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## Rapid diagnosis

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**"T**HAT OTHER DOCTOR diagnosed me in 30 seconds. All he did was ask me to stand up and walk. I took three steps and he said, 'You have Parkinson's disease.'"

I think all doctors wonder about how we are perceived. Occasionally our patients let us know. Mostly, when they are pleased they say nice things, but sometimes the opposite happens. From time to time I hear a comment like the one above. A patient, commenting on my performing a seemingly meticulous, or at least, lengthy exam, is impressed and compares it to their previous experience, clearly indicating that a diagnosis so serious should merit more than a brief eyeballing. In my mind, though, I sometimes am thinking, why am I doing all this? This person has Parkinson's disease. I knew it as soon as I saw him. What's the point of testing strength, reflexes and a lot of other things? Then I feel guilty, being complimented for doing things that may not be completely necessary.

I always perform a complete exam at the first visit because it is important to identify all neurological problems, whether they're related to the problem for which the patient was referred or not. I assume that all doctors do this. An unexpected reflex asymmetry may point to a stroke or a peripheral nerve



problem that the patient may not be aware of. That's important in and of itself, but may also explain an atypical sign that alters the presenting features of Parkinson's disease or other movement disorder. Equally important, the complete exam establishes a baseline so a complaint down

the road, like sciatica, where an ankle reflex abnormality is found, will be verifiable as new, indicating a newly pinched nerve to go with new back pain, or old, and therefore unrelated to the new back pain.

While some patients denounce a rapid diagnosis, some embrace it. They extol the doctor who made it. "I went to three doctors who did a zillion tests and couldn't figure out what was wrong with me and Dr. X took one look at me and said, 'You have Parkinson's disease.' He was brilliant." Obviously Dr. X was a star, and the three other doctors were morons. I assume that these patients are less impressed with my exam, and may judge me a yeoman neurologist who plods along, and, having spent a lot of time and examining everything in sight, finally figures out what Dr. X observed in a glance.

How the rapid diagnosis sits with the patient depends on a lot of things. Partly it depends on what follows. If some time is taken to explain how the diagnosis

was made, what happens next, what the future will bring, some information about the disease, some indication of caring about the patient, working together for a "team" approach, the doctor enters the pantheon of the gods. If he doesn't do some more examining, and says, "Parkinson's isn't too bad. Take this medication and I'll see you in a month," the reaction is usually not so positive.

When I was in training, the chair of the department, a justifiably renowned neurologist, explained why he became an academic subspecialist. "The very first patient who came into my office clearly had Parkinson's disease. As soon as he entered the room the diagnosis was clear. I wondered what we were going to do for the next hour." He thought general clinical neurology was going to be boring because, for him, the challenge of the diagnosis was important. By becoming an academic researcher, he would see arcane, hence challenging disorders, and maintain scientific interest by trying to solve problems posed by the diseases.

Another renowned neurologist, Houston Merritt, was famous for his highly focused histories and exams. I only observed him examine a few patients and I don't recall any strokes of brilliance, but in his heyday he was known to listen to the history and physical findings of a patient who baffled the neurology house staff and attendings, ask one or two questions, tap one reflex

and make a diagnosis. One famous anecdote was of an enigmatic patient with an unknown diagnosis, in the days before angiograms and CT scans. After hearing the case, asking a question or two, he opined, "Giant basilar aneurysm." "How did you get that?" asked an incredulous neurologist. "What else could it be?" responded Merritt. I never learned if he was correct.

Clinicians are not usually impressed by rapid diagnoses because they typically represent pattern recognition, rather than problem solving. If one has seen a rash or heard a story that fits a syndrome, it is a memory feat, not a diagnostic achievement. There is an apocryphal story of an argument between two eminent clinicians in England in the days before modern imaging. The question at hand was where the brain tumor was located. The neurosurgeon, who would, of course,

decide where to focus the operation, chose one location and the neurologist a different one. When the neurosurgeon turned out to be correct, the neurologist, severely chagrined to be bested by a surgeon, said, "I should give up neurology." The neurosurgeon, responded, "On the contrary, my good man, why not take it up?" Since the clinical picture did not fit an identifiable pattern, each clinician had to summon his skills to deduce the tumor's location. It was clearly not a straightforward question. One was better at it than the other in the particular case.

I am not a fan of the rapid diagnosis, unless I'm called in to see a colleague's patient and a complete exam has already been done. Then I'll hone in on the essentials. I never provide a diagnosis until I'm finished with the exam. Sometimes, of course, I may need the help of diagnostic tests. I don't think it pays to

try to impress, and one is occasionally surprised when the detailed examination reveals a hidden disorder or the true diagnosis, perhaps masked by an abnormal facial expression or peculiar posture. I would prefer to be considered a careful rather than a brilliant clinician. ❖

#### Author

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#### Disclosures on website

## Rhode Island Medical Journal Submissions

The Rhode Island Medical Journal is a peer-reviewed, electronic, monthly publication, owned and published by the Rhode Island Medical Society for more than a century and a half. It is indexed in PubMed within 48 hours of publication. The authors or articles must be Rhode Island-based. Editors welcome submissions in the following categories:

#### CONTRIBUTIONS

Contributions report on an issue of interest to clinicians in Rhode Island. Topics include original research, treatment options, literature reviews, collaborative studies and case reports. Maximum length: 2000 words and 20 references.

