Episode: *Ethics Talk: Does Normalization of Turfing Explain Why There's No Recent Literature on It?*

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[mellow theme music]

[00:00:04] TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. When a patient is admitted to the hospital, the hope is that clinicians and health care staff are working together to find the most appropriate place for them and to find the clinicians best situated to respond to their unique health needs. Sometimes this requires being moved around. A patient initially admitted to surgery, for example, might instead find that they need medical management of certain symptoms before being well enough to receive surgery. When transfers of care are justified and are explained well, patients feel cared for and valued as members of the decision-making team. When a patient is transferred for other, perhaps less legitimate, reasons, that is when they're "turfed," patients notice.

In a study conducted by our guest on this episode, Dr Catherine Caldicott, and her coauthors Drs Kathleen Dunn and Richard Frankel, appropriately managed patients reported less conflict between themselves and their clinicians and were able to express their complaints about their care with humor and with understanding. Turfed patients, on the other hand, were, "explicit about their anger and frustration." One turfed patient reported, "I got a different story from every doctor I talked to. I can't get a straight answer from any of the doctors. It was just a nightmare from day one. This is very traumatizing for everybody."

Turfing is a problem for clinicians and patients that is caused by clinicians when organizations don't situate clinicians well to respond to the full scope of social determinants that exacerbate patients' vulnerabilities and clinical needs. One reason turfing is an ethical problem is that a turfed patient is a neglected patient. [00:02:02] A turfed patient is one who is seen as not belonging. A physician who turfs a patient is one whose moral perception expresses moral damage. Their conception of what a patient deserves from them has narrowed. And why might a physician's conception of what a patient deserves from them narrow to the point at which a physician turfs a patient? Turfing happens when clinicians don't accept the full scope of responsibility for responding with care to patients' needs. That is, to turf a patient is to pass them to colleagues in a way that is more physician-centered than it is patient-centered. A clinician might turf a patient to manage their workload or to avoid dealing with dimensions of care that they'd rather not manage, like looking after a patient's hypertension on surgical service.

There are usually structural flaws in organizations that exacerbate why some clinicians might be motivated to turf a patient, for example, who has co-morbidities that are seen as too medically complex, or a variety of surgical, behavioral, or general medical conditions that make it unclear where a patient belongs or should be placed in an organization whose units are labeled by clinical specialty and not by patient needs. In this way, ethical harm of turfing is obscured. It's an act that's motivated by clinician interests, but it's couched in patient interests.

Joining us now is Dr Catherine Caldicott, an internist and medical director for PBI Education, a provider of intensive remedial courses in ethics, professionalism, boundaries, communication, prescribing, and record keeping. She's here to discuss why turfing, despite being such a common, troublesome ethical issue, receives such little attention in the literature, how clinicians can ensure appropriate and safe transfers of care, and what health professions students and trainees can do to confront turfing when they see it. Dr Caldicott, thank you so much for being on the podcast with me. [music fades]

DR CATHERINE CALDICOTT: Oh, and thank you so much for this invitation. I'm delighted to be here today.

[00:04:07] HOFF: So, given how common turfing is, listeners might be surprised at the lack of attention it has received as an ethics problem. Very few have contributed to the literature on turfing since you have. So, why do you think that turfing gets so little attention as an issue of clinical and ethical relevance in the literature?

CALDICOTT: Honestly, I've wondered the same thing, but I can think of a couple of reasons. So, first, in my view, turfing is a phenomenon of interprofessional conflict couched in terms of patient-carer workload. It reflects individual physicians' understandings of their roles, which may be at odds with others' understandings of their roles. It is difficult and potentially threatening to study health care subcultures and stereotypes and power imbalances; however, there are other clinical and ethical aspects to turfing that warrant further study. So, when turfing occurs, it creates an inhospitable, and even in some cases, a hostile working and learning environment. It squelches effective interprofessional communication. And this is a situation where morale suffers and moral distress increases.

We do know from the literature on quality of care and patient safety that hostile working and learning environments, low morale, and moral distress have a detrimental effect on patient care and safety. So, perhaps studying turfing in that context, as others have done by studying bullying and harassment, would be a more productive way of looking at this phenomenon. So, let's say somebody wanted to study turfing in isolation and not in the context of, say, bullying and harassment. Well, who would do that study? It's unlikely that the turfers would want to study it. They rationalize that the patient is going to get better care on a different service. And even though you and I today are talking about the phenomenon of turfing, I want to make the connection to misguided reasoning in general.

[00:06:03] So, health care professionals often use misguided reasoning to justify their actions. So, the turfer's rationalization is not too different from other examples of impaired moral reasoning among clinicians. For example, in the health care professionals I teach, especially those who are mandated to take courses in professionalism, ethics, and boundaries, rationalization often gets them into trouble. They make poor judgments about what is in a patient's best interests when in reality, they are acting out of self-interest. Now, to be sure, any clinician, no matter how smart or well-meaning or well-trained or accomplished, can make mistakes and exercise poor judgment. And I don't want to come across as sounding critical of them. My job in my current role is to help them understand why and how they went off track and to de-stigmatize that remediation process.

