

Safety netting: time to stop relying on verbal interventions to manage diagnostic uncertainty?

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‘Safety netting’ refers to a range of activities to manage clinical uncertainty during consultations. This can include uncertainty about diagnosis, how disease may progress or whether or not a treatment will work. It is frequently delivered along the lines of ‘*come back and see me if this does not get better*’, but can also include more specific advice and steps to monitor the patient through lists or codes in the patient record. The desired effect is for patients to seek medical attention again if needed and to be reassured if not. Ten years of safety netting research has established that safety netting is ubiquitous and inconsistently practised. It is invariably delivered with missing details about how quickly symptoms may resolve or reappear, and what the implication would be.¹ Requests to ‘*come back*’ are often made without clear instructions for how and when to do so.¹ Follow-up appointments are rarely made for the patient unless clinicians judge this to be necessary, but where this happens, patients invariably feel very reassured and validated.^{2,3} Almost all the attention has been directed at primary care, despite widespread clinical and diagnostic uncertainty in secondary care. This setting has its own literature mainly driven by US authors and efforts to unpick the best ways to manage and communicate diagnostic uncertainty, without reference to safety netting^{4,5}; ne’er the twain have met.

Cox *et al*’s study of safety netting in hospital internal medicine settings is therefore a significant addition to the literature⁶; the authors used vignettes of typical patients to prompt medical participants to suggest what advice they would give to the patient. This was followed by semistructured interviews giving depth and further explanatory detail to their answers. Their findings are remarkably

similar to those in primary care studies, with advice being delivered in a rather passive manner, leaving patients to ponder whether they felt it was necessary to return. This may be particularly appropriate to emergency department settings where continuity of care is not expected, but similar findings have been reported in primary care.^{1,7,8} Cox *et al* reported that clinicians tried to be explicit to patients about their uncertainty and used the spectre of potentially serious diagnoses to catch patients’ attention.⁶

A particular interest in Cox *et al*’s study is the inclusion of a range of different conditions in the vignettes. While it is not always acknowledged, many safety netting studies in primary care are about suspected cancer or about acute childhood illness.^{9,10} Cox and colleagues highlighted the differences in safety netting delivery depending on the potential urgency of the patient’s complaint⁶; it stands to reason that a clinician may express themselves differently if they are worried about serious worsening of the patient’s condition within the next few hours, rather than days or weeks. This could account for some of the differences in the way safety netting was expressed by participants, although some undifferentiated symptoms are dynamic and unpredictable at early presentation.¹¹

There are few alternatives to safety netting in managing periods of uncertainty. The importance of this intervention is recognised in a few different ways in the UK: Safety netting is financially incentivised as part of financial contracting in English NHS primary care and is included in national guidance for the management of suspected cancer.¹² Safety netting can be coded in the predominant electronic patient record systems, and this forms clinicians’ main defence in a medicolegal

situation as well as providing evidence for funding contracts.¹³

Safety netting research has largely focused on the anxieties (or lack thereof) experienced by the clinician, prompted by gut feelings, the memory of missed diagnoses in the past and worries about the patient.^{10 14} Several studies have interviewed clinicians or formed consensus groups about the ‘ideal’ way to deliver safety netting^{11 15 16}; their answers are invariably different to studies reporting actual delivery.^{12 17}

Rarely acknowledged is the social function of safety netting; the phrasing to ‘*come back if it does not go away*’ is both a way of maintaining the rapport between clinician and patient, but also offers a cadence that will let that patient know that it’s time to leave.^{8 18} A small number of studies have explored the impact on patients, showing that patients can feel reassured by safety netting; however, if delivered in a passive or offhand way, it can have the opposite effect.³ An important consideration, particularly in paediatrics, is the dichotomy between providing too much information leading to unnecessary returns, and too little information resulting in delayed returns. Anxious parents may be dissatisfied with incomplete or irrelevant safety netting advice, prompting premature returns for issues that may not warrant further clinical attention. Acknowledging this dichotomy is essential to refine safety netting strategies that better cater to the specific needs of different patient populations.¹⁹ As the UK health service experiences ever deepening crises relating to workforce and funding, safety netting is also being used to overcome uncertainty about administrative functions, such as what to do if an expected appointment letter does not arrive.^{3 8}

