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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

When, If Ever, Is It Appropriate to Regard a Patient as "Too Medically Complex" for One Inpatient Service, But Not Another?

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Abstract

Patients with chronic health conditions often find their admission for orthopedic surgery from the emergency department held up due to disagreement between orthopedists and internal medicine physicians, such as hospitalists. One reason for this delay is that orthopedists must decide which patients they will admit. Although this decision is based on clinical criteria, variation in orthopedists' practices and views of a patient's condition's medical complexity is a common source of physician disagreement. This commentary on a case describes constraints on hospitalists and orthopedists, as well as other factors in patient disposition, and suggests quality improvements to admissions processes that might help mitigate the distress that patients can experience as a result of health professional disagreement.

Case

AJ is an 89-year-old man with a history of hypertension, type 2 diabetes, chronic kidney disease, and dementia who presents to the emergency department (ED) by ambulance 3 hours after a witnessed mechanical fall down 2 steps. AJ's son is bedside and states that AJ did not hit his head or suffer other injuries and is ambulatory with a cane at baseline. AJ's son also clarifies that AJ has not been able to walk since he fell. Dr ED does a thorough examination and orders appropriate imaging, which reveals a fractured left hip and no other injuries. Dr ED consults an orthopedic surgeon, Dr O, who, after reviewing AJ's case and getting consent to operate from AJ's son, agrees to repair AJ's fractured hip. "But," Dr O stipulates, "I won't admit AJ to the orthopedic service. He's too medically complex."

Dr ED then calls Dr H, the hospitalist, to admit AJ and manage his chronic comorbidities before and after the surgery. Dr H resists, however, stating that AJ is a surgical patient and therefore an inappropriate medicine admission.

Dr ED wonders what to do next and how to explain this situation to AJ's son.

Commentary

Emergency physicians (EPs) quip that patients with gastrointestinal bleeding are either not sick enough to justify endoscopy outside of usual business hours or too sick to have it done. We can never quite find the Goldilocks patient for gastroenterology. People like AJ, who live with multiple medical conditions and end up in the ED requiring surgery, often find themselves similarly stuck. What AJ and his son likely would have experienced in this situation is multiple phone calls between Dr ED and Dr O and then several more calls to Dr H. They might wonder why AJ had not been admitted yet and why Dr ED is agitated. In a busy ED, it is likely that they would have moved by now into a hallway to make room for new patients. They might ask why AJ is a "second-class" patient who seems undeserving of a room. Although relevant specialists should come together to treat AJ since he's been diagnosed with a hip fracture, Dr ED instead must mediate between specialists, manage AJ's case, and reassure AJ that appropriate care will follow soon.

In Whose Care Does This Patient Belong?

Individuals like AJ seeking medical evaluation in an ED generally want to be treated. Dr ED has done everything to identify an active diagnosis and rule out other diagnoses. A reasonable next step is *disposition*—identifying a proper admission location—so that EPs have space in which to evaluate the needs of new ED patients. To fully understand AJ's admission delay, it is helpful to first consider the surgeon's and hospitalist's perspectives.

Surgeons' competing demands. Dr O's choices are constrained by a few key factors. First, as a consultant, Dr O might be an independent contractor who consults for ED patients and therefore might be more accountable (or feel more accountable) for the efficient use of their time than do hospital employees. More specifically, time spent on contract-based hospital admission-related administrative tasks is time that Dr O is not operating and not maximizing revenue for their practice and partners. It is also time spent on tasks that some surgeons—particularly those who enjoy operating—might find unsatisfying. Second, competing demands on surgeons' time can make them harder to reach and might delay—or completely prevent—their timely arrival at an ED. An orthopedist might be operating, seeing clinic or office patients, sleeping, or consulting when called. Moreover, orthopedists might see ED patients on their own or share this responsibility with resident physicians, fellows, or mid-level clinicians, further slowing the speed with which ED patients are evaluated and admitted.

Surgeons' comfortable scope of practice. Finally, some orthopedists might not feel comfortable managing a patient's chronic conditions, since their training focuses on orthopedic conditions, not on internal medicine. The Accreditation Council for Graduate Medical Education requires only 6 months of non-orthopedic surgery rotations, of which 3 months must be in surgical specialties or intensive care.[1] This means that orthopedists will have had no more than 3 months of 5 years of residency training in nonsurgical conditions, unless they go out of their way to get it. All 3 of AJ's medical conditions—although he was stable while at home on his usual medications, diet, and circadian rhythm—could change, requiring immediate attention from a generalist.

