Diagnostic Errors

Issues in Behavioral Health

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IOM Committee on Diagnostic Error- 3rd Meeting
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Psychiatric Diagnosis

• Current state
  • Essentially descriptive/atheoretical
  • Based on patient report/observation
  • Few biological tests
  • Limited relationship to underlying etiology or treatments
  • Not “nature carved at its joints”
  • DSM development a response to unreliability

• Benefits/Costs of reliability
  • “Convention for communication”
    • Clinician to Clinician to Science to Patient
  • Pseudospecificity
  • Complexity = Not used as intended
  • Coding vs “Reality”
Controversies

• Boundaries with Normality
  • Diagnostic Proliferation
  • Pathologizing human condition/social problems/cultural relativism
  • Grief/Mourning, Minor Depression, Neurasthenia, Adolescence

• Boundaries among Mental Disorders
  • Splitter, Not Lumper System
  • Maximal vs Optimal Comorbidity
  • Comorbidity or Syndromal Complexity?

• Boundaries with Biology
  • Endophenotypes/Genetics/Circuits
  • NIMH - RDoC

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Epistemology Of Psychiatric Diagnosis

• Umpire 1- There are balls and there are strikes and I call them as they are.

• Umpire 2- There are no balls and no strikes until I call them.

• Umpire 3- There are balls and there are strikes and I call them as I see them.
Similarities with the Rest of Medicine

• Most diseases manifest on a continuum
  – Arbitrary/Probablistic Thresholds
  – Ideal vs Average vs Suprathreshold
• Dx often relies on history and observation
• Etiology is largely unknown
• Non-Medical issues affect Dx
• Diagnosis is not enough
  – X-sectional vs Longitudinal
  – Dimensional outcomes
  – Patient perspectives
Key Risks

• Interface with General Medicine/Consultation Liaison Psychiatry
  • “Physical” Conditions masquerading as psychiatric and vice versa, Somatic Symptom Disorder, Conversion Disorder, Malingering
  • Failure to detect/treat Medical Dx in SMI
• False Negatives-- failure to diagnose/Identify
  • Clinical Dx- Bipolar, Depression vs Dementia, “Due To”
  • Suicide, Homicide, Violence
  • Quality Measures and Risk Adjustment
  • Role of Screening and USPSTF
• False positives
  • Exposure to unnecessary treatments
  • Stigma and other personal consequences
  • Prodromal Schizophrenia, Dementia
Woman Sold Home to Fund Care After Dementia Error

A woman who had dementia wrongly diagnosed sold her home to pay for specialist care she did not need.

Winnie Hill, 88, from Plymouth, spent over a year in a specialist unit before being told that she had mild cognitive impairment, which is less severe than dementia.

Her daughter, Katherine Hicks, had requested a second opinion after she became concerned that her mother was struggling to cope. Ms. Hill, who is now in another home, told the BBC’s Inside Out South West: “A doctor said to me, I didn’t need to be in here. He said: ‘As far as I’m concerned there’s nothing wrong with you.’”

An NHS spokeswoman said that it did not record misdiagnosis rates.

* London Times- October 15, 2014
Stigma

• Prevalence/Impact
  – Celebrity vs Reality

• By Patients
  – Self Image and “Recovery Movement”

• By Providers
  – Primary Care vs MH vs SUD

• By Health Systems/Plans/Employers
  – Parity and ACA
  – Privacy Rules (over/under interpretation)
Special Issues

• Diversity of Clinical/Non-Clinical Settings/Providers
• Missed General Medical Conditions
  – Mental Disorders due to General Medical Condition
  – Comorbidity
    • SMI 25 year less life expectancy
• Substance Abuse
  – 42 CFR Part 2
• Legal Interface Influencing Diagnosis
  – Domestic Violence, Paraphilias/Sex Offenders, Competency to Stand Trial, NGRI, Torts, Disability
  – Separating legal categories from medical categories
• Influence of Reimbursement
• Suicide
  – “PHQ-8”
  – Florida gag law
Possible Recommendations

• IOM Quality Chasm for MH SUD Report
• Develop standardized assessment
  – Mental Health “Vital Signs”
• Apply Principles of “Measurement-Based Care”
  – Systematic, consistent, longitudinal use of clinical measures (e.g. HA1c, PHQ-9)
  – Ruthless Follow-Up
  – Action-oriented/menus of reasonable options
• Enhanced integrated training
  – Across MH and Primary Care disciplines
• Support/Incentivize Infrastructures for MBC
  – PCMH/EHR/Effective Communication/Privacy Rules