

Belonging, Placement, and Turfing
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AMA Journal of Ethics®

December 2023, Volume 25, Number 12: E857-860

FROM THE EDITOR

Turfing, USA

Sophia Görgens, MD

When it comes to patient placement, we often avoid explicit use of derogatory terms like *turfing* or *pawning*, which both mean that one health care team places a patient with another team rather than taking care of the patient themselves. Perhaps we often don't talk about patient placement at all because we wish to avoid our roles in its ethical troubles and because we tend to divert attention from what turfing and pawning might suggest about our characters. A literature search on patient placement will bring up few literature reviews or even policy articles about what is one of the most significant and ethically relevant problems in US health care, which will, without changes, only be exacerbated as our population ages and requires more care.^{1,2,3,4}

Turfing's ethical problems tend to be expressed as responsibility avoidance or as a failure to define a **patient's belonging** in our own professional "circle of human concern."⁵ It is systemic and can be traced throughout all veins of the US health care system. In outpatient settings, some physicians choose to refuse to see patients covered by Medicaid,^{6,7} although the Medicaid program supports graduate medical education.⁸ Additionally, as physicians become more subspecialized, a patient might be sent to multiple subspecialists, creating difficulties for patients trying to manage their multimorbidity, while their primary care physician—under billing and insurance pressures—might only have 10 minutes to try to respond to their needs or address their concerns.^{9,10}

Moreover, as the **emergency department** (ED) has become the safety net of America, it has increasingly become a site of turfing. When patients don't understand where to go, when waiting times to see a specialist are several weeks,¹¹ when their insurance is not accepted elsewhere, or when they are uninsured, patients know that they can come to the ED, where everyone will be seen.^{12,13} The accessibility of the ED, of course, creates long waiting times, even though emergency medicine physicians try their best to triage patients by the severity and urgency of their health problems. They treat what they can and refer what they can't treat to outpatient physicians, but what about the patients who have difficulty following up and who return to the ED again for the same problem?

Not every problem can be resolved in the ED or referred to outpatient follow-up, as some **patients require admission**, creating yet another moment of patient placement conflict.^{1,2,3,4} Questions such as the following are considered in this theme issue: Should a patient with a broken hip go to medicine, which must also manage perioperative care, or to orthopedics, which must also manage that patient's general medical care? Is a patient sick enough for intensive care or well enough for floors? Which team should be regarded as "in charge" of a patient and which team should be regarded as "consulting"? Conflicting views of what's best for a patient generally need to be negotiated collaboratively in order to avoid the harms of turfing and to maintain a patient's faith that their caregivers are acting together to promote the best care and to express professionalism and collegiality.

Upon discharge, all problems about where patients should be seen as belonging are not solved. In a country that seems to have a perpetual and worsening staffing shortage and therefore decreased patient capacity at nursing homes, rehabilitation facilities, and assisted living facilities, figuring out where and how to place a patient who needs extra help after discharge may be difficult.¹⁴ Some patients have to wait for days until a proper facility placement is found, and, in the meantime, they occupy hospital beds that they do not need anymore.⁴ This backup on the floors adds to the notoriety of boarding problems in EDs,^{15,16} with patients in hallway beds as they await admission to an appropriate location where they will receive indicated care.

The prevalence and problematic nature of turfing—essentially, poorly executed placement decisions—makes it a ripe topic for ethical discussion. Should physicians have the right to avoid patient care by forcefully handing over care to someone else? Should patients be seen as benefiting from being out of the care of a team that does not want them? Fighting over who "has to" take care of a patient is thus detrimental to interdisciplinary and interspecialty relationships. More generally, a negative work environment in which clinicians are overworked and lack control over aspects of their work lives can lead to increased fatigue and burnout.¹⁷ A toxic culture of classifying patients as "turfable" or undesirable is not sustainable for the well-being of either health care workers or patients.

Although entrenched practices can be hard to address or root out, turfing is long overdue for change. Change starts by clinicians and administrators having a candid discussion about turfing's **ethical and legal implications** as well as by making workplace cultural shifts (including improving interdisciplinary communication, focusing on patient-centered rather than disease-centered care, and bringing humanity into our discussions with each other and with patients) and implementing policies that could turn arguments about patient turfing into humane discussions about proper patient placement.

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Citation

AMA J Ethics. 2023;25(12):E857-860.

DOI

10.1001/amajethics.2023.857.

Conflict of Interest Disclosure

Author disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Should Physicians Be Able to Refuse to Care for Patients Insured by Medicare?

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Abstract

This commentary on a case considers whether and to what extent refusal to care for Medicare patients is a form of “turking.” Medicare is a federal program to provide insurance for people over age 65, those who have certain disabilities, and those with end-stage renal disease; eligibility criteria include contributions from wages and salaries during a patient’s working career. Although all clinicians in the United States can care for Medicare patients, some opt out, resulting in harms to eligible patients and in oversubscription of remaining clinical practices. Opting out should be reconsidered, given that resident training is supported by Medicare funding. Although patients who receive services upon engaging with a health care practice might believe that they are under the care of a clinician, any harms of administrative nonadherence to practice guidelines accrue to the clinician.

Case

JT is a 65-year-old male with a history of hypertension (HTN) who is newly enrolled in Medicare. He is generally in good health, and his HTN is well controlled on hydrochlorothiazide, which he has been on for the past 10 years. He takes no other medications. He is a retired high school history teacher and recently moved with his wife to a new neighborhood. Since A1 Primary Care Clinic is within walking distance from their home, he decides to visit in person to make an appointment with Dr N to establish care with a new primary care physician. “I’ve been fasting, so I’m ready to have blood drawn this morning.”

The office staff member responds, “Dr N does not normally take Medicare patients. Let me check with him in back.” The staff member does so and then says, “We can schedule you, and he always orders the same blood work for new patients, so we can draw your blood now.”

JT agrees, and a phlebotomist draws JT’s blood. Dr N’s office, however, never schedules JT’s clinic visit and JT’s blood sample is never sent to the lab.

Commentary

The first question to consider is whether JT and Dr N have a patient-physician relationship. In her article, “When Is a Patient-Physician Relationship Established?,” Valerie Blake argues that a “patient-physician relationship is generally formed when a physician affirmatively acts in a patient’s case by examining, diagnosing, treating, or agreeing to do so.”¹ At the initial visit to Dr N’s office, JT was not examined, diagnosed, or treated, but he was told that he needed to get blood work done as part of Dr N’s practice. This act fulfills one of the criteria of Dr N agreeing to take JT on as a patient. Thus, JT and Dr N have a patient-physician relationship.

Another question is whether it is permissible for Dr N, as JT’s physician, not to have an agreed-upon test sent to the lab. The American Medical Association (AMA) *Code of Medical Ethics* states: “The process of informed consent occurs when communication between a patient and physician results in the patient’s authorization or agreement to undergo a specific medical intervention.”² The intervention in JT’s case is pre-visit blood work. Although Dr N does not speak with JT, the clinical clerk provides a description of the testing (eg, pre-visit blood work) and a stated benefit (eg, patients need to do this before seeing Dr N, and seeing Dr N is one of JT’s goals). JT is not informed that the blood he might have drawn could be discarded rather than being tested. This omission thus constitutes a violation of the informed consent process. In addition, this omission meets the Agency for Healthcare Research and Quality (AHRQ) definition of an incident, which is “a patient safety event that reaches the patient, regardless of whether the patient was harmed” and would further be categorized as a preventable incident, as it is an error related to “monitoring ... or assessing patients.”³

Rights and Obligations

Medicare, which was signed into law in 1965,⁴ is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with end-stage renal disease.⁵ Part A covers inpatient care in hospitals and other facilities, while Part B covers physician services and outpatient care.⁵ Medicare is funded primarily by a tax on wages and salaries; citizens or permanent residents of the United States who have been employed by organizations that withhold payment of payroll taxes for at least 10 years are eligible for coverage at the age of 65.⁶ Since JT has Medicare coverage, it can be assumed that he had his wages or salary taxed in the stipulated way, and as the purpose of Medicare is to pay for health care for those aged 65 years or older, JT has a right to receive care through this funding mechanism.

One question is whether JT has a right to receive care specifically from Dr N through Medicare coverage. Medicare regulations permit clinicians to opt out of the **Medicare program**; this decision must apply to the physician’s entire practice and cannot be made on a case-by-case basis.⁷ As of 2022, fewer than 1% of physicians in the United States had elected to opt out, so these few physicians do not unduly burden the remaining physicians who do accept Medicare patients.⁸ Of note, in the case under discussion, the clinic staff member explains to JT that the physician “does not normally take Medicare patients,” which implies that Dr N is utilizing the opt-out mechanism on a case-by-case basis rather than as a rule that applies to the entire practice—in violation of Medicare regulations. Although the AMA *Code* stipulates that, unless there is a medical emergency, “physicians are not ethically required to accept all prospective patients,”⁹ it lists “limited circumstances” under which physicians may decline to accept patients, including when “meeting the medical needs of the prospective patient could seriously compromise the physician’s ability to provide the care needed by his or her other

patients.”⁹ This is the reason some physicians use to defend opting out of caring for Medicare patients. If the Medicare reimbursement rate is relatively lower than the rates of private insurers and would have the effect of limiting the ability of the practice to sustain itself, this financial shortfall could then limit the ability of the clinician to provide care to others in the patient pool. In 2012, Howrigan stated: “in some situations, Medicare pays more than 30% less for a service than the commercial insurance companies.”¹⁰ More recently, a Kaiser Family Foundation literature review based on data from 2010 to 2017 found that, on average, private insurers pay 199% of Medicare rates for hospital services and 143% of Medicare rates for physician services,¹¹ suggesting that there is a short-term and a longer-term financial cost of including Medicare patients in one’s practice. Moreover, as mentioned, the Medicare program regulations permit individual clinicians to opt out of participation, so it is permissible, on a regulatory basis, for Dr N to withhold care from the entire category of patients who want to use Medicare.

