

## **Patient record review of the incidence, consequences, and causes of diagnostic adverse events.**

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Zwaan L, de Bruijne M, Wagner C, et al. Patient record review of the incidence, consequences, and causes of diagnostic adverse events. Arch Intern Med. 2010;170(12):1015-21.

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Evidence from [autopsy studies](#) indicates that thousands of patients die every year due to missed or delayed diagnoses, leading to diagnostic errors being termed the "[next frontier](#)" in patient safety. This Dutch study used [trigger](#) methodology (based on the classic [Harvard Medical Practice Study](#)) to analyze the epidemiology and underlying causes of diagnostic errors in a broad sample of hospitalized patients. Approximately 1 in 250 patients experienced a diagnostic error, most of which were considered preventable. The contributing factors primarily centered around knowledge-based errors and faulty information transfer between physicians—a problem noted in [prior studies](#) of diagnostic errors. A [Patient Safety Primer](#) discusses the [heuristics](#) that cause physicians to err in the diagnostic process and the system failures that lead to delayed or missed diagnoses.