

## The Case Cackling Consulting Resident

### Case

Dr. Teresa Chan  
Dr. Sarah Lockett-Gatopoulos

### Objectives / Questions:

Dr. Teresa Chan

### Expert Responses

Dr. Megan Boysen-Osborn  
Dr. Dara Kass

### Curated Community Commentary

Dr. Sarah Lockett-Gatopoulos

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It was a long, busy night in the ED. Ellen was tired. The department was nearly bursting at the seams, and dispatch had called to notify her that another multi-system trauma was on the way. As the only overnight attending, she had been constantly running throughout the shift. She had just spent a half hour trying to find somewhere to discharge Mrs. Patterson, a mostly-well 83-year-old lady with early dementia. Mrs. Patterson had been dropped off at the hospital with a “positive suitcase sign” per the triage note and worsening urinary incontinence. Despite home care, Mrs. Patterson’s family just could not provide the level of support that she needed to live at home anymore. Unfortunately, they were nowhere to be found when her workup came back normal. The nurses had heard them discussing their flights to Mexico.

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*\*CRASH\**

“Everything okay?” asked Ravinder, after witnessing some significant handset-on-phone violence.

Ellen had just slammed down the phone when her colleague Ravinder

had walked by and was stopped in his tracks by the look of shock and frustration on her face. She had called the medicine service to request a social admission for Mrs. Patterson.

“No!” she replied emphatically. “But maybe I’m just tired or something. Can I run this case by you?”

“Sure.”

Ellen recounted the nuances of the case back to Ravinder, describing the various red flags for elder abuse, and how Mrs. Patterson’s family had clearly just dropped and run.

“Sounds reasonable to me,” Ravinder agreed with Ellen’s plan. “I mean, what else can you do? She needs an admission. Sure, it’s mainly for social reasons, but still...”

“I know! But I told the resident on call and she laughed at me! I couldn’t even tell her the story because she kept interrupting with laughter. She said there was no way that I should even think about admitting her. I’ve been doing this for nearly a decade and never has anyone been so rude.”

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### Questions for Discussion

1. As her colleague, what advice would you give Ellen?
2. Where should she go from here?
3. How should she respond to the resident? What is your role as an attending from a different discipline?

## Competencies

ACGME	CanMEDS
Professional Values (PROF1) Systems-Based Management (SBP2)	Professional Communicator Collaborator Manager Health Advocate

## Intended Objectives of Case

1. Discuss and identify how best to discuss issues of professionalism issues with learners in a different specialty.
2. Describe an approach for handling an unprofessional colleague.
3. List systems-based solutions to the patient-care dilemma presented in this case, and contrast with the systems level differences mentioned by other physicians in the expert responses and/or curated commentary.

## Accidents in Professionalism

by Megan Boysen-Osborn MD, MHPE

When he was teaching me how to drive, my father told me, "Every accident can be avoided." While our trauma patients might disagree, the general sentiment rings true. There are usually steps we can take to avoid accidents, even if they're not our fault. Calling for consultations and admissions in emergency medicine, like driving, is a skill. You don't think so? Just listen to a medical student-consultation interaction. Filled with extraneous information and lack of direction, the novice learner often hands the phone back to a senior resident or attending with, "They don't want to see the patient." Five minutes later, after the attending has explained the concern, the consultant agrees to come in. Maybe the attending's authority influenced the consultant, but more likely, the expert explained the clinical concern in such a manner that the consultant understood the necessity for her expertise.

The interaction between Ellen and the resident is a collision in professionalism. As emergency physicians, we play some role in the decompensated professionalism of our consultants and hospitalists. Like a car accident, there is usually something we could have done to avoid the difficult interaction.

### **Defensive Driving**

Kessler and Chan have written extensively on best practices in consultation.[1-3] These authors have focussed on two models: the five "Cs" and PIQUED. Central to both models is the core question, or the specific need for the consultation. In the case of admitting a patient, this is the need for admission. Unfortunately in America the 'social admission', by itself, is not a true indication [4] and will not be covered by Medicare.[5] Most geriatric patients who present to the ED for "social" reasons will have an acute medical condition as the cause of their decline.[6] Thus, it is essential that we perform a thorough history, physical examination, and work-up to avoid missing occult infection, myocardial infarction, or stroke. Then, if admission is necessary based on our work-up, we must emphasize the reason why the patient cannot be discharged home; even in clear-cut cases (non-surgical lower extremity fractures), however, the patient may still fail to meet inpatient criteria from a funding standpoint. [5]

In cases where no indication is found, admission is not the easy way out. Admitting Mrs. Patterson may not actually improve the departmental flow, as it takes a bed away from an at-capacity hospital and exposes a frail geriatric patient to undue risk of nosocomial infection and prolonged hospitalization. So what to do with Mrs. Patterson? If there truly is a concern for elder abuse (and abandonment is abuse [7]), the case should be reported to adult protective services (APS) or their equivalent in your jurisdiction. In an ideal world, an APS worker will be dispatched to the hospital and may be able to assist with safe placement of Mrs. Patterson.