However, there is one additional aspect of Medicare obligation that should be considered. Medicare provides substantial **funding for residency programs** accredited by the Accreditation Council for Graduate Medical Education; the funding is used to cover resident stipends as well as other direct and indirect costs associated with running a residency program.¹² If the Medicare program funds the training of new physicians and if Medicare services exist to allow older patients to receive health care, a reasonable assumption is that Medicare supports physician training in the hopes that those physicians will, upon graduation, be available to care for patients covered under Medicare. This physician obligation is not explicit, but, much as medical students receive student loans to fund their undergraduate medical education and are expected to repay those loans upon graduation, graduate trainees such as residents arguably ought to be required to take Medicare patients as compensation for the funding of their further training. This obligation wouldn’t be a permanent one but could reasonably be interpreted to require that physicians accept a certain number of Medicare patients or provide care for a specific number of years for Medicare patients postgraduation. Physicians, however, might argue that hospitals that accept Medicare funding to support their residency programs are able to generate additional revenue based upon the larger workforce that now includes residents; they might argue that by allowing for this additional revenue to be generated, residents have already repaid any obligation related to Medicare funding.

Referral Duties

The AMA Code specifies that physicians must “facilitate transfer of care when appropriate” when terminating the patient-physician relationship.¹³ As stated previously, by ordering blood work for JT, Dr N initiated a patient-physician relationship, so not offering an office visit would be congruent with a termination of the relationship. Thus, Dr N should provide JT with a list of other physicians. Moreover, Dr N’s choosing to exclude patients with Medicare expresses an unwillingness to provide treatment for those patients, and, as such, Dr N has an obligation to refer JT to physicians who do accept Medicare.

Conclusion

In summary, Dr N has the right to exclude patients with Medicare insurance from their practice. However, this decision must be applied to all prospective patients equally and not deployed on a case-by-case basis. By informing JT that blood work would be ordered and by directing him to have the testing, the office assistant has established a patient-

clinician relationship between JT and Dr N. By not sending the blood specimen to the laboratory for testing, Dr N violated JT's right to informed consent; this act would also be considered a preventable safety incident by AHRQ criteria. Having chosen not to set up an appointment for JT but having already established a patient-clinician relationship, Dr N is obligated to "facilitate transfer of care" to another clinician.¹³ If Dr N and JT had not established a patient-clinician relationship, Dr N should have provided JT—as Dr N should provide all prospective patients who will not be accepted into their practice because of Medicare insurance—a list of local clinicians who do accept Medicare.

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Editor's Note

The case to which this commentary is a response was developed by the editorial staff.

Citation

AMA J Ethics. 2023;25(12):E861-865.

DOI

10.1001/amajethics.2023.861.

Conflict of Interest Disclosure

Author disclosed no conflicts of interest.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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ISSN 2376-6980

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

When and How Should Clinicians View Discharge Planning as Part of a Patient's Care Continuum?

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Abstract

Inpatient admission of unhoused patients from an emergency department is becoming more frequent. Clinicians have ethical obligations to engage early in thorough discharge planning for these vulnerable patients, as discharge to the street or even to a shelter can produce poor health outcomes. This commentary on a case considers factors that influence safe discharge planning and execution, including linkage to follow-up, patient engagement, and multidisciplinary teamwork.

Case

DP is a 52-year-old woman admitted to University Hospital (UH) for a below-the-knee amputation (BKA). DP has no known friends or relatives and came to UH from a shelter. Following a 6-day stay, DP is ready to be “discharged to home.” The case manager, GG, notes, however, that regional shelters are currently full. With Dr A, who oversaw DP's inpatient stay, GG canvasses available discharge options: UH postpones discharge and keeps DP at UH to await a shelter opening; UH rents a motel room temporarily for DP; UH discharges DP “to the streets,” knowing she will be unsheltered; or UH tries to secure a bed for DP at a regional long-term acute care hospital (LTAC) known to accept a limited number of patients with no income by making a case that proper clinical management of DP's wound site and infection risk requires regular diagnostic follow-up. GG sees no notes in DP's electronic health record that such follow-up is indicated, but because DP has diabetes that is not well controlled, GG approaches Dr A about this option.

Dr A is certainly not comfortable discharging DP to a shelter, much less to the streets, and worries that “DP will just get sick again and have to be readmitted if we pursue either of those options. I'd really just be turfing her to the future.” Dr A and GG consider their options.

Commentary

Homelessness is on the rise worldwide, with numbers in some countries increasing due to the economic strain of the COVID-19 pandemic.¹ Individuals experiencing homelessness suffer from high rates of morbidity and access preventative services at a lower rate than those who are housed.² These factors contribute to higher rates of

hospitalization for those experiencing homelessness.³ Once hospitalized, persons without stable housing experience longer lengths of stay, partly due to nonmedical discharge delays.³ Pressure to discharge those no longer in need of acute inpatient medical care can present clinicians with multiple ethical dilemmas. Here, I use the clinical case of DP to examine various factors clinicians must address to safely discharge their patients experiencing homelessness. Such planning requires early detection of patient needs, multidisciplinary teamwork, creative problem solving, emphasis on patient-centered and evidence-based decision making, and advocacy for system-wide change.

Patient Factors

The physical care of a hospitalized patient is of overt importance. In our case, DP has just undergone a BKA. Even under the best of circumstances, BKAs are associated with a high rate of readmission for stump complications, with wound infection being the leading cause. More than one third of these readmissions result in surgical revision (ie, above-the-knee amputation).⁴ Because DP does not have a stable place to live, she lacks access to routine hygiene. She may also lack the financial resources to purchase any necessary prescriptions (such as those to regulate her blood glucose), dressings, and other medical supplies. She is thereby at even greater risk of wound infection if discharged to the street. Yet delay in discharge is not without its own medical risks. If DP remains inpatient despite not needing acute care, she faces an increased risk of infection, reduction in mobility, and overall mortality.

Both options leave Dr A and GG suboptimally fulfilling their duty to uphold the principles of beneficence and nonmaleficence. Medical respite, defined as recuperative care for those who are too sick to be living on the street or in a traditional shelter but who are not ill enough to warrant inpatient hospitalization, allows clinicians a middle path between these 2 options. Medical respite care has been discussed in the US clinical literature since 2006 and has been shown to improve posthospitalization outcomes, including hospital length of stay and readmission rates, for those suffering homelessness.^{5,6} However, medical respite is not a cure-all in its current state. While respite care exists in some communities, it has yet to be widely available, as is the case for DP. Additionally, in existing medical respite facilities, there is often limited bed space, and exclusionary rules apply to certain patient behaviors, such as substance use and “challenging” behavior.^{5,7}

As respite care is not an option for DP, Dr A might try to optimize DP’s chance of healing if discharged by arranging close medical follow-up for early detection of any reversible complications. However, persons experiencing homelessness have lower rates of follow-up than those who are housed.⁸ Lack of insurance coverage has been shown to be the leading barrier to follow-up for those without fixed housing.⁹ Unemployment can exclude those suffering from homelessness from employment-based insurance offerings, and the financial burden of purchasing private insurance can be insurmountable. Insurance applications are complex, and individuals suffering from homelessness often lack the documentation needed for such applications.¹⁰ Early discharge planning during hospitalization is an excellent opportunity to employ the assistance of an insurance navigator to begin the process of **obtaining insurance**.

Yet lack of insurance is not the only barrier to patient DP’s successfully arriving at her follow-up appointment. Many individuals suffering from homelessness have low health literacy,¹¹ which impedes their understanding of the importance and logistics of follow-

up. Thus, discharge planning for DP should include education on her disease, next steps in her healing journey, and how to detect complications, as well as discussion of where and how to meet with her assigned outpatient clinician.

The location and office hours of DP's follow-up appointment may also impede her ability to attend. Transportation is an oft-cited barrier to accessing care for those without fixed housing.¹⁰ Additionally, the working poor compose a significant number of individuals experiencing homelessness.¹² Inflexible employment rules and the financial strain of taking time off work often prevent the working poor from obtaining outpatient care.¹⁰ Discharge planning should therefore involve a conversation with the patient about what is feasible. Transportation vouchers, identification of clinics with after-hours or weekend appointments, or provision of a doctor's work excuse can all go a long way to improving the patient's ability to follow up as indicated.

Another patient factor that has ethical implications in DP's discharge is her potential mistrust of clinicians and the overall health system. Patients suffering from homelessness cite fear of authority and past negative experiences with the health care system (eg, discrimination, stigmatization) as undermining of their trust.¹⁰ Patients might be hesitant to disclose their housing status, which can lead to delays in appropriate discharge planning; one study from the United Kingdom reported that early identification of inpatients' homeless status is a key element in reducing hospital length of stay.¹³ Additionally, respect for patient autonomy and optimizing quality of life underscore the need for clear lines of communication when clinicians counsel patients about all aspects of their care. Consideration of the patient's quality of life (including physical, emotional, psychological, social, and spiritual health) requires that the clinician know the patient's preferences and values. Eliciting this information requires trust. And earning patient trust takes time, particularly when patients (like those experiencing homelessness) have been marginalized by society. Yet the importance of patient engagement as a distinct mechanism in successful **discharge planning** cannot be overstated; data show that initial engagement is as important as securing housing after discharge in terms of patient outcomes.⁵

Engaging patients starts with compassionate curiosity about the patient and their context. Clinicians can use nonverbal cues, such as sitting down and putting away examination tools and cell phones, to signal both interest and respect. As stated previously, attention to the patient's level of education and health literacy can increase clear communication. Consistency and accuracy in informing the patient of clinical aspects of care (timing of rounds, blood draws, and other diagnostic testing) can imbue a greater sense of safety. A basic social history taken at admission can be built upon in subsequent conversations to include much more than housing details and next of kin, such as sources of support and joy, faith-based or spiritual beliefs, and social or cultural identity. Open-ended questions, such as "How would you describe yourself?" or "Can you tell me a bit about your spiritual beliefs?" can help clinicians elicit a wider view of the patient's inner world.

