THE JOURNAL OF FAMILY PRACTICE

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EDITORIAL

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Getting that Dx right, keeping patients safe

Even the best physicians make mistakes.

Each of us can recall a patient for whom our initial diagnosis was incorrect, or conversely, where we uncovered the correct diagnosis. My memorable mistake was missing an obvious case of hypothyroidism, and my happier encounter was correcting an incorrect diagnosis of asthma when the patient actually had primary pulmonary fibrosis. These patients came to mind as I read this month's cover story, "COPD and asthma: Diagnostic accuracy requires spirometry" (page 76).

Listening closely to the patient's and family's concerns can lead in a direction other than my initial impression.

In a previous editorial, "When our biases derail the diagnosis,"[1] I discussed types of cognitive bias that can lead us to the wrong conclusion. Today, I want to address diagnostic errors in medicine as a patient safety issue.

The patient safety movement gained traction in 1999 with the publication of the Institute of Medicine (IOM, now National Academy of Medicine) report, *To Err is Human: Building a Safer Health System.* That report focused on health care system issues and had little to offer regarding improving diagnoses. It was not until 2015, with the publication of the IOM report *Improving Diagnosis in Health Care,* that serious national attention was directed to accurate diagnosis. It is worth reading the summary of this report, which includes 8 goals and is available at nas.edu/improvingdiagnosis.

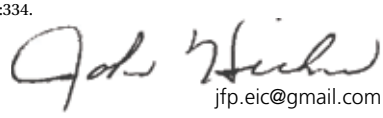
The recommendations most pertinent to family physicians are to: 1) facilitate more effective teamwork among health care professionals, patients, and families, 2) teach health care professionals about the diagnostic process, 3) ensure that technology supports proper diagnosis, 4) establish a work culture that supports diagnostic processes, and 5) identify diagnostic errors and learn from them.

Teamwork. The first recommendation is intriguing because the focus on teamwork includes patients and their families. I have found that listening closely to the patient's and family's concerns can lead me in a direction other than my initial impression—especially when they are insistent about a particular diagnosis.

Technology. Despite all of their "warts," electronic health records are gradually incorporating clinical decision support tools that really do help steer us in the right direction. I have found that electronic point-of-care references can be very helpful in establishing an accurate diagnosis in the exam room—and can help convince patients that my diagnosis is correct when they read it for themselves!

Finally, discussing our mistakes openly with our colleagues helps us—and them—to avoid that mistake in the future. Let's be sure to keep that dialogue open. And let's continue to refine our diagnostic skills so that we can continue to keep our patients safe.

1. Hickner J. When our biases derail the diagnosis. *J Fam Pract.* 2018;67:334.



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