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Authors submit an interesting image or series of images (up to 4), with an explanation of no more than 500 words, not including legends for the images.

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## An EPIC Adventure

KENNETH S. KORR, MD

**W**ELL, EPIC IS FINALLY HERE, AT LEAST at Lifespan hospitals. So what's the verdict on this long-anticipated, much-dreaded "enhancement" to our electronic health care system?

First, let me start with the educational process, or EPICschool. In the Lifespan System that involved at least four, four-hour group-training sessions in the months leading up to "Go Live." The first session was a nightmare; I could barely keep up with the multiple ways of accomplishing the same task... like writing a note, Smart sets, smart phrases, .dot phrases, "hover to discover," "left click to pick, right click to stick." By the end of that first session, many of us had a bad headache and the ominous sense that this was going to be painful. But by the fourth session we were getting more comfortable, working independently to set up our own note templates and increasingly more savvy in the new language of EPICspeak, or really EPICclick.

### "Go Live"

"Go Live" was another adventure in itself. I started on service for a week at the Miriam. Fortunately we had a lot of onsite trainers and EPIC Superusers – Lifespan docs, residents, nurses and other staff with advanced (ie, 2 more training sessions) skills. On the first day, I could not write a note, write an order or drop a bill without a Superuser at my side. By the end of day 2, I was working pretty independently with only

occasional reliance on the Superusers and by the end of the week I was on my own. One could begin to see the potential advantages of viewing all this data with just a few clicks. And the actual writing of the H&P or progress note actually became much easier, just pulling all the data elements together into the note template and *voilà*.

There was also a great sense of community; we were all in this struggle together and we taught each other on the fly, sharing little bits of EPIC knowledge as we learned a new skill, like importing lab data in a fishbone diagram into the note or learning to split-screen the X-ray image and view comparative images simultaneously. It was particularly helpful working with medical students and residents who are much more computer savvy. So partnering with a 20-something is a must do.

Fortunately, as an attending I was spared from writing inpatient orders, but for the residents and mid-level providers this was just another onerous task that had to be learned and struggled through. In the near future, as we get more tech savvy, customized Order Sets for specific admission diagnoses should help a lot.

### Outpatient office experience

The outpatient office experience that week and since has been slightly more challenging. Each patient visit requires a problem list, med list, allergy list, all of which need to be individually reconciled. Any test, even the routine

office visit EKG requires an order, an appropriate diagnostic indication and a reconciliation. When you multiply this to several lab tests, an echo and anything else, it's a lot of clicks. And then there are the medication orders, again diagnosis specific, number of pills/yr. refills, etc. – all with the requisite clicks.

Finally you get to the visit note, which will self-populate the meds, problem list, vital signs and labs if you have previously filled those out correctly. Then all you are left with is typing or dictating the current chief complaint and related symptoms and the conclusion. Fortunately the system works pretty well with Dragon. Once you learn the proper flow the note becomes relatively straightforward. But all of this needs to be completed before you can print the AVS (After Visit Summary) which is given to the patient. And finally you have to drop the bill and route the note to the PCP and other consultants. Pretty slick when it works well but a nightmare if you come up against a dreaded Red Hard Stop. And that's a lot to get done before you can go on to the next patient.

I actually feel pretty good about navigating through the system after the first month and am almost back to a full office panel, although it's bit of a marathon getting through an office day.

### The In Basket

The In Basket in another adventure under the heading of "Things I can do

at home” and which can be readily accessed from an iPad (which I prefer) or an iPhone (which is too small to read). Every day (even Saturday and Sunday) you can review lab and other test results, refill RXs and sign charts. Oh joy! Is this a blessing, a work efficiency or just another intrusion into my “free” time? Maybe it’s all of these. And it’s definitely taking time away from reading the other avalanche of daily information coming through my email. I’m not sure how all this will actually work out in practice. What happens when I am away? Does my In Basket come with me or do I forward it to one of my partners? Right now it seems like information overload, and much of it is redundant.

### **The Patient Portal**

Someday in the very near future, you will be able to respond to patient

messages and questions in your In Basket, through the Patient Portal. What you can’t answer you can always re-assign to someone else but that goes both ways and a lot can get re-assigned to you, too. I can almost anticipate a CME program on the medical-legal consequences of In Basket management. Right now, I am hoping this will only be for the most computer savvy patients, who fortunately are not many in the age group I care for.

So every EPIC day is another new learning experience. There is still a lot of group sharing and commiserating as we all struggle to find simple solutions to what we used to do quite simply. We are now entering the stage of Post Live sessions for Advanced Personalization and In Basket Management. These are somewhat helpful, like group therapy, with a lot of ah-ha moments: “I can do

that?” And there is still a lot of “...we don’t have a solution for that yet...” But there is hope.

So EPIC is here, and it’s doable, and certainly not the insurmountable obstacle that have led some to hang up their stethoscopes. Ultimately, I think this is going to be OK and actually quite good 1–2 years down the road. Right now, I am still struggling with how to handle the flood of information cluttering my In Basket and requiring attention. I haven’t taken EPIC on vacation yet, but that will be another story. ❖

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