Patient-Identified Needs Related to Seeking a Diagnosis in the Emergency Department

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Study objective: Although diagnosis is a valuable tool for health care providers, and often the reason patients say they are seeking care, it may not serve the same needs for patients as for providers. The objective of this study is to explore what patients specifically want addressed when seeking a diagnosis at their emergency department (ED) visit. We propose that understanding these needs will facilitate a more patient-centered approach to acute care delivery.

Methods: This qualitative study uses semistructured telephone interviews with participants recently discharged from the ED of a large urban academic teaching hospital to explore their expectations of their ED visit and postdischarge experiences.

Results: Thirty interviews were analyzed. Many participants reported wanting a diagnosis as a primary reason for seeking emergency care. When further asked to identify the functions of a diagnosis, they described wanting an explanation for their symptoms, treatment and guidance for symptoms, and clear communication about testing, treatment, and diagnosis. For many, a diagnosis was viewed as a necessary step toward achieving these goals.

Conclusion: Although diagnosis may not be a feasible outcome of every acute care visit, addressing the needs associated with seeking a diagnosis may be achievable. Reframing acute care encounters to focus on addressing specific patient needs, and not just identifying a diagnosis, may lead to more effective transitions home and improved patient outcomes. [Ann Emerg Med. 2018;72:282-288.]

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INTRODUCTION

Background

Patients come to the emergency department (ED) because they believe it is the place where they can be assessed and treated for their symptoms most quickly.[1-6] In previous studies, patients reported expecting to receive a diagnosis as an outcome of their ED visit, and identified the desire for more answers and an explanation about the cause of their symptoms as an ongoing need after discharge.[1,3] Although all patients do receive a diagnosis on their ED discharge paperwork, the fact that patients report needing more answers and explanation at ED discharge suggests that this "administrative" discharge diagnosis is often not sufficient to fulfill their needs.

Having a diagnosis is a valuable tool for both patients and providers. Yet the meaning of a diagnosis and the roles it fulfills are likely different for patients and providers. For providers, diagnosis is a primary classification tool, giving structure for much of medical care. Administratively, diagnosis is the means for billing and charting, with every visit requiring a "diagnosis code" for billing to occur. Because reaching a pathologic diagnosis is a process that often takes more time and testing than achievable in a single visit,[7] patients may be given a "symptom-based" diagnosis as an outcome of the ED visit. This symptom-based diagnosis purposefully reflects an inconclusive evaluation, thus preventing early diagnostic closure and potentially suggesting that more testing is needed or that observation at home or in the hospital would be prudent. From the patient standpoint, however, this symptom-based diagnosis, which often simply restates the patient complaint, may not be enough.

Diagnosis has been described within a sociologic context as a sense-making tool to organize the disarray of physical dysfunction.[8-10] It is tightly linked to treatment and prognosis, providing what may feel like a "road map" for patients. Although different patients may present with similar symptoms, they may seek diagnoses to fulfill different needs. A diagnosis has the potential to legitimize a

Editor's Capsule Summary

What is already known on this topic

Although patients frequently desire a diagnosis at discharge from the emergency department (ED), those provided are often nonspecific or symptom based.

What question this study addressed

This qualitative study of 30 patients recently discharged from the ED investigated why patients seek a specific diagnosis.

What this study adds to our knowledge

What patients desire after an ED visit is varied and complex; the desire for diagnosis incorporates both social and medical needs.

How this is relevant to clinical practice

Meeting patients' needs requires an understanding of the many questions and concerns that may underlie a desire for "diagnosis." Broader understanding allows the emergency physician to better shape conversations with and discharge instructions for patients.

patient's suffering or dysfunction, and to provide access to resources such as prescriptions, sick leave, and reimbursement.[11-13] Because symptom-based diagnoses, such as chest pain or abdominal pain, are often reiterations of the symptom for which the patient presented to the ED, they may be inadequate in meeting patients' functional, emotional, or social needs related to seeking acute care. We use the social model of diagnosis as our underpinning conceptual frame.[11] This model posits that the social consequences of diagnosis feed into the need for diagnostic classification in ways that surpass the clinical necessity. With diagnosis come many services and social goods that might be available outside of the diagnostic process itself.

Importance

Minimal attention has been given to the needs patients associate with seeking a diagnosis in the acute care setting. Although all patients are provided with a discharge diagnosis on their paperwork, more than one third of ED patients are discharged without a pathologic diagnosis.[14] Considering the high number of patients who do not receive a pathologic diagnosis when they identify the need for a diagnosis as a primary reason for seeking acute care, it is important to evaluate whether what they expect from a diagnosis can be met in other ways.

Goals of This Investigation

We propose that understanding why patients seek a diagnosis will facilitate a more patient-centered approach to acute care delivery. The goal of this investigation is to explore what patients are expecting from an ED visit, particularly in relation to diagnosis. Although providers may not be able to provide patients with a pathologic diagnosis, they may still be able to meet patients' expectations if they focus on identifying and addressing diagnosis-related needs.

MATERIALS AND METHODS

Study Design and Setting

This qualitative study is part of a larger study that recruited 200 participants to test a scale measuring symptom uncertainty among patients seeking care in the ED. The study was conducted at Thomas Jefferson University Hospital, an urban academic teaching hospital that has approximately 13,000 inpatients and 63,000 ED visits annually, with an admission rate of 21%. Patients sent to the fast track area of the ED are cared for by a single provider, and patients within the rest of the ED are cared for by a team that usually includes a medical resident, an attending physician, and sometimes a student. Patients for the overall study were enrolled during an ED visit, once they were identified as ready for ED discharge. A subset of the overall enrolled population was contacted by telephone for participation in an interview, with the goal of enrolling patients 9 days after their ED discharge to inquire about their experience during and after their ED visit.[15] Patients were contacted postdischarge, as opposed to while they were still in the ED, to give opportunity for them to reflect on their needs and experiences in the days after ED discharge.

A semistructured interview guide was used for the interview, with questions focusing on participants' expectations for the ED visit and experiences postdischarge (Appendix E1, available online at http://www.annemergmed.com). The guide was refined after administration to the first 10 participants to improve clarity and to ensure that questions were broad enough to capture participants' unique experiences, including questions about their perceptions of diagnosis. All interviews were audio recorded to facilitate transcription. The interviewer was a medical anthropologist who had no relationship with enrolled patients before the telephone interview. She was not part of the team that designed the survey or implemented the overall study, although she provided input into the structure of the interview guide.