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# What Should Students and Trainees Be Taught About *Turfing* and Where Patients Belong?

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**Abstract**
*Turfing* is a colloquialism that refers to what clinicians do to patients whose needs do not fit neatly and tidily into typical clinical placement protocols, especially during inpatient admissions from a hospital's emergency department. This term and this practice are both clinically and ethically problematic because a patient is rarely, if ever, "turfed" to their advantage. Ethically speaking, turfing constitutes deferral of responsibility for a patient's admission or care to colleagues. This article suggests when and under which circumstances it is clinically and ethically appropriate to defer a patient's care and suggests why turfing happens despite its negative influence on both physicians and patients.

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*"What's a TURF?" asked Potts.*
*"To TURF is to get rid of, to get off your service and onto another, or out of the House altogether."*
Samuel Shem[1]

## Emergency Medical Treatment and Labor Act and the Origins of "Turfing"

Prior to 1986, patients with emergency conditions could be turned away because they did not have insurance or ability to pay for services.[2] The federal Emergency Medical Treatment and Labor Act (EMTALA) was passed that year to increase health care access and prevent patient "dumping" based on insurance status.[2,3] The EMTALA mandate requires emergency physicians (EPs) and their institutions to evaluate and stabilize all patients regardless of their ability to pay, which commonly requires the expertise of and further care from consultants.[2,3] EMTALA was intended to create both a more equitable health system by removing systemic barriers to care and what could be called a culture of belonging by ensuring emergency care for "anyone, anytime."[3]

On occasion, a consultant may decline emergency department (ED) evaluation of a patient, admission to that consultant's service, or outpatient follow-up. Both the EP and consultant must determine if the reasons for refusal to provide care to the patient are proper and if reasonable alternatives can be put in place to ensure that the patient's

needs are met.[2] In some instances, a consultant might have less altruistic reasons to deny care or defer care to another clinician, leading to the pejorative term *turfing*, popularized in the book, *The House of God*.[1,4] Physicians, other health care professionals, and institutions are accountable for inappropriate patient routing, which could result in civil monetary penalties for hospitals or physicians, physicians being excluded from Medicare, or Centers for Medicare and Medicaid Services terminating its provider agreement with the hospital.[3] It is critical that clinicians understand the nature and scope of EMTALA-related care, their institutional policies and pathways to ensure compliance with the law, and the reasons for, implications of, and consequences of declining care. Ethically, health professionals should be concerned about turfing because it may narrow students', trainees', and clinicians' conception of what a patient deserves based on where that patient might be thought to belong, and belonging informs whom clinicians see as within the scope of their responsibility and concern.[5] This article will discuss specific circumstances wherein deferral of care to another provider is clinically and ethically appropriate and situations wherein it is not, and it will also address the reasons why turfing still occurs.

## Legitimate Reasons to Defer Care

There are many legitimate reasons a consultant may appropriately defer a request to place admission orders to someone else to best serve the interest of the patient.

*Patients require higher levels of care*. The consultants, in collaboration with the EP, might determine that a patient requires specialized services, diagnostic testing, more intensive nursing, or expertise that they and the institution are not equipped to provide. If so, it might be in the patient's best interest to be admitted to a step-down unit, intensive care unit, or other facility with the resources to properly provide care.

*Patients' insurance dictates where they can be admitted*. EMTALA prevents turfing based on a patient's inability to pay, but some insurance types require that a stable patient be transferred to a hospital within a specific health system.[6,7] Military hospitals are allowed to admit civilians in some emergency cases, but in many other instances, patients might not be eligible for care or admission.[8]

*A surgical specialist requests admission to the medicine service for surgical patients with complex medical conditions*.[9] This occurs because an on-call surgeon or surgical specialist might be in the operating room for several hours or the entire day. He or she might not be available to answer pages, evaluate patients, or enter orders. In these situations, evaluation and admission by a team (by established protocol) might decrease risk to the patient who is waiting for a surgical consult. Alternatively, some surgical patients have complex chronic conditions that are better managed by a primary care physician or a hospitalist who has more experience of and familiarity with the medications and underlying conditions. Consider a nonagenarian presenting with a hip fracture who also has several comorbidities: diabetes, renal insufficiency, and dehydration. Best practices dictate that hospitals have standing agreements among departments to expedite effective patient-centered admission processes. For example, many hospitals have created a hip service pathway for geriatric falls to expedite admission with orthopedic consultation for patients with hip fractures.

*Consultants defer admission to an outpatient setting for testing and follow-up.* Administrative costs of hospital admission are a major driver of health care system costs.[10] Hospitals are responding by expanding systems, hours, and outpatient services,

which have decreased the need for hospitalization.[11] Shared decision making with the patient, family, and EP might allow further evaluation and testing to be performed on an outpatient basis if it does not put the patient at significantly increased risk.

*Patient or consulting physician requests transfer to another facility*. A patient requiring admission might request a transfer—or a consulting or admitting clinician might urge the EP to transfer the patient—to an institution that previously provided care. This approach might be reasonable and appropriate if, as stipulated by EMTALA, the patient has been stabilized before transfer.[3] Once a patient is stabilized, the EMTALA mandate no longer applies.[3]

In most cases, the patient is best served by following up with the physician or surgeon who provided previous, related care or who performed an invasive surgery or procedure, an approach guided by the principles of beneficence, nonmaleficence, and respect for patient autonomy.[12] Surgical or procedural complications should preferably be managed by the physician who performed the procedure and who has a relationship with the patient.[12] The initial hospital will also have more familiarity with the patient and the patient's health record. It is reasonable to transfer the patient to the initial hospital, if requested by the patient, as continuity of care is an important aspect of care and might well be a legitimate reason for transfer.