### **Responding to the Damage**

Realizing the aforementioned caveats, Ellen's only choice may be to admit Mrs. Patterson. When calling the resident, she should expect a courteous phone conversation.[3] Even if the resident disagrees with Ellen's request, she should be collaborative, respectfully offering alternatives or additions to the current plan. Instead, she behaved unprofessionally. Professionalism missteps during training correlate with future actions by state medical boards.[8] Ellen should give feedback directly to the resident and/or to the resident's program director; for significant issues, Ellen should also use the hospital's incident reporting system. While feedback is most effective when it timely, Ellen should wait until she can provide the feedback unemotionally. Her feedback should focus on the facts of the situation—the specific actions that she found unacceptable (you know, the laughing and all).

### **References**

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### **About the Expert**

Megan Boysen Osborn is the residency program director for UC Irvine Emergency Medicine in Orange, CA. Megan did her residency at UC Irvine and an academic EM fellowship at Stanford University. She received her master's in health professions education (MHPE) at the University of Illinois, Chicago. Megan's interests are in curriculum design and residency recruitment.

# Expert Response

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## Rewarding and Frustrating

by Dara Kass MD

A shift in the emergency department can be the both extraordinarily rewarding and exceedingly frustrating. The unpredictable flow of patients and the adrenergic surge of a critical resuscitation come together to set the stage for emotional lability even amongst the most centered of clinicians. The *need* to separate our own emotional state from clinical care and professional interaction is often difficult to perceive; it is even more difficult to implement.

### Unpacking our own emotions

EM physicians must take stock of our own internal stressors when approaching a new patient or speaking with a consultant. Bad nights occur, and they almost often get worse before they end. We've all had nights like Ellen's. Maybe it starts with a socially-difficult interaction; a family member is overly-demanding, or a patient won't comply with your exam. Maybe it's your fourth chronic inebriate or homeless patient in a row, and you are frustrated by the lack of "real patients". You may not even realize your level of frustration rising, your brow furrowing, and your tone becoming terse. You are going through the motions, just waiting for your shift to end. You just know that something else is going to go wrong. And then, of course, it does. A nurse doesn't pick up an order fast enough, or a clerk forgets to page a consultant. Whatever the spark, you lose your cool.

Taking stock of our own frustrations helps us avoid situations like Ellen's. Personal awareness of physical manifestations of rising frustration may help us de-escalate early in the process. Taking a walk around the ED or getting a drink of water may provide a crucial opportunity to decompress. If a multi-system trauma was emotionally taxing, make sure debriefing with the team can provide emotional and academic closure. When the ED is busy, making a list of what really needs to get done and setting out to accomplish one goal at a time can make tasks feel more manageable

### Using our resources

Part of the Ellen's frustration seems to stem from Mrs. Patterson being 'dumped' in the ED. At the beginning of the case, Ellen had just spent 30 minutes trying to find *somewhere* to discharge Mrs. Patterson. Did Ellen have to do all that herself? Could she have used her ED resources better? Was there an ED social worker or administrator that could help her solve this non-medical

problem? As emergency physicians, we are jacks of all trades. We do what we need to in order to care for our patients. When the ED is bursting with acute trauma patients, however, it is okay to reach out and ask for help.

### Patient Safety

Regardless of any frustrations Ellen may have with her shift, it is clear that she cannot discharge Mrs. Patterson home. Mrs. Patterson's family brought her in with suitcase packed, a subtle indication that they expect her to be in the hospital for a while. The family has indicated that Mrs. Patterson needs services they can't provide at home, and have consequently made themselves unavailable during disposition planning. Atul Gawande, MD wrote eloquently about aging in his 2007 New Yorker piece "The Way We Age Now" [1]. He described the aging process through the eyes of many elderly patients. To quote one aging geriatrician, "...the process is gradual and unrelenting. We just fall apart". As elderly patients fall apart, their families become ill-equipped to meet their needs. Dementia, difficulties ambulating, and chronic illness all increase the burden on families caring for elderly relatives at home.