But then if we circle back to the question of who would study turfing, how about the recipients of turfed patients? Well, I don't think they would study it either, because during the turfing experience I have seen that they adopt an ethos of trying to take the high road, appearing to be collegial and honoring the duties of their clinical specialty; however, they may also harbor negative feelings and stereotypes about the turfers. They may develop feelings of moral superiority towards them. So, even though they may be annoyed and frustrated and feel manipulated, those other attitudes may be self-serving. And we're back to the misguided reasoning that justifies attitudes and actions, which is something that can be remediated.

[00:07:45] HOFF: So, it sounds like researching this phenomenon is difficult for a variety of reasons, and that might contribute to why your work that was mentioned in the introduction is some of the most prominent in the literature, despite it being, I guess, almost 20 years old at this point. So, can you tell our listeners more about the state of the research into patient experiences of turfing, including your own work that we mentioned earlier?

CALDICOTT: I guess I'm either embarrassed or proud, I don't know, to admit the only research about it is my own with two colleagues, Kathleen Dunn and Rich Frankel. And we had semi-structured interviews. It was a qualitative analysis of patient experiences. And these were patients who had been evaluated by more than one service in the emergency department, and then we

followed to see what service they went to. And if clearly it seemed like they had been turfed from what would have seemed initially to have been the appropriate service, but turfed onto a different one, those were the patients that our research assistant interviewed. And it was really interesting that.... And then we also interviewed other patients who had been appropriately managed on the right service. And so, the patients who had been appropriately managed all had very positive things to say about their hospital experience.

The patients who fell into the turfed category, though, had a mixed bag of comments. They were able, certainly, to say some positive things about their hospital experience, but peppered in with those comments were other complaints. And they couldn't quite put their finger on what was at issue, but they sensed that something was off, and something was wrong. That, to us, was really quite striking, and again, goes to, it fits in with other studies on patient safety and patient care in that hostile learning environment, in a bullying environment where it is known that patient care does suffer because teamwork falls apart, morale is lower. And when members of teams don't talk to each other or they don't talk to consultants, that's where mistakes happen and patient satisfaction decreases.

[00:10:05] HOFF: I'm glad you mentioned patient safety since care transitions like shift changes or referrals, even when a patient isn't being inappropriately turfed, are widely documented sites of potential harm from key gaps in care continuity. So, what should clinicians who might be handing patients off or taking patients on do during these transitions to help patients feel like they belong within their care and to ensure patient safety?

CALDICOTT: I would just say talk to them, tell them your name and role in their care or the name and role of the person who'll be assuming their care. Tell them the plan for night coverage or referral care. Let them know whom they can call with questions. And write down this information, particularly if there isn't a loved one with the patient who was also listening to the conversation. And finally, don't turf this conversation to someone else on your team if you are the one the patient is expecting to hear from. Don't send the medical student or resident in when the patient is waiting to hear from or even meet the attending. Now, to be fair and practical, patients don't always understand how training programs work and how capable students and residents can be. So, then it's the attending's job to tell patients who will do what.

I think it would be helpful for teams to talk to each other as well, and not just the lowest person in the hierarchy talking to their counterpart, but multiple team members discussing patient-related goals. Here is where collegiality, respect, and civility are essential. In my current role, I teach a remedial course on civility and communication that many clinicians are mandated to take, and it is most frequently because of interprofessional conflicts. Civility doesn't mean simply being nice, it means conduct befitting a citizen. [00:11:57] And when you help people understand that they are essentially citizens of a medical enterprise, they shift their perspective about belonging and connection and shared goals and teamwork. We saw a great example of this during the height of COVID because clinicians of all stripes felt as though they were in the same boat battling a common enemy to save lives. We saw silos break down and extraordinary teamwork across disciplines, all for the good of the patients. That is an excellent example of what it means to function as a citizen of a medical enterprise. So, if institutions were to draw from those lessons of collegiality—and they would have to apply to everyone from the top to the bottom—that would decrease professional isolation and improve the professional relationships necessary for good patient care, including care transitions.

[00:12:50] HOFF: So, at this point, we've covered a bit about how clinicians and other health professionals can help facilitate good transfers of care for patients who need different kinds of management. But can patients or their loved ones do anything about turfing? I mean, your research certainly points to the fact that patients notice when they've been turfed, although I guess they might not use that term for what happened to them. But is there anything that patients can do when they find themselves being handed off between clinicians?

CALDICOTT: It is so difficult for patients and loved ones to advocate for themselves in the face of illness or hospitalization. But if a patient is not alone and has someone who can ask questions, I would encourage them to make sure that every health care professional who comes to see them identifies themselves and their role and relationship in the health care team. This is more difficult if a patient is alone and has to have the presence of mind to ask these kinds of questions when they are feeling sick. And if the patient or loved one has any questions about why, for example, they are on a medical service when they came in for a urologic problem, they should ask. It's not the patients' or families' jobs to fix this. It's up to institutional leadership to fix this through good role modeling and policy development and a culture of respect and collegiality. You asked what ordinary people should know about turfing in health care. I imagine they have some notion of what it is from TV, and I suppose patients and families should know that turfing exists, but I really don't want them to.