At times, patient preferences regarding discharge may contradict the advice of the medical team, as when patients opt for premature discharge (ie, leaving against medical advice).⁵ The same challenge is faced in medical respite centers, where up to a third of patients depart prematurely.⁵ Often, premature discharge stems from unmet patient needs. Tri-morbidity—co-occurring medical, mental, and substance use disorders—is common in persons with homelessness; one study showed that 48% of patients without

fixed housing suffered from substance misuse, 33% from mental illness, and 17% from a dual diagnosis.¹⁴ These conditions are also associated with greater risk of readmission after hospital discharge¹¹ and should be screened for and addressed during inpatient hospitalization and as an integral part of discharge planning.

When weighing patient requests, particularly those that appear to be against the patient's best interest, the patient's decision-making capacity must be evaluated. Generally, capacity is assumed to be present, and a formal evaluation is not necessary. However, capacity might be diminished in patients with cognitive problems, including those with mental illness. Nevertheless, clinicians must guard against societal stigma and unconscious bias against those with housing insecurity, as bias may influence capacity assessments. When patients experiencing homelessness are deemed incapable of decision making, finding a surrogate may be challenging. Like DP, many patients do not identify any next of kin or friends who can assist with their care.

Clinician Factors

Moral distress is defined as the negative feeling state experienced when a person "knows the morally correct action to take but is constrained in some way from taking this action."¹⁵ Dr A's moral distress is apparent as he considers the ethical conundrum of discharging patient DP. In general, health care practitioners cite feeling overwhelmed when facing the unmet health needs of those without stable housing.¹⁰ Often contributing to clinicians' sense of helplessness is a lack of knowledge of local resources and a feeling of reaching beyond their scope of practice when addressing the financial and housing difficulties of their patients. Although not widely available, specialist services dedicated to navigating the discharge plans of patients without fixed housing might mitigate clinician moral distress. Such initiatives recognize the need for discharge planning to begin at admission for those who suffer from homelessness and typically employ clinical case managers to engage those patients and to coordinate postdischarge disposition and follow-up care.¹³ These initiatives can improve patient outcomes, including quality of life.² If such specialist services are not available, collaborating with members of a multidisciplinary group with expertise in health, housing, and social work might help clinicians optimize discharge planning.⁵ In order to ensure flow of referrals and ease of communication, clinicians might invite the multidisciplinary team to participate in rounds.⁵

Unconscious bias against persons suffering from homelessness is another clinician factor that might have ethical implications for patient discharge planning. A perceived or real cultural difference between clinician and patient can lead to the clinician's avoidance of the patient and to both parties' suboptimal engagement.⁵ Clinicians' assumptions about patients' substance use, mental illness, or volition to engage in healthy behaviors can lead to suboptimal medical care and compromise respect for patient autonomy and patient engagement in decision making. Clinicians should strive to improve their knowledge of—and obtain training in working with—populations suffering from homelessness. Clinicians can then use their position as leaders to champion improvements in caring for those without fixed housing. Clinician familiarity with the needs of such patients might partially explain why patients suffering from homelessness treated at hospitals serving greater number of such patients have lower rates of readmissions.¹¹

Health Systems Factors

Hospital-centered care emphasizes the financial interests of health care institutions, including UH and LTAC, as mentioned in DP's case, rather than the interests of DP and other individuals experiencing homelessness. Increasing pressure to shorten length of stay can lead clinicians like Dr A to discharge patients with alacrity despite their being unhoused and at risk for adverse medical outcomes. Likewise, an institution's concern about scarcity of resources (such as inpatient and LTAC beds) may impact discharge plans when medical requirements for an individual's acute care are no longer met, regardless of potential for harm once a patient is discharged. Health care organizations' emphasis on **financial interests** engenders a limited framework with acute discharge as the main goal and thus reinforces discharge to street or shelter as the standard of care. Discharge planning offers a unique opportunity to address larger patient life outcomes (such as employment, education, self-care) that may lead to housing and health.

Focus on acute inpatient discharge also makes an arbitrary distinction between inpatient and outpatient care. The American Medical Association Council on Ethical and Judicial Affairs states that the care of the physician extends beyond acute inpatient care, such that a physician "should not discharge a patient to an environment in which the patient's health could reasonably be expected to deteriorate due solely to inadequate resources at the intended destination."¹⁶ Increasingly, legislation supports this sentiment. For example, California's 2019 Senate Bill 1152 states that hospitals are required to discharge patients experiencing homelessness to a social service agency or provider, a dwelling designated as the patient's residence, or another location designated by the patient.¹⁷ The bill further states that hospitals must provide transportation, medication, and follow-up care for all such patients at discharge.¹⁶

Despite consensus statements and legislation backing improved discharge planning for those suffering from homelessness, a lack of allocated resources can prevent such plans from being realized due to limited ability to meet an optimum timeframe in transition of care and to fully address rehabilitative and resettlement goals.⁵

Tackling systemic problems can be a daunting task for clinicians. Clinicians might choose to lead research initiatives on the care of individuals suffering from homelessness. This endeavor is of particular importance, given the relative dearth of data on discharge planning for people experiencing homelessness.⁷ In addition, clinicians can advocate for individual patients without fixed housing or advocate for such patients on a larger stage.

Conclusion

Safe discharge after acute medical hospitalization of patients suffering from homelessness presents an ethical dilemma when alternatives to street or shelter are unavailable. While keeping such patients in the hospital for subacute care may seem in their best interests, prolonged hospital stay is associated with its own risks of harm. Discharge planning in such circumstances is complex and involves consideration of various patient, clinician, and systems factors. Although the current hospital-centered framework emphasizes acute patient discharge when patients are medically stable as the ultimate goal, there are many opportunities for clinicians working in the inpatient setting to alleviate moral distress and focus on patient-centered care.

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Editor's Note

The case to which this commentary is a response was developed by the editorial staff.

Citation

AMA J Ethics. 2023;25(12):E866-872.

DOI

10.1001/amajethics.2023.866.

Conflict of Interest Disclosure

Author disclosed no conflicts of interest.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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?

David Marcus, MD, HEC-C

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

The case to which this commentary is a response was developed by the editorial staff.

Citation

AMA J Ethics. 2023;25(12):E873-877.

DOI

10.1001/amajethics.2023.873.

Conflict of Interest Disclosure

Author disclosed no conflicts of interest.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE**How Should Technology-Dependent Patients' Care Be Managed Collaboratively to Avoid Turfing?**

Emma Cooke, MD, MA and Holland Kaplan, MD, HEC-C

Abstract

Technology-dependent patients require interventions (eg, tracheostomies, gastrostomy tubes, or total parenteral nutrition) to survive. Such patients are commonly “turfed” between general services or from subspecialty to general services within the hospital. This case commentary proposes several explanations for why technology-dependent patients are particularly susceptible to turfing, including clinicians’ lack of familiarity with managing patients’ technology, bias and ableism, and quality-of-life quandaries. It also addresses ways to combat turfing of technology-dependent patients and proposes educational strategies for managing common problems in the care of technology-dependent patients.

Case

JJ, a 7-year-old with a history of cerebral palsy, epilepsy, global developmental delay, and gastrostomy tube dependence, is seen in plastic surgery clinic for a chronic decubitus ulcer. Although JJ is clinically stable, the surgeon, Dr S, determines that, since JJ’s ulcer is worsening, JJ should be admitted for wound care and surgical debridement. Plastic surgery team members are not comfortable managing JJ’s general medical and equipment needs and request that JJ be admitted to a general pediatric service, led by Dr P. Dr P considers whether the pediatric team should manage JJ’s perioperative care or whether the plastic surgery team should take primary responsibility for the patient. Dr P considers how to respond to Dr S.

Commentary

“Turfing” occurs when patients are transferred for nonmedical reasons to an inpatient service that will not address their primary reason for admission. To date, no studies that we know of have specifically identified risk factors for turfing; in our experience, patients with **medical complexity** and technology dependence often appear to be at greater risk. When care of a particular patient becomes challenging in one of a variety of ways, the patient might be turfed, an experience that can harm the therapeutic alliance between patients, families, and medical teams.¹ Turfing might thus be framed as a morally and ethically problematic abdication of responsibility by the turfing team; however, one might also argue that patients with medical complexity *should* be transferred to the service

most experienced in caring for this patient population. In a case like JJ's, what criteria should we use to determine the appropriateness of a transfer? In this article, we define *technology dependence*, propose why technology-dependent patients might be particularly susceptible to turfing, and provide recommendations on how to meet clinically complex patients' needs in ways that are caring and robustly responsive to their unique vulnerabilities.

