IOM report on diagnostic errors expected this fall

Charles Fiegl

August 2015—The Institute of Medicine is expected to release in September a consensus study on diagnostic error in health care that will offer recommendations for policymakers, payers, medical institutions, physicians, and patients aimed at preventing harmful mistakes. This will come after nearly two years of studying the U.S. health system and reviewing the perspectives of stakeholders such as the CAP.

The CAP believes the IOM effort is of value in reducing the risk of error and welcomes the upcoming release of the "Diagnostic Error in Health Care" report, says CAP president Gene N. Herbek, MD. "As the largest and most experienced organization in medical laboratory performance, the College has led and enhanced laboratory improvement programs such as proficiency testing and accreditation for more than 65 years. We are looking forward to the publication of the study and discussing its findings with CAP members as well as making known our views on the findings and recommendations that are made."

The CAP hopes to host a forum to discuss the IOM report at the CAP '15 meeting in Nashville, Tenn., in October.

The IOM has a history of studying the issue of errors throughout the health care system, and its reports are well known among health policy experts and the physician community. The landmark 1999 IOM report, "To Err Is Human," greatly influenced efforts to improve patient safety and reduce medical errors. The IOM's 2001 report, "Crossing the Quality Chasm," urged the alignment of payment policies and quality improvement.

For this new report, the IOM committee that was assigned the task of researching and writing the report will evaluate what is known about diagnostic error as a quality-of-care challenge. "The committee will examine current definitions of diagnostic error and illustrative examples; the epidemiology, burden of harm, and costs associated with diagnostic error; and current efforts to improve diagnosis," the IOM says on its website.

The CAP is listed on the IOM website as an activity sponsor for the report, along with the American Society for Clinical Pathology, American College of Radiology, Agency for Healthcare Research and Quality, Cautious Patient Foundation, Centers for Disease Control and Prevention, The Doctors Company Foundation, Janet and Barry Lang, Kaiser Permanente National Community Benefit Fund at the East Bay Community Foundation, and Robert Wood Johnson Foundation. Two of the 21 committee members are CAP members: Michael B. Cohen, MD, and Michael Laposata, MD, PhD. The IOM study committee has held six meetings since April 2014.

The report is expected to review errors that occur in the preanalytic, analytic, and postanalytic phases of the laboratory and pathology testing process.

Dr. Volk

The committee will propose solutions to the problem of diagnostic error, which the IOM website says may include "clarifying definitions and boundaries; integrating educational approaches; addressing behavioral/cognitive processes and cultural change; teamwork and systems engineering; measures and measurement approaches; research; changes in payment; approaches to medical liability; and health information technology and other technology changes."

The CAP's longstanding devotion to excellence in quality improvement "supports efforts to prevent diagnostic errors in all phases of the testing process," says Emily E. Volk, MD, a member of the CAP Board of Governors and vice chair of the Council on Government and Professional Affairs. "For example, the CAP is committed to patient safety and dedicated to improving the practice of laboratory medicine through rigorous standards and thousands of requirements pathologists and laboratory personnel must meet to achieve CAP accreditation."

The CAP's public policies reflect a commitment to patient safety, Dr. Volk adds. For instance, CAP policy urges transparency in reporting errors. Significant errors by a pathologist that have had a negative impact on the prospective health or management of a patient should be discussed first with the physician who ordered the pathology and the two physicians should then jointly determine communication with the patient, the College's policy says.

The CAP also believes patients should be empowered to understand the laboratory and pathology report and be able to obtain information about pathology results, including second opinions. The quality of clinical laboratory testing rests on the ability of laboratories to replicate each other's measurements and evaluations, formally through proficiency testing and accreditation programs such as those of the CAP and informally for individual patients through second opinions.

The CAP and the Association of Directors of Anatomic and Surgical Pathology in May announced an evidence-based guideline to provide recommendations for secondary and timely reviews of surgical pathology and cytology cases to improve patient care (see "Evidence drives guideline on reducing interpretive error," CAP TODAY, July 2015, page 60). The guideline, published in the Archives of Pathology & Laboratory Medicine, provides guidance on how to establish an appropriate secondary review program (Nakhleh RE, et al. Epub ahead of print May 12, 2015. doi:10.5858/arpa.2014-0511-SA).

"Although numerous studies have shown that case reviews help detect interpretive diagnostic errors, there have been no efforts to formalize this practice as a strategy to reduce errors," the CAP/ADASP guideline says. "In considering processes occurring in surgical pathology and cytology, targeted case reviews could be an integral component of a quality assurance plan that is aimed proactively at preventing errors before they have a potential adverse impact on patient care."

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