## Turfing and Other Inappropriate Deferrals

Turfing could reflect concern for lower reimbursement and compensation,[4] perceived increased risk of complications, unclear policies, or work avoidance or physician burnout.

*Specialists decline consultation or admission based on anticipated loss of revenue or decreased reimbursement*. As mentioned, refusal to see or admit a patient requiring emergency care based on reimbursement factors is a violation of federal law.[2,3] Hospitals or physicians receiving an unstable patient refused by another hospital or physician can file an EMTALA complaint, which might result in a significant penalty for the originating hospital or its physicians—not only EPs but also consultants who are on call to provide services or respond to the ED—if the hospital had the capability to care for the patient.[2,3]

Despite these legal protections, inappropriate transfers (turfs) occur. Physicians are rarely held accountable for EMTALA violations. Between 2002 and 2015, only 8 civil monetary penalties were levied against physicians (4% of the total), with only 1 against an EP.[13] Furthermore, as physicians are increasingly evaluated by quality metrics, complication rates, and readmission rates, some physicians might be hesitant to admit patients known to have risk factors that could impact their care. For example, patients who have diabetes have worse cardiovascular surgical outcomes and higher rates of infection than patients without diabetes,[14] and women of color are more likely to experience perioperative complications after some routine surgeries.[15] Because it is unlawful and unethical to deny care to or turf patients based on their predicted outcome, specialties and hospitals should fight for risk adjustments to proposed quality metrics. A risk adjustment allowance would account for a higher anticipated complication rate associated with underlying disease processes and would decrease the financial risk physicians take when providing equitable care. All patients deserve high-quality care, and physicians and providers are obligated to address patients' acute needs regardless of their race, ethnicity, gender, sexual orientation, underlying risk

factors, or socioeconomic status.

*Some hospitals have unclear policies regarding the appropriate admitting service for certain patient presentations*. Patients do not always follow the textbook when presenting with an emergency condition. The patient might have more than one chief complaint or acute issue that requires admission. Fighting between services causes unnecessary delays and could worsen outcomes. The situation often results in the EP playing telephone operator and mediator among multiple consultants. This use of EPs' time might not be in the best interest of patients if care coordination delays treatment or leads to unstandardized routing of patients, exacerbating inequities of care.

Best practices encourage multidisciplinary meetings and policies that develop clear communication, proactive planning, and procedures that are mutually agreed upon between services and the ED. Common situations involving more than one service should have admission guidelines and protocols for several types of presentations:

- Trauma patients with acute conditions (eg, seizure or heart attack causing a car crash)
- Medical or pediatric patients with suicidal ideation
- Isolated fractures in geriatric, medically complex, or fragile patients
- Pregnant patients with acute surgical or other needs unrelated to pregnancy

At some institutions, a service might have multiple teams responsible for certain types of patients.[16] Cardiology, for example, might admit patients with high-risk chest pain and some congestive heart failure but may be permitted to defer some of these patients to medicine or other services if they feel the cause of the patients' symptoms is not their heart. In other instances, there might be more than one hospitalist answering pages or the patient might be assigned to a nonteaching team or service. This situation could result in delays in callbacks, as well as in information lost in an endless "game of telephone" between different physicians, none of whom is accepting responsibility for the patient.

*"Someone else will take care of it."* In some circumstances, turfing is simply a delaying tactic. By avoiding an admission, physicians tend to believe that someone else will take ownership of the patient. Best practices dictate that a department and hospital chain of command be established to help escalate resources when a consultant is unable to be reached. A time or boarding metric can be used by hospitals to alleviate the boarding burden of EDs overwhelmed with patients awaiting admission orders. The backlog of patients unnecessarily waiting in the ED might significantly limit the space for new patients to be seen. Overcrowding significantly increases length of stay in the ED, and ED boarding before transfer to an intensive care unit has resulted in significantly worse patient outcomes for both admitted and new patients.[17,18] Hospitals should have a policy in place to determine disposition in circumstances in which services do not agree on optimal management, which leads to delays in care. The hospital and health care team need to be in alignment, with processes and policies that facilitate moving patients out of the ED and into inpatient beds as quickly as possible to maintain patient flow and improve care. The patient and family, when available, should be included in shared decision making.

## Effects of Turfing

Turfing has an impact on how patients perceive their care and on how physicians deliver

care.[19,20] Some clinicians feel demoralized when they receive patients who have been "rejected" by other colleagues or for whom they are unable to provide more effective therapy than the transferring physician.[20] Respect and job satisfaction are paramount to physicians having empathy and delivering patient-centered care. Declining reimbursement and resources, misalignment of physician incentives, and increasing patient volumes contribute to physicians' sense of moral injury.[21] Turfing can cause both patients and physicians to feel unappreciated, undervalued, and powerless to control their situation or environment. Ultimately, burnout and conflicts among physicians impact the patient-physician relationship and could erode the trust and underlying ethical premises foundational to quality care and professional satisfaction.

## Conclusion

It is critical that all clinicians understand their hospital policies to ensure they are meeting the ethical and legal requirements of EMTALA. There are numerous reasons consultants may defer admission from the ED, some of which are legitimate and patient centric. However, turfing, defined as inappropriate transfers or deferral of care, threatens both physician and patient well-being and undermines physicians' ability to deliver the empathetic care that patients deserve. Creating multidisciplinary teams and solutions is a patient-centric approach to addressing these challenges that realigns patient care with incentives grounded in ethics and equity.

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