Successful hospitalization of patients with no discernible pathology

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"Take your work seriously — not yourself."

Introduction

Patients frequently present to the emergency department (ED) with complaints of chronic pain, dizziness, neurasthenia, cognitive deterioration, or neuromuscular dysfunction. Generally, they have already undergone extensive and fruitless investigation. Their clinical exam is invariably unrevealing, and even the most aggressive testing strategies turn up nothing.[1] In most cases, the emergency physician's only viable option is hospitalization, but without a clear diagnosis, inpatient consultants become testy, typically spouting irritating clichés like, "be a wall."

Emergency physicians who admit patients with no discernible illness are often viewed as wimps or losers, and the admissions themselves as "dumps." Because of the lack of a useful diagnostic test, the patients in question are labelled with derogatory descriptors like dwindles, failure to thrive, weak and dizzy all over, malignant fibromyalgia, unstable chronic fatigue syndrome, supratentorial pansynaptopenia, or gomer.

Recently, however, NIH (Northern Institute of Hypochondriasis) researchers have discovered that these seemingly diverse syndromes are, in fact, variants of a single pathophysiologic entity,[2] designated PWDP (patient without discernible pathology). The discovery of PWDP diagnostic criteria is a significant advance ($p = 0.02$); however, this entity remains a huge source of conflict for emergency physicians (EP). On a daily basis, EPs are caught between PWDP victims who require (or believe they require) admission, and inpatient consultants who cling to the outmoded belief that hospital beds should be reserved for patients with treatable problems.

Most experienced emergency physicians have developed strategies for hospitalizing patients with no discernible illness. Such strategies are critical, but they are not described in the EM literature and they are poorly represented in EM residency teaching curricula. The objective of this article is to illustrate a common PWDP presentation and to describe effective dispositional strategies for EPs.

Case report

A debilitated middle-aged male was transported to the ED by paramedics after he was found creating a disturbance in a dumpster. On arrival, he was combative and screaming obscenities. He smelled of urine, alcohol and ketones. The triage nurse quickly identified him as "Phil," a frequent flyer well known to the department. The attending emergency physician rapidly established that Phil's presentation was consistent with alcohol intoxication, drug overdose, head trauma, metabolic derangement, sepsis, intracranial hemorrhage, personality disorder, multi-organ failure or hepatic encephalopathy. Road-testing revealed that Phil could not stand or walk. His old chart documented 79 identical episodes dating back 3 decades. On each occasion he required 7 to 10 days in hospital and, on each occasion, the discharge diagnosis was "weakness secondary to chronic alcoholism." Phil had never been successfully discharged from the ED.

Using our PWDP Admission Algorithm (Fig. 1), the ED physician determined that the only viable course of action was to admit Phil to an inpatient service. It was clear, however, that no consultant would be receptive — especially after viewing the old chart — and that it would take a wily emergency physician to succeed.

The ED admission team leaped into action, resuscitating Phil according to evidence-based PWDP guidelines. The ED nurse administered 10 mg of haloperidol for motor and profanity control, then 2 orderlies stripped Phil, burned his clothing, hosed him off, lathered him with "Kwell," scrubbed him with a soap brush, trimmed his hair, shaved him and applied honeysuckle-scented socks to his feet. The

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ED resident selected khaki pants and a Hugo Boss sweatshirt from the clothing bin and, finally, the unit manager tucked a copy of *The Wall Street Journal* under his arm. The transformation was unsettling. Now — mumbling, semi-responsive, and staring, dissociated, at the ceiling — Phil looked like a surgical resident after a tough night on call.

With help from the attending EP, our senior resident selected a diagnosis from the PWDP guidelines document and notified the admitting service of Phil's arrival. On hearing that a case of Dengue fever was waiting in the ED, the admitting resident arrived moments later, breathless. She attempted to take a history but Phil just muttered incoherently, like a sick patient should. He appeared vaguely unwell but there were neither diagnostic findings, nor notable laboratory values (we had deleted his blood alcohol result from the lab database).

The resident scanned the vital signs on the chart, pausing at the temperature. She placed the back of her hand on Phil's forehead, frowned and rechecked the temperature on the chart. Seeing this, the ED nurse stepped forward and slipped an electronic temperature probe into Phil's mouth. The thermometer's digital readout quickly rose to 38.9 degrees — its pre-programmed setting (note: the ***HiTemp***™ PWDP thermometer is advanced technology recently developed by our own ED researchers). Bewildered, the resident left the bedside and ordered a head CT.

