

Diagnostic Errors: A Threat to Health and Impediment to Health Reform -- Comments

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“Mistakes in diagnosis may be due to various causes—to inherent obscurity of signs and symptoms of disease, to misleading statements by patients or malingerers, or to our imperfect physiological knowledge; but in addition to these inherent causes of error, mistakes too frequently arise from the carelessness or the ignorance of the surgeon. We may, perhaps, divide medical men into two classes, those who are overcautious and those who are overconfident.”

— William Cadge, 1891

(Excerpt from a speech read at East Anglian Branch meeting of the British Medical Society)

“A goodly number of ‘classic’ time-honored mistakes in diagnosis are familiar to all experienced physicians because we make them again and again. Some of these we can avoid; others are almost inevitable, but all should be borne in mind and marked on medical maps as a danger-signal of some kind: ‘In this vicinity look out for hidden rocks’ or ‘Dangerous turn here, run slow.’”

— Richard C Cabot, 1912

(JAMA, 1912; LIX (26) : 2295 - 2298)

The Invisibility of Diagnostic Failure – in the Delivery System

In addition to human illness's *inherent obscurity, complexity, and uncertainty*, reasons for lack of focus on diagnostic failure include:

- Amorphous nature of many illnesses
 - A “scientific” approach not always possible
- Invisibility
 - Decision-making process poorly understood
- Accountability
 - Core responsibility of physicians – assumption that physicians have it under control
- Attitudes and cultures of silence
 - Traditionally, physicians not forthcoming about their own and colleagues' failures.
- Denial: discounting and distancing
 - Physicians unwilling to confront failings, “it wasn't me”



The Invisibility of Diagnostic Failure – in the Delivery System (cont.)

- Investigation
 - Diagnosis failure often not apparent from retrospective chart review
- Lack of awareness
 - Physicians don't receive feedback on patient outcomes
- Unavailability of tangible solutions
 - No fool-proof checklists to assure dx accuracy
- Lack of understanding of decision-making process
 - Physicians not trained in decision-making or influence of cognitive biases
- Tolerance
 - True cost of dx errors difficult to assess; hospitals and payers tolerate
- Poor business case
 - Payers and hospitals see investigation and remediation as poor business case.

“If you can’t measure it, you can’t manage it”

- And its derivative cousin, “If something... cannot be measured, it cannot be improved.”
 - Called a “truism” by highly respected health policy experts David Blumenthal and Michael McGinnis
 - JAMA 2015; 313:1901-2
- The original quote is commonly attributed to W. Edwards Deming, one of the revered experts on management practices (and father of PDCA cycles for total quality management)

Forget “taken out of context” – it is a gross distortion of what Deming said and believed

- “It is wrong to suppose that *if you can’t measure it, you can’t manage it* – a costly myth.”
 - The New Economics, 1994, page 35.
- Other consistent Deming quotes (of many available):
- “The most important figures one needs for management are unknown or unknowable, but successful management must nevertheless take account of them.” Out of the Crisis, 1982, p 121
- “Management by numerical goal is an attempt to manage without knowledge of what to do, and in fact is usually management by fear.” Out of the Crisis, p. 76

Dueling aphorisms

- *“If you can’t measure it, you can’t manage it”*
 - Commonly attributed to Deming (sometimes, Peter Drucker, another management scholar, who also did not believe it)
- *“Not everything that can be counted counts, and not everything that counts can be counted.”*
 - Who said this?

No, Not Albert Einstein

(although if you google the saying, you will find dozens of images of the learned professor writing it on his blackboard)

but rather a sociologist named William Bruce Cameron, writing in the 1960s, after Einstein had died

The Prevailing Policy Consensus About Measurement

“... As the science has advanced, we now have a surfeit of measures that meet [four rigorous] accountability criteria with which to populate accreditation, public reporting, and pay-for-performance programs.”

Ref: Chassin MR, Loeb JM, Schmaltz SP, Wachter RM. Accountability measures--using measurement to promote quality improvement. N Engl J Med 2010; 363(7):683

In fact, the current effort is to dramatically reduce the number of measures in use to arrive at a small set of core measures

A surfeit?

with virtually no measures of
accuracy of diagnosis or more than a
couple on appropriateness or patients
with multi-morbidity or care for those
approaching the end-of-life

Berenson View of the Policy Consensus About Measurement

*What we measure is considered important and
worthy of attention*

*What we can't or don't measure is marginalized
or ignored altogether*

*There is no better example than diagnostic
accuracy*

Alternatives to Reliance on Measurement and Financial Incentives

- We might be better off with “incentive neutral” payments, relying more on intrinsic motivation.
 - Would involve, first, fixing the mis-valued fees in the MPFS and, second, reducing the financial impact of FFS in hybrid payment approaches
- Lucian Leape on the success of the Michigan Keystone Project at eliminating central line-associated blood stream infections in MI hospitals.
 - **The most powerful methods for reducing medical harm are: feedback, learning from the best, and working in collaboration**

Non-Financially Based Initiatives

- Promote local responsibility for quality improvement activities
 - Partnership for Patients
 - Conditions of Participation
 - Accountable care organizations
 - Health Care Innovation Awards
- QI Collaboratives
- Develop partnerships among payers and providers
- Follow-Up and Feedback (memorable if not measurable)