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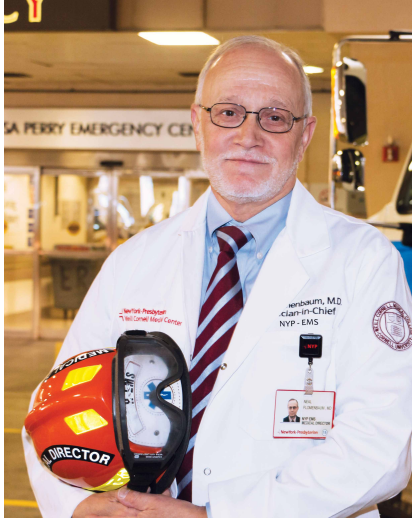
EDITORIAL

Neal Flomenbaum, MD, Editor in Chief




# Physician Communications: Avoiding the Blame Game

A recent opinion piece in *MedPage Today* by an internist about poor communications between emergency physicians (EPs) and primary care physicians (PCPs) was subtitled "We've gotten better going from office to ER, but not the other way," and complained about the lack of a "live, warm handoff" from EPs to PCPs of patients being discharged from EDs. Similar complaints were examined in two recent *Emergency Medicine* (*EM*) editorials (Anger Management, 2015;47[4]:149 and Broadside Journalism, 2015;47[6]:244). In the first, we noted that PCPs sometimes are angered when they are not consulted about one of their patients in the ED or about a treatment or disposition plan with which they disagree, while EPs are frustrated by the number of phone calls required to reach some PCPs or a knowledgeable covering physician.

Only 2 months later, we expressed concerns about a *New York Times* opinion editorial describing a young patient whose vertebral artery dissection had been "diagnosed correctly and acted on in the ED," but then angrily criticizing an initial recommendation that the patient curtail her physical activities based on what a famous neurologist considered an erroneously interpreted vascular imaging study. (Presumably, the recommendation was by another neurologist and the interpretation by a radiologist, but all of the neurologist's caustic criticism was directed at the EP and ED.) Although the neurologist subsequently apologized in a letter to his emergency medicine colleagues for "being quoted out of context," few if any *Times* readers ever learned of the "clarifications."

We concluded the second *EM* editorial with the suggestion that "all physicians must be very, very careful in framing statements to the media, and should assume that their remarks will *not* be placed 'in context' or nuanced as they may have been intended....Most important, is to not disparage entire specialties or use belittling terms such as 'ER docs'....[that] heighten...patients' fears" of being treated in EDs.

Why another editorial about physician-to-physician miscommunications and name-calling? Because patient care is significantly affected.

The Centers for Medicare and Medicaid Services originally classified four medical specialties as "primary care" for reimbursement purposes: family medicine, internal medicine, pediatrics, and obstetrics-gynecology, and the 2010 Affordable Care Act added geriatrics. Although emergency medicine had been considered initially, it has never been categorized as a primary care specialty. That being the case, isn't it incumbent upon us to learn as much as we can from PCPs about their ill patients en route to the ED for treatment or admission, and afterward ensure that an ED visit is part of a continuum of patient care and not an isolated episode?

In 1996, when I accepted an offer to become New York Presbyterian-Weill Cornell's first Emergency Physician-in-Chief, I created a new position of full-time "ED follow-up nurse practitioner" to track and report test results to discharged patients and their designated PCPs. When we added a fourth unit to the ED a few years later, I designated an experienced, senior attending EP among the four on duty as the "administrative attending" (AA) who, among other tasks, took all phone calls from PCPs about patients they were sending to the ED and entered the information in the "en route" section of our electronic tracking board. In this way, important patient information, including PCP contact information, was no longer misplaced during shift changes. The AA carried a direct-dial cell phone-like device and eventually all attending EPs and the charge nurse were equipped with such phones. In a short time, most of the communications problems and complaints about incoming patients were eliminated.

But despite numerous attempts, for the reasons mentioned above, systematically ensuring effective communications with PCPs for discharged patients has proven to be a more difficult task. At present, handing off discharged patients to PCPs still depends largely on a combination of judgment, understanding, compassion, and respect. ■

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