The Case of the Orphaned Patient

Case by Dr. Kaif Pardhan

Case
Dr. Kaif Pardhan

Objectives / Questions:
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Expert Commentaries
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It was midday on a Sunday at a large academic teaching and trauma center. It had been a rough night with several unstable traumas and all of the consulting surgical services were playing catch up. There were now several admitted and consulted patients boarded in the emergency department, as the hospital was at 115% capacity, a phenomenon much too common these days.

Dr. Patel, one of the emergency physicians, was only a couple hours into her shift when she overheard the orthopedics off-service junior resident – who she recognized as Jenny Wu, an emergency medicine resident currently on her ortho rotation – having a long discussion over the phone with the internal medicine senior resident. While she could only hear one side of the conversation, it appeared that a patient referred to orthopedics the previous night did not have a primary orthopedic problem and, over the past several hours, had started to clinically deteriorate. The patient was still in the emergency department and easily visible from Dr. Patel's work station. Jenny was pleading with the internal medicine team to see the patient for consideration of admission. After a long discussion, Dr. Patel watched as Jenny slammed the phone down and sighed, clearly frustrated.

"That sounded unpleasant," said Dr. Patel, fishing for the story.

"Horrible," she replied.

"What's going on?" Dr. Patel asked.

Jenny dropped into one of the nursing station chairs and the story unfolded: the patient had a recent total knee arthroplasty, and presented the previous evening with joint pain and swelling, but no fever. Orthopedics was consulted for a potentially septic knee and performed a tap, which yielded minimal fluid and a lab analysis inconsistent with a septic joint. Meanwhile, the knee remained largely unchanged, despite the patient becoming increasingly unwell. She was febrile, tachycardic and without a clear source of infection. A full workup, however, had not been performed. The senior resident and staff orthopedic surgeon were in the OR and instructed Jenny to consult the medicine service for further workup and admission. Jenny felt thoroughly out of her depth, unprepared, and unqualified to tell them that this patient does not have a surgical problem. She was also concerned that something more sinister was going on: no service was taking responsibility for this patient and her care may be compromised as a result. The internal medicine team felt that the source of infection was likely the fresh surgical joint. They agreed to add the patient to their consult list, but declined admission.

"Would you like me to call your staff or the internal medicine staff and help facilitate this?" asked Dr. Patel.

"No, no, it's my problem. I'll take care of it. Thanks for listening to my rant." replied Jenny as she picked herself back out of her chair and walked out of the department, clearly anxious and frustrated.

Questions for Discussion

1. If, after an appropriate work up, a service determines that a patient is not appropriate for admission to their team, but still requires admission to hospital, who is responsible for consulting the second service? Should this be a job for a junior resident?
2. If the patient is still in the emergency department, at what point should the emergency physician mediate between two services? Or should they at all?
3. Many hospitals have a "one way" consulting approach from the emergency department. What are the benefits and potential risks of this system?
4. How might we create the conditions for organizations to be successful when there are disagreements between services and ensure that the patient receives the best care possible?

Competencies

ACGME	CanMEDS
Professional Values (PROF1) Team Management (ICS2) Systems-Based Management (SBP2)	Professional Collaborator

Intended Objectives of Case

1. Discuss the roles of individuals, clinical groups, and leaders in determining the "Most Responsible Physician".
2. Describe your local policies and procedures for determining "clinical jurisdiction" for various disorders.
3. List specific systems that have been created to fix consultation-systems and work-flows. Identify what does and does not work within these systems.

Expert Response

Who's Patient Am I?

by Aikta Verma MD, FRCPC

Situational Awareness

This case has several facets, but the first one is not often discussed in medical education: as an Emergency Department (ED) staff, when do you decide to make something your problem? Focus is extremely important to an ED physician; interruptions are frequent and can have serious consequences (1). So, we learn to tune out most of the "white noise" around us. However, the more experienced physicians are able to identify what are actually crucial signals through all the noise of a busy ED, a skill known as situational awareness. Situational awareness means knowing what is happening around you, and understanding how those events and your actions (or inactions) will impact your objectives (2). In this case, an ED physician with high situational awareness will actually hear the conversation, and will also understand how the events (the patient disposition stagnating between orthopedics and internal medicine) and their own actions (either getting involved or not) will impact their objectives (providing high quality patient care). But this is not my patient, so not my responsibility, right?

