A New Approach to Diagnosis: More Conservative, 'Care-full'

By Dana Murphy

It's a complex challenge to balance the potential for under-diagnosis (or delaying important diagnoses) with the wasteful and potentially equally harmful prospect of over-diagnosis. But now, a new report from an international panel of experts on this issue recommends a wholesale reappraisal of thinking about diagnosis: they suggest a new approach, richer and more patient-centered. It's not just about ordering more or fewer tests. It is a framework for more conservative diagnosis processes that the report's authors say is "more thoughtful and caring."

The panel comprises experts in safety and policy who participated in a series of calls and meetings in 2016 to 2018, convened by the Brigham and Women's Hospital Center for Patient Safety Research and Harvard Medical School Center for Primary Care PRIDE (Primary Care Research in Diagnostic Errors).

Here are the 10 principles that, the panel has determined, will support better decision-making for both providers and patients.

1. Promoting enhanced care and listening. The standard paradigm in responding to a patient's symptoms, wherein testing is key to making an accurate diagnosis, the panel says, is in fact based on questionable assumptions. It downplays the role of patient history and the physical examination. It also overlooks the part that the patient can play in "co-producing" diagnoses.

The standard paradigm also assumes that patients want a label for their issues more than they want their concerns addressed. Similarly, the paradigm is

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grounded in the notion that the best way a doctor can evidence concern is by ordering lots of tests.

A further illusion may be at work in the first two assumptions: a definitive diagnosis can routinely be made and that a diagnosis is always essential for choosing therapies.

2. Developing a new science of uncertainty. In recent years, there has been a wider appreciation of the extent of uncertainty in medicine. In many instances, tests that, it was hoped, would provide certainty have, instead, only magnified diagnostic complexity and ambiguity.

Physicians need to accept uncertainty as an unavoidable element in what they do and avoid countering the discomfort it engenders just by ordering yet more tests. They need to find ways to communicate uncertainty to patients effectively. The creation of a differential diagnosis is an important element in acknowledging uncertainty, and it should be coupled with estimates of probability for each item in the list. Like so much in this new approach to diagnosis, what is involved here is a rebalancing of the processes involved.

3. Rethinking symptoms. The majority of office visits are driven by common symptoms; but up to half of these don't have a reliable medical diagnosis. And 75% to 80% will improve over the next four to 12 weeks anyway, even in the absence of treatment.

Also, many symptoms meet the criteria for depression, anxiety, or somatoform illnesses, and these very often go unrecognized.

4. Maximizing continuity and trust. In the absence of well-informed trusting relationships, doctors often fall back on defensive, costly, and less-productive practice styles. Knowing a patient's baseline (healthy) status can critically inform a diagnostic strategy and helps promote diagnostic restraint.
Inevitably, money enters into the picture too. If patients are aware of financial incentives for ordering (or withholding) tests, they may find it hard to trust clinicians' recommendations about them. For this reason, ongoing (single payer) health insurance might serve to insulate the diagnostic process from monetary issues.

5. Taking time. Since taking time is essential for excellent care, clinicians need to do what they can to re-engineer care so as to maximize their in-person time with patients. Strategies for this could include:

- More efficient delegating to other team members
- Re-engineering telephoning and electronic communications
- Developing systems for monitoring patients longitudinally.

The strategies promote the process of watchful waiting—the test of time. This is a basic element in conservative diagnosis.

6. Linking diagnosis and treatment. This may be the most provocative aspect of the new approach to diagnosis: the notion that diagnosis should not be done in isolation, but instead more closely coupled with treatment. Diagnosis has greater value when there are more specific and effective treatments for the condition identified. Its value is diminished when there is no therapy or when a diagnosis is not necessary for choosing a treatment option.

Specific examples wherein this principle can be usefully applied include back or neck pain without neurologic findings and acute upper respiratory or sinus symptoms. Clinicians should avoid ordering tests without considering whether the results will influence treatment.