So, what is there to do? Mrs. Patterson is clearly not safe at home. Her primary care givers are seeking help in the only way they know how, but just because she was left at a hospital doesn't necessarily mean she has to be admitted. Can Mrs. Patterson be assessed and cleared for assisted living or some other form of social support environment? If the answer is no, she does have to stay in the hospital for her own safety.

### Patience and Conflict Resolution

As Emergency physicians, our conversations with consultants often deteriorate into "us vs them" arguments. All of our interactions *should* begin and end with common goals (the best care of our patients) and mutual respect (the best care of each other). This often does not occur. Marco and colleagues [2] addressed conflict resolution in the ED. Marco asserts that although EPs are "routinely compelled to multitask and carry heavy patient loads [as Ellen was doing in this case], consultants also suffer from taxing call schedules and workloads...sleep deprivation, stress, and perceptions of ineffectual accomplishments may contribute to difficulties in interpersonal skills and communication." She also addresses the biases inherent between individuals of

# Expert Response

different ages and perceived levels of expertise. Although not included in the article, unconscious biases regarding gender or race may permeate a heated interaction.

What should Ellen do now, and how should she respond to the resident? First, she and the resident need to establish common goals. Opening a conversation about the best way to ensure Mrs. Patterson's safety might set the tone for mutual problem solving. In fact, Ellen feels that Mrs. Patterson is not "really medically ill", but is still in need of a safe disposition; addressing this might facilitate a collegial conversation. Once things got a bit heated, Ellen began to take the resident's laughter personally. Instead, she might have redirected the conversation back to common goals. If the medicine resident felt that there was a better disposition for the patient, this would provide an opportunity for her to make suggestions. As the more experienced clinician, it is Ellen's responsibility to refocus the conversation on patient needs. The medicine resident is behaving inappropriately; reacting to that inappropriate behavior with anger and frustration, however, does nothing to further Mrs. Patterson's care.

Should Ellen address the inappropriate behavior of the medicine resident once the shift is over? Of course, she should! Ellen opened her conversation with the medicine resident full of anxiety and frustration (from her external ED stimuli); the medicine resident may have been feeling similar pressures. Post-conflict debriefing can go a long way in resolving disagreement, especially in an environment where both parties will have to work together in the future.

## References

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## About the Expert

Dara Kass (@darakass) was born and raised in Brooklyn, New York. She completed her residency training at SUNY Downstate/ Kings County Hospital and is currently the Director of Undergraduate Medical Education at NYU/ Bellevue Hospital. Her academic passions are student education and understanding and promoting programs that support the retention and advancement of women in EM. She is raising 3 children: Hannah, Charlie and Sam with the help of her non-medical husband, Michael, and the village of her own design. She is also the founding editor-in-chief of FemInEM (@FemInEMtweets), the first open access professional development resource for women in emergency medicine.

# Curated Community Commentary

By Sarah Lockett-Gatopoulos MD, FRCPC (candidate)

This week's case introduced us to Ellen, an emergency physician nearing the end of a tough shift. Hoping to have her patient, Mrs. Patterson, admitted to hospital for social reasons, Ellen speaks with the consulting medicine resident. The resident laughs her off the phone.

In discussing the case online, a few main themes arose.

There was general consensus that the consulting resident's laughter on the phone represented a lapse in professionalism. Dr. Sean Kivlehan felt that 'laughing over the phone when discussing the best care of a patient is disrespectful not just to the person calling, but to the patient and the entire profession of medicine'. He recommended immediately speaking with the resident's superiors. Dr. Dan Furmedge agreed that 'this behaviour is not acceptable' and recommended Ellen try to discuss with the resident before escalating the issue. Dr. Michelle Gibson reminded us that 'the patient must come first' and that Ellen must advocate for the best care of Mrs. Patterson. Dr. Ben Addleman, on Twitter, said that he would speak with the attending but wouldn't address the professionalism issue with the resident herself, unless he had a reason to suspect that the resident's attending would not adequately address it. Dr. Alika Lafontaine, on the other hand, advocated for a formal reprimand and mandatory professionalism course for the laughing resident.

