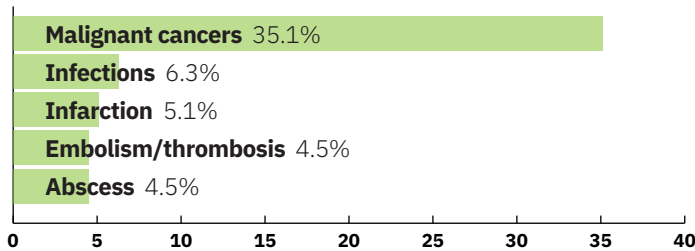# Misdiagnosis/delayed diagnosis/all specialites

Over the last ten years, diagnosis-related errors continue to be one of the top contributing factors in high-severity malpractice claims across all specialties.

## Top missed diagnosis in high-severity cases[1]

- **Malignant cancers** 35.1%
- **Infections** 6.3%
- **Infarction** 5.1%
- **Embolism/thrombosis** 4.5%
- **Abscess** 4.5%

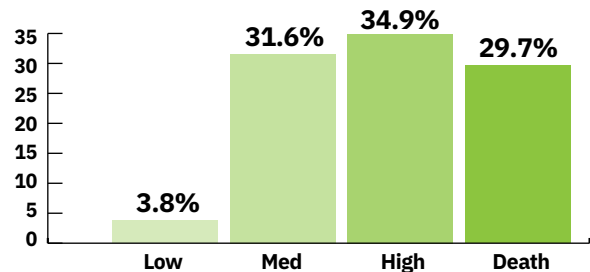(x-axis: 0, 5, 10, 15, 20, 25, 30, 35, 40)

## Average indemnity payments[1]

Average indemnity for diagnosis related claims: **$608K**

Average indemnity for high-severity diagnosis related claims: **$811K**

Percent of diagnosis related claims closed with payment: **46%**

## Clinical severity distribution[1]

| Low | Med | High | Death |
|-----|-----|------|-------|
| 3.8% | 31.6% | 34.9% | 29.7% |

(y-axis: 0, 5, 10, 15, 20, 25, 30, 35)

**Low =** Temporary insignificant injury or emotional only
**Medium =** Temporary major or permanent minor injury
**High =** Permanent significant, major, or grave injury
**Death =** Adult, child, infant, or fetal death

## Actions that contributed to missed diagnosis events[1]

**46.2%** Failure to appreciate and reconcile relevant sign/symptom/test result

**43.9%** Patient assessment—failure/delay in ordering diagnostic test

**32.0%** Patient assessment—narrow dx focus—failure to establish differential diagnosis

**29.2%** Failure/delay in obtaining consult/referral

**27.7%** Patient assessment—misinterpretation of diagnostic studies (xrays, slides, fms)

## Misdiagnosis risk management opportunities

1. Physician practices should promote a just culture that creates a psychologically safe environment that encourages all clinical staff to share opportunities or concerns to improve diagnostic safety without fear of retribution.
2. Create and or review processes to close the loop on communication and follow up on abnormal test results and referrals.
3. When diagnostic errors are discovered review them jointly with colleagues and other treatment teams such as through interdepartmental morbidity and mortality rounds. Lessons learned can help reduce future diagnostic errors.
4. Encourage patients to utilize patient EMR portals to review labs, tests and report inaccuracies in their health records. Develop an organizational response plan for corrective action if inaccuracies are identified.
5. Encourage and educate patients on how to report when they have changing symptoms or sense things are not right.

**miec**