Thus, the panel advises that, "Diagnosis should be pursued based on the availability, effectiveness, specificity, urgency, and acceptability of a therapy."

7. Tests—more thoughtful ordering and interpreting. The panel advises that "testing must be used more strategically and held to a higher standard of evidence than it is currently." This requires a more balanced understanding of the benefits of tests—their benefits, but also their potential harms, costs, and limitations.

Both patients and doctors need to understand that, as compared with medications, new tests are not held to high and rigorous evidence standards or regulatory requirements.

Using more conservative diagnosis doesn't mean just saying no to tests. Instead, it is about more intelligent selection of tests, and their timing and interpretation.

8. Safety Nets—Incorporating Lessons from Diagnostic Errors. The recent reports on diagnostic error might seem to support an argument for more testing. Instead, clinicians need to anticipate the potential for *specific* diagnostic errors. The National Academy of Medicine has provided guidance, rec-

ommendations that will help clinicians maintain more conservative diagnostic approaches. The report suggests the clinicians compile what they term "situational knowledge"—such as key pitfalls to avoid, red flags, and critical diagnoses for various scenarios.
It is also helpful to incorporate the lessons we have learned about safety culture into the diagnostic process, including avoidance of blame, encouraging staff and patients to speak up, learning from errors and near misses, and disclosure/apology. All of these can help provide a supportive context for more conservative diagnostic practices.

9. Cancer—fears and challenges. The U.S. populace has been repeatedly encouraged, for many years now, to get screening for various types of cancer. But there are some difficult issues with current screening procedures, notably:

- Lead time bias—the false impression of improved survival in a screened population without affecting mortality, because the cancer is diagnosed earlier in the natural history of the disease but the patient still dies of the cancer
- Over-diagnosis of incidental cancers that are best left untreated
- False-positive and false-negative test results
- Uncertainties as to the value of treatment
- Questions about the possibly marginal benefits of early treatment.

10. "Diagnostic stewardship"—transforming the role of specialists and emergency departments. One important aspect of conservative practice is limiting the extent of referrals to specialists and also of the emergency department (ED). But there are benefits to using both. Specialists in particular can provide:

- Reassurance that more testing is not always needed
- Triage consultations
- Rapid electronic second opinions
- Safe harbors
- Legal protections for both patients and doctors
- Counseling for patients whose diagnosis was initially (but not negligently) missed or delayed.

Most important, the panel advises, is that specialists and ER staff can help in promoting conservative diagnosis "by showing in practice and providing evidence to guide real-world testing strategies for both acute/argent and chronic symptoms, in the context of low probability serious disease, critically weighing therapeutic alternatives."

This summary is based on the article, "Ten Principles for More Conservative, Care-full Diagnosis," by Gordon Schiff et al., Annals of Internal Medicine, October 2, 2018. The full text is available on the Internet, free, at: https://psnet.ahrq.gov/resources/resource/32482/Ten-principles-for-more-conservative-care-full-diagnosis. MPL

Dana Murphy *is editor of* Inside Medical Liability; *dmurphy@MPLassociation.org.*

Inside Medical Liability *asked the principal author of the study, Gordon Schiff, MD, to comment on the potential impact of a more conservative approach to diagnosis on MPL. The following is his response:*

In the paper (Principle 10), we urge specialty societies to take conservative diagnosis seriously, just as many have begun to do with the Choosing Wisely campaign, and other types of guidelines. Clinicians should feel more confident deferring or avoiding a test that on balance that may cause more harm than benefit when it is backed up by these recommendations.

That should be combined with a good, caring, trusted relationship with the patient AND careful follow-up with a plan to re-evaluate, should the patient not progress in getting well or respond as expected. Keeping the door open with good communication and follow-up safety nets means getting patients and doctors on the same page, working together in the face of diagnostic uncertainty. And better listening to the patient has first priority (Principle 1); this is at the heart of better more care-full diagnosis.

I think such an approach has been shown to lead to fewer plaintiffs, fewer suits, and better clinical outcomes.