

Ignorance Is Not Bliss, It Is Dangerous: Hospitals Need to Take Action to Prevent Harm

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Body

Preventable diagnostic errors remain a significant cause of harm in U.S. hospitals, yet there is a substantial gap in the implementation of evidence-based practices to stop these errors. Two recent articles, "[Hospital Commitments to Address Diagnostic Errors](#)" (2024) and "[Burden of Serious Harms From Diagnostic Errors in the USA](#)" (2023), underscore the severity of diagnostic failures and highlight the most responsible culprit-hospital leadership.

According to the "Burden of Serious Harms," an estimated 795,000 Americans suffer permanent disability or death annually due to diagnostic errors across various medical settings, including hospitals and outpatient clinics. This places diagnostic errors among the most significant sources of preventable harm in health care, with these mistakes responsible for more serious injuries than many other patient safety issues combined. One troubling revelation is that every patient in the United States is likely to encounter a diagnostic error during their lifetime.

Despite these alarming rates, hospitals routinely fail to take evidence-based, proven steps to reduce these errors. In "Hospital Commitments," one of the nation's most prestigious patient safety organizations surveyed a subset of self-selected hospitals who were among the nation's top performers when it comes to institutionalized patient safety efforts. The study reveals that on average, hospitals implemented about 56% of validated practices aimed at reducing diagnostic errors. Key practices, such as forming multidisciplinary teams and conducting risk assessments focused on diagnostic errors, were among the least implemented. Only 13% of CEOs made a formal commitment to diagnostic excellence.

These failures are particularly glaring given the existence of well-documented, evidence-based practices designed to address diagnostic errors. A 2022 Leapfrog Group report recommended 29 practices for improving diagnostic safety, ranging from enhanced communication protocols to real-time access to diagnostic expertise. However, the 2024 study lays bare that many hospitals have been slow to adopt even the most basic measures. For example, while 92% of hospitals had established policies for notifying patients about diagnostic errors, only 33% trained their staff in clinical reasoning to prevent these errors in the first place.

Only 26% of hospitals conducted diagnostic-focused risk assessments, despite the clear evidence that such assessments could identify gaps in expertise, technology and teamwork that contribute to diagnostic errors. The lack of leadership commitment to implementing these measures further undermines diagnostic safety, as many hospitals do not allocate sufficient resources or support to initiatives designed to improve diagnostic accuracy.

With clear guidelines and proven strategies available to reduce diagnostic errors, the failure of hospitals to implement these practices is not merely an oversight—it is a form of institutional negligence that endangers patient lives. When hospitals do not prioritize diagnostic safety or provide the necessary training and resources to their staff, they are directly contributing to preventable harm. By imposing legal and financial consequences for

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preventable errors, hospitals will be incentivized to adopt comprehensive safety measures that have been recommended for years but remain underutilized. Until hospital leadership is held responsible for these lapses, patients will continue to suffer the consequences of preventable diagnostic errors.

The data clearly shows that diagnostic errors are both common and preventable, yet hospitals have been slow to implement proven strategies that save lives. The reluctance of hospital leadership to fully commit to diagnostic excellence-despite the availability of clear, evidence-based practices-demonstrates a failure of responsibility that should not go unaddressed.

Hospitals must be held liable for preventable harm caused by diagnostic errors, especially when they fail to take the necessary steps to reduce these risks.

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