DIAGNOSTIC TIME-OUT

Complete for patients with risk factors for diagnostic error (see reverse) either in or out of the room.

1. **Name the primary working diagnosis.**
   - Could the patient have a different understanding of this diagnosis?
2. **Identify what does and doesn't fit with the primary working diagnosis.**
   - Are there unexplained signs and symptoms, unexpected responses to treatment, and/or discrepancies with test results?
3. **Discuss alternative diagnoses.**
   - Could there be a variation of a common disease, multiple diagnoses, or a complication of treatment?
   - Have "don't-miss" diagnoses been ruled out?
4. **Identify potential gaps in the diagnostic process and consider changes to the plan.**
   - Revisit historical and clinical data with patient, family caregiver(s), and providers.
   - Consider possible changes to the diagnostic plan (e.g., additional tests or studies).
5. **Communicate diagnostic uncertainty.**
   - Assess whether the patient understands and agrees with the diagnostic possibilities and plan.
   - Update EHR documentation to communicate diagnostic uncertainty as well as the current diagnostic thought process.

What is a diagnostic error?

A diagnosis that is missed, incorrect, or delayed

When to Consider a Diagnostic Time-Out

- Multiple ambulatory visits prior to admission, early readmission
- Limited history or physical exam (altered mental status, language barrier, isolation precautions)
- Undifferentiated symptoms (e.g., abdominal pain, SOB)
- No clear trigger for exacerbation of chronic disease
- Co-morbid psychiatric disease or personality disorder
- Transitions (admission from ED, inter-hospital transfer, new team, transfer from a different service)
- Multiple consultants or team members with differing opinions
- Clinical deterioration or response to treatment not as expected
- Unexpected events: Rapid response, codes, unplanned procedure/surgery
- Patient concerns about their diagnosis

Common Cognitive Biases to Consider During the Diagnostic Process

Anchoring Bias: Locking on to a diagnosis too early and failing to adjust to new information (e.g., dismissing a negative urine culture in a patient admitted with presumed UTI).

Visceral Bias: Emotional influence on behavior when patient is perceived as difficult or special (e.g., stereotyping symptoms as psychosomatic).

Availability Bias: Thinking that a similar recent presentation is happening in the present situation (e.g., putting hemophagocytic lymphohistiocytosis on ddx after it was featured in morning report).

Confirmation Bias: Looking for evidence to support presumed diagnosis, rather than for information to prove oneself wrong (e.g., asking only about symptoms that fit a certain diagnosis).

Representativeness Restraint: Looking for classic presentations of disease rather than common atypical variants (e.g., missing diffuse alveolar hemorrhage in a patient with pulmonary infiltrates and anemia but no hemoptysis).