

Editorial

DOI: 10.22114/ajem.v0i0.54

Good Interdepartmental Relationships: The Foundations of a Solid Emergency Department

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Published online: 2018-02-05

“No man is an island” said the English poet, John Donne, and nowhere can that statement be better appreciated than in a modern emergency department (ED). As emergency physicians, we work in the setting of a close knit team involving nurses, technicians, consultants, clerks, security guards and many more. On a macroscopic level as well, the ED itself needs productive relationships with every other department in the hospital. Back when the ED was staffed by physicians-in-training, general practitioners and moonlighting specialists, the care of patients was jealously divided between the long-entrenched traditional specialties. Anesthesiologists handled difficult airways; Surgeons took care of trauma; Radiologists did the ultrasounds and read all the films, and so forth. Emergency medicine—a specialty that encompassed parts of many disciplines—was initially met with skepticism and resistance from the traditional fields.

I have been in practice long enough to remember when anesthesiologists fought against emergency physicians doing RSI and how they tried to stop us from using propofol or ketamine for procedural sedation. Orthopedists wanted to be consulted before we reduced a shoulder. Surgeons got angry if you gave morphine to a belly pain patient. In the early 1990’s at the University of Rochester, my colleague, Dr. Steve White, had to sneak into the ED with his own portable ultrasound device (with its postage stamp sized screen), because to have done so openly would have brought down the wrath of radiologists who believed that ultrasonography belonged to their department alone.

These turf battles are mostly a thing of the past, thanks to clinical studies conducted by our specialty that proved what we can and should do. But challenges regarding interdepartmental relationships still remain. In the following discussion we will look at current friction points between the ED and other departments, including radiology, anesthesia, surgery, obstetrics/gynecology, cardiology, and the internal

medicine admitting services.

Radiology

Though the issue of who “owns” ultrasound has been settled and point-of-care ultrasound in the ED by emergency physicians is now a standard, many EDs still have problems regarding the issue of how to deal with discrepant radiology readings. Because radiology, unlike the ED, is not a 24/7 specialty in most hospitals, emergency physicians must make diagnoses for their patients based upon their own initial interpretations of plain radiology studies. Emergency physicians are becoming better trained in the reading of radiographs—and the time may come when emergency physicians do the primary reading without oversight, which would be very cost effective—but at present such training varies and some physicians working in EDs cannot match the skill levels of fully-trained radiologists (1). However uncommonly we miss findings on x-rays, errors do occur. Most involve minor conditions (i.e., a missed base of the 5th metatarsal fracture), but others are more significant and can lead to serious consequences if not appropriately followed-up. (i.e., missed pulmonary nodules). EDs need a failsafe system for dealing with such discrepancies (2).

One approach to discrepancy-catching involves a three-step process, simple in theory but which easily breaks down without good communication between the ED and radiologists. First, emergency physicians must indicate their “wet readings” on the picture archiving and communication system (PACS) —and they must diligently do so. This will alert the radiologist, who may be reading the film the next day, to the presence of a missed finding.

Secondly, when radiologists detect a miss, they must act upon it immediately and notify the ED in a timely fashion. Conflict may arise over which department—the ED or radiology—should take responsibility for notifying the patient of a significant miss for altering the follow-up plans, if needed. I would make a strong argument in favor of the ED being the department responsible for

notifying the patient and for arranging any new follow up. We treated the patient and we ordered the study, and therefore we must take responsibility for the patient's ultimate wellbeing. A good system for dealing with discrepancies, therefore, requires a formal plan between the two departments that is respectful of each other's time-constraints, and that is monitored and adjusted as needed.

Anesthesiology

In most hospitals nowadays, emergency physicians are considered the co-equals of anesthesiologists in the management of difficult airways—especially in the trauma setting (3); And thanks to a growing body of excellent studies conducted by emergency physicians, we are now also considered experts in procedural sedation, using agents such as propofol, etomidate and ketamine. In some U.S. hospitals, however, anesthesia departments remain involved in the credentialing of emergency physicians for RSI and deep or dissociative sedation for procedures (4). This is not right. The ED should credential its own providers in these matters. If this becomes an issue, the best way for ED directors to win autonomy is to engage the anesthesiologists collegially but armed with a stack of studies demonstrating that our specialty has done its scientific homework.

Surgery

Many EDs in the U.S. were once run by the department of surgery, or sometimes administered jointly by surgery and internal medicine. The overwhelming trend in the past two decades has been for emergency medicine to become an independent department within a given facility's medical staff or academic framework. By and large, the relationship between the ED and surgery tends to be smooth and cooperative.

