Failure to Cope: The Hidden Curriculum of Emergency Department Wait Times and the Implications for Clinical Training

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Abstract

Purpose

The study explored optimal intraprofessional collaboration between physicians in the emergency department (ED) and those from general internal medicine (GIM) at a major academic teaching hospital. Prior to the study a policy was initiated in Ontario that mandated reductions in emergency room wait times. The researchers explored its impact on clinical practice and the implications for medical education.

Method

In 2010-2011, an ethnographic study was undertaken to observe consults between GIM and ED at an urban teaching hospital in Ontario, Canada. Additional formal and ad hoc interviews were conducted with residents, nurses and faculty from both GIM and ED.

Results

Participants described their impression that efficiency was more important than education and was in fact the new definition of "good" patient care. The use of the informal term "failures to cope" suggested that in many instances, patients were experienced as a barrier to optimal efficiency. This resulted in tension during consults as well as reduced opportunities for education.

Conclusions

The authors suggest that the emphasis on wait times resulted in more importance being placed on "getting the patient out" of the ED than on providing safe, compassionate, person-centred medical care. Resource constraints are hidden within a discourse that shifts the problem of overcrowding in the ED to patients with complex chronic conditions. The term "failure to cope" becomes activated when overworked physicians try to avoid assuming care for high-needs

patients. It masks institutionally produced stress and conflict and may alter the way patients are perceived.

Interprofessional teamwork in healthcare can be defined as "a type of work which involves different health and/or social professions who share a team identity and work closely together in an integrated and interdependent manner to solve problems and deliver services."[1] Such an approach to health care provision has been growing in popularity in recent years; many influential healthcare bodies are now advocating for collaborative care as an imperative for providing optimal, patient-centred care.[2-4] Moreover, Health Canada links interprofessional collaboration in healthcare with "greater provider satisfaction."[5]

Interprofessional collaboration has long been a focus of study and discussion in medical education, with a focus on interpersonal, individual-level phenomena such as working in teams, as well as on systematic analysis of care processes involving multiple medical specialties.[6-8] There is now a growing research basis for interprofessional collaborative care.[9-10] While some studies have demonstrated benefits,[10] uncertain diagnosis has been identified as a "high-risk trigger for dangerous handoffs" and there is little agreement as to how this process can be standardized.[11]

Teamwork between health care providers of the same profession, or 'intRAprofessional' care, can also pose challenges related to communication and uncertainty of diagnosis.[12] Comparably less research has examined the nature and outcomes of this type of intraprofessional collaboration. This is a significant omission in the literature, given the rising rates of hospital admissions for complex patients with medical and social problems which require the expertise of multiple physician specialties.[13] To explore this under-researched aspect of health care provision, our study examined intraprofessional collaboration between physicians in an academic hospital in Canada in order to explore optimally successful intraprofessional collaboration between physicians (faculty and trainees) in the emergency department (ED) and those from the internal

medicine service (GIM).For the purposes of this study, health care provision is interprofessional and collaborative when a team composed of health care professionals from a range of relevant specializations are "working collaboratively, [and when] they seek common goals and can analyze and address any problems that arise" [14].

We were particularly interested in how intraprofessional interactions impact medical education. In the harried and stressful environment of acute care hospitals, medical educators have to balance the educational needs of their trainees with the clinical needs of their patients and the administrative goals of their institutions. As a result, trainees in the clinical workplace are exposed not only to the formal curriculum mandated by their faculties of medicine and the informal curriculum taught purposefully by their clinical preceptors, but also to a "hidden curriculum." The hidden curriculum, first described in the medical education literature by Hafferty[15] refers to "cultural mores that are transmitted, but not openly acknowledged, through formal and informal educational endeavours."[16] For Hafferty, there is often significant incongruency between the stated goals and methods of the formally-endorsed medical curriculum, and what is actually modeled and deployed in policy, evaluation, and institutional practice. The applicability of the hidden curriculum for our research study arose out of the data itself and was not predetermined. During observations and interviews, we encountered frequent reference to concepts and strategies which were not included in medical students' formal curriculum, but were modeled and taught to them by their mentors in the clinical context.

