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Diagnostic error in medicine: analysis of 583 physician-reported errors.

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Schiff G, Hasan O, Kim S, et al. Diagnostic error in medicine: analysis of 583 physician-reported errors. Arch Intern Med. 2009;169(20):1881-1887. doi:10.1001/archinternmed.2009.333.
https://psnet.ahrq.gov/issue/diagnostic-error-medicine-analysis-583-physician-reported-errors

Diagnostic errors are a known cause of preventable adverse events, and while safety prevention efforts have traditionally focused more in other areas, this may be the new frontier. This study analyzed 583 self-reported diagnostic errors and found that 69% were rated as moderate or major. The most common missed or delayed diagnoses were pulmonary embolism and drug reactions or overdose, with the errors occurring most frequently in the testing phase (eg, failure to order, report, and follow up on results). The authors developed a comprehensive taxonomy tool, Diagnostic Error Evaluation and Research (DEER), as a method to aggregate cases by diagnosis and error types, which assisted in identifying future prevention strategies. An invited commentary [see link below] by a leader in the patient safety field, Dr. Robert Wachter, discusses the importance of this study's findings while reflecting on the 10-year anniversary of the landmark IOM report. A past AHRQ WebM&M commentary and perspective also discussed diagnostic errors.