In trauma centers, the trauma response must be closely coordinated between surgery and emergency medicine. A common and very logical paradigm in the trauma code situation is for the airway to be controlled by an emergency physician and the trauma code to be otherwise run by a trauma team consisting of surgeons (and often rotating emergency medicine residents).

Three other areas of conflict frequently arise between the ED and surgery. One involves the surgeons demanding a CT on all potential acute abdomens before they will evaluate the patient. A recent ED based study, however, suggests that an ultrasound-first approach to children with possible appendicitis is safe and can reduce the burden of

radiation exposure (5). Only if the ultrasound results were equivocal would the patient receive a computed tomography (CT) scan. Such a program can be instituted through meetings between ED, surgery and radiology with the goal of developing an ultrasound-first evaluation algorithm.

Another potential conflict area with surgery (and surgical subspecialty services) involves the question of who will be the admitting attending—the surgeon or the hospitalist. With the rise of dedicated hospitalist services across the world, many surgeons have become comfortable with the practice of having a hospitalist manage their patients. A common complaint among hospitalists is that surgeons have become too comfortable with this practice. While it makes good sense for patients with multiple serious comorbidities to have their overall care managed by an internist, when it comes to medically uncomplicated surgical patients, however, having the hospitalist admit them all relegates the hospitalist to a subservient, house staff-like role. When hospitalists balk at this, we emergency physicians sometimes get caught in the crossfire during admission responsibility disputes. The cure is to have service admission criteria agreed upon well in advance by surgery and the hospitalist service.

A third conflict between the ED and surgery in teaching hospitals involves the distribution of low-volume procedural training resources. I am currently based in a relatively small teaching hospital. My emergency medicine residents need to become proficient in the placement of chest tubes. So do the surgery residents, but there are only a relatively small number of patients needing chest tubes. We solved the dilemma at my hospital by sharing the duty. On even days, EM residents are the primary placers of chest tubes, and the surgical resident assists. On odd days, the situation is reversed. So far it is working well. On a recent day, one of our senior emergency medicine residents taught a surgery intern how to place a chest tube. That is progress.

Obstetrics/gynecology

Some EDs come into conflict with the obstetrics and gynecology department over the issue of whether to send certain pregnant patients—for example, those at or beyond twenty weeks gestation, or those in active labor—directly from the triage desk straight to the labor and delivery floor, bypassing the emergency physician. This is a policy fraught with risk. The safest strategy is to have all pregnant patients, regardless of their presenting complaint or stage of gestation, receive

at least a basic medical evaluation. The ED needs to collaborate closely with the department of obstetrics and gynecology to develop a policy that determines which pregnant patients should be subsequently sent to labor and delivery after the initial ED evaluation.

Cardiology

It goes without saying that EDs in hospitals with 24/7 cardiac cath labs need to work closely with their interventional cardiologist colleagues to develop systems so that the time from ED arrival to PCI for STEMI patients is as short as humanly possible.

Another important relationship between the ED and cardiology involves the coordination of outpatient stress testing and consultation. For the ED to safely discharge low-risk chest patient patients, we need a process to ensure they receive appropriate follow-up evaluation. For chest pain patients placed in ED observation units, the ability to obtain stress testing the following morning can make the difference between efficiency and gridlock.

The Internal Medicine Admitting Service

I have saved this discussion for last because herein lies the ED's most problematic interdepartmental relationship. Poor communication between the ED and the medicine admitting service spells disaster. Between 15% and 25% (or more) of patients presenting to the ED on any day end up being admitted to a medicine service. When we cannot move these admitted patients rapidly and safely to the inpatient setting, throughput suffers and

patients are put at risk (6).

Process delays in getting admitted patients out of the ED are both common and difficult to fix because they frequently involve factors beyond either service's control, such as nurse staffing levels and bed availability. When admitted patients must "board" in the ED, lines of patient care responsibility become blurred. Orders are lost. Multiple handoffs lead to increased rates of error. Frustration over these situations can lead to a spiraling toxic atmosphere between the ED and the admitting service, with each side blaming the other for making things worse.

Good and frequent communication between the ED and admitting service is essential—including dedicated throughput meetings, taskforces and joint departmental grand rounds—but will not solve the admission delay problem alone (7). Hospital administration must be actively involved and willing to provide the necessary resources and support (8).

In summary, far from being an island, the ED is at the center of a continent bordering every other department in the facility. To provide high quality care to our patients, the ED must have relationships of efficiency and mutual respect with all our colleagues in other departments, along with firm support from hospital administration. This makes a good case for ED leadership being actively involved in medical staff activities and assuming leadership roles within the hospital and the broader medical community whenever possible (9). We must strive to create win-win relationships with our colleagues, to the ultimate benefit of our patients.

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