Research context

In 2008, the Ontario government introduced a strategy to reduce emergency department (ED) wait-times, with speed of processing as a key focus of measurement. Hospitals are monitored, ranked, and data is publicly provided in "stocktake" reports that are intended to inform a "performance management approach."[17] Previous Canadian research has examined the

impact of wait-times management strategies on nurses in the ED.[18] Our study builds on this literature by considering the perspective of physicians and the impact of wait-times management on hospital wards that provide consultations to, and receive admissions from, the ED.

The original impetus for the study was an experiential observation among physicians on our team of increasing tension between the ED and the GIM at the point of consults. On the one hand, ED residents complained about long waits for consultations and ward admission. On the other hand, the GIM residents were dismayed by the amount of inappropriate consultations they received from the ED.

Methods

We obtained institutional research ethics approval for an observational study of intraprofessional interactions in the healthcare environment focusing on the moment of specialty consultation. Data collection took place in 2010 and 2011. Our primary method was ethnographic participant observation.[19] Ethnographic methods have increasingly been utilized by multi-disciplinary research teams to understand the many complex interactions and processes involved in clinical medical education.[20-23] Ethnography allows researchers to directly observe *"what actually happens"* in a particular social environment.[23] Our observations were supplemented with ad hoc interviews with residents, nurses and faculty from both GIM and ED in the field. Data collection and analysis were undertaken in an iterative fashion until saturation was reached.[24]

Data was collected by a medical anthropology student (KR) under the direct supervision of an experienced sociologist with extensive training in ethnographic data collection in medical settings (FW). The observer's entry to the field involved shadowing both ED and GIM residents. In order to control for Hawthorne effects,[25-27] KR dressed in a lab coat like a medical student and

carried a notebook. However, she was always appropriately identified by a name tag which specified her status as "Research Associate," and all members of the ED and GIM teams were informed that the study was taking place.

Over 60 hours of observations took place in the ED and on the GIM ward. More observations took place at night and at the weekends due to a higher volume of nighttime and weekend consults; these were often more stressful due to additional pressures such as an absence of technical personnel to carry out necessary medical tests at these hours. In addition to quietly observing, the RA also engaged in unstructured research-related conversation with physicians in the ED and GIM. These conversations focused on challenges to providing optimal ED patient care in a major academic trauma hospital, the challenges of meeting the new wait-time targets, the nature of interactions with GIM doctors (for ED doctors) or ED doctors (for GIM doctors), and the challenges of balancing patient care with teaching of medical students. The researcher also asked for information and clarification regarding various relevant patient cases that came up during these observations. During observations, the RA took scratch notes that were later expanded into ethnographic field notes.[28] In keeping with research ethics protocols, identifying information was always omitted, the researcher never accompanied a physician to the patient bedside, and she did not interact with patients or their friends and families.

When telephone consults took place, the RA would observe and then ask the physician requesting the consult questions about the nature of the consult directly after the call. When the ED physicians were busy at the patient bedside, the RA would sometimes do observational rounds of the ED zones. Outside of business hours (8 a.m.-5 p.m.), members of the GIM team were often present in the ED, and it was often possible for the RA to be physically present for consults between the ED and GIM physicians. In addition to collecting observational data, the

observer also shadowed both ED and GIM residents. Through shadowing, the observer was better able to observe the obligations and pressures experienced by individual residents over the duration of a shift. Moreover, because GIM residents work involves regular mobility back and forth between the GIM ward and the ED, shadowing was the only way in which the observer could observe the full scope of a GIM resident's work throughout the duration of a shift.

Five residents on both the GIM and ED teams were shadowed during overnight shifts.

