Step 1. Assessment of Confidence and Self-Reflection
How Confident am I in this diagnosis? (or Why am I confident?)
How Clear and unbiased is my thinking? (Check list of biases)

Step 2. If confident, still consider that you might be wrong (or prematurely stopping thought) and ask:
What else could it be? (At least common, dangerous and exotic (CDE) alternatives)
Broaden DDx w/support tools, e.g., John Ely’s Cklist http://pie.med.utoronto.ca/DC/index.htm
Why does this patient-problem exist? Think systematically such as VITAMINC CD (on reverse).

Step 3. If not confident, label the problem as Not Yet Diagnosed (NYD).
STILL develop lead diagnosis, active alternative dxs, other and ruled out hypotheses.
Take a time out to intentionally analyze and document using this SOAP format:
Subj1: Listen again to the patient – Get the worst or first symptom and complete history.
Subj2: Recruit patient’s help: Ask directly what (s)he thinks is wrong.
Obj1: Refresh your ROS&PE. Focus on symptoms and the problem list.
Obj2: Review all lab and radiology studies (recent & past), esp for changes
Asst1: Refresh & prioritize a complete problem list. Verify DXs from the PMH
Asst2: Reflect systematically WHY each new problem exists (at least CDE)
(Always consider meds/iatrogenesis and affective dx)
Asst3: Propose multiple etiologies when Occam’s razor does not fit.
Pers1: What’s YOUR perspective? Check your biases/emotions (and listen to gut).
Pers2: Ask colleagues to help. Set up a “diagnostic huddle”
Proceed to diagnostic testing to rule out can’t-miss diagnoses, with awareness of test characteristics including sensitivity, specificity.

Step 4: AFTER a diagnosis (or a NYD label)
GET FEEDBACK: Call /revisit/invite patient to reassess, identify any overlooked issues.
Set up and USE a system to verify that test/referral data were received/acted upon.
If your diagnosis was WRONG (studies suggest 15% error for IM cases), ask:
1. WHY? (missed data, incomplete HPE, rare disease, unusual presentation, etc).
   Did disease pace outrun the diagnostic pace?
2. How clear was your thinking. Review biases and limitations (time, pace)
3. Keep a running list of your errors, successes & surprises.
   Read /review periodically about often confounding, missed or rare foes.

Heuristics/Thinking Patterns to consider:
Anchoring/Premature Closure: Too early choice of Dx/stopped thinking; Could I be wrong?
Blind obedience/Diagnostic momentum: over-trusting a prepackaged dx; was that info reliable?
Availability: Swayed by recent or memorable case of easy recall?
Visceral/Emotional: feelings toward patient. How would I treat my parent?
Representativeness: Hearing hoof beats is more likely horse than zebra.
Framing: Overemphasizing certain selected features or outcome; try to change perspective
Confirmation: actively selecting and seeking confirming/refuting evidence. Take the opp side.