

Step1. Self-Reflection and Assessment of Confidence

How Clear and unbiased is my thinking? (Consider self-health and cognitive biases at bottom)

How Confident am I in this diagnosis? (or Why am I confident?)

Step2. If confident, still consider that you might be wrong (or prematurely stopping thought) and ask:

a. What else could it be? (At least common, dangerous and exotic (CDE) alternatives)

Broaden DDx w/support tools, e.g., John Ely's Cklist <http://pie.med.utoronto.ca/DC/index.htm>

b. Why does this patient-problem exist? Think systematically (ex VITAMINC CD on reverse).

Step3. If not confident, label the problem as Not Yet Diagnosed (NYD).

STILL develop lead diagnosis, active alternative dxs, other and ruled out hypotheses.

Take a time out to intentionally analyze and document using items from this SOAP format:

Subj1: **Listen again to the patient** – Get the worst or first symptom and complete history.

Subj2: **Recruit patient's help:** Ask directly what (s)he thinks is wrong.

Obj1: **Refresh your ROS&PE.** Focus on symptoms and the problem list.

Obj2: **Review all lab and radiology studies** (recent & past), esp for changes

Asst1: **Refresh & prioritize a complete problem list.** Verify DXs from the PMH

Asst2: **Reflect systematically WHY each new problem exists (at least CDE)**

(Always consider meds/iatrogenesis and affective dx)

Asst3: **Propose multiple etiologies when Occam's razor does not fit.**

Pers1: **What's YOUR perspective? Check your biases/emotions (and listen to gut).**

Pers2: **Ask colleagues to help.** Set up a "diagnostic huddle"

Proceed to diagnostic testing to rule out can't-miss diagnoses, with awareness of test characteristics including sensitivity, specificity.

Step 4: AFTER a diagnosis (or a NYD label)

GET FEEDBACK: *Call /revisit/invite patient* to reassess & identify any overlooked issues.

Set up and USE a **system** to verify that test/ referral data were received /acted upon.

If your diagnosis was WRONG (studies suggest >10-15% error for IM cases), ask:

1. **WHY?** (missed data, incomplete HPE , rare disease, unusual presentation, etc).

Did disease pace outrun the diagnostic pace?

2. **How clear was your thinking?** Review biases and limitations (time, pace)

3. **Keep a running list of your errors, successes & surprises.**

Read /review periodically about often confounding, missed or rare diseases.

Self-Reflection and Heuristics/ThinkingPatterns to consider:

"I'M SAFE": **I**llness, **M**edications, **S**tress (psychosocial, caloric) , **A**lcohol, **F**atigue, **E**motional bias (visceral feelings toward patient, good or bad. Counter: How would I treat my parent?

Anchoring/Premature Closure: Too early choice of Dx/stopped thinking; Counter: Could I be wrong?

Blind obedience/Diagnostic momentum: over-trusting a prepackaged dx; Counter: was that info reliable?

Availability: Swayed by recent or memorable case of easy recall? Counter: Force listing of broader DDx.

Confirmation: Actively selecting and seeking confirming > refuting evidence. Counter: Take the opp side.

Framing: Overemphasizing certain selected features or outcome; Counter: change perspective

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Step1. Confidence and Self-Reflection. Am I being influenced by biases/ fatigue/pace of day/illness? Is level of confidence high or not high?

Step2. If confident, you still might be wrong. “Keep death as a consultant.” (What is worst possible dx that might injure the patient?)

-Think about pretest probability and prevalence of disease.

-Most errors display a DDx of 1 (or zero) items. At least consider common/dangerous/exotic. , is this unusual disease or unusual presentation of the common?

Step3. If not confident, label the problem as Not Yet Diagnosed (NYD)

Subj1: From your history, focus on the worst complaint, r the first occurrence, or the top three. If the patient cannot identify one, consider affective or cognitive impairment.

Subj2: Patients concerns about a dx may be correct or you can relieve worry about very unlikely disease.

Obj1: Think, re-examine and ask questions. Consider using JAMA’s Rational Clin Exam series to quantify diagnostic possibilities. Don’t just pursue additional testing. Tests should be viewed as confirming or supportive, and rarely diagnostic.

Obj2: Are labs different from baseline? Prove what can be proved and see if connections can be made to explain the chief complaint(s).

Asst1: Many diagnoses/labels are suspect. It is critical to determine how these diagnoses were made and by whom. Was previously quiescent dz now active? Have there been changes in management/treatment by other providers? Also consider iatrogenesis from OTCs, procedures, misinformation from other MDs or family, self-inflicted wounds, etc.

Asst2: “Sorrow that hath no vent in tears may make other organs weep”. Emotions may alter or amplify "physical" diseases or symptoms, may produce behavior changes (e.g., ETOH, drugs) or may produce symptoms directly.

Asst3: We usually strive for just one diagnosis but sometimes patient problems do not always have just one cause.

Pers1: Sit back and ask how the patient makes YOU feel (irritated, mad, frustrated).

Pers2: Describing a problem to a colleague often identifies new approaches and referring can remove visceral/emotional biases. If you cannot save your patient, find someone who can.

Step 4: GET FEEDBACK: (Do NOT depend on patients to give you this). Have a well-defined and consistently followed process.

If your diagnosis was WRONG:

1. WHY ? Regularly discuss errors w/ friends. Discuss tools to help, e.g.: **VITAMIN C D:** Vascular, Infections, Toxins, Auto-immune, Metabolic/endo, Idiopathic & iatrogenic, Neoplastic, Congenital, Conversion (psych), Degenerative/trauma.

2. How clear was your thinking? Stay mindful (journal) of your biases & weaknesses (ex: times of day, hunger, body system, areas of weakness)

3. Keep a running list of your own errors, successes & surprises. Common confounders: syphilis, PE, HIV, Still’s, Lyme, GCA/vasculitis, celiac, endocarditis, TB, lymphoma, sarcoid, OSA and others. See John Ely’s list of commonly missed diagnoses from website on reverse.