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# Privileged Communication

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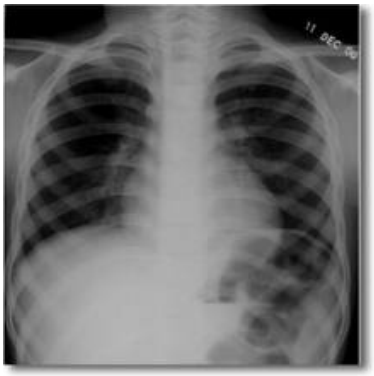
## Diagnostic Errors

*Missed or wrong diagnoses cause 40,000 to 80,000 deaths a year in the United States. Forty percent of medical liability lawsuits involve diagnostic errors. Because of this we thought a few articles we recently read might be of interest.*

Everyone is prone to taking mental shortcuts when thinking through difficult problems and physicians are no exception. Below are a few of the cognitive biases that can lead to diagnostic errors.

- Anchoring bias: Locking on to salient features in a patient's initial presentation too early in the diagnostic process and failing to adjust in light of later information
- Availability bias: Judging things as being more likely if they readily come to mind; for example, a recent experience with a disease may increase the likelihood of it being diagnosed
- Confirmation bias: Looking for evidence to support a diagnosis rather than looking for evidence that might refute it
- Diagnosis momentum: Allowing a diagnosis label that has been attached to a patient, even if only as a possibility, to gather steam so that other possibilities are wrongly excluded
- Overconfidence bias: Believing one knows more than they do, and acting on incomplete information, intuitions and hunches
- Premature closure: Accepting a diagnosis before it has been fully verified
- Search-satisfying bias: Calling off a search once something is found



Nearly two-thirds of missed or delayed diagnoses involve systems-related problems that can make it harder for physicians to reach the correct diagnosis. Below are areas of system failure and the problems they represent:

- Policies and procedures: Lack of protocols exist to ensure appropriate follow-up
- Inefficient processes: Unnecessary delays in scheduling clinic visits or procedures
- Teamwork: Needed information or skills go unshared
- Management: Studies are not read in time; x-rays are lost or misplaced
- Care coordination: Consult requests are lost or not acted upon promptly.
- Equipment: Test instruments are faulty, miscalibrated or unavailable
- Supervision: Failure to oversee trainees properly
- Expertise: Required specialists are not available in a timely fashion

*Sources: "The importance of cognitive errors in diagnosis and strategies to minimize them," Academic Medicine, August 2003 and "Diagnostic Errors in Internal Medicine," Archives of Internal Medicine, July 11, 2005, American Medical News, Dec. 2010.*✦

## Communication Guidelines for Radiology

A new practice guideline for communication of diagnostic imaging has been recently published by the American College of Radiology. This guideline states that there is a reciprocal duty of information exchange and the provider that orders the test should also be responsible for following up on the results.

The information that should be included in the final report is discussed in the guideline. Also discussed are communication of preliminary reports, non-routine communications, documentation of non-routine communications, methods of communication and information communications.
This guideline as well as many others can be found at www.acr.org.✦

## Hospitalized Patient Safety has not Improved

Hospitals kill an estimated 180,000 patients a year due to adverse events, according to a recently released report by the Department of Health and Human Services's Office of Inspector General. This report offers the first national incidence rate of adverse events among hospitalized Medicare patients.

Some of their findings included:

- About one-in-seven Medicare patients-or about 134,000 of the estimated 1 million discharged in October 2008-were hurt by hospital care
- Another one in seven Medicare beneficiaries experienced adverse events during their hospital stays that resulted in temporary harm
- Hospital care that led to adverse events and temporary harm cost Medicare an estimated $324 million in October 2008
- The most common adverse events were related to medication, patient care, surgery and infection
- 44 percent of adverse and temporary harm events were clearly or likely preventable

These findings suggest that not much progress has been made since the 1999 Institute of Medicine report on medical errors. As a result of this study, CMS will be aggressively expanding their patient safety efforts with regard to hospital-acquired conditions to address more types of adverse events.

*Source: www.fiercehealthcare.com, Feb. 8, 2011* ✦

## Some Appendicitis may be Treated with only Antibiotics

In January 2010, a study was published in the *Archives of Surgery* that implied a ruptured appendicitis is a different disease from nonperforating appendicitis. The study says that some inflamed appendix will not burst, no matter how long you wait to remove them. The study linked nonperforating appendicitis to viral infections, that may predispose the lining of the appendix to bacterial infections. There are other studies that suggest that simply treating these cases with antibiotics may be enough. But if the patient does not improve on antibiotics within 12-24 hours, surgery is still warranted.

*Source: USAToday.com*, Jan. 19,2010.✦

## Fall Reference

*Clinical and Medical-Legal Perspectives of Falls Across the Lifespan* is a comprehensive resource for attorneys, legal nurse consultants and clinicians. "This resource represents the best collection of evidence based data concerning the assessment and prevention of falls for adults and children, as well as the care of the person at risk or with a history of falling." If you handle fall cases this reference may prove to be invaluable. You can purchase for $49 by calling 908-788-8227 or visit www.patiyer.com.✦



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*Source: www.Galluppoll.com, December 2010*