HOFF: Hmm. Yeah. It would be nice if turfing was only a narrative device on TV medical dramas, but as you know, it's a real problem that requires some kind of intervention. And even when patients are aware of being shuffled around vaguely, they're likely unfamiliar with the specific intricacies of hospital admissions or services or how health systems determine where and with whom patients rightfully belong.

CALDICOTT: Right.

[00:14:46] HOFF: So, whose responsibility might it reasonably be to manage appropriate transfers and then help resolve incidences of turfing when patients are unable to themselves? Is that a job for case managers? Is it perhaps a new position that needs to be developed? Help us think through this.

CALDICOTT: This might be pie in the sky, but I still think that it's an institutional leadership issue. Because if management of this phenomenon is, pardon the expression, turfed onto another party, a case manager, for example—which is a reasonable suggestion for sure—I can well imagine people creating workarounds. And still, if they really still feel motivated that they have to move patients off their service or not accept them in the first place, I still think they'd be able to accomplish it, perhaps in other ways. I really think it's more of an institutional ethos that, yes, absolutely in some cases patients need to go to services that might not seem obvious initially when they hit the door. There are very, very good medical reasons for those kinds of dispositions. But when we're talking about issues that have more to do with status and power and workload and stereotypes about other disciplines, I really feel like institutional leadership has to be very open and public about, "You know what? This is a phenomenon, this is an issue, and it's not good for patient care, it's not good for staff and team morale, and we need to fix it." And perhaps there should be some institutional policies about how dispositions are made. But I really, I really do think that it's got to be something overt that everybody hears about, everybody talks about, and everybody works on together to figure out how to solve.

HOFF: I'm glad that you are framing it that way, because currently, obviously, it is very not overt.

CALDICOTT: Mmhmm.

HOFF: In fact, it's often part of the sort of hidden curriculum that medical students receive during their training.

CALDICOTT: Yeah.

[00:17:09] HOFF: They often learn to turf from their faculty, from their mentors. So, what should health professions students and trainees do when they see turfing happening? Because they often do know what they're seeing when they see it. And what should they do when they see it happening and feel uncomfortable about it?

CALDICOTT: Yeah, that's a tough question.

HOFF: [chuckles]

CALDICOTT: That's a question that comes up time and time again about all sorts of things that trouble trainees that they observe. They're always faced with moral dilemmas that go like this: "Do I speak up for what I believe is right, or do I risk my grade or evaluation or risk how I am perceived?" So, one approach is to carefully think through the risk to the patient from whatever is occurring versus the perceived risk to yourself for speaking up. And I emphasize perceived. If a trainee believes that patient care will suffer, or even if they think it might suffer but aren't entirely sure, then that's a strong argument in favor of speaking up. But the speaking up can be done productively. A trainee could ask the faculty to help them understand their decision-making process. The approach should be, "I am a student or resident, and I'm trying to prepare myself for the future. Teach me how you made this decision to transfer." So, with a non-adversarial approach like that, the trainee might feel it is possible to ask the faculty their thoughts even about more morally laden issues such as abandonment, both abandonment of the collegial relationship that should exist between the original and receiving services, and also about patient abandonment.

[00:18:48] HOFF: So, what's the role of faculty and staff in building an environment where trainees and students feel comfortable asking these questions directly rather than having to frame their questions in a way that sort of sidesteps the potential for interpersonal conflict?

CALDICOTT: Yeah, the faculty, and I would even say, fellows, chief residents, senior residents, they all have a role in being good role models and inviting questions, creating a hospitable learning environment. There's always the power dynamic at play. You can't get around it. Even if a faculty member were to say, "Ask me anything,"—say, to students and interns, let's say—"Ask me anything. If you have a problem or a question about anything, if you see something you're not sure about, if you want to question my judgment, go right ahead," I think even though it's explicit, it's an explicit invitation, I can imagine a number of students and interns still feeling rather intimidated and shy about speaking up and asking questions. But they might not feel so shy and intimidated around a senior resident. [theme music returns] And so, if the senior resident has had good role modeling and good teaching and has trained in an environment where they felt safe to ask questions, then maybe that's a kind of trickle-down effect that would give, would encourage trainees to really speak up about things that they are hearing and observing or that they believe they're hearing and observing. They may be misunderstanding, but it's important for them to get it right.

[00:20:38] HOFF: Dr Caldicott, thank you so much for your time on the podcast today. We really appreciate your expertise on the subject.

CALDICOTT: Oh, thank you so much as well. I appreciate your questions.

HOFF: That's it for this month's episode of *Ethics Talk*. Thanks to Dr Catherine Caldicott for joining us. Music was by the Blue Dot Sessions. To read the full issue on *Belonging, Placement, and Turfing* for free, visit our site, journalofethics.org. For all of our latest news and updates, find us on Twitter and Facebook @journalofethics. And we'll be back in the New Year with an episode on *Critical Theory in Medical Education*. Talk to you then.