whose care is shared by multiple doctors ever become able to identify the Captain of their Ship. And in this new age of Hospitalists providing more and more of in-house patient care, plus the circumstance of rotating hospitalists on a daily basis, such a lack of critical understanding becomes even more important. Captain of the Ship should be clearly designated in the patient's medical record in all such instances, and at all times.

Dr. Graber, "to identify and measure diagnostic errors, which often aren't revealed unless there is a lawsuit."
Doctors, long ago, chose medical malpractice litigation (Sue or Forget It) as the primary system for the review of questionable patient care, and continue to blame the potential for possible litigation as the principle deterrent in their ability to fairly judge such care using medical peer review. Their incessant mantra of "frivolous lawsuits" belies the accepted estimate of carnage that has taken place in every estimate of needless hospital deaths during the past quarter century. Which brings me to my greatest dispute with the well-intended efforts of SIDM.

Such devastating errors lead to permanent damage or death for as many as 160,000 patients each year, according to researchers at Johns Hopkins University.

Diagnostic errors are only a subset of the much larger medical problem of the estimated annual rate of needless hospital deaths that has quadrupled during the past quarter century.

Needless Hospital Deaths Track Record

1990 Brennan, Leape, et al: The seminal estimate of 98,000 NHDs annually after four years of research in up state New York hospitals. Brennan made the first report in 1989. Several smaller such studies had also taken place helping to illustrate the problem.

2000 IOM To Err Is Human: Used the Brennan & Leape estimate of 98,000 as their benchmark. Dr. Leape actively participated as a member of one of the two committees formulating To Err Is Human and their prediction of a 50% reduction in NHDs in five years. Another far more accurate observation was, "One oft-cited problem arises from the decentralized and fragmented nature of the health care delivery system--or "non-system," to some observers." Unfortunately, they failed to recognize the importance of that recognition.

2009 Dead By Mistake, Hearst Newspapers: "but all available research indicates that the death toll from preventable medical injuries approaches 200,000 per year in the U.S. Ten years ago, a highly publicized federal report called the death toll shocking and challenged the medical community to cut it in half – within five years. Instead, federal analysts believe the rate of medical errors is actually rising."

2013 John James, PhD, Journal of Patient Safety, September: Estimated NHDs at more than 400,000 per year, and serious harm seems to be 10-t0-20-fold more common than lethal harm.

2013 ProPublica, September: Drs. Leape, Makary, and Classen soundly support James' findings. Dr. Leape was proclaimed the Father of Patient Safety in BMJ Careers in Dec. 2012.

2014 SIDM 7th International Conference, Atlanta, September 14-17: Dr. Leape, the Father of Patient Safety, will be a Keynote Speaker on Monday, September 15.

Question: How can a quarter century track record recorded in thousands of needless deaths continue to remain "under the radar" and with only the Hearst Newspapers attempt for national recognition of this enormous national disaster five years ago? Where is the outrage? While national decision-makers contest how to carve up the health care financial pie, thousands continue to die needlessly in our hospitals with less attention than is given to sporadic acts of needless deaths by violence at the hands of deranged individuals. When will NHDs receive the attention that crisis has long deserved?
See References below

References:

http://is.gd/2Dj0Uu The Biggest Mistake Doctors Make, WSJ Nov. 18, 2013
http://is.gd/LTnBli Brennan, Leape, et al, 1990
http://is.gd/2MSBhR To Err Is Human IOM, 2000
http://is.gd/60TFKy Dead By Mistake, Hearst Newspapers, Aug. 2009
http://is.gd/GzKOg3 John T. James, PhD, 2013
http://is.gd/Gag91b ProPublica article Sep. 19, 2013
http://is.gd/WLsHky Father of patient safety" BMJ Careers, 12-9-12
http://is.gd/maRf1A SIDM 7th International Conference, Atlanta Sept. 14-17, 2014