In order to expand on topics raised during observations and shadowing, twelve one-on-one interviews were conducted by the same RA with staff and residents from both the GIM and ED teams. An email was sent out by the chief of staff to all staff and residents in both the ED and GIM, notifying them of the possibility of being interviewed for the study. Willing respondents replied to the chief of staff, who subsequently passed their contact information along to the RA. The RA de-briefed with the lead investigator (FW) following observations and interviews. Interviews were digitally recorded, transcribed and coded thematically using MAXQDA version 8 (VERBI GmbH, Berlin) qualitative data analysis software. All transcripts were read independently by two researchers (FW and KR) and the codes were entered into the software by the RA. Codes were organized into categories and emergent themes were presented to the larger research team for further discussion and analysis across several meetings.

Our analysis drew on concepts from institutional ethnography (IE). IE recognizes that people's everyday lives are sites of interface between individuals and a vast network of institutional relations, discourses, and work processes; it takes as its object of interest this interface between embodied individuals and institutional relations. IE emphasizes "a person's experience of their own work"[29] and examines how their work is coordinated with that of others.. IE researchers explore the experiences of real people in actual settings by seeking to understand

their standpoint. In our study, we took up the standpoint of internal medicine physicians as an entry point for our investigation of the social relations organizing consults between ED and GIM. In conducting observations and analysis we also drew on Hafferty's concept of the hidden curriculum, designing our study with an eye to "what students learn, instead of what they are taught."[15]

Results

Two key aspects of the hidden curriculum stood out over the course of our research. First, participants described an impression that efficiency is understood as being more important than education and has in fact become the new definition of "good" patient care. Second, the persistent use of the informal term "failure to cope" to describe high-needs patients suggests that they were viewed as a unit of work – and in many instances experienced as a barrier to optimal efficiency – rather than as individuals requiring care. Our informants described engaging in practices that avoided or redirected patients; indeed, having to perform patient care was often negatively associated as having less power than others on the team.

Efficiency trumps education

Repeatedly, participants' accounts of their approach to teaching referred explicitly to efficiency. While the formal curriculum may emphasize accurate diagnosis and high-quality, patient-centred care as the over-arching objective for ED and GIM physicians, during structured interviews, informal conversations, and observations, we found a clear emphasis on efficiency instead. For example, when asked how he teaches residents and students consultation skills, a staff ED physician responded:

> **…** I try and teach efficiency … really my focus down there [ED] is on
>
> efficiency and work flow, so that's what I sort of try and teach them
>
> *(*participant #6, senior GIM physician*)*…

Several physicians noted that the emphasis on efficiency sometimes comes at the expense of providing good training to medical students and junior residents:

> The department is being funded based on meeting performance targets, so
>
> trying to get people either referred quickly or out of the department quickly. So
>
> that's one issue, and that leads probably to earlier referrals than we would have
>
> in the past. It probably leads to less learning opportunities for our trainees
>
> because there's increasing pressure to get the patient referred quickly or to send
>
> them home quickly so, you know, the procedure that you would have had your
>
> trainee do is now going to be referred to the consultant (participant #5, senior
>
> ER physician)*.*

Physicians from both the ED and GIM told us that they were often not able to diagnose patients before referring them to a specialty due to the pressure on ED physicians to admit or discharge patients as quickly as possible. Rather, the emergency room physicians would often eye-ball patients, ascertain they were ill, and refer them to an admitting specialty – usually GIM, especially if the patient was frail and elderly. This did not actually cut down on the amount of time that the patient waited for care, but it did transfer the work out of the ED.

Perhaps the strongest evidence that efficiency has become a paramount priority is the creation of a new role in the hospital that was developed to address the wait-times issue. The Clinical Care Leader (CCL) is a nurse who is responsible for making sure that the hospital meets

wait-time targets by ensuring that patients are discharged or admitted quickly. S/he circulates the ED, doing whatever s/he can to advance this goal.