Characterizing Technology Dependence

The term *technology dependence* was first used in the 1980s to describe a growing population of children with previously life-limiting conditions whose survival was due to new technological innovations. A 1987 report identified technology dependence in children according to these criteria: ventilator dependence, total parenteral nutrition dependence, and any other device-based support of vital functions (eg, tracheostomy, gastrostomy tube, home oxygen, colostomy, dialysis).² Since then, these interventions have become widespread in the care of both children and adults. In 2005, 20% of pediatric inpatients at one regional tertiary care hospital were dependent on at least one medical device.³ Based on data from the Eurovent survey, one study estimated that 20 377 adults and children in the United States in 2010 required long-term ventilator use.⁴ In 2008, it was reported that 46 510 tracheostomies were placed in adults and children in the United States.⁵ Gastrostomy tubes are even more common, with an estimated 437 882 Medicare patients in the United States relying on them for enteral nutrition in 2013.⁶ While it is difficult to characterize the population of technology-dependent adult inpatients since the term *technology dependence* is primarily used in pediatric populations, it has been shown that, for example, adult patients with recent tracheostomy placement are frequently hospitalized and have poor clinical outcomes.⁷

Despite the growing prevalence of technology-dependent patients, many clinicians are uncomfortable caring for this population. Pediatricians often feel they have limited training in the management of gastrostomy tubes, tracheostomies, and other technologies; consequently, managing patients with these devices can provoke anxiety.^{8,9} Emergency medicine residents likewise express a lack of confidence in caring for technology-dependent patients.¹⁰ Tracheostomy management skills do not significantly improve during internal medicine residency, indicating that these skills are either not included in internal medicine curricula or are not mastered during training.¹¹ These findings raise concerns that clinicians in the primary services to which technology-dependent patients might be transferred are themselves not comfortable with the management of the technologies required by these complex patients.

Proposed Explanations for Turfing Technology-Dependent Patients

In our experience, it is not uncommon for technology-dependent patients to be admitted or transferred to the pediatric, internal medicine, or general surgery services regardless of their reason for admission. We have observed that this practice is sometimes based on the rationale, whether or not justified, that subspecialty services lack the expertise to manage these patients' complex medical and technological needs. Technology-dependent patients also acquire an "undesirable" status likely due, at least in part, to clinicians' sense of inadequate proficiency.⁸ Consequently, we have noted that the admission of technology-dependent patients to primary medical, pediatric, or surgical services can be a source of resentment for members of the primary service, particularly if team members feel that they are not providing any specialized care.¹² To subspecialty teams, these complex patients fall within the purview of general medical, pediatric, or surgical services. To general services, a sense remains that someone else must have

greater expertise—whether or not this is actually the case. Here, we discuss 4 reasons why clinicians might turf technology-dependent patients.

As mentioned, some clinicians might hesitate to take primary responsibility in caring for technology-dependent patients because of a sense of clinical unfamiliarity. A 2021 survey found that only 41% of physicians feel “very confident” in their ability to provide equal care to patients with disabilities, a category to which technology-dependent patients often belong, and only 57% “strongly” welcomed patients with disabilities in their practices.¹³ Only a few residency programs have published formal curricula that cover patients who are disabled or technology-dependent,¹⁴ suggesting a larger institutional deprioritization of this population. On the other hand, some clinicians’ unwillingness to care for technology-dependent patients may be simply a recognition of their limitations, particularly if they practice in a specialty or geographic area where these patients are uncommon. For example, technology-dependent patients and their caregivers tend to seek treatment in urban areas with specialized hospitals,¹⁵ which may improve some patient outcomes. However, this tendency also means that clinicians in less specialized centers rarely see these patients, creating a feedback loop that further concentrates expertise in urban areas.^{15,16}

Unconscious clinician bias and **ableism** may also contribute to turfing of technology-dependent patients. It is important to note that many patients with technology dependence also have physical or cognitive disabilities, which may lead to their being stigmatized by clinicians. Physicians as a group are overwhelmingly non-disabled, with an estimated 3.1% of physicians and 4.6% of medical students in 2019 identifying as disabled,^{17,18} compared to 26.8% so identifying in the general population.^{19,20} Physicians’ lack of personal familiarity with disability may lead to their underestimating the quality of life of people with disabilities: 82% of physicians believe that people with disabilities have a lower quality of life than those without disabilities despite this belief being unsubstantiated¹³ (ie, the so-called “disability paradox”²¹). Physician ableism is likely exacerbated by the medical training process, which emphasizes intellectual ability (to succeed in college and medical school) and physical resilience (to cope with long shifts and frequent sleep deprivation). After progressing through a pipeline that prioritizes these qualities, physicians may consciously or unconsciously adopt a mental model that devalues individuals with physical or cognitive disabilities.

Clinicians’ professional priorities can also play a role in stigmatizing technology-dependent patients. Clinicians may aspire to discharge patients with their medical problems “cured” or definitively treated—a goal that is rarely feasible in technology-dependent patients with multiple, chronic conditions. In situations in which a cure is clearly impossible, clinicians have been demonstrated to manage their own feelings of inadequacy or helplessness by mentally, physically, or emotionally distancing themselves from the patient.²² Subspecialty teams might engage in physical distancing by turfing the patient to another service; primary teams might engage in metaphorical distancing, manifested as resentment toward the patient or the turfing team or disengagement from the patient’s care. As a result, patients might perceive a signal of “unwantedness” that can harm the therapeutic alliance.¹

Finally, clinicians caring for technology-dependent patients may have concerns about patients’ quality of life and medical futility. Long-term, life-sustaining interventions, such as home ventilation, have become more widely available, so patients previously deemed ineligible for these technologies due to poor prognosis may now be offered these

treatments. However, some clinicians have expressed concern that offering certain pediatric patients long-term home ventilation is “pushing the ethics limits.”²³ Such concerns may be rooted in the perception that the harms of ongoing medical technology use—frequent hospitalizations, additional medical procedures, increased infection risk—outweigh the benefits. Clinicians obligated to provide such interventions despite these concerns might experience moral distress, particularly if they feel that the intervention causes suffering or that the patient is unable to give consent.²⁴ In the face of morally distressing circumstances that clinicians cannot change, clinicians might, as described above, attempt to avoid the patient or disengage emotionally from the patient’s care.²² Turfing can thus function as a mechanism through which some clinicians attempt to avoid **moral distress** or uncertainty—regardless of whether clinicians are aware of their intentions.

Recommendations

At the institutional level, additional training in technology-dependent patients’ unique needs is a necessary first step in mitigating turfing and improving care for this patient population. If all medical trainees—not just those in primary medical specialties like internal medicine, pediatrics, and general surgery—receive practical education in managing common technology-related problems, subspecialty services might feel more ready to take on primary responsibility for technology-dependent patients. It is important to note that some technologies are more common and easier to maintain, while others are complex and might require additional technical or clinical expertise.

Education can also be beneficial in addressing stigma, which could stem from the perception of technology-dependent patients as “high maintenance,” given that they often have a high level of case management and psychosocial needs.⁸ Following the lead of diversity, equity, and inclusion initiatives addressing other forms of discrimination in medicine,²⁰ efforts to admit larger proportions of disabled medical trainees may (among other benefits) weaken ableist norms and beliefs in the clinician workforce. Additionally, programs that facilitate relationships between technology-dependent individuals, caregivers, and clinicians outside the hospital could help counterbalance the view of technology dependence as synonymous with illness and misery. These initiatives should be implemented throughout the continuum of clinical training and practice. Social workers specializing in medically complex patients could also help mitigate the demands that patients’ psychosocial needs can place on clinicians. However, clinicians attempting to offload technology-dependent patients’ case management needs via turfing must maintain awareness that managing these needs is not solely the province of “generalist” services.

Conclusion

It is incumbent on all clinicians who allocate responsibility for the care of technology-dependent patients to recognize the medical profession’s role in creating this patient group and thus the obligation to care for this group. There is no easy answer for services faced with the complex decision of whether to transfer a technology-dependent patient to a different service. Even with improved educational initiatives and reduced stigma, patient complexity and clinicians’ level of comfort in caring for technology-dependent patients will vary. However, a label of “medically complex” or “technology-dependent” should not mandate that a patient be placed on a general service if another service is better equipped to address that patient’s primary reason for admission. Subspecialty services needing additional support in managing technology-dependent patients’ chronic complex medical needs can work together with general medicine consult

services—or, in academic pediatric centers, the new field of complex care medicine²⁵—while still retaining these patients on their primary service. Most importantly, the choice of a patient’s primary service should reflect the most pertinent needs of that specific patient, at that specific time.

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Citation

AMA J Ethics. 2023;25(12):E878-884.

DOI

10.1001/amajethics.2023.878.

Conflict of Interest Disclosure

Authors disclosed no conflicts of interest.

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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

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

Gillian R. Schmitz, MD and Robert W. Strauss, MD

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 Shem¹

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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Citation

AMA J Ethics. 2023;25(12):E885-891.

DOI

10.1001/amajethics.2023.885.

Conflict of Interest Disclosure

Authors disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

HEALTH LAW: PEER-REVIEWED ARTICLE

Why Should Physicians Care About What Law Says About Turfing and Dumping Patients?

Makenzie Doubek and Scott J. Schweikart, JD, MBE

Abstract

When a physician refers a patient for a nonclinical reason, that patient has been “turfed.” There are numerous reasons why turfing is clinically, legally, and ethically problematic; a main one is that the practice is physician centered and does not serve or center the best interests of patients. Legally, turfing patients is distinct from dumping patients: there are no civil or criminal laws regulating turfing, unlike dumping. Clinically and ethically, however, both turfing and dumping are poor practice, express poor character, and damage patient-physician and interprofessional relationships. This manuscript canvasses clinical, legal, and ethical dimensions of turfing and dumping that deserve investigation.

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Patient Dumping vs Patient Turfing

Physicians and hospitals sometimes desire to transfer or rid themselves of certain patients who, for various reasons, are deemed troublesome or undesirable. These transfer practices are known as “turfing” or “dumping,” and they are frequently scrutinized, as such practices are traditionally at odds with ethical fundamentals of the medical profession, which centers caring for patients and putting their best interests first. Understanding the differences between patient turfing and patient dumping can help illuminate the spectrum of physicians’ legal repercussions. While both practices may seem similar, each practice has different legal ramifications.

