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Supporting Nurses as Essential Partners in Diagnosis

By Susan Carr, Senior Writer

> *…these changes may take some time and may meet some resistance.*[1(p147)]
>
> – Institute of Medicine's Committee on Diagnostic Error in Health Care

As the Institute of Medicine (IOM) anticipated in 2015, reframing diagnosis as a team-based process, with nurses included as essential partners, has been neither quick nor easy to accomplish. Now, 6 years after publication of the IOM's *Improving Diagnosis in Health Care,*[1] there has been progress, but nurses and other members of the care team continue to encounter barriers to being recognized as partners in the diagnostic process.[2-7]

The vision of nurses taking a more active role in diagnosis has roots in *The Future of Nursing: Leading Change, Advancing Health*, published by the IOM in 2011.[8] It similarly calls for nurses to work in partnership with physicians and others to improve the safety and quality of health care. Although diagnosis is barely mentioned in *The Future of Nursing,* the report's call for nurses to be empowered and trained to transform health care is consistent with the IOM's recommendations for improving diagnosis published 4 years later.

There are many reasons why this effort to elevate nursing's role in diagnosis has been so slow. The recommendation to elevate nursing's role in diagnosis and improve collaboration, consistent with other efforts to improve patient safety, disrupts the norms of a resistant industry, requiring institutions to alter established patterns, redistribute power among clinicians, and realign professional roles.

Nurses have always been involved in medical diagnosis, offering specialized skills and information and facilitating communication, especially in complex cases. But the profession has not drawn attention to that role, focusing instead on "nursing diagnosis"[7] and an approach to clinical reasoning referred to as "thinking like a nurse."[9] Treating this important work as something separate from medical diagnosis may have contributed to an underappreciation of the contributions of nurses. Calling for "more effective"[1(p8)] teamwork, the IOM acknowledged that nurses' inputs are often overlooked:

> *…nurses are often not recognized as collaborators in the diagnostic process, despite their critical roles in ensuring communication, care coordination, and patient education; monitoring a patient's* condition; and identifying and preventing potential diagnostic errors.[1(p8)]

Preparing Nurses to Take a More Visible, Active Role

Registered nurses already possess important components of the education and experience they need in order to participate in diagnosis, but they often run into systemic and operational barriers to fully

realizing their potential.[7] Limited opportunity to fully practice all they know — to practice to the full extent of their license — is one of those barriers and is not a new problem.

The first recommendation in *The Future of Nursing* is to enable nurses to practice to the "full extent of their education and training."[8(p4)] The report identifies historical, regulatory and policy challenges, many of which still exist, reinforced by workplace strains that deter nurses from being able to advance their role in diagnosis.

To practice to the full extent of their capability, nurses need both time and agency. Working environments that are understaffed and inefficient may result in nurses responding only to immediate crises, less able to devote time and attention to clinical reasoning and collaboration. Torn between giving full personal attention to patients and families in their care and proactively reassessing and rethinking the diagnosis with colleagues is a reality of current practice, especially when nurses are pressed for time. In conversation, Kelly Gleason, R.N., Ph.D., has said that nurses sometimes feel they are able to practice only to the "bare minimum" of their license. She observes,

> *It's not a training issue — floor nurses can sometimes be overwhelmed by all the things they are assigned to do. They get caught up in the tasks and may be unable to engage in the critical thinking component.*

She goes on to point out that to fully exercise their professional capabilities, nurses must also be recognized and empowered as members of the team: "In those moments, in addition to support, nurses need to have confidence that participating in the diagnostic process is also explicitly recognized as part of their job"(personal communication, February 2021).

The legal system, however, does recognize nursing's role in diagnosis. A review of malpractice cases from 2007–2016 in a database representing approximately 30% of U.S. claims found that nursing was named as the "primary responsible service"[6(p1)] in 139 cases related to diagnosis and in 647 cases related to "failure to monitor physiologic status."[6(p2)] In their review, the authors found evidence that contributing to the diagnostic process is considered a right and duty of nursing:

> *The legal mandate is clear that nurses must exercise independent judgment and communicate effectively to ensure safe, competent medical care.*[6(p3)]

Gleason, who was involved in the review and published findings, reflects on the significance of this legal duty and the reality of daily challenges in nursing: "Even when there are a million other urgent things to do, being involved in diagnosis is important. It is the nurse's responsibility and must be a high priority" (personal communication, February 2021).

