markedly changed our results. Finally, we identified "confusion" by using a combination of administrative codes and the chief complaint. Although we may have underestimated rates of confusion, especially in individuals with less overt signs, we do not believe a more precise method for characterizing confusion would substantially change our central findings.

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https://doi.org/10.1016/j.annemergmed.2018.10.035

Funding and support: By *Annals* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). The authors have stated that no such relationships exist. Drs. Donnino and Moskowitz are funded by National Institutes of Health grants 5K24HL127101 and 5K23GM128005, respectively Dr. Grossestreuer is supported by a KL2/ Catalyst Medical Research Investigator Training award (an appointed KL2 award) from Harvard Catalyst, The Harvard Clinical and Translational Science Center (National Center for Research Resources and the National Center for Advancing Translational Sciences, National Institutes of Health Award KL2 TR001100).

The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

1. Patel JJ, Bergl PA, Maso K. Off the CURB and quickly onto the SOFA. *Ann Emerg Med*. 2018;73:320-321.
2. Ilg A, Moskowitz A, Konanki V, et al. Performance of the CURB-65 score in predicting critical care interventions in patients admitted with community-acquired pneumonia. *Ann Emerg Med*. 2018; https://doi.org/10.1016/j.annemergmed.2018.06.0173.
3. Singer M, Deutschman CS, Seymour CW, et al. The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3). *JAMA*. 2016;315:801-810.
4. Moskowitz A, Patel PV, Grossestreuer AV, et al. Quick Sequential Organ Failure Assessment and systemic inflammatory response syndrome criteria as predictors of critical care intervention among patients with suspected infection. *Crit Care Med*. 2017;45:1813-1819.
5. Tokioka F, Okamoto H, Yamazaki A, et al. The prognostic performance of qSOFA for community-acquired pneumonia. *J Intensive Care*. 2018;6:46.
6. Ranzani OT, Prina E, Menendez R, et al. New sepsis definition (Sepsis-3) and community-acquired pneumonia mortality. A validation and clinical decision-making study. *Am J Respir Crit Care Med*. 2017;196:1287-1297.

Diagnosing and Treating a Mindset: The Intersection Between Patient and Physician Needs

To the Editor:

It is 3 AM, and after surviving the evening influx, you settle in to begin documenting when a new patient checks in for 3 months of *X*. But why? we ask. We can weigh down this encounter with our perceptions of the patient, the diagnosis, and even the futility. This can devalue our role in the patient's care and lessen "meaning." Answering the patient's "why"—evaluating needs—could free us from these anchors.

As a practicing emergency physician responsible for the care and education of patients, as well as students and residents, I have been troubled by this issue. Gerolamo et al[1] explore the underlying patient needs driving diagnosis and care. By highlighting the intersection of a diagnostic label with psychological and sociologic factors, further significance is given to "why" but as a needed anchor to reframe motivations and deliver effective care. I argue that to answer their call, we need to transition from the fixed mindsets that accompany many encounters in the emergency department (ED).

Fixed mindsets, the chains of our anchors, set the expectations for our patient interactions. Up front, we decide that our patient has an ulterior motive, that we cannot catch a break, or that we will not find the answer. The latter leaves little room for consideration of our patient's needs, lessens motivation, and, at an extreme, lessens effort. In reality, patients see accessibility, convenience, treatment, reassurance, and limited access to other care as reasons for ED use.[1-3] Acknowledging these needs and others highlighted in the article by Gerolamo et al is taking Dweck's[4] so-called growth mindset step as a transition from a fixed outlook to a solution. Asking what both the patient and physician can learn from this experience validates our presence and changes the meaning of the why.

Just as Gerolamo et al give meaning to diagnosis, we too can give meaning to our encounter, learn from our patient, and carry this knowledge forward. With practice, this can be maintained and lessen the influence of our fixed mindset triggers. So I ask that the next time it is 3 AM and you see the patient with 3 months of *X* that you take a growth mindset step. I am going to learn something. He or she is here because I am accessible. I am an expert. I have access to services. I have a chance to provide answers. He or she is here because I provide safety. I know the system. I am efficient.

They are here because I want to know why. Please join me in meeting this challenge with an open mind and open heart.

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https://doi.org/10.1016/j.annemergmed.2018.11.002

Funding and support: By *Annals* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). The author has stated that no such relationships exist.

1. Gerolamo AM, Jutel A, Kovalsky D, et al. Patient-identified needs related to seeking a diagnosis in the emergency department. *Ann Emerg Med*. 2018;72:282-288.
2. Howard MS, Davis BA, Anderson C, et al. Patients' perspective on choosing the emergency department for nonurgent medical care: a qualitative study exploring one reason for overcrowding. *J Emerg Nurs*. 2005;3:429-435.
3. Durand A-C, Palazzolo S, Tanti-Hardouin N, et al. Nonurgent patients in emergency departments: rational or irresponsible consumers? perceptions of professionals and patients. *BMC Res Notes*. 2012;5:525.
4. Dweck C. *Mindset: The New Psychology of Success*. New York, NY: Ballantine Books; 2008.