“That’s So Meta”: Cognitive Bias

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Medical students get pretty familiar with taking multiple-choice exams. The one and only nice thing about them is that there is always a right answer. Reflecting back on my preclinical years as they relate to my clinical years, though, I’ve realized that real patient encounters don’t always play out that way, especially when it comes to diagnostic thinking in the emergency department. At the end of three emergency medicine rotations, one of the most important lessons I’ve learned is that there is often no clear answer. In fact, the final diagnosis entered in the ED discharge paperwork is frequently a restatement of the presenting symptom.

I recall several instances when a patient presented and subsequent blood work or imaging we ordered in the ED returned negative for an obvious life-threatening etiology. I still felt an urge to make sense of the patient’s complaint and place it neatly into a diagnostic box. When this wasn’t possible, I frequently attributed the symptom to anxiety. I later realized that wasn’t quite fair or accurate. Another underlying medical etiology could exist despite a negative ED work-up, but would require more extensive outpatient follow-up to be elucidated.

If it’s difficult for health care providers to accept that we just don’t know the answer, it’s all the more difficult for the patient. It may be reassuring to hear that the ED work-up has excluded immediately life-threatening diagnoses, but often that’s not enough to placate a scared, frustrated patient.

Managing patient expectations in the emergency department, where stress and anxiety levels are unparalleled, is critically important for achieving patient satisfaction. Several patient expectations are realistic — to be listened to, to receive a clear explanation and instructions, and to be treated with compassion and professionalism. Tension arises from unrealistic expectations, which stem from the different goals between patients and staff. Emergency providers approach each encounter with the goal of stabilizing patients, excluding immediately life-threatening diagnoses, and securing an appropriate disposition. This may compete with patient goals of an immediate full work-up, definitive diagnosis, and total healing.

Identifying and managing patient expectations is important for several reasons. When expectations are not met, patients are more likely to return to the ED with the belief that they were not managed appropriately the first time, leading to increased costs and overcrowding. Patients with unmet expectations are also more likely to be noncompliant, and will quickly spread the word about their dissatisfaction with the offending provider or institution, thereby harming its reputation and ultimate financial security. Conversely, when patient expectations are appropriately managed, patient stress is reduced, trust increases, staff satisfaction and patient compliance improves, and the likelihood of malpractice lawsuits decreases.

The solution is communication. I’ve found it helpful to ask my patients up front about their expectations and goals regarding the visit. It may be difficult for patients to be forthcoming about some issues, in which case it’s important to read between the lines. I’ve also found it critical to explain the rationale for tests, and how the results will change the course and outcome of the patient’s stay. Most importantly, I’ve realized the necessity of communicating the goals of emergency department care, and clarifying with the patient that our work-up will aim to exclude life-threatening etiologies. If results return negative, we may not ultimately identify the actual diagnosis, but we can arrange the appropriate follow-up to do so and we can provide education on red flags that warrant return to the ED.

References
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