

# **Academic Emergency Medicine Editor-in-Chief Pick of the Month**

## **Precision Emergency Care**

Leaders of federal research efforts and of medical schools around the country have embraced the concept of –omic-driven precision medicine. Ostensibly, this means taking a sample of the ill human, such as cancer tissue, blood, or maybe something unusual — like breath — then analyzing the sample, and comparing the result to a database to make predictions about response to treatments. This approach, hypothetically, will foster "high value" medical care\*.

As Schoenfeld and colleagues cogently note in this month's EIC POTM: "Patients in the ED are often in a different physical and emotional condition compared to patients in an office setting, making it important to understand the unique perspectives of ED patients..." I would extend the word "office" to include any setting other than the ED in the hospital.

The ED represents the only forum — or at least the largest and broadest medical stage — where the patient has no prior relationship with the doctor. None. Zero. In almost every other setting, the patient has some choice, or direction, prior to seeing the doctor. Even with a hospitalist, another doctor refers the patient. And, the ED is the safety net.

This "different" setting provokes the obvious question of exactly what data source needs to be biopsied and analyzed to provide high-value health care. Is it blood, tissue, urine or sweat? Or, is it simply the words of the patient, but processed differently? Taking and thinking about the patient's perspective is often the only way for a doctor to make a truly informed decision. Shared decision making is personalized emergency care: the acquisition of data reflecting the ability of the patient to understand us and then act in a way that will not worsen, and might possibly improve, his or her health.

The broad term "social determinants of health" has been well diffused. In the ED, I submit that this term includes individual patient fears,

beliefs, prior education, as well as whether or not the electrical power will be turned on when the patient gets home (if the patient has a home). Nine out of 10 pulmonologists agree that the old nebulizer works better with alternating current.

Anyway, as Schoenfeld et al point out, patients have a wide spectrum of confidence in what doctors say, influenced by a wide spectrum of preexisting rational and irrational notions. In an accompanying invited commentary, Hess gently and non-judgmentally reminds us that doctors have a responsibility to consider the patient's opinions, perspectives, and intentions, no matter how rational or irrational they may be. No doctor should desire to be this provider, described by one patient participant in Schoenfeld et al: "He just has his own opinion on how everything should be, and talks over you, and doesn't care what you have to say." You know what that sounds like? That sounds like the deposition of an angry plaintiff (or family member, if the patient is dead) in a lawsuit alleging negligent medical care.

Perspective-taking requires cognitive work, and slightly more time at the bedside. But it is worth the effort. Patients want it, and doctors deserve it. I predict that the next decade will show that empathic medicine will reduce error and burnout.

*\*Favorite slide of administrators: Health care value = Quality/Cost  
Free commentary from the EIC: This "equation" may represent the worst bastardism of the science of mathematics by its unauthorized use of the equal sign. There should be a formal application process, judged by actual mathematicians, before the equal sign can be used by administrators.*

Best wishes,  
Jeffrey A. Kline, MD  
Editor-in-Chief, Academic Emergency Medicine

## **Narrative Summary**

**Zachary F. Meisel, MD, Associate Professor of Emergency Medicine at the Perelman School of Medicine at the University of Pennsylvania, places the EIC Pick into perspective in the emergency setting:**

I was recently sitting in a meeting with one of my favorite physician thinkers. We were talking about shared decision making in the ER. He said to me, "In medicine, the older I get, the more paternalistic I become." I scratched my head. After all, these words were coming from the mind of this friend who I knew to be compassionate, a great listener, exceptionally smart, and up to date with current approaches to care (including shared decision making). What was he talking about? We dug in a little deeper; we talked about decision science and some of the ways that people make decisions in predictable, but not necessarily rational, ways (see [Daniel Kahneman](#)). It turns out that my friend and colleague wasn't rejecting shared decision making per se, but he felt that we needed to know more about how it worked, when to deploy it, and how we can help patients make decisions that not only align with their stated preferences and values, but also their best interests. Schoenfeld and colleagues have helped us understand more about emergency department patients' perspectives on being part of decision making. [Their paper](#) in this month's AEM delivers some of nuanced aspects on the "how," the "why," and the "for whom" we do ED shared decision making. I am sending it to my colleague with the hope that it will start chipping away at his self-declared paternalism.