The ED staff released a collective sigh of relief, and the attending EP and charge nurse exchanged high fives. Victory was at hand! The tests to rule out Dengue fever would take days, and only one thing — Phil's old chart — stood in the way of successful admission. But it wasn't really in the way; it was safely locked in a drawer in the back medication room.

One hour later, Phil rolled out of the department, trailed by 2 baffled residents. The ED staff waved a fond goodbye, knowing he was in excellent hands.

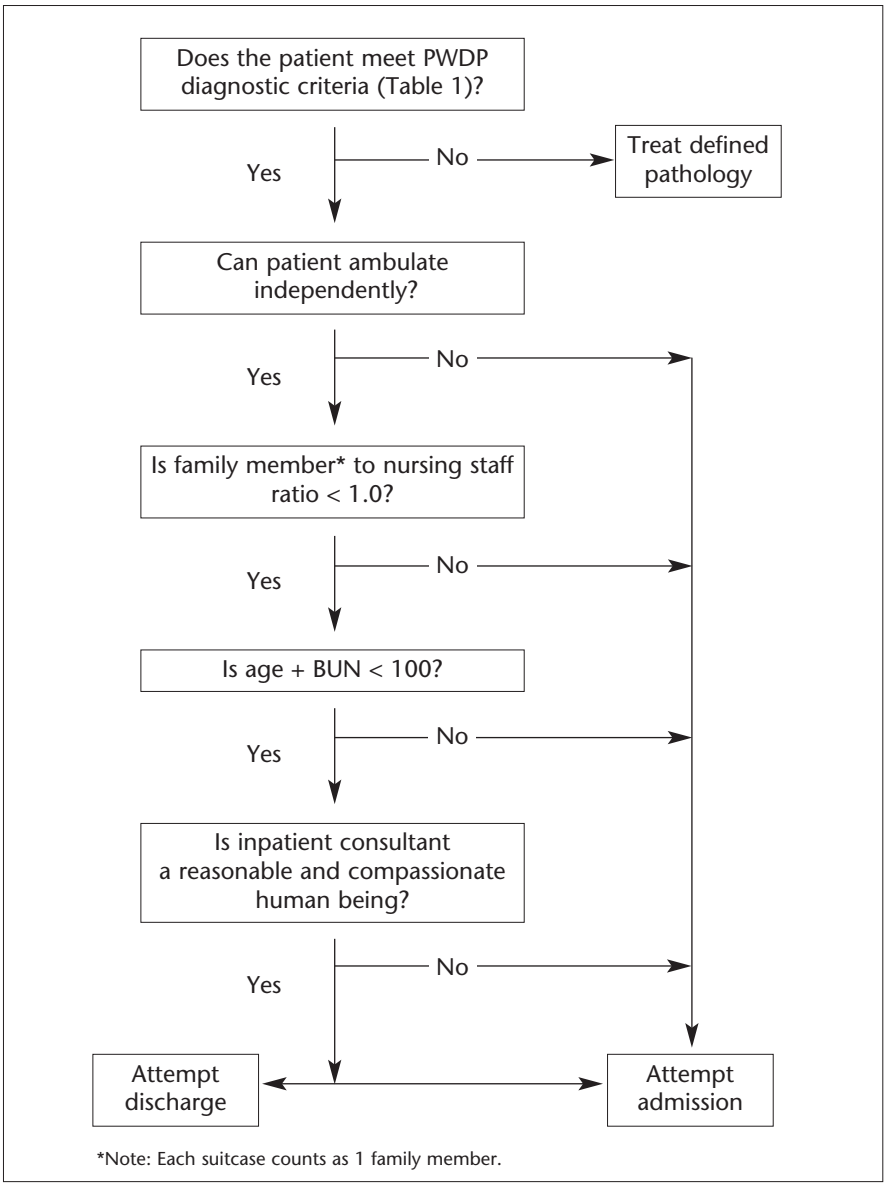

Fig. 1. PWDP Admission Algorithm

Discussion

With the discovery of PWDP diagnostic criteria (Table 1), the sheer magnitude of this problem became evident. A 1998 nation-wide ED survey[3] showed that PWDP is the most common condition treated in Canadian hospitals, surpassing even "abdominal pain NYD." Every 30 seconds, a PWDP victim presents to a Canadian emergency department, requiring admission, and every 30 seconds, an unenlightened consul-

Table 1. PWDP diagnostic criteria

1.	Patient has no definable illness or pathology
2.	Patient or family member believes hospitalization is essential
3.	Consulting physicians believe discharge is essential

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tant who believes that hospital beds should be limited to patients requiring hospital interventions attempts to block it. It is now clear that the need to admit patients with no discernible illness is emergency medicine's greatest challenge. The case report above and the discussion below describe easily mastered admission techniques that can be adapted to any ED.