A malpractice case decided by the Illinois Supreme Court in 1965 is referenced as having set a precedent for this high standard of responsibility.[6,7,10] In the case, *Darling v. Charleston Community Memorial Hospital,* nurses had correctly observed and documented a patient's deteriorating condition. They followed orders but did not act to ensure that the concerning signs were properly addressed, which resulted in life-changing harm to the patient.

> *The court held that the nurses were expected to recognize the critical complication, exercise independent judgment, and report substandard medical treatment to higher authority.*[7(p5)]

Shared Competencies for the Diagnostic Team

Although current curricula for most nursing programs provide graduates with a good foundation for participating in the diagnostic process, most nurses and other clinicians lack the interprofessional training needed to ensure that they can work together effectively, as imagined by the Institute of Medicine (now, the National Academy of Medicine) and other groups. That training should provide shared competencies as well as practical experience.

The Society to Improve Diagnosis in Medicine, with funding from the Macy Foundation, has worked with more than 40 experts, including educators, students and patients, to develop a curriculum for 12 competencies tailored to the recommendations in the 2015 report on diagnosis. The 12 competencies are presented in 3 sections — individuals, teams, and systems— with half falling into the "individual" category. Those 6 competencies focus on clinical reasoning, emphasizing the need for physicians and non-physicians, including nurses, to have command of knowledge and actions that contribute to "arriving at a justifiable diagnosis."[5(p338)]

In addition to acquiring new skills, developing those competencies involves having learners across different professions develop a shared vocabulary and mental model for the diagnostic process. Competencies related to the team include functions already in the nursing skill set: the ability to engage, collaborate, and communicate with patients and families; facilitate information transfer at transitions of care; close the loop on test result communication; and more.[5] Implementing those team-based skills, however, often depends on system-based competencies, such as understanding the influence of human factors and "advancing a culture of diagnostic safety,"[5(p338)] without which individuals and teams will not be able to perform at their highest level.

The consensus curriculum that helps schools teach these competencies was released in 2019. That was an essential first step, but schools internationally need to incorporate these to truly empower the next generation of nurses. Guidance for the next steps education-focused organizations need to take is currently being drafted by a second consensus-driven interprofessional group under SIDM auspices.

A possible silver lining

It is frustrating and puzzling that it takes so long to implement change that powerful groups agree on and have forcefully advocated.

The pandemic may offer an opportunity to accelerate progress. Unfortunately, the need to care for a sudden influx of critically ill, infectious patients has put clinicians and organizations under tremendous pressure, prompting immediate adjustments in practice that may persist as improvements. There is some anecdotal evidence that the demands of caring for severely ill COVID patients in hospitals, where infection control protocols demand new workflows, may elevate the position of registered nurses in the diagnostic process. According to Kelly Gleason, because personal protective equipment is still a limited resource in many places and it takes so long for clinicians to prepare to enter COVID patients' rooms, nurses are being asked to do more. Gleason has heard nurses around the U.S. say they are being trusted to do more than ever and asked to practice at the top of their license. Gleason says, "They're succeeding and that will hopefully pay off afterwards (personal communication, February 2021)."

While nurses in some specialties— notably, intensive care and emergency medicine — have routinely been practicing as trusted partners in diagnosis, more registered nurses are now being thrust into those roles with added responsibility. These changes are imperfect, unfolding under the duress of the pandemic, but they may result in lasting progress.

In a crisis, people often find they need to depend on each other more than in normal times. During the pandemic, everyone has been called on to contribute to the full extent of their training and experience. New collegial relationships will form, clinical reasoning muscles will strengthen, and teamwork will be enhanced, at least in some organizations, for some individuals. More empowered, enabled nurses and collaborative diagnostic teams may be a silver lining of the current crisis.