Physicians' impressions of the CCL role were uniformly negative:

It's [the CCL] a useless position. I mean, maybe there's something they're doing that I don't see, but in my interactions with them, if anything they just take up more time and slow us down … we're always balancing competing interests, and **to have a person whose sole job, it seems to be, is to tell you to work faster,** is just... you know, it's poor judgment, it's insulting, and **it causes a lot of friction between the Emergency room and medicine** (Participant #3, GIM Resident).

The CLL was evidently a source of stress on staff and residents alike. There was almost unanimously expressed negative feedback on the CLL role, especially from residents. It was clear that students and residents understand the CCL not as role that one that exists to provide better patient care, but rather one that reinforces the hidden curriculum of efficiency. In the following example a GIM resident talks about their impression that the CCL is there to "offload Medicine" :

I think the big thing is having the [CCL], having a way to offload [to] Medicine with the grey area consults, I think that's the biggest change. I think that'll improve the Emergency efficiency more than any other intervention (Participant #2, GIM resident).

However, in making the ED more efficient by transferring these "grey area consults" on to GIM, GIM staff and residents come to feel undervalued and taken advantage of:

Sometimes I think it's personal but at other times it's just I think the stress that's on everyone to meet the demands of seeing a lot of patients. For instance, on Medicine we're more than happy to see patients who we consider... you know, I guess the word would be appropriate for us, but we don't... we often feel like we're getting taken advantage of (Participant #3, GIM resident).

Failure to Cope

During initial observations we noted the pervasive use of the term "failure to cope" as a description of certain patients. During an evening observation, one GIM resident explained to the researcher that a newly admitted patient was a "failure to cope," and continued by reflecting that "we're getting a lot of these failure to copes today." We subsequently paid particular attention to how this term was used, asking for further clarification when necessary.

"Failure to cope" was frequently used in a diagnostic sense. Although it is not a recognized medical condition or diagnostic category, a number of physicians implied that it was a legitimate diagnosis:

> **Participant #4, GIM Resident:** So, failure to cope is a very interesting diagnosis. There's not a lot of literature on the topic, but a failure to cope ... can encompass a lot of different things but generally it's felt to be someone who doesn't have a clear overriding medical problem, or at least not an acute medical problem, but is not safe or well-supported enough to continue living in their current situation.
>
> **Researcher:** Now, when that person comes into the Emergency room, will the ED docs actually refer that patient to you guys as a failure to cope?
>
> **Participant #4**: Yeah, they will.

Among physicians, there seemed to be a consistently articulated understanding of what a typical "failure to cope" patient "looks" like that was expressed during formal and informal interviews: elderly, frail, likely confused, and otherwise unable to look after daily needs without help. Yet failure to cope was clearly not descriptive of the patient's medical condition. Participant #1, an ED resident, said the term is used "if there's no obvious diagnosis but you just don't think the patient can go home or maybe it's not a great social situation or they're elderly and then maybe the rest of the team is pretty busy…" Other physicians also noted the "failure to cope" diagnosis is often related to needs that they understand to be "social" in nature:

> They're not really being admitted for a medical reason, they're being admitted
>
> for a social reason (Participant #2, GIM resident)

In addition to being understood as a social diagnosis, "failure to cope" is also described as a sort of hidden diagnosis in the context of medical coding and billing:

> And the thing is, in order to meet the requirements for the Ministry of Health
>
> billing, that's not a diagnosis that is recognized – like, you can't put a code on
>
> that – so you have to find something, which may be sort of misrepresenting the
>
> case of what the patient actually has **…** But someone who is purely just a social
>
> admission, you have to be pretty creative to come up with a billing code,
>
> otherwise you're not going to get paid for the work you're doing (Participant
>
> #4, GIM resident).