Dumping. Patient dumping is defined as “[t]he practice, often by private, for-profit hospitals, of transferring indigent, uninsured patients to other, usually public, hospitals for economic reasons; patient-transfer guidelines and laws are generally limited to cases of ‘unstable’ emergencies and women in active labour.”¹ In 1986, the US Congress enacted the Emergency Medical Treatment and Active Labor Act ([EMTALA](#)) in response to growing concerns of patient dumping, wherein “hospitals were discharging patients before stabilizing them and refusing to care for poor people with medical emergencies”² and instead transferring them to other hospitals. EMTALA made patient dumping illegal

in the emergency context, federally mandating that Medicare-participating hospitals provide emergency care within their abilities and that no patient be turned away based on ability to pay.^{2,3} EMTALA notably requires such hospitals to “stabilize” emergency patients before transfer, with the threat of civil penalties for hospitals and physicians who fail to meet its statutory requirements.^{2,3} Penalties may include “monetary fines, exclusion from Medicare reimbursement, and federal prosecution.”⁴

EMTALA, while improving on patient protections that existed prior to its enactment, has been criticized as an inadequate solution, as the problem of patient dumping is ongoing.³ A recent study has shown that uninsured and underinsured patients—eg, Medicaid beneficiaries or those requiring specialized care—are more likely to be transferred than admitted compared with patients who have private insurance or Medicare coverage.⁵ Critics note that EMTALA is an incomplete response to broader systemic problems caused by the “underfunded health care system of the United States” and that even if EMTALA is maximally enforced, the “solution to patient dumping may lie in addressing its root causes,” ie, in addressing **systematic inequities** of the US health care system that leave many patients without health insurance or funding.³

Turfing. Patient turfing is “the act of foisting a patient to another service or hospital by manipulating the patient’s history so that the transfer seems appropriate.”⁶ Manipulation refers to a physician making the patient’s medical issue appear too difficult for them to treat and enables the physician to transfer a patient under the **guise of being incapable of treating** the patient’s medical issue.⁷ What constitutes “manipulation,” however, is debatable (eg, actually manipulating patient records would be a legal violation). Most instances of turfing likely do not involve illegal record tampering. The crux of a turf is that some wrongful motive or conduct is tied to the action to make the transfer inappropriate.⁸ In other words, there is no medical basis for turfing, as the original physician is capable of caring for the patient before transfer⁹; thus, patient turfing may be done purely for a physician’s convenience. Turfing is distinct from referral, or “[t]he act of sending of a patient to another physician for ongoing management of a specific problem, with the expectation that the patient will continue seeing the original physician for co-ordination of total care” or sending a patient to a “specialist or subspecialist, because the patient has a disease or condition that the primary or referring physician cannot, or does not wish to, treat.”⁸ Hence, there is a distinction between what would be deemed an “appropriate transfer” of a patient and the turfing of a patient, which is generally viewed as inappropriate. Additionally, turfing is distinguished from patient dumping, which is limited to the context of emergency care of indigent patients.

There are a variety of nonmedical justifications for physician turfing of a patient. For example, a physician’s choice to turf a patient may be based on whether that physician finds a particular patient annoying or difficult.¹⁰ Additionally, a physician may be more likely to turf a patient if there is no financial benefit to caring for a patient, as when a physician is salaried.⁹ Some might perceive a financial benefit to turfing, as turfing often allows a physician to cull “sick patients out of the practice to make the utilization profiles look better,” thus allowing a physician or practice to appear to be a “low-utilizing provider.”⁹ Furthermore, some physicians will turf a patient as a means of “defensive medicine,” or protecting themselves from legal liability (eg, a physician might “refer” a high-risk patient to another physician, eliminating the possible legal penalties for providing or refusing care to that patient).¹¹ Regardless of the potential justifications for

patient turfing, the practice can incur real harm. Indeed, turfing's consequences for patients and other physicians often outweigh the perceived benefits.

From a legal standpoint, patient turfing is not considered a medical negligence issue wherein a patient is injured by a breach of standard of care. Hence, physicians are not legally sanctionable for turfing. Patient turfing at its core is a referral to another physician or health care practitioner. Although it may be considered unethical in many instances, patient turfing is simply a "referral" or inappropriate transfer and is not illegal. By contrast, patient dumping is more closely related to malpractice and patient harm, as it refers to the refusal to provide care or failure to stabilize patients before transferring them.

Distinguishing Appropriate Transfers From Turfing

Catherine Caldicott describes several criteria to help determine whether a transfer is appropriate or a turf.⁹ One criterion is the perception of the receiving physician. When a patient is turfed, the receiving physician may have negative feelings of anger and frustration and perceive that "the patient disposition is based on informal norms" and not on "clinical or research evidence" relevant to the patient's needs. Another criterion is whether the transfer prioritizes physicians' needs over patients'. For example, following a transfer, a physician's feelings of relief and satisfaction in no longer having to care for a patient may be an indication that the patient was turfed and that the transfer was motivated primarily by the physician's desire to offload an undesired patient. A third criterion is whether the transfer reflects interspecialty conflict or collegiality. A patient transfer may be fostered by various specialties' disagreements regarding the scope of their responsibilities toward patients; disagreements and "conflicts in priorities" between emergency physicians and internal medicine physicians are particularly well recognized.¹² Such disagreements between specialties supersede professional collegiality, resulting in a patient transfer being a turf.¹⁰

Negative Effects of Turfing

Turfing can negatively impact interprofessional relationships between physicians and other health care professionals. Although receiving physicians may feel a sense of pride in caring for a turfed patient, they often cannot—absent a patient being beyond the physician's skill to treat or a physician's exercise of conscience—refuse to provide care to the transferred patient.⁹ This obligation to treat often creates tension between the physicians initiating the transfer and the receiving physicians; the receiving physicians often feel frustrated because they are stuck caring for a patient they perceive another physician as not wanting to deal with.^{9,13}

Turfing can also negatively impact the patient-physician relationship. Patients who are turfed may be perceived by physicians as "difficult" and therefore as "deserving of inferior care."¹⁰ Moreover, turfed patients may suffer further when they pick up on physicians' negativity.⁹ Indeed, one study demonstrated that turfed patients may have different care experiences than non-turfed patients and that these experiences skew negative.¹⁴ These negative perceptions and experiences can in turn lead to a breakdown of trust in the patient-physician relationship, which is built upon mutual respect.¹³ A lack of continuity of care is a further risk of turfing, as many physicians who initiate a turf do not wish to treat the patient, exacerbating the risk of lack of care coordination.

Legal Recommendations

There are a few options to limit or stop patient turfing. One potential solution would be a ban on patient turfing in a hospital's or organization's code of ethics or professional conduct. For example, the American Medical Association (AMA) *Code of Medical Ethics* stipulates that a physician terminating a relationship with a patient has a fiduciary duty to ensure continuity of care or, if that is not possible, to notify the patient in advance so that the patient can "secure another physician."¹⁵ With regard to discharging a patient (especially relevant in the context of dumping), the AMA *Code* states that the "discharge plan should be developed without regard to socioeconomic status, immigration status, or other clinically irrelevant considerations."¹⁶ Hospitals and other health care organizations should incorporate [AMA Code guidance](#) related to turfing and dumping in their policy guidelines and professional codes. Additionally, it is important that hospitals include such ethical obligations not only in policy, but also in employment contracts, such that employed physicians will be contractually bound by these ethical guidelines.

However, ethical obligations—even if written in hospital policy or contract—may not be enough to eliminate patient turfing. Without the threat of more significant legal ramifications (eg, civil or criminal liability) for failing to adhere to an ethical code, physicians may not fulfill these ethical obligations due to a lack of penalty. Establishing legal sanctions for a failure to adhere to ethical guidelines could help limit patient turfing because civil or criminal sanctions would carry serious consequences for physicians, providing a strong deterrent. Indeed, malpractice remedy already provides a legal deterrent against some turfs. Legal sanctions could be enacted by expanding EMTALA to cover patient turfing or by creating another civil statute that would similarly target patient turfing, just as EMTALA targets patient dumping in emergency care settings. Such an anti-turfing statute could also potentially create an option for patients to file a civil claim against a physician for turfing when a traditional common law claim like negligence is not available.

Attempting to sanction patient turfing, however, would be difficult and possibly futile. First, it may be difficult to prove that the patient was intentionally turfed. For example, the physician who initiates the patient transfer could argue that they were ill-equipped to care for that particular patient, as physicians are not obligated to care for patients when the necessary care is outside the scope of their training and abilities.¹⁷ Physicians generally are not legally obligated to establish a relationship with or treat a patient unless they choose to.¹⁸ Thus, if physicians argue that they are ill-equipped or had not agreed to treat the patient—and that this is why they are initiating transfer—it would be difficult to penalize them for patient turfing because neither reason (on its face) is illegal or unethical. Hence, the intent behind a physician's decision to transfer could often be mixed or difficult to prove.

Therefore, a novel legal solution—ie, a new cause of action or new statute at the local jurisdictional level—for turfing would be difficult to enforce, as it is often an ethical problem. State board involvement and medical malpractice law—both existing regulatory options—may be the best way to regulate turfing if greater awareness of the problem can be leveraged to address it.

Conclusion

Creation of new laws to sanction turfing would come with challenges, as demonstrated by the history of EMTALA's uneven enforcement and inability to completely solve patient dumping.³ However, implementing the law did have impact; the threat of penalty did

influence hospital and physician action.³ Additionally, any hypothetical statute prohibiting turfing would require adequate specificity to strengthen its enforcement potential. While the notion of creating new laws to govern turfing and allowing for new sanctions may be controversial, sometimes law is needed to help solve problems in health care when existing ethical guidelines—such as those found in the *AMA Code*—are not enough to influence the behavior of physicians or medical organizations.

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Citation

AMA J Ethics. 2023;25(12):E892-897.

DOI

10.1001/amajethics.2023.892.

Conflict of Interest Disclosure

Authors disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

AMA CODE SAYS

AMA Code of Medical Ethics' Opinions Related to "Turfing"

Maya Roytman

Abstract

This article summarizes AMA *Code of Medical Ethics'* guidance about patient transfer practices and discharge planning that are relevant to "turfing."

