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Risk Tips

Engaging Patients/Families 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 states 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 often are more common, involve more severe patient harm, and result in higher indemnities than other types of cases.[3]

Improving quality of care and reducing diagnosis-related liability exposure requires understanding the diagnostic process and identifying potential risks at each stage. To do this, experts have advocated for a team-based approach to diagnosis that includes patients/families as crucial members of the care team.[4]

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

The following tips offer ways for healthcare providers to nurture patient-centered approaches to care and partner with patients/families for better diagnostic and treatment outcomes.[5]

1

Invite patients/families to learn about and actively participate 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 maintain an accurate medical history and how to think about and discuss their symptoms (e.g., frequency, location, timing, aggravating and alleviating factors, and associated symptoms). The *Toolkit for Engaging Patients To Improve Diagnostic Safety* and *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 information systems, such as patient portals and electronic health records, so they can review clinical notes and results from diagnostic tests. Develop easy-to-read instructions for registering for and accessing systems, and have staff members who can assist.

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, Ask Me 3: Good Questions for Your Good Health, and *The Patient's Toolkit for Diagnosis.*

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., consider creating 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 (e.g., through the use of patient surveys and other feedback mechanisms).

Endnotes

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[1] Johns Hopkins Medicine, Armstrong Institute for Patient Safety and Quality. (n.d.). *The impact of diagnostic errors.* Retrieved from www.hopkinsmedicine.org/armstrong-institute/center-for-diagnostic-excellence

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

[3] MedPro Group. (2023). *Data insight: A ten year overview of medical & surgical cases.* Retrieved from www.medpro.com/documents/10502/5086245/Ten+Year+Overview_Data+Insight_2023.pdf

[4] National Academies of Sciences, Engineering, and Medicine, *Improving diagnosis in health care.*

[5] The risk tips in this publication are based on the following resources: 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.