Shared Care Models

ED patients who are referred to a consulting service but are not yet admitted can present a significant patient safety risk due to lack of clarity surrounding the Most Responsible Physician (MRP). In some institutions, these patients are considered to be the “shared responsibility” of the ED and the consulting service until they are admitted. In that interim period, the patient does not have a clearly defined MRP. Shared care can be a good thing, but it can also lead to a diffusion of responsibility, where no one person is accountable to take critical actions (3). This interim period may be quite prolonged if the first consultant does not admit the patient and become MRP, but instead refers to another consulting service, who also “shares the care” of the patient.

Returning to the case, one can predict a possible course of events. No one is taking responsibility, so the source of the fever goes undiagnosed, and untreated. Eventually, this could lead to sepsis, shock, and even death. Since the ED physician has some part of the “shared care” of this patient, at what point should she get involved? Once the blood pressure becomes low enough that the nurses override the orthopedics resident’s request to handle things on her own, and come get the ED physician? Or perhaps when a Code Blue is called overhead? Obviously, that is not the ideal time to get involved! After this happens to an ED physician once or twice, they will start to improve their situational awareness. That is, they understand that their actions (getting involved in the case early) will impact their goals and objectives (prevent a bad patient outcome) in the near future (as the patient deteriorates).

That is not to say that ED physicians should get involved with every patient and conversation around them. Focusing and minimizing interruptions are still essential skills. The key is identifying which events around us are important and why. Situational awareness can be difficult to learn, but has been described as the most important human factor in healthcare(4). A highly aware ED physician would not able to ignore the conversation presented in the case. They would recognize that this will soon be their problem, and it’s better to intervene sooner rather than later.

Second Referrals

What is the best way to help in this case? Should the ED physician take over care from orthopedics, then refer to GIM? Most organizations have a policy on second referrals for ED patients. There are two possible approaches: either the first consultant refers back to the ED who refers to the second service, or the first consultant directly refers to the next service. Most hospitals where I have worked use the latter option. It has many advantages, including minimizing the number of handovers, known to be high risk (5). It also allows the first consulting service to directly discuss their findings and rationale for wanting the second referral. The main disadvantage, however, is that the first consultant may not have the skills to manage the patient while waiting for the second consultant to take over. The first consulting service, in this case, is orthopedics. While their expertise allows to them to rule out septic joint as the cause of fever, their proficiency in working up other causes of fever is more limited. This may result in referral to the next specialist without appropriate workup and/or treatment, or without recognizing the urgency of the situation (e.g. early sepsis).

Weighing the pros and cons, I still prefer the latter option (the first consultant should refer directly to the second) with a major caveat: the ED has to be willing to step in and help as needed. Help does not mean take over care, but it does mean using our skills and expertise to help the first consultant (in this case the orthopedics resident) provide the best patient care possible. At a minimum, in this case, the ED physician should review the patient’s vital signs to see if more rapid decision making needed to happen (such as ordering blood cultures, providing

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antibiotics, etc.) If so, the ED physician should directly get involved in the patient's care, working with the orthopedics resident to ensure the patient receives the care they need, regardless of the policy about not handing back to the ED. Either she makes it her problem now, or it will be a larger issue when the patient crashes. However, if the patient was more stable, the best way the ED physician can help is to encourage the resident to move things up the chain of command. If the junior resident is not able to definitively rule out a surgical cause of fever, then that responsibility should move towards someone who can. Ultimately, the staff orthopedic surgeon and the staff internal medicine physician should discuss the patient, provide their respective expertise, and try to reach an agreement. However, it is always good to know the local hospital policy on what to do if staff consultants are still not able to reach a decision, which may be the point when the ED physician, given her skills as a generalist, should be the one to make a final binding decision.

Disagreements

Disagreements are inevitable, even when all parties have the best interests of the patient in mind. I find the best way to ensure patient safety despite these disagreements is to expect them, and to have a plan as to how to manage them. I strongly recommend that every organization brings together leaders from the ED and consulting services to create a policy regarding referrals and disagreements, which everyone can look to when patient care demands are overwhelming, and tempers are short. In my organization, there is a step wise policy on what action to take in the case of a disagreement, as well as guidelines around common referral scenarios. This (usually) prevents unnecessary time and energy with residents fighting while patients deteriorate.

Conclusion

In the ED, try to pay attention to the surrounding noise, and identify what might be a critical signal versus an unnecessary interruption. Remember that ED physicians share the responsibility for patients not yet admitted to hospital, and stop to address issues before they become critical. Plan on disagreements happening and manage them in advance with hospital-wide policies.