"Social" admissions seemed to be understood quite dichotomously in relation to "medical" patients, whose health problems were more easily identified, isolated, and treated through strictly biomedical means. Both staff and residents also suggested that "failure to cope" patients somehow have a less legitimate claim to hospital bed-space, indicating that these

patients "block" beds that could better be used by others:

> When you're running at 110% capacity it's disheartening to see a failure to cope
>
> because you know that they may end up tying up a Medicine bed for very long
>
> period of time that someone who is acutely ill is not going to have access to.
>
> (Participant #4, GIM clinical associate)
>
> They're time-consuming and they're not as great educationally and they tend to
>
> block beds. I understand they're still people and still need care but those are
>
> challenges for us. (Participant #6, senior GIM physician).

These accounts focus on the patient as failure, yet there is also a less-visible accounting logic embedded within them; a logic that is consistent with broader political developments that have imposed a culture of management through measurement on virtually all aspects of the delivery of health care (30). The wait times problem in ED is articulated as being the result of limited resources, and specifically, lack of beds. And underlying the lack of bed space is the problem of patients who "should not be" taking up an expensive acute-care bed. As one internal medicine resident noted during an observation, "There's nothing we can do for these patients, it's a bed issue."

Physicians noted that the emphasis on speedy admission meant that many "failure to cope" patients end up in GIM regardless of whether GIM could best offer the kind of care that they require. Physicians were often candid that these patients may require support and services that they are not able to provide within the parameters of their specialized professional capacity:

> Partly because of the **new performance targets** … these patients just need to
>
> be admitted to hospital pending placement. It's probably not the best place for
>
> them: **they're taking up an acute care bed**, but we don't have any other

infrastructure available to us (participant #5, senior ED physician, emphasis

ours).

Interestingly, some GIM physicians acknowledged that "failure to copes" often *do* have

an underlying medical condition that led to their admission to hospital but the impetus for speedy

admission means that these conditions are oftentimes not recognized in the ED:

Often I think it's come up, you know, **there are eventual medical things that**

are found to explain patients' deterioration that weren't readily apparent in

the Emergency Department and just take some time to present themselves

(participant #5, senior ED physician, emphasis ours)

While we observed many examples of effective collaboration between ED and GIM

doctors, it seemed that failure to cope patients – and the push to admit them to GIM, perhaps

without a concrete diagnosis – was demoralizing for the physicians in GIM:

And we already have 15 patients to see on an average night there, so one of

those – which you always get one of those failure to copes a night, sometimes

two or three a night – and they each [take] up 30-45 minutes to deal with, and

it's not really medicine, it's you're being, like, a glorified secretary, almost,

which is not really the job of the consultant, that's the job of the Emergency

doctor to decide on a patient's disposition, and when they rush it, it creates

more work upstream (participant #3, GIM resident).

Discussion

Ontario's wait times strategy introduced new, time-sensitive pressures for the emergency

department, as the problem was defined as one of physicians and nurses not working fast

enough. We observed that the policy changes that formed the context of our study are having unplanned effects on the education of the trainees involved in the consultation process.

Our study provides an account of how the logic of accounting permeates physician consciousness, refocusing the medical gaze, restructuring social relations between physicians, and ultimately leading to profound changes not only in how residents and trainees are taught, but what they are taught. In our study the shift in priorities moves from teaching/learning good clinical care and assessment to meeting organizational performance measures. This creates tension and conflict during consults between ED and IM physicians, while the medical gaze is refocused on the "next patient waiting" rather than on the patient in front of you.

As Hafferty observes, "the process of learning to differentiate between what is 'important' and what is 'not important' within the life-world of medicine is at the very heart of learning to become a doctor" (15). In examining the learning and modeling of interprofessional collaboration between the ED and GIM department of a major academic trauma hospital in Ontario, we found that government policies aimed at reducing ED wait-times are having a significant impact on the training of medical students and junior doctors. The pressure to reduce wait times meant fewer opportunities for teaching, resulting in medical staff both explicitly and implicitly teaching trainees that efficiency is paramount.

