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### Title

Author's reply to Hill-Smith

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Dr. Hill-Smith makes an excellent observation that reflects the different environments in which we work. Emergency physicians are trained to rule out the worst, before accepting a benign cause for the patient's symptoms. This is at least in part because the pre-test probability of serious illness is higher in patients attending an ED than those choosing another avenue for care. However, we did not mean to imply that all patients get extensive testing to rule out a serious cause of disease. The patient with vomiting and abdominal pain does not get CT scan for appendicitis if the history is one of diffuse crampy pain, diarrhea or multiple sick contacts, and the exam shows no focal tenderness. However, the patient's initial complaint could have been due to appendicitis and only an experienced clinician make the judgment that it is just gastroenteritis.

Studies that look at proportion of patients who are seen in the ED with "minor illness" use the discharge diagnosis to make a judgment about whether a patient's visit was appropriate. Hence the classification is made in retrospect, after an experienced clinician uses either clinical judgment or tests to make a diagnosis. A recent study in JAMA, referenced in our editorial, looked at the chief complaints of patients whose visits were later classified as "primary care treatable" based on the discharge diagnosis. The chief complaints in this group were similar to those of patients who needed immediate treatment, were admitted or went directly to the operating room. The point of our statement was simply that determining something is minor often takes some form of expert evaluation, and it is not fair (or feasible) to expect patients to be able to make this determination.