Hospitalists' competing demands. Hospitalists are some of the busiest clinicians in a hospital, as they care for large numbers of admitted patients and might not have adequate support to safely care for all of them equitably.[2,3] Hospitalists are not necessarily trained in perioperative care and may feel ill equipped to manage surgical or

anesthetic complications of a patient like AJ. Finally, administrative burdens tend to be greater for hospitalists than for consultants; discharge planning, compliance documentation, health record management, and care coordination are time-consuming, nonclinical tasks. It might seem to Dr H as if AJ were being "dumped" by Dr ED to clear the ED or by Dr O so that they can focus on clinical tasks only. Moreover, Dr H or Dr ED might feel burnt out, as 60% of emergency physicians and 48% of internal medicine physicians experience burnout, with 60% of all physicians reporting administrative tasks as a leading cause of burnout.[4]

Complexity and Equity

In the past, care of patients admitted to a hospital for nonsurgical reasons was overseen by those patients' primary physicians, who would visit, evaluate, write orders, and regularly return.[5,6] Now, however, most hospitals admit nonsurgical patients to the care of hospitalist teams, whose clinicians are hospital employees or contractors. Such teams are safe and present around-the-clock, reduce length of stay and costs, increase adherence to evidence-based practice, and potentially improve overall quality.[7,8,9,10,11] For patients like AJ, surgeons would likely have the right of first refusal.[12] Some surgeons admit anyone on whom they intend to operate; others decline admissions they see as "too complex."

Complexity is frequently the deciding factor in the disposition of patients. But reasonable clinicians can disagree about which patients should be viewed as complex for clinical or nonclinical reasons. However, to say that a patient is too complex to treat because being in charge of that patient would be too labor intensive or administratively burdensome should probably trigger a clinical and ethical review, as bias—implicit or explicit—can influence actual and perceived care quality.[13] As a result of bias, certain immigrants or uninsured or underinsured patients might end up on a hospitalist service despite clinical indication for surgical care, while wealthier, better-insured patients might be more readily admitted for orthopedic surgical care. Ethically, more guidance is needed to promote equity in how clinical criteria are interpreted and applied to admissions decisions.

Standardization of admissions has been proposed as one way to promote objectivity and equity. Some organizations, for example, use age thresholds to determine disposition, despite the risk of tracking older patients to suboptimal care pathways.[14] Other organizations have attempted to create objective admission criteria by adopting a scoring system, such as the American Society of Anesthesiologists (ASA) Physical Status Classification System.[15,16,17] The ASA classification system is designed to assess patients' overall health status, not their medical complexity, to aid in predicting perioperative risk. However, it is unknown to what degree ASA grade correlates with factors contributing to complexity during the course of a hospital stay (eg, length of stay, adverse events).[15] Moreover, ASA scoring is itself subjective. How should a reasonable clinician compare "mild" with "severe" systemic disease, for example, as required by the scoring system?[17] Admission to orthopedics with direct hospitalist input is also used in some organizations to curb subjectivity that exacerbates turfing and inequity, but orthopedics-internal medicine co-management models may, despite the name, only serve to better define the existing division of labor between the 2 separate admitting services.[12,18]

Patient-Centered Admissions

Although there might be few significant differences in health outcomes for so-called "healthy" patients admitted from the ED to a hospital's medical or orthopedic service, there are key differences in 30-day morbidity and mortality for patients more like AJ.[15] As mentioned, we do not know how to predict which patients will be so complex as to require interventions beyond an orthopedist's comfortable scope of practice.[19] Lacking such evidence, we wonder what patient-centered—not preference- or even criteria-driven—admissions might look like in this case.

Dr ED and, ideally, Drs O and H, should make time to speak with AJ and his son. They should describe the situation with as much transparency, clarity, and precision as possible and share decision making with them. If AJ and his son are anything like the patients for whom I care daily, they want AJ out of the ED, in a hospital bed, and on his way to timely receipt of indicated surgical care. Co-management by Drs O and H might be most effective if professionally and collegially operationalized: ideally, orthopedics departments should hire hospitalists to manage patients' perioperative care needs. However, until true co-management systems can be implemented, it would be prudent to admit most, if not all, patients with comorbidities requiring inpatient orthopedic surgery to a hospitalist service.

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Editor's Note

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