Turfing and Professional Responsibilities

How physicians refer to patients can reflect what those physicians think that patient deserves from them.¹ "Turfing" is a colloquialism referring to the practice by some clinicians of offloading to others their own responsibilities for or duties to patients they view as *difficult*.² Turfing can be a source of harm to patients and undermines **interprofessional collaboration and quality care**.³ The American Medical Association (AMA) *Code of Medical Ethics* offers guidance relevant to turfing: patients' rights to continuity of care, referrals, and discharge; upholding patient-physician relationships; and collaborative care in medicine.

Care Coordination and Continuity

As detailed in Opinion 10.8, "Collaborative Care," collaborative care means sharing responsibility for a patient's care, avoiding lapses in care continuity, and facilitating transfers and referrals that respond to a patient's needs and vulnerabilities.⁴ Opinion 1.1.3, "Patient Rights," specifically outlines the nature and scope of a patient's right to continuity of care.⁵ Patients "should be able to expect that their physician will cooperate in coordinating medically indicated care with other health professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care."⁵ In addition, Opinion 1.1.5, "Terminating a Patient-Physician Relationship," states that "physicians' fiduciary responsibility to patients entails an obligation to support continuity of care for their patients."⁶

Referrals and Safe Discharge

Ethical guidelines for terminating a patient-physician relationship, referring a patient to another caregiver, and **discharging a patient** are outlined in several places in the AMA *Code*. Opinion 1.1.5 states that if physicians withdraw from that patient's care, they must "notify the patient (or authorized decision maker) long enough in advance to permit the patient to secure another physician" and "facilitate transfer of care when appropriate."⁶ Opinion 1.2.3, "Consultation, Referral and Second Opinions," addresses ethical obligations of physicians seeking consultation or referring a patient.⁷ A decision

to refer should be intentional, should be based on a patient's clinical needs, and must benefit a patient. Moreover, physicians have ethical obligations to formulate a discharge plan that is safe, as stated in Opinion 1.1.8, "Physician Responsibilities for Safe Patient Discharge From Health Care Facilities."⁸ Discharge planning requires consideration of "the patient's particular needs and preferences" and collaboration with "health care professionals and others who can facilitate a patient discharge to establish that a plan is in place for medically needed care."⁸

Patient-Physician Relationships

Criteria of a functional patient-physician relationship are outlined in Opinion 1.1.1, "Patient-Physician Relationships," which specifies that a relationship "exists when a physician serves a patient's medical needs."⁹ Patient-physician relationships are "based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on the patients' behalf, and to advocate for their patients' welfare."⁹ While a patient is in a physician's care, the physician is accountable for meeting a patient's needs, including through referral and transfer practices.

Expressing regard for patient-physician relationships also requires that physicians avoid biased and discriminatory evaluations of patients that can disadvantage them. For instance, Opinion 8.5, "Disparities in Health Care," discusses how "differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care."¹⁰ Opinion 1.1.2, "Prospective Patients," similarly states that physicians must "uphold ethical responsibilities not to discriminate against a prospective patient on the basis of race, gender, sexual orientation or gender identity, or other personal or social characteristics that are not clinically relevant to the individual's care."¹¹ In matters of conscientious objection to providing a service to a patient, Opinion 1.1.7, "Physician Exercise of Conscience," states that physicians are obligated to "refer a patient to another physician or institution to provide treatment the physician declines to offer."¹²

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Citation

AMA J Ethics. 2023;25(12):E898-900.

DOI

10.1001/amajethics.2023.898.

Conflict of Interest Disclosure

Author disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.



AMA Journal of Ethics®

December 2023, Volume 25, Number 12: E901-908

POLICY FORUM: PEER-REVIEWED ARTICLE

Cheating the Rules of Admission With “Observation”

Laura Haselden, MD, MPM and Sabrina Rahman, MD

Abstract

When physicians admit patients to a hospital, their decisions about where—and to whose professional stewardship and services—those patients belong are influenced by federal policies, of which many clinicians are not aware. The distinction between *observation* and *admission* has clinical and ethical implications for patients and practices. The evolution of “observation status” from a clinical tool to a catchall of vague and imprecise meaning has been driven by changes to physician payment and compensation structures, particularly Current Procedural Terminology codes and Centers for Medicare and Medicaid Services regulations, and its current value to clinicians and patients is questionable. This article contextualizes clinicians’ admission and observation practices and considers how metrics influence patient costs and how clinicians and organizations are compensated.

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Criteria for Admission

“The patient doesn’t meet criteria for admission. Just put them in obs,” is now commonly suggested by emergency department (ED) clinicians. When we think about where and in whose care patients belong, we consider clinical questions: *Does the patient need further workup? Is the problem medical or surgical? Should or can the patient get indicated care as an outpatient? If not, what is an appropriate level of hospital inpatient care?* We ask questions like these so that patients receive indicated care, but we still find our practices restricted by nonclinical factors.

Decisions about where and to whom patients belong are heavily driven by regulatory policies we are required to follow without fully understanding. We speak of meeting “criteria” for admission or observation, but our education often does not include the philosophy, rationale, and goals behind these criteria. Yet these policies have a significant impact on our clinical practices, the regulation and reimbursement of our hospitals, our own moral well-being or injury, and the financial well-being of our patients. Understanding the policy background and clinical implications of the rules that govern

care delivery allows clinicians to offset their harms and facilitate advocacy efforts for change.

Distinguishing Admission From Observation

When deciding whether a patient in the ED needs admission or observation, we may think of this distinction in terms of the level of care needed. However, *observation* and *admission* are often not descriptors of clinical differences but rather status designators of allowable reimbursement, which are codified as Current Procedural Terminology (CPT®) codes and subject to regulation by the Centers for Medicare and Medicaid Services (CMS).¹ Admission to inpatient status is only justified—and only compensated—for patients who are expected to need hospital-based care for more than 2 midnights and for whom receiving care in a less intensive setting would pose a risk to their health or well-being.¹ Observation under outpatient status is instead indicated for patients who need a shorter period of treatment and assessment to determine the course that their care should take; it allows a period of decision making to determine whether the patient is best served by further inpatient or outpatient care.¹

From the perspective of care, there's often very little difference in these designations. A patient under observation is often on the same inpatient floors, with the same nurses—and often receiving the same care—as an inpatient. For clinicians, the distinction may also often be irrelevant when considering disposition: a patient who needs hospital-based care for a short period is not significantly different from a patient who needs care for longer periods. Financially, however, the implications are significant for both patients and hospitals.

Since observation stays are deemed outpatient, they are governed by Medicare Part B, and the elements of care provided are billed as they would be if the same care were provided to an outpatient.^{2,3} Each service provided is assigned a value based on its “ambulatory payment classification” within the outpatient prospective payment system.² Patients are responsible for a copayment for each outpatient service provided, generally 20% of total charges, and must either provide or pay out of pocket for any home medications they may need while in the hospital.^{3,4} While patients' copay for each individual service provided must be less than their deductible would be for an inpatient admission, patients can receive multiple services—and thus multiple individual charges—during their stay.³

By contrast, inpatient stays are covered by Medicare Part A and are reimbursed at a fixed rate that is standardized for the patient's admitting diagnosis and adjusted for relevant comorbidities.² Payment is issued to hospitals as a single fixed sum regardless of length of stay, and patients are responsible for paying a single deductible for each hospital admission (\$1600 for 2023), which also covers any acute posthospitalization nursing care or readmissions for 60 days following admission.³ These different designations are frequently driven not by a patient's clinical presentation but by pressures imposed by other CMS policies and penalties.

Two Midnights, Utilization Review, and Metrics

In 2013, CMS introduced the 2-midnight rule as disposition policy. Under this rule, patients can only be admitted to a hospital if their physician reasonably expects them to require at least “2 midnights” of inpatient care; shorter expected lengths are called “observation status.”⁵

This rule undermines the stated role of observation status—to determine if admission is necessary—by aspiring to dictate the appropriate level of care solely by the anticipated length of stay.⁶ The 2-midnight rule has, anecdotally, resulted in patients with labor-intensive, life-threatening conditions requiring intensive care being placed in observation if their conditions can be expected to resolve quickly.⁷ Such conditions do not pose a diagnostic dilemma—they clearly require intensive, hospital-based care that cannot be provided as an outpatient. However, while CMS has issued a list of services that can only be provided under inpatient status, many critical medical conditions, such as atrial fibrillation with rapid ventricular response, diabetic ketoacidosis, and flash pulmonary edema, are left off this list.⁸ These high-intensity, short-stay patients may face exorbitantly high costs from the required 20% copays for multiple outpatient services rendered in a single intensive care unit stay, even as hospitals receive reduced compensation for resource-intensive care that is compensated as though it were provided as outpatient care.

In general, however, when uncertain about a patient's needed length of stay, hospitals are incentivized to err on the side of observation by the Medicare Fee for Service Recovery Audit Program, which reviews the appropriateness of hospital admissions.^{9,10} Since hospitals are often not paid at all for an observation-length stay that is incorrectly submitted for reimbursement as an inpatient stay, they are incentivized to begin any potentially short stay as an observation stay to avoid losing the payment altogether.⁵ However, in actual practice, patients are often kept under observation status for more than 48 hours,¹¹ despite CMS protocols stating that longer observation stays should be rare.¹

Hospitals are indirectly pressured to overutilize observation stays not only by the Fee for Service Recovery Audit Program, but also by quality initiatives like the Hospital Readmissions Reduction Program (HRRP), which can reduce a hospital's reimbursement by up to 3% for all admissions should the hospital fail to meet any readmission metric.^{12,13} This program, while intended to improve discharge planning and quality of care to reduce readmissions, is of questionable impact. Some studies have suggested that the HRRP has meaningfully reduced readmissions^{14,15}; others have concluded that the reduction in readmissions has been falsely created by changing admissions to observations, which do not count as either an index admission or a readmission.^{16,17,18,19,20}

Disposition and Inequity

There is indirect evidence that the HRRP has contributed to disparities in care and costs for Medicare patients. Significant disparities have been described in admission vs observation decisions, with Black and Hispanic patients being observed more frequently than White patients.^{21,22} Observation care is also utilized more frequently by Medicare patients with low incomes and in economically disadvantaged neighborhoods.^{23,24} While some studies have suggested that patients of color may have better outcomes when observed than when admitted,²² the financial and ethical implications of these disparities are significant.

