Table 1. Modified DEER Taxonomy*

DIAGNOSTIC PROCESS STEP	FAILURE POINT
1. Access/ Presentation	A. Failure or delay in patient seeking care
	B. Failure or denial of access to care
2. History	A. Failure or delay in providing or eliciting a piece of history data
	B. Inaccurate or misinterpreted piece of history data
	C. Suboptimal weighing of a piece of history data
	D. Failure or delay in acting on or following-up on a piece of history data
3. Physical Examination/ Assessment	A. Failure to perform a physical examination or assessment
	B. Inaccurate or missed physical examination or assessment finding
	C. Suboptimal weighing of a physical examination or assessment finding
	D. Failure or delay in acting on or following-up on a physical examination or assessment finding
4. Testing (Laboratory/ Radiology/ Other)	A. Failure or delay in ordering needed test(s)
	B. Failure or delay in performing needed test(s)
	C. Suboptimal test sequencing
	D. Wrong test(s) ordered
	E. Test(s) ordered the wrong way
	F. Identification failure (e.g., sample mix-up, mislabeled specimen, or test performed on the wrong patient)
	G. Technical or processing error (equipment problem, poor processing of specimen/test, or skill issue)
	H. Specimen delivery problem (e.g., specimen never sent, delayed delivery, or lost specimen)
	I. Misread or misinterpreted test(s)
	J. Failure or delay in transmitting or communicating test result to healthcare provider
	K. Failure or delay in acting on or following-up on test result (including results not communicated to the patient)
5. Hypothesis Generation	A. Failure or delay in considering correct diagnosis
	B. Suboptimal weighing or prioritizing
	C. Too much weight given to lower probability or priority diagnosis
6. Referral/ Consultation	A. Failure or delay in ordering a referral or consult
	B. Failure or delay in obtaining or scheduling an ordered referral or consult
	C. Failure or delay in communicating consultation findings
7. Monitoring/ Follow-Up	A. Failure or delay in monitoring (e.g., failure to routinely check vital signs, failure to apply monitor, technical issue)
	B. Inaccurate or missed physiologic monitoring finding (e.g., misinterpreted fetal monitor strip)
	C. Failure or delay in recognizing urgency of condition or complication
	D. Failure or delay in communicating findings among healthcare team members
	E. Failure to refer the patient to appropriate setting or for appropriate monitoring
	F. Failure or delay in timely following-up with or rechecking the patient

*__Source__: Adapted from Schiff GD, Kim S, Abrams R, Cosby K, Lambert B, Elstein AS, Hasler S, Krosnjar N, Odwazny R, Wisniewski MF, McNutt RA. Diagnosing diagnosis errors: lessons from a multi-institutional collaborative project. In: Henriksen K, Battles JB, Marks ES, et al, editor(s). Advances in patient safety: from research to implementation. Vol. 2, concepts and methodology. Rockville (MD): Agency for Healthcare Research and Quality; 2005 Feb. p. 255-78.

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