Furthermore, safety netting has been established as a way of transferring responsibility—the ball is in the patient’s court. Several studies have suggested that clinicians offer safety netting advice differently depending on how easily they think the patient will understand the advice.²⁷ The vignettes in Cox *et al* did not specify anything about the patient’s likely comprehension of the advice, nor ask the clinician about how they would tailor/express this, which is a limitation of the study.

A tangible problem for judging the effectiveness of safety netting is the lack of feedback in everyday care. If a patient never returns, they may be fit and well and managing their own health very well or have sought help elsewhere with unknown consequences. A limited amount of research has tried to solve this by creating empirical data relating safety netting to patient outcomes. One study used recorded telephone and face to face consultations and then tested patient recollection of the content.^{7 20} This study demonstrated that patients remembered safety netting more effectively if they were consulting by telephone than face to face, but remembered the plan of action less well. This and other studies have shown that General

Practitioners rarely used methods to enhance recall (eg, checking the patient’s understanding, using written information).^{7 20}

A compelling approach for future research might be to return to two neglected cognitive functions: comprehension and memory. To know when to return, particularly when it is conditional on symptoms appearing or disappearing, can be quite hard to understand and remember over several weeks. Prior research has suggested that patients remember less than a quarter of the content in a consultation.²¹ Some interventions have been designed to aid comprehension and recall: the The Shared Safety Net Action Plan (SSNAP) tool is an intervention designed to support patient’s memory of clinical advice by using written information on a paper diagram²²; text message reminders have also been suggested, with scant evidence of clinical implementation.^{23 24} Another avenue worth exploring in the context of improving patient comprehension and recall is the increasing adoption of digital communication methods within the National Health Service (NHS). The Modern General Practice Access model, for instance, encourages offering patients a choice of access channels, such as emails or patient portals, which could potentially document safety netting advice more effectively.²⁵

Above all, we should acknowledge and safeguard against the limitations of safety netting to manage periods of diagnostic uncertainty. Verbal instructions to monitor symptoms could be considered equivalent to asking patients to ‘be careful’ when crossing a wet floor—the environment remains risky and we know that some patients will slip. We cannot expect clinicians to consistently deliver perfectly rehearsed safety netting lines within the constraints of a 10-minute consultation; we cannot expect patients to remember it without additional interventions to support recall and comprehension. Complimentary systems should be developed to support patients who are monitoring symptoms over time, designed to ensure equitable outcomes and prioritising patient’s understanding and memory. The development of community-based support systems, such as patient navigators or help-lines, could offer real-time guidance, helping patients interpret and act on safety netting advice.²⁵