Dr. Loice Swisher encouraged us to take a step back and consider the other medical 'tribes' in the hospital. She said, 'often we in emergency medicine feel we know what is best for the patient...; however, other tribes might have other priorities or beliefs, which are at odds'. She acknowledged that 'the different aspect here is laughter. That would be a disarming response that I suspect few have had experience with in dealing with a junior,' but goes on to point out that the resident may be punchy from lack of sleep, and not a 'certified jerk'. She reminded us to 'be curious' about why the resident acted as she did. Dr. Morton, an internist practicing in Canada, pointed out that certain consultant attendings may give their residents 'free reign' to be rude to ED staff and residents either implicitly or explicitly by reminding the resident to not accept 'dumps', or social admits.

In speaking with the resident, Dr. Muhammad reminded us that 'we should be nice to all people, and especially our colleagues...even if they are sometimes being obnoxious' but cautioned that 'we cannot continue to be nice or apologetic to people who just do not get that it is not safe for [the] patient to go home'. For those who felt that a social admission for Mrs. Patterson was justifiable (primarily those practicing outside of America), there was widespread agreement that the discussion should be escalated to the attending or higher.

## Contributors

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

Dr. Muhammad  
Loice Swisher  
Sean Kivlehan  
Dan Furmedge  
Dr. Morton  
Michelle Gibson  
Michael Farca  
Eve Purdy  
S. Lockett-Gatopoulos

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Loice Swisher (@L\_swish)  
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Casey Glass (@TheCaseyGlass)  
Ben Addleman (@addleben)  
Dan Furmedge (@danfurmedge)  
S. Lockett-Gatopoulos (@SLockettG)

Dr. Muhammad, who practices in Australia, reiterated that 'if you are genuinely convinced that [the] patient needs admission and it is not safe for the patient to be discharged back home, then one MUST escalate the matter' to either the consultant attending or higher up the ladder, to the administration. Dr. Kivlehan felt that if there were clear concerns about elder abuse, the appropriate authorities should be contacted. Were that not the case, but Mrs. Patterson was still unsafe at home, Ellen should continue to pursue admission, involving hospital administration to avoid a discharge if necessary. Dr. Furmedge, who practices in the UK, agreed that, overnight, there may be 'no other choice' but to admit Mrs. Patterson; he recommended Ellen speak with the resident's attending if the resident were not willing to see and admit the patient. Dr. Gibson, who practices in Canada, would speak directly with the resident's supervisor should she have concerns for Mrs. Patterson's welfare. Dr. Kivlehan recommends approaching the social admit honestly with the consulting physician from a perspective of collaborative problem-solving; 'it is always hard dealing with this type of admit, for people on both sides of the phone'. Dr. Morton agreed that social admits are challenging, pointing out that non-medical admissions tie up acute care beds and perpetuate the myth that internal medicine services are the dumping ground for patients that nobody wants.

Other participants, mostly those practicing in America, questioned whether a 'social admit' was justifiable. Michael Farca pointed out that, in America, " 'Social admissions' are not reimbursable." He went on to state that, "in this case, advocating for the admission is not right' and suggested delaying discharge until social work could interview the patient and develop a safe plan for discharge. Participants from outside America brought a different perspective. Dr. Muhammad, who practices in Australia, said that he would be

# Curated Community Commentary

“very surprised” if a patient who “genuinely needed an admission (like the patient in the story shared)...was declined,” and reiterated that ‘social admits’ are a very real entity in Australia. Dr. Swisher acknowledged that this reflects a difference between health care systems, responding to Dr. Muhammad that “In your country, it would seem like the registrar was an idiot [for refusing the consult and laughing, but] in my country laughing would be disrespectful but the admission refusal might be defended”. Dr. Swisher encouraged participants to consider the consulting service; perhaps it makes sense to have Mrs. Patterson stay in the ED for a while to “wait and see if the family comes back in, or if social service can work some magic”, especially as the consulting service won’t be paid for the social admission within the American system.

## About

The Medical Education In Cases (MEiC) series puts difficult medical education cases under a microscope. We pose a challenging hypothetical dilemma, moderate a discussion on potential approaches, and recruit medical education experts to provide their insights. The community comments are also similarly curated into a document for reference.

## Did you use this MEiC resource?

We would love to hear how you did. Please email [MEiC@aliem.com](mailto:MEiC@aliem.com) or tweet us @Brent\_Thoma and @TChanMD to let us know.

## Purpose

The purpose of the MEiC series is to create resources that allow you to engage in “guerrilla” faculty development – enticing and engaging individuals who might not have time to attend faculty development workshops to think about challenging cases in medical education.

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