For most patients with Medicare, an observation stay is less expensive than a short-stay inpatient stay of similar length, but for about 10% of Medicare beneficiaries in 2009, observation stays ended up costing the patient more.²⁵ Hockenberry et al found that observation stays of more than 48 hours were associated with a 42% increase in patient costs,¹¹ and more than 20% of observation stays last for more than 48 hours.²⁶

Furthermore, observation status does not qualify for the 3-day admission requirement for Medicare coverage of skilled nursing facility (SNF) care,²⁷ resulting in high out-of-pocket costs for SNF, lower SNF utilization, and subsequently higher readmission and reobservation rates.²⁴ Each reobservation incurs a separate cost for the patient—even when these reobservations are the result of inadequate care coordination—whereas repeat inpatient hospitalizations confer a single copay per 60-day period.^{23,28} When observation charges are disproportionately borne by patients with low incomes and patients from economically disadvantaged neighborhoods, their cost is magnified as a percentage of total income and results in patient-led rationing of health care.²³

Social Determinants of Disposition

Clinicians are often faced with patients who need more social resources from a system that has fewer to offer—from patients experiencing homelessness needing housing, to geriatric patients needing in-home assistance or long-term placement, to uninsured patients needing complex care coordination. Although these vulnerable populations form a growing (and inescapable) proportion of patients, their special needs are not reflected in CMS regulations.¹ Under existing rules, these patients do not meet CMS standards for admission, as the necessary care could be rendered in a less resource-intensive setting.¹ However, this rule assumes that **less resource-intensive settings** exist, are accessible, and have adequate resources for all patients. Clearly, this is not the case. By failing to recognize the social needs, housing and food insecurity, and barriers to outpatient care that plague our patients and our health care system, CMS regulations harm our most vulnerable patients.

Hospitals are ethically bound to provide optimal medical care to their patients and financially penalized for readmissions. However, for many patients, unmet social needs represent the greatest threat to their health.²⁹ Clinicians recognize this reality; they are obligated to protect and promote health but are unable to admit patients who may not be able to access care otherwise and whose health is undermined by social factors they cannot control. These mutually incompatible obligations—to promote health and to follow rules that deny patients care—create moral distress and arguably justify subversion of these rules.

Building a Better Cheater

Although observation status is intended as a clinical decision-making tool, it has become more of an all-purpose loophole to artificially improve hospital metrics and pose barriers to inpatient care. It is widely recognized by clinicians (and explicit in CMS guidelines) that clinician discretion (and creative documentation) can circumvent CMS policies and restrictions to justify an observation or admission stay. Documenting the expectation of a longer length of stay and retroactively explaining why care was shorter might excuse an inpatient admission lasting less than 2 midnights. On the other hand, when a patient without an acute medical diagnosis needs hospital care for social reasons, an unquantified clinical diagnosis of dehydration or ambulatory dysfunction might justify an observation stay. The newly implemented incorporation of social determinants of health in billing metrics can help upsell “soft” admissions and observations.³⁰

But if these rules can (and arguably must) be evaded, it’s worth questioning both their utility and their moral value, as rules that must be broken for the good of the patient should not exist. Clinicians should not be forced to choose between breaking the rules or contributing to their patients’ harm. If noncompliance can be justified with expanded documentation and metrics can be gamed with loopholes and cheats, the rules serve

only to increase clinicians' workloads. If quality improvement initiatives do not generate improved practice but instead harm patients, clinicians, and hospitals, they must be changed.

Solutions

Any solution to working around CMS regulations and **CPT codes** must take account of the fact that clinicians are notoriously bad at knowing which patients will need more than a 2-midnight stay. Gabayan et al found that 19% of observation patients went on to be admitted and that 22% stayed more than 48 hours.²⁶ One way to reduce the high percentages of observation stays lasting more than 48 hours would be to change the determination of observation vs admission from an up-front guess made at the time of hospital admission to a retroactive designation based on true time spent in the hospital.²¹ As all of us in health care work toward policy changes, clinicians can advocate for admission of patients with a high probability of needing prolonged care—for example, those with adverse social determinants of health or significant medical comorbidities—rather than erring on the side of observation.¹¹ Hospitals have utilization review teams to correct admissions that result in short stays; patients are far less able to challenge the bill they receive when an inappropriate observation results in a prolonged stay.³¹ In the face of this power imbalance, our responsibility is to protect our patients.

More broadly, social determinants of health should be incorporated in diagnoses and qualify as broad criteria for admission.^{30,32} To facilitate access to long-term care, days spent under observation should count towards the 3 days required for SNF coverage.^{23,28,33} Hospitals should be incentivized to **invest in community health initiatives** that address social determinants of health, perhaps by eliminating HRRP penalties for hospitals that choose to invest in community infrastructure and primary care.³⁴ While preventable readmissions should be measured, shifting from the stand-alone HRRP to the Hospital Value-Based Purchasing Program (HVBPP), which rewards quality and efficiency of inpatient care more generally³⁵—and expanding the HVBPP to encourage community infrastructure investments as facilitators of value—could maintain quality assessment and improvement without disproportionately burdening hospitals in economically disadvantaged and underserved neighborhoods with financial penalties.³⁶

Correcting the negative impacts of observation status on our patients will be a slow and political process, but our awareness of these issues—and the small ways in which we can help along the way—is essential.

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Citation

AMA J Ethics. 2023;25(12):E901-908.

DOI

10.1001/amajethics.2023.901.

Conflict of Interest Disclosure

Authors disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.



AMA Journal of Ethics®

December 2023, Volume 25, Number 12: E909-913

MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Reasons Not to Turf a Patient Whose “Belonging” in a Hospital Is Unclear

Patricia Luck, MBChB, MPhil, MSc and Arman M. Niknafs

Abstract

Through the lens of metaphor and the arts, this article aims to illuminate how persons who are ill *tarry* through uncertainty to receive care, and, in response, clinicians must resist *turfing* such patients in a health system that often confers upon patients unclear criteria for belonging. In addition, this article considers relationships among clinicians, patients, and their loved ones through the perspectives of Maris and Ludlow, characters in the book, *A Hospital Odyssey*, by Gwyneth Lewis. The article suggests that engaged curiosity and empathy are helpful responses to clinical detachment, distraction, and disengagement.

*Sometimes all that's left for a physician
is to make a new tune from the hours of waiting,
to recompose the story in a broader tone, so doctor and patient
can both lose themselves, be found by the muse of time rearranged...*
Gwyneth Lewis¹

Tarrying in the Realm of Uncertainty

Engaged curiosity and empathy can serve as antidotes to clinical detachment and disengagement from patient care, which can result in *turfing* responsibility for that care. We explore these dynamics through the perspectives of Maris and Ludlow, characters in Gwyneth Lewis' fictional narrative, *A Hospital Odyssey*,¹ which describes both encounters with *turfing* and the invitation for physicians to *tarry* with patients—to remain engaged with the inherent uncertainty of patients' care and linger long enough for them to be heard and seen. These experiences of *tarrying* become an antidote to *turfing* for both patient and physician.

Turfing and Tarrying

The *turfing* witnessed in *A Hospital Odyssey* is not a new phenomenon, and neither are patients' experiences of uncertainty, suffering, shame, and stigma while seeking care. In Lewis' description of the hospital, the medical encounter becomes an odyssey, an epic narrative journey depicting how those who are ill *tarry* through the realm of uncertainty to receive care from a health care system that delineates criteria for sickness. Those who are ill and those who love them arrive in this realm having already lost the previous maps that guide them toward the expected destinations of their lives.² They arrive in need of sensitivity and compassionate responses to the seismic shift occurring in the

world around them. Instead, they find themselves in an increasingly complex and impersonal system that challenges the ability and capacity of those providing care to tarry and resist the impulse to turf, to stay alongside them while they work through their illness experience.

Turfing harms those who are ill by interrupting continuity of care and delaying potential benefits; additionally, it **harms health care team members**, who experience a range of emotions related to care of the turfed patient that may negatively impact relationship building.³ In one study on alleviating residents' frustration about caring for turfed patients, residents identified the potential power of empathy as an antidote to turfing: "you can empathize with 'em and help them out as much as possible. And you get something out of that."⁴ To receive care and *not* be turfed, patients must belong to—must fit the criteria of—categories of disease bounded by arbitrary lines, categories that denote illnesses some professionals will tarry with and illnesses some will not tarry with and that often minimize the psychosocial contexts of illness. How categories of disease are delineated and patrolled can mean the difference between a clinician's ability to stay and linger longer—to tarry—or to turf the patient. In this manner, the "individual doctor or service becomes a territory, and the patient is moved (*turfed*) from one to another."⁴ To tarry with those who are ill and to resist the temptation to turf is to commit, to settle in, to be present with,⁵ to learn from listening *for* story—that unique plotment that is singular⁶—to attend to the changing nature of illness experiences, and to resist categorizing every symptom experience under a disease label. To heal this tendency toward separation, detached concern, and turfing is to challenge the professional culture of medicine.⁷ To encourage tarrying offers care and belonging not only for those who are ill but for those who provide care.