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REFERENCES

- Edwards PJ, Ridd MJ, Sanderson E, *et al.* Safety netting in routine primary care consultations: an observational study using video-recorded UK consultations. *Br J Gen Pract* 2019;69:e878–86.
- Evans J, Macartney JI, Bankhead C, *et al.* How do GPs and patients share the responsibility for cancer safety netting follow-up actions? A qualitative interview study of GPs and patients in Oxfordshire, UK. *BMJ Open* 2019;9:e029316.
- Black GB, van Os S, Renzi C, *et al.* How does safety netting for lung cancer symptoms help patients to reconsult appropriately? A qualitative study. *BMC Prim Care* 2022;23:179.
- Alam R, Cheraghi-Sohi S, Panagioti M, *et al.* Managing diagnostic uncertainty in primary care: a systematic critical review. *BMC Fam Pract* 2017;18:79.
- Meyer AND, Giardina TD, Khawaja L, *et al.* Patient and clinician experiences of uncertainty in the diagnostic process: Current understanding and future directions. *Patient Educ Couns* 2021;104:2606–15.
- Cox C, Hatfield T, Fritz Z. How and why do doctors communicate diagnostic uncertainty: An experimental vignette study. *Health Expect* 2024;27:e13957.
- Byrne JV, Whitaker KL, Black GB. How doctors make themselves understood in primary care consultations: A mixed methods analysis of video data applying health literacy universal precautions. *PLoS One* 2021;16:e0257312.
- Russell J, Boswell L, Ip A. How is diagnostic uncertainty communicated and managed in real world primary care settings? *BMC Prim Care* 2024;25:296.
- Roland D, Jones C, Neill S, *et al.* Safety netting in healthcare settings: what it means, and for whom? *Arch Dis Child Educ Pract Ed* 2014;99:48–53.
- Friedemann Smith C, Lunn H, Wong G, *et al.* Optimising GPs' communication of advice to facilitate patients' self-care and prompt follow-up when the diagnosis is uncertain: a realist review of "safety-netting" in primary care. *BMJ Qual Saf* 2022;31:541–54.
- Edwards PJ, Silverston P, Sprackman J, *et al.* Safety-netting in the consultation. *BMJ* 2022;378:e069094.
- NICE. Overview | suspected cancer: recognition and referral | guidance.
- Network Contract Directed Enhanced Service: Early Cancer Diagnosis Guidance. NHS England Primary Care Group; 2021. Available: <https://www.england.nhs.uk/wp-content/uploads/2021/03/B0431-network-contract-des-early-cancer-diagnosis-guidance-21-22.pdf> [Accessed 11 Jul 2024].
- Jones D, Dunn L, Watt I, *et al.* Safety netting for primary care: evidence from a literature review. *Br J Gen Pract* 2019;69:e70–9.
- Friedemann Smith C, Duncombe S, Fleming S. Electronic safety-netting tool features considered important by UK general practice staff: an interview and Delphi consensus study. *BJGP Open* 2023;7:BJGPO.2022.0163.
- Blok GCGH, Berger MY, Ahmeti AB, *et al.* What is important to the GP in recognizing acute appendicitis in children: a delphi study. *BMC Prim Care* 2023;24:217.
- Tompson A, Nicholson BD, Ziebland S, *et al.* Quality improvements of safety-netting guidelines for cancer in UK primary care: insights from a qualitative interview study of GPs. *Br J Gen Pract* 2019;69:e819–26.
- Beck Nielsen S. "If you don't get better, you may come back here": proposing conditioned follow-ups to the doctor's office. *Text & Talk* 2018;38:217–42.
- Neill S, Roland D, Jones CHD, *et al.* Information resources to aid parental decision-making on when to seek medical care for their acutely sick child: a narrative systematic review. *BMJ Open* 2015;5:e008280.
- McKinstry B, Watson P, Elton RA, *et al.* Comparison of the accuracy of patients' recall of the content of telephone and face-to-face consultations: an exploratory study. *Postgrad Med J* 2011;87:394–9.
- McGuire LC. Remembering what the doctor said: organization and adults' memory for medical information. *Exp Aging Res* 1996;22:403–28.
- Heyhoe J, Reynolds C, Bec R, *et al.* The Shared Safety Net Action Plan (SSNAP): a co-designed intervention to reduce delays in cancer diagnosis. *Br J Gen Pract* 2022;72:e581–91.
- Zallman L, Bearse A, West C, *et al.* Patient preferences and access to text messaging for health care reminders in a safety-net setting. *Inform Health Soc Care* 2017;42:32–42.
- Hirst Y, Lim AWW. Acceptability of text messages for safety netting patients with low-risk cancer symptoms: a qualitative study. *Br J Gen Pract* 2018;68:e333–41.
- Peart A, Lewis V, Brown T, *et al.* Patient navigators facilitating access to primary care: a scoping review. *BMJ Open* 2018;8:e019252.