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Risk Tips

Engaging Patients to Improve Diagnosis

Diagnostic errors are a common, yet harmful and costly issue in healthcare. They are estimated to affect 12 million Americans every year,[1] and the National Academies of Sciences, Engineering, and Medicine (NASEM) note that "all of us will likely experience a meaningful diagnostic error in our lifetime."[2]

Diagnostic errors also represent a significant liability burden. Malpractice cases involving diagnosis-related allegations, when compared with other types of cases, are more common, involve more severe patient harm, and result in higher indemnities.[3]

Improving quality of care and reducing diagnosis-related liability exposure requires understanding the diagnostic process and identifying potential areas of risk at each stage. To do this, experts have advocated for a team-based approach to diagnosis that includes patients/families as essential members of the care team.

Engaging patients/families as partners in care and crucial members of the diagnostic team may involve reshaping established healthcare norms (e.g., the solo practitioner as the authoritative diagnostician) and addressing other patient engagement barriers, such as poor communication and inadequate health literacy.

The following tips[4] offer ways for healthcare providers to nurture patient-centered approaches to care and partner with patients/families for better diagnostic and treatment outcomes.

1

Invite patients/families to learn about and be active participants in the diagnostic process. For example, clearly explain the process and encourage patients to provide thorough information about their health and medical histories, ask questions (e.g., "What else could cause these symptoms?"), and follow up on test and laboratory results.

2

Advise patients on how to be good historians of their medical histories and how to think about and discuss their symptoms (e.g., frequency, location, timing, aggravating and alleviating factors, and associated symptoms). The Agency for Healthcare Research & Quality's (AHRQ's) *Toolkit for Engaging Patients To Improve Diagnostic Safety* and NASEM's *Improving Diagnosis in Health Care: Resources for Patients, Families, and Health Care Professionals* offer helpful tips for improving information sharing.

3

Optimize verbal and electronic communication with patients/families, and ensure that information is timely and accurate (e.g., voicemail and email responses).

4

Make sure that patients have access to necessary systems, such as patient portals and electronic health records, so they can review clinical notes and results from diagnostic tests.

5

Recognize cultural competence as a distinguishing feature of patient-centered care and a vital component of developing an effective communication process with patients/families. Use techniques and methods that can aid in cross-cultural communication, such as motivational interviewing, the explanatory model, and the RESPECT model.

6

Provide information to patients in ways that they can understand, such as using visual aids, providing plain language educational materials and follow-up instructions, and using techniques such as the teach-back method to assess comprehension.

7

Provide patient-friendly tools to assist with information management, encourage dialogue, and support collaborative problem-solving. Examples of useful tools include Be Prepared to Be Engaged (AHRQ), Ask Me 3: Good Questions for Your Good Health (Institute for Healthcare Improvement), and The Patient's Toolkit for Diagnosis (Society to Improve Diagnosis in Medicine).

8

Work with patients/families to develop shared knowledge and goals about care and treatment as well as to foster mutual respect and trust.

9

Reassure patients that they should be assertive about their care, raise concerns, and notify providers if their symptoms change or their conditions worsen or do not improve. Make sure patients know the appropriate ways to communicate (e.g., appropriate use of patient portals, social media, email, and phone calls).

10

Encourage patients to review their health records for accuracy and completeness and transfer relevant health records and test results to treating clinicians.

11

Include patients/families in efforts to improve diagnosis and learn from diagnostic errors and near misses (e.g., create a patient/family advisory committee).

12

Create opportunities for patients/families to provide feedback about the diagnostic process and any concerns related to their care.

Endnotes

[1] The Society to Improve Diagnosis in Medicine. (n.d.). What is diagnostic error? Retrieved from www.improvediagnosis.org/what-is-diagnostic-error/

[2] National Academies of Sciences, Engineering, and Medicine. (2015). *Improving diagnosis in health care.* Washington, DC: The National Academies Press.

[3] The Society to Improve Diagnosis in Medicine, What is diagnostic error?

[4] National Academies of Sciences, Engineering, and Medicine, *Improving diagnosis in health care;* Graber, M., Rusz, D., Jones, M., Farm-Franks, D., Jones, B., Cyr Gluck, J., Thomas, D. B., . . . Eichbaum, Q. (2017). The new diagnostic team. *Diagnosis, 4*(4), 225-238; National Quality Forum. (2020). *Improving diagnostic quality and safety/reducing diagnostic error: Measurement considerations.* Retrieved from www.qualityforum.org/Publications/2020/10/Reducing_Diagnostic_Error__Measurement_Considerations_-_Final_Report.aspx; Olson, A., Rencic, J., Cosby, K., Rusz, D., Papa, F., Croskerry, P., Zierler, B., . . . Graber, M. L. (2019). Competencies for improving diagnosis: An interprofessional framework for education and training in health care. *Diagnosis, 6*(4), 335-341; Health Research & Educational Trust. (2018). *Improving diagnosis in medicine change package.* Retrieved from www.improvediagnosis.org/improving-diagnosis-in-medicine-change-package/