While it is the patient who suffers through illness, families also bear intimate witness to the travails of illness and, ultimately, the death of their loved one. They, too, find themselves adrift between 2 worlds as they traverse the kingdom of the ill, reflecting the sentiment that those who are ill and their families experience illness as one unit.⁸ Maris, Lewis' protagonist whose husband is critically ill and lost within the hospital's rhizomic expanse, very early in the text implores the reader to pause and tarry with those who are ill: "Stop reading. If your partner's near I want you to put this poem down, surprise them at the morning paper.... When they ask, 'What's wrong?' Say, 'Nothing,' but hold them close, while you can."¹ Maris thus warns the reader of the challenges ahead.

The Odyssey of Maris

As told through rhyme and metaphor, Maris' journey begins once she enters the hospital, an unfamiliar territory with its futuristic "infinite corridors" and "sophisticated alien culture."¹ Maris searches in desperation to find her turfed husband through a maze of people only to stumble upon one stiff, guarded doctor, a "Knight Templar" named Ludlow sitting rigidly before her.¹ With some interrogation, we learn that Ludlow's experience embodies that of the burnt-out doctor, one who feels imprisoned by the heavy armor of his role and who "never asks what the hours are for, but suffers them."¹ Ludlow's station transformed him from someone who was curious, feeling, and engaged to a person exhibiting detached concern, and it is not until Maris pries off his helmet that he can "hear what you're [Maris is] saying!" Serving as a metaphor for the realities of modern medicine, the caregiver in this scene is weighted with the charge to undo the armor and defenses of doctors, to reacquaint them with their duty, and to encourage them to embrace intimacy and tarrying.⁹ When Maris painstakingly removes his armor, Ludlow appears with his "alabaster flesh" relit, and beneath the chainmail she finds a

“defenseless man,” who exclaims, “I know that person. I think I am ... a doctor! I remember now what I do.... How may I serve you?” In this way, Ludlow demonstrates the reenergizing capacity of connection and curiosity.

By following Maris and Ludlow on their journey through a “bureaucratic and technically alienated” medical environment,¹ we see examples of how people who are sick can help doctors tarry. The newly reactivated Ludlow starts to engage in Maris’ new disease-defined reality as they travel past territories to which patients have been turfed. With Maris’ lead and example, they navigate the challenge of how to counter unbelonging. One such instance is when Maris finds Phil, an alone and abandoned patient with a malodorous *Clostridium difficile* infection who, apologizing for his illness and its stench, begs her not to leave. Maris tarries with Phil, remaining at his side despite “gagging ... with waves of decay washing over her,” comforting him and crying tears that “soothed the gore” and closed his wound.¹ Through Maris’ encounter with Phil, we see a profound illustration of the intimacy and engaged concern that patients and caregivers can offer to their fellow sufferers, highlighting that there remains a choice for doctors to connect when a patient is turfed and placed before them, however inappropriately. Yet, during this interchange, Ludlow is nowhere to be found; he’s foregone the opportunity to stay engaged with Maris as she interacts with others on her journey. These lost moments to respond to emotional cues and clues reflect missed chances for both empathy and building trust within the medical encounter.¹⁰

We reconnect with Ludlow again at the “microbe ball,” exuberantly enjoying the parade of pathogens and host defenses alike.¹ A succession of diagnostic possibilities, categorized and then discarded, draw Ludlow along as, with excited curiosity, he follows a “fascinating smudge” and “a trail of phlegm and slime,” intrigued at the potential for new discovery—that is, until they all fall headlong into a web of loss and despair.¹ Here, we learn not only that doctors risk being caught up in a maze of medical curiosity and self-interest, but also that family members can become stuck in this ruminative loop while those who are ill suffer the experience of sickness and do the work of healing.¹¹ Ludlow’s folly underscores how, in seeking to reduce and avoid uncertainty within disease categorization, physicians may overlook precious opportunities to tarry with the uncertainties that weigh on patients and their caregivers.

Eventually, as with many great odysseys, we travel to the underworld, to the Island of Uncertainty, where we meet Hippocrates, who counsels Ludlow in the art of uncertainty and to stay attuned for opportunities to tarry with patients when it might simply be “enough to be with your patient.”¹ The healer must learn not only to tarry with uncertainty to survive in the territory of the sick, but also to cultivate and express the practice of presence that helps patients flourish. For Hippocrates in the Island of Uncertainty, this education in intimacy comes in the form of the arts, as he hands Ludlow a boxwood flute and instructs him to remember the music when he’s about to perish or reinhabit his former detached and armored existence. The **music will heal** Ludlow and help create harmony with those he is guided to serve: “others will follow if you find the melodies that heal yourself.”¹ Through Ludlow’s reclaimed confidence in his “healership” and, consequently, his clinical leadership, we see him in the final chapter—catalyzed by Maris—riding the “dragon of disease in triumph” at the head of a parade.¹ He has come to understand that “[g]ood doctors co-ordinate the body’s rhythms orchestrat[ing] a place to live. For we perform our health, like music, in ensembles, with the limit of our genome.... We can only be as well as our loved ones so, when they fall ill, we suffer.” Thus, having traversed the expanse of the hospital and its many territories of

uncertainty where patients are susceptible to being turfed, we arrive at the conclusion that it is in the engaged stillness of intimacy and compassionate empathic care that healing and belonging are possible.

Tarrying as an Antidote to Turfing

Ultimately, the capacity to tarry and resist the impulse to turf resides within the ability of clinicians to journey alongside their patients—those who are ill and their families—through the land of uncertainty. *A Hospital Odyssey* exhorts us to consider that attending to our patients necessitates settling in, doffing our armor, and exercising our capacity for sustained empathy, compassion, and being present. This commitment can be reenergized through active engagement with those who are ill and, critically, with their family members.⁸ At its core, a journey that helps to reintegrate existential uncertainty benefits all of us. As Paul Han writes, “Uncertainty enables us to let go of our blinding preconceptions and to simply be silent, open to new possibilities and experiences of meaning.”¹² Despite our having established landmarks for tarrying on our journey through the land of uncertainty, there is no denying that policies, mores, and other demands within the present health care system are implicated in the reflexive construction of territories and fiefdoms and of armor and frustration. However, by accompanying Maris and Ludlow, we can find our path forward—nonlinear and uncertain as it may be—whereby intimate engagement and persistence are the first steps in establishing alliance and healing. It is here—through tarrying with turfed patients in the realm of uncertainty—that the opportunity exists to recognize the armor, to remove it, and to closely follow the patient’s lead in composing a new tune of healing in these hours of waiting.

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Citation

AMA J Ethics. 2023;25(12):E909-913.

DOI

10.1001/amajethics.2023.909.

Conflict of Interest Disclosure

Authors disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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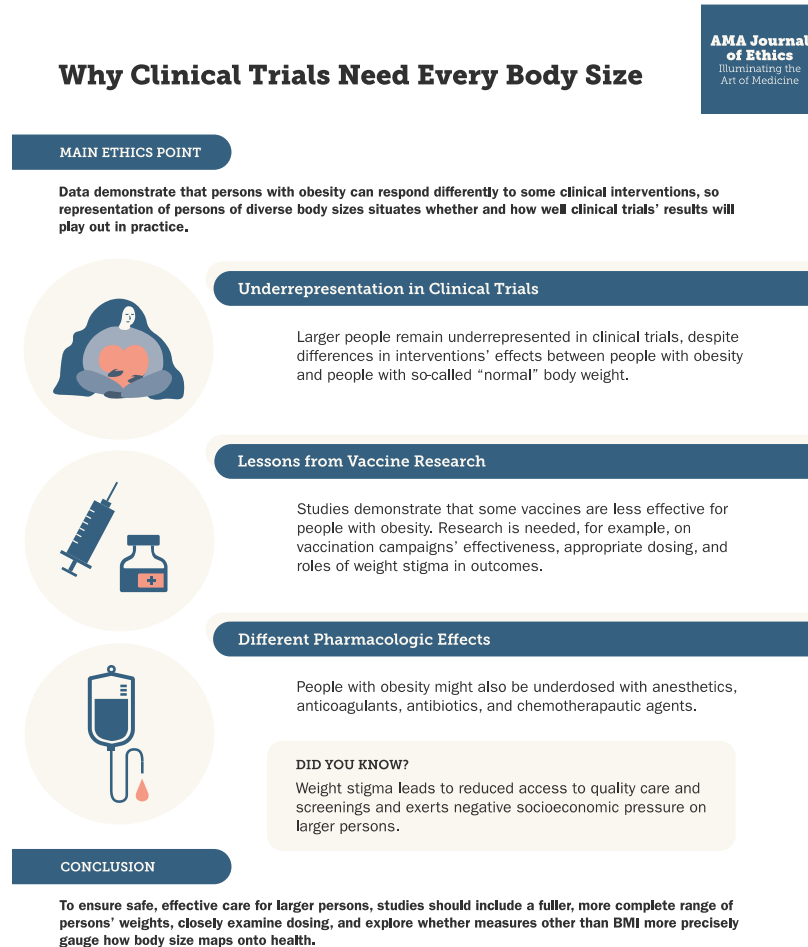
Visual Abstract of “How Should We Approach Body Size Diversity in Clinical Trials?”

Hanna Renedo

Abstract

This visual abstract is based on an [article](#) from the July 2023 issue of the journal.

Figure. Why Clinical Trials Need Every Body Size



Visual abstract by Hanna Renedo.
Learn more at: Pagarkar D, Harrop E, Erlanger L. *AMA J Ethics*. 2023;25(7):E517-527.

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Editor’s Note

This visual is freely available to all online and as a PDF for digital and print circulation in any clinical or teaching setting.

Citation

AMA J Ethics. 2023;25(12):E914-915.

DOI

10.1001/amajethics.2023.914.

Conflict of Interest Disclosure

Author disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.