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About the Expert

Dr. Aikta Verma (@aiktaverma) completed both her FRCPC Emergency Medicine residency training and a Masters of Health Sciences in Health Administration at the University of Toronto. She works as an emergency physician and holds the position of Director of Clinical Operations at Sunnybrook Hospital. She is an Assistant Professor as well as the Assistant Program Director and Competence Committee Chair for the FRCPC Emergency Medicine residency training program at the University of Toronto.

Expert Response

Prioritizing Patients First

by Colm McCarthy MD, MSc, MSc-HSED (c), FRCSC (c)

The "Case of the Orphaned Patient" is a common problem seen within medicine. With more and more hospitals working over-capacity, the orphaned patient phenomenon is likely to occur with increasing frequently. [1, 2] Within orthopaedic surgery, patients often come to our service not only with a fracture but also multiple medical co-morbidities and possible underlying acute medical issues which may have precipitated the orthopaedic insult. The debate as to who should be the admitting service, or most responsible physician (MRP), has raged since the first bed shortage.

Possible root causes:

Before investigating how one can manage these bed shortage issues or orphaned patients, one should first understand why there is conflict. Over the years, the sentiment that doctors "turf" or dump patients onto one another has led to a counter-accommodating culture.[3] This sentiment perpetuates a negative stigma that discourages physicians from providing help or accepting patients. Doctors can feel undervalued and overburdened when they perceive that a patient who someone else did not feel like managing is being placed in their care unfairly. Additionally, as hospital services continue to operate over-capacity with limited resources, stress inevitably increases. This negative cultural attitude, along with a resource deficient system, can exacerbate tension within the hospital environment. Furthermore, residents and health care providers are often rotating between hospital sites which may have their own set of rules, regulations, and policies that the physicians may not understand.[2]

Management of Orphaned Patients:

The management of orphaned patients can be navigated via two paths: what should happen for the patient versus what is hospital policy. Ideally, these two paths should be merged. However, hospital policy often has difficulty providing guidance for the near infinite number of patient need combinations. As such, both paths should be navigated simultaneously before beginning to form a final patient plan. When understanding "what should happen to the patient", providers should consider: how will the patient receive the best care, who can provide this care, and what steps need to occur for this care to be provided? When considering "what is hospital policy?", providers should evaluate whether this policy will facilitate the provision of the best care or the care that the patient desperately needs.

Often, the provision of the best care of complex patients cannot be provided by a single service. Even so, a single service must take the lead and admit the patient. Sometimes the admitting service is the best service and the patient should remain under their care. Other times, the admitting service may not be the "best" service for the patient. Regardless of who is taking lead, it is mandatory that all appropriate services are at least involved in the patient's treatment team.

Communication:

Many challenges result from communication issues between health care providers. Personal factors such as fatigue, emotional state, pressure, and other extrinsic stressors can play a major role in communication errors.[2] Management of these personal considerations is vital before discussing patient plans with a colleague. Prior to discussing an orphaned patient, one should also prepare a structured discussion identifying what one wishes to achieve.[2] Another unexpected challenge is finding the correct person with whom to talk, i.e. can the person you are talking to actually make the decision you need made? Not all hospital systems allow for a resident to admit a patient and change a patient's MRP.

Find a champion:

As outlined by CanMEDS, health care providers have a duty to advocate for their patients.[2,4] If you are unable to ensure or provide appropriate care for your patient due to your seniority, experience, or any other reason, you must find someone to help champion this cause. Often, as a resident, a great deal of work can produce minimal results while a simple phone call from the senior staff will move mountains. Therefore, do not forget to go up the ladder within your discipline. Seniority has been associated with accommodation and ease of communication between groups of specialists. [3]

Summary:

Orphaned patients represent a patient who has fallen outside of hospital policy, who has a relatively unique or complex combination of co-morbidities, and/or a patient whose care has affected by a communication challenges between health care specialties. The critical concept when managing orphaned patients is to realize that most of them already have a "home" due to hospital policy. This "home" may not be an ideal one, perhaps it is a short-term foster home until an ideal one can be found. Nonetheless, while housing their patient, the MRP must continue to advocate that their patient has access to the best available care. When these orphaned patient cases arise, physician staff should report or log them for quality assurance purposes to allow for policy change in the future.

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About the Expert

Dr. Colm McCarthy (@colmjmccarthy) is a PGY 4 orthopaedic surgery resident at McMaster University. He is Currently completing his Masters in Health Science Education at McMaster concurrently with his residency. He has an interest in patient, medical student, and resident teaching as well as lower extremity reconstruction and trauma. He is passionate about patient and physician advocacy and has always strived to make learning a fun, humorous, and memorable experience.