This emphasis on efficiency was exemplified by the use of the informal description, "failure to cope," as a medical diagnosis, despite the fact that it confers no medical information about the patient and is not recognized as a diagnosis in the medical literature. In addition, use of the term "failure to cope" implies that the patient themselves have somehow failed, and may be stigmatizing. Being labeled as such may alter the way these patients are perceived, and may furthermore mask institutionally produced stress and conflict. Observations during shadowing

and interviews all suggest that these sorts of patients very regularly present in the ED, and their care has become part of the daily responsibilities of GIM doctors. The working use of "failure to cope" advances the accomplishment of performance targets to the detriment of clinical care and intraprofessional collaboration.

There has long been debate in both social science and health services research about how to properly describe patients, often with a particular focus on how these definitions inform our understanding of the proper relationship between patient and physician.31, The medical gaze has been deconstructed for decades by medical sociologists, anthropologists and critical theorists (Becker[32]; Atkinson[31]; Sinclair [33]; Foucault[34]; Art Frank[35], to name but a few) who have examined the impact of medical culture on how patients are constructed. These perspectives have allowed us to recognize that the language we use to describe patients is not just a matter of semantics. Language confers meaning, it does not just describe, and each of the terms used to describe patients is historically deep, as well as salient in the present. In addition to the many and varied terms used to describe patients over the years, there are of course also the informal terms that circulate unofficially amongst caregivers and administrators. Many of these terms developed in response to specific government policies and are thus highly problematic. When wait times became a government priority in Ontario, certain patients became known as *bed blockers*. This term refers to those complex, often elderly patients with high comorbidities and lack of community support who could not be treated quickly and released. The current focus on efficiency and accountability has also led to patients being described increasingly in terms that suggest they are the source of the problem in relation to system inefficiencies (*frequent fliers*), bed shortages which resulted in the need for shorter lengths of stay (thus creating *bed blockers*), and poor health planning for an aging population (*failure to cope patients*). The patient always

seems to present some sort of problem that the health care system must overcome. And more importantly, they become a *problem* for the individual clinical team rather than a focus of care. These policies and resultant discourses shift the clinical focus away from the patient and toward the achievement of "system" efficiencies.

We also observed that the emphasis on efficiency meant that more patients were transferred to GIM following fewer diagnostic tests, meaning more work was pushed onto GIM doctors. This caused increased tension between ED and GIM doctors, further reducing opportunities for trainees to observe good, collaborative consultation processes between these specialties. These findings, as well as explicit statements by staff physicians about teaching efficiency – sometimes at the expense of other aspects of medical training – suggests that the hidden curriculum of efficiency is barely hidden at all.

Finally, the introduction of a CCL nurse whose specific job it was to ensure that patients were seen within the specific time periods set by administration dramatically worsened rather than improved collaboration between physicians and nurses. As has been noted extensively elsewhere, traditional hierarchies between physicians and nurses often place nurses in an unequal position in hospital settings.[36] The CCL role exacerbated these professional tensions and re-focused the nursing gaze to achieving system goals rather than patient care in a manner that did not allow for good team work to be modeled or learned between residents and nurses.

Our study provides an empirical example of how a policy introduced to reduce system inefficiencies (in this instance an ED wait-time strategy) has unintended implications for medical education, and thus for the care that medical trainees will ultimately provide to the public. Through the hidden curriculum of efficiency, trainees are learning that knowing how to deflect patients elsewhere is an important component of good medical practice. Policy makers should

consider the potential for policies that affect medical practice to also influence the hidden

curriculum, and the impact that the hidden curriculum can ultimately have on patient care.

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Disclosures

Disclaimers

None.

Previous presentations

Some of our findings have been presented as an oral presentation at the Canadian Conference on Medical Education (Toronto ON 2011) and at the Association for Medical Education in Europe (poster presentation 2012 Vienna Austria).