Avoiding Fumbles and Understanding Populations

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It seems right to be talking about handoffs in the midst of football season. Anyone who has family who have encountered the health system in the past decade likely has a story of miscommunication, misinformation or simply poor care that is, at the least, aggravating and, in some cases, life threatening. The press also is full of stories of fumbles from badly managed medical handoffs.

In the simpler days of 30 years ago, the handoff consisted of a phone call to a specific doctor—who the referring physician generally knew well—asking either his or her opinion about management or referring the patient for a consultation. The referring doctor told the consultant the "story" and followed with a letter about the patient. In turn, the referring doctor often got a call back with the consultant's opinion or ideas and a letter followed. Doctor to doctor, in person. The hospital was easier, since we cared for patients in the hospital and arranged the discharges ourselves. In recent years, many generalist groups created a weekly hospital rotation for their clinic, so they made the handoff in person to partners. Hospitals, even for those who spent little time with inpatient care, were places that helped create social networks among clinicians. Breakfast in the doctor's dining room of the city hospital where I worked was where the practicing doctors broke the new people in and where we listened to lots of cases being talked about. It was the best continuing medical education (CME) I ever had. Those informal social spaces have been replaced, for the most part, by functional 7 AM meetings about tasks and administrative chores. Personal connections are being lost.

In large health systems like those in Wisconsin, the simplicity of past handoffs has come unglued to the point where their number, internally and externally, can be truly staggering. They involve primary care clinicians and their advanced practice clinicians; emergency department physicians; admitting hospitalists; consultants in the hospital—each with an opinion—and advanced practice clinicians, fellows and residents in tow; discharge planners, and then, if things work well, back to the primary care clinician with an accurate summary of care and communication about plans and goals that have been worked out between the hospitals and the community-based generalists. We all know there are far too many opportunities to fumble things during a hospitalization, and reliance on the EHR to solve the problems is misinformed, at best. Technology is more about documentation than communication and the fragmenting of care continues unabated today. The next generation of physicians who come from a culture whose overall communication skills may be subverted by the ubiquitous cell phones they glance at continuously will have to work harder than we did without those distractions.[1]

In this issue of *WMJ* the very important article by Carnahan and Fletcher[2] describes a high level of confidence of internal medicine house officers expressed in their discharge planning skills, while questions about specific skills challenge whether that confidence might be misplaced. The house staffs admit to little formal education about handoffs during their training and rely on rounds and other informal methods to learn. One particularly chilling comment from the discussion is "house staff also identified communication with primary care providers, especially via discharge summaries, to be of great importance in the transition of care from hospital to home. Interestingly, many house staff did not believe that discharge summaries were usually available for primary care providers at the time of hospital follow-up." The unexpressed question in this statement is whose responsibility is it to see that failure never happens? Seeing a "hospital follow-up" on one's schedule for the day, with no idea what happened or what is expected during the visit is more the rule for my family medicine

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colleagues than the exception. A phone call from the hospital consultant to a patient's primary physician saying "here is what went on, here is the plan for ongoing care, and here is what you could do to help" is essential to a completed handoff.

My favorite story about this scenario comes from my first job in Worcester, Massachusetts in the 1970s, when a senior resident in family medicine came to see me with an amazed look on her face, saying that the chair of pediatric surgery at the Mass General had just called her personally. He thanked her for her referral, reinforced that her diagnosis of a patent urachus was correct, reported that the patient's surgery went well as anticipated and that he wanted the resident to talk with the family at follow-up to reassure them about the child's future well-being and that a letter would follow. The call took less than 3 minutes and established a referral pattern from that resident for the rest of her clinical career. Some today might feel a text or e-mail might suffice, but I don't think so. Getting a thank you call from Hardy Hendren was still one of the most important events in my colleague's life 40 years later. Technology will never replace simple courtesy.

Communication

On the topic of communication, the article by Olejniczak and colleagues[3] reinforces the challenges of communicating effectively with adolescents who need to have confidence and trust to talk about difficult things, like family and personal struggles. The authors describe a statewide program to improve clinicians' skills in talking with adolescents and to increase the comfort of adolescents in talking with clinicians. The program showed real progress in both groups and the involvement of teens as educators for clinicians was an added benefit for the program.

The Value of Looking at Populations

This issue also contains a number of articles on populations in the region and set the stage for how clinical systems might approach risk and prevention. Fortunately, maternal mortality is a rare event and the overall state rate remains substantially lower than national averages. But, as Schellpfeffer and colleagues[4] report, the disparity between African American mothers and all other races and ethnicities remains and, following on past studies, has not made progress. Their study reports data from the Wisconsin Maternal Mortality Review team, which goes into detail about reviewing circumstances and management of deaths. Morbidity review is the traditional way medicine tries to understand causes and avoid future tragedies. But the data also reveal the extent to which social determinants of health like education, family structure, and poverty add to risk. There are certainly clinical issues that should be attended to, but the majority of the factors lie outside the hospital and require community solutions of which health professionals should be a part.

What is particularly amazing in this issue is the "Looking Back" piece from Dr Amy Louise Hunter from the 1940 *Wisconsin Medical Journal,*[5] which discusses the situation with maternal and infant mortality in the state. While reporting systems and definitions may differ from 1939 to now, the disparities at that time were more rural than urban and the correlations with poverty and lack of access to care resonate with the findings of Schellpfeffer et al 75 years later.

Peterson and colleagues[6] report from the state cancer registry on the widely discussed phenomenon of increased incidence of malignant melanomas, with the good news that survival has increased in the state, which is in contrast to decreased survival nationally. This article would serve as an excellent discussion paper for physicians in training and students since it raises questions about targeting populations for prevention (mortality in men went up while women went down), or the value and methods of education about risk in targeted younger sun-exposed populations, or might enter the debate about whether the increase is due to an increased awareness, but may not affect patient outcomes.

Thao and colleagues[7] chronicle the high prevalence of diabetes in the Hmong population in the state, which is even more dramatic since the Hmong came from a region in Asia with a low prevalence of diabetes. Their work also shows the unhelpfulness of EHRs in identifying at-risk subpopulations, since Thao had to devise search strategies based on last names to identify Hmong patients in the clinical dataset. As the number of immigrants and refugees rises dramatically in the United States, lumping populations under very broad umbrellas such as Hispanic or Asian or African will not help identify at-risk groups and possibly be blurred by lumping rather than splitting. We can't do a good job with populations unless the available tools help us.

Finally, Gupta and colleagues[8] report on a rare case of a twin molar/fetal pregnancy and how the use of early ultrasound aided the clinicians in the management of a difficult situation that enabled the family to be involved early enough to help them find options under trying and potentially dangerous circumstances.

This issue also includes the moving personal story by Vijay Aswani, MD, PhD,[9] of his service to West Africa during the recent Ebola virus epidemic. Doctor Aswani's story is helpful for understanding how the desire to run toward the burning building, as he says it, has implications at home and for institutions that many of us may not consider when thinking about helping out in a crisis.

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