Curated Community Commentary

By John Eicken MD, EdM

This month's MEdIC case focused on the challenges faced by a junior orthopaedic resident who was trying to transfer the care of patient still boarded in the emergency department (ED) who was becoming septic from an unclear etiology and encountering significant resistance from another consulting service regarding hospital admission for the patient. The case is confounded by the fact that the patient had recently underwent an orthopaedic surgical procedure. The evaluation performed thus far in the ED, however, does not clearly support an orthopedic etiology for the patient's deteriorating clinical status. The junior resident finds herself in the middle of a "turf war" between two consulting services who believe the other service should admit the patient; Meanwhile, the patient continues to deteriorate without proper care. With summer approaching, the quantity of responses from the ALiEM community surrounding this month's case was less than average, however, the quality of the discussion was high and we were fortunate to hear opinions from several emergency physicians as well as from providers in surgical sub-specialties.

Taking care of sick patients in the ED requires collaboration – sometimes at the patient's bedside

Glenn Posner (a provider in gynecology) and Mark Lispon (a provider in general surgery) agreed that admitting the patient to the most appropriate service for their current condition is very important. Everyone in the discussion agreed with this sentiment, including that determining the most appropriate service for a sick, undifferentiated patient, can be quite difficult. Eve Purdy (an emergency provider) highlighted the common scenario that often results from this type of situation – one where the ED physician becomes a "go-between" that requires fielding multiple phone calls from providers of different services that have not evaluated the patient in the ED. It is at this junction where the discussion blossomed into highlighting the importance of patient-centered care as a collaborative team of physicians. Mark Lipson underscored that the ED provider is the "primary point of contact" for patients in the ED and has the most comprehensive perspective for this particular patient encounter. ED physicians frequently encounter sick patients who are clinically deteriorating from unclear etiologies – it is appropriate for the ED provider to resuscitate the patient to the best of their ability while also seeking assistance from consultant providers who can potentially provide definitive care.

Contributors

Thanks to the participants (in alphabetical order) for all of their input:

Chris Cole
Lisa Calder
Mark Lipson
Glenn Posner
Eve Purdy
Graham Walker

Lisa Calder, an emergency physician, added that this is a *"challenging and all too common case where the system isn't designed for safety. Residents try and advocate for patients, as they should, but the ED attendings must be ready to mediate!"* Glenn Posner similarly noted that the responsibility of the ED provider is to advocate on behalf of the patient to the specialty he/she thinks is most appropriate to admit the patient. Mark Lipson highlighted that consultants can positively impact these types of scenarios by attempting to initiate what they think is the appropriate work up in collaboration with the ED provider as well as attempt to contact the service they think is more appropriate to admit the patient.

In this particular case it is clear that the patient needs to be admitted to the hospital – if possible, the next best step for the ED provider and the consultants is to evaluate the patient together at the bedside, review the available data, and collaborate together to determine the most effective and appropriate treatment plan and disposition.

Resident Support and Hospital Policy Can Help Facilitate

As Eve Purdy noted, the junior resident herself did not fully understand why the patient wasn't being accepted to the orthopedic service so it is not surprising that she is unable to explain the reasoning behind this decision to the medical consultant. Eve advocated that Jenny should not be expected to mediate between consulting services but should rather be focused on actively managing and caring for the patient. Similarly Mark Lipson highlighted the opportunity this scenario provides to senior residents to step in and assist Jenny given the social and political capital they have earned throughout their years of training. This role can also be filled by the supervising ED provider. The type of scenario described in this month's case has negative impacts on both ED throughput and flow (i.e. patients waiting to be seen cannot occupy the bed until the previous patient is admitted) as well as on the care that particular patient is receiving. Therefore, some hospitals have policies in place to help address the most common clinical

scenarios where the disposition for the patient is oftentimes ambiguous. These types of policies, such as the "one way consult rule" noted by Eve Purdy, remove the onerous duty of the ED provider repeatedly navigating the difficult, and time consuming, conversations required to disposition a patient between two services who do not think they are responsible for admitting the patient.

Finally, Mark Lipson and Eve Purdy discussed the importance of providers taking "ownership" and taking "charge" of patient care while ultimate disposition is determined. Without a clinical leader who is focused on resuscitating the patient in that moment then it is the patient who suffers the deleterious consequences. Mark noted the potential positive effects of hospital policies which facilitate patient transfer to a different service following initial admission to another service. Such policies can promote collaboration between services and provide expedited patient admission which can later be transferred throughout the patient's hospital course if deemed appropriate.

About

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