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Moore Foundation Advances Work in Clinical Quality Measures to Improve Diagnosis

The Gordon and Betty Moore Foundation has a mission to improve the experiences and outcomes of patient care. The foundation's Diagnostic Excellence Initiative is focused on work to reduce harm from diagnostic errors and improve quality in diagnosis. This work is framed around a philosophy of diagnostic excellence, acknowledging that many healthcare quality goals exist in tension with one another. Health quality goals for accuracy, timeliness, patient-centeredness, safety, efficiency, and equity sometimes require tradeoffs and a nuanced balance to achieve optimal diagnosis. Assessments about quality of diagnosis may be difficult, but that shouldn't prevent action. While philosophers debate, the Moore Foundation accepts the challenge to begin to find ways to improve.

The foundation's Diagnostic Excellence Initiative is grounded in the goal to improve measurement for diagnostic quality through the development of clinical quality measures that can help define standards for diagnostic excellence, guide improvement efforts, and strengthen public accountability. Providers and healthcare systems want to provide excellent care, but many simply don't know where to start or what they can do to improve diagnosis. Judgements about quality in diagnosis have largely eluded standardization and measurement.

In an attempt to address this "measurement gap," the Moore Foundation recently launched a third request for proposals to fund development of clinical quality measures for diagnostic excellence. Details about work underway from the first two cohorts of grantees in measure development are available on Moore.org (see cohort 1 and cohort 2). The current funding opportunity will give priority to proposals addressing the "big three" health care conditions, which are responsible for a majority of preventable harm from missed or delayed diagnosis:

- acute vascular conditions (such as acute coronary syndromes, strokes, thromboembolic events, and aortic emergencies),
- infections (such as pneumonia and sepsis, as well as urinary tract infections, skin and soft tissue infections, meningitis, and spinal epidural abscesses), and
- cancers (lung cancer, colorectal cancer, as well as other common cancers).

Up to eight grants will be awarded $250,000 - $500,000 each for work done over 18 months. Submissions from individuals with deep clinical experience and content expertise are encouraged, and while measure development experience is useful, it is not a prerequisite for funding. Grantees will be supported in the work of measure development through a technical assistance partnership with Battelle. This strategy aims to promote meaningful measures that are useful and desired by frontline providers and patients. Online applications are due May 10. Individuals interested in applying for the current funding for measure development are invited to register for the April 12 informational webinar by submitting their desire to attend to diagnosis@moore.org.

From the Field: Call for Abstracts

The Society to Improve Diagnosis in Medicine (SIDM) has announced the theme for the 14th Annual Diagnostic Error in Medicine Conference – SIDM2021 taking place October 25-27, 2021. The theme — **Reducing Disparities; Improving Diagnosis** — will include keynotes and panels that will look at how social determinants of health can impact diagnostic decision making. As always, the conference will also showcase research, education, patient engagement, and practice improvement developments in the field of diagnostic quality and safety.

Ron Wyatt, MD, MHA, Vice-President and Patient Safety Officer at MCIC Vermont and Co-Chair of the SIDM2021 Conference Planning Committee, articulated a vision for the conference, where we would come together as a community to better understand all types of disparities, including race, gender, and age. "We need to have difficult, but important conversations about implicit bias and look at how disparities and inequalities contribute to misdiagnosis and diagnostic delays. We will all have to be comfortable with being uncomfortable during these discussions."

SIDM recently issued a Call for Workshops for the conference where they are seeking high quality interactive workshops that provide conference attendees with actionable knowledge or key takeaways. The Call for Workshops closes April 6; a Call for Abstracts will be announced in mid-April.

Peter Provonost, MD, Chief Clinical Transformation Officer at University Hospitals and Co-Chair of the SIDM2021 Conference Planning Committee, noted that "the pandemic has brought into sharp focus the impact of disparities on health care quality. Overlooked however, has been how disparities have long affected the ability to get an accurate, timely, and well-communicated diagnosis."

The conference will be preceded on Sunday, October 24, with the annual SIDM Patient Summit – with a focus on disparities as they relate to the disability community. This year's conference will also highlight the latest research in the field through poster and abstract sessions. Additionally, there will be more networking opportunities for attendees.

SIDM2021 brings together physicians, patients, advanced practice clinicians, and other allied health professionals, as well as researchers, institutional leaders, policymakers, educators, and trainees to highlight and share recent innovations to improve the diagnostic process.

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To stay abreast of conference news, visit www.improvediagnosis.org/SIDM2021