Step 1. **Confidence and Self-Reflection.** Am I being influenced by biases/ fatigue/pace of day?

Step 2. **If confident, you might be wrong.** Keep death as a consultant. (What is worst possible dx that might injure the patient?)

- Think about pretest probability and prevalence of disease.
- In considering CDE, is this unusual disease or unusual presentation of the common?

Step 3. **If not confident, label the problem as Not Yet Diagnosed (NYD)**

**Subj1:** From your history, identify the worst complaint, the first occurrence, the top three. If the patient cannot identify one, consider affective or cognitive impairment.

**Subj2:** Patients concerns about a dx may be correct or you can relieve worry about very unlikely disease.

**Obj1:** Think, re-examine and ask questions. Consider using JAMA’s Rational Clin Exam series to quantify diagnostic possibilities.

- Don’t just pursue additional testing. Tests should be viewed as confirming or supportive, and rarely diagnostic.

**Obj2:** Any changes in labs from baseline? Prove what can be proved and see if connections can be made to explain the chief complaint(s).

**Asst1:** Many diagnoses/labels are suspect. It is critical to determine how these diagnoses were made and by whom. Was previously quiescent dz now active? Have there been changes in management/treatment by other providers? Also consider iatrogenesis from OTCs, procedures, misinformation from other MDs or family, self-inflicted wounds, etc.

**Asst2:** “Sorrow that hath no vent in tears may make other organs weep”. Emotions may alter or amplify "physical" diseases or symptoms, may produce behavior changes (e.g., ETOH, drugs) or may produce symptoms directly.

**Asst3:** We usually strive for just one diagnosis but sometimes patient problems do not always have just one cause.

**Pers1:** Sit back and ask how the patient makes YOU feel (irritated, mad, frustrated).

**Pers2:** Describing a problem often identifies new approaches and referring can remove visceral/emotional biases. If you cannot save your patient, find someone who can.

Step 4: **GET FEEDBACK:** (Do NOT depend on patients to give you this). Have a well-defined and consistently followed process.

If your diagnosis was WRONG:

1. **WHY?** Choose friends and regular timing to discuss errors. Discuss systems to help, e.g.: **VITAMINCD:** Vascular, Infections & Intoxications, Trauma & toxins, Auto-immune, Metabolic, Idiopathic & iatrogenic, Neoplastic, Congenital, Conversion (psych), Degenerative

2. **How clear was your thinking?** Stay mindful (journal) of your biases & weaknesses (ex: times of day, hunger, body system, “I hate __”)

3. **Keep a running list of your own errors, successes & surprises.** Common confounders: syphilis, PE, HIV, Still’s, Lyme, GCA/vasculitis, celiac, endocarditis, TB, lymphoma, sarcoid, OSA and others. See John Ely’s list of commonly missed diagnoses from website on reverse.