General principles

1. Recognize high-risk patients. Consultants are especially resistant to admitting alcoholics, drug abusers, hypochondriacs, the demented and the mentally ill. It is critical to conceal these traits whenever possible.

2. When communicating the need for admission, avoid the term "chronic." Instead, substitute adjectives like "explosive, paroxysmal or unstable."

3. When admitting marginal patients, select an appropriate diagnosis. The ideal diagnosis is exotic, difficult to disprove, and mandates hospitalization. Some of my favourites are Tumarken's otolithic crisis, familial periodic paralysis without hypokalemia, and Oppenheimer's progressive hemorrhagic leukodystrophy.

4. Order a large number of tests. Physicians are more impressed by abnormal values than by sick patients. It is, therefore, helpful to order a huge battery of nonspecific tests on anyone who may require admission. A skilled ED physician should be able to generate 2 to 3 intriguing false-positives on any patient. Best bets include C-reactive protein, anti-mitochondrial antibodies, serum lactate, myoglobin, d-dimer assay, and thick smears for Malaria. **Hint:** Always send body fluids for India ink stains. Although they are rarely positive, it is guaranteed to impress.

5. Be positive. "Sell" your patient. Consider the following telephone dialogue.

YOU (the wrong approach, regarding a weak patient): "I'm sorry about this, Dr. Smith, but I have a demented, incontinent gomer who needs admission because of weakness."

CONSULTANT (angrily): "Whaddya expect me to do? Be a wall! Send him home!" Click.

YOU (the correct approach, regarding the same weak patient): "Hello, Dr. Smith. I have an interesting elderly gentleman with delirium, muscarinic overdrive and generalized muscular weakness — probably an organophosphate overdose."

CONSULTANT (fascinated): "Hmm. Get him admitted and I'll be right down."

6. Supplement tests with new technology. Several admission adjuncts have recently been developed.

- ***HiTemp***™ PWDP digital thermometer reads 38.9° regardless of patient temperature.
- ***Admit-Tech***™ pulse oximeter automatically adjusts saturation levels down 10%.
- ***ED Ace***© 12-lead ECG machine prints out 1 of 6 pre-programmed patterns on demand, including ST-elevation infarct, nonspecific T-wave inversion, sinus tachycardia, ventricular fibrillation, ventricular tachycardia, and complete heart block. An optional pacemaker module, which shows pacing spikes without capture, is now being beta tested and will be available early next year.
- Pre-prepared rhythm strips showing runs of ventricular tachycardia, which can be rapidly "generated" from any bedside monitor in cases where consulting physicians express inappropriate reluctance to admit.

7. Document the ED chart well. Some consultants become annoyed when ED physicians consult them without even trying to solve the problem. An ED chart with only 2 or 3 scribbled words to describe a complex patient may be appropriate and succinct, but it will sometimes provoke anger from our more obsessive colleagues. It's better to present the consultant with a long and detailed ED note — even if you haven't assessed the patient. To accomplish this, we use ***ED ChartMaster***™, which generates authentic-looking medical reports consisting of a correct patient health care number followed by several pages of randomly-generated quotes from the collected works of William Shakespeare. In phase 3 trials, consultants were given ***ED ChartMaster***™ notes to review, then asked to comment on the quality of the ED evaluation. In 97% of cases, the consultants rated the ED work-up as "excellent" or "very good." Researchers determined that ***ChartMaster***'s success was largely due to the fact that the consultants *never* read beyond the patient's health care number.

8. Use pharmaceuticals. Several agents have proven effective in well-designed clinical trials.[4-6] We've found a simple, cost-effective approach is to slip 18 mg of adenosine into the patient's IV line while the consultant is listening to heart sounds. Invariably, the patient clutches their chest, moans, and undergoes 4–10 seconds of asystole — a small price to pay given the 100% CCU admission success rates achieved using this strategy.

9. Know your consultant. If the consultant has an interest in infectious diseases, suggest that your weak patient may have anthrax. If the consultant leans toward neurology, suggest subacute sclerosing pan-

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encephalitis or late-onset Werdnig–Hoffman disease. Bovine spongiform encephalopathy never fails, even with highly resistant consultants.

10. Avoid clichés. The phrases, "I have an interesting patient" or "this is a good teaching case" may fool medical students and junior residents; however, they just set off alarm bells for more experienced physicians.

11. Finally, never apologize. It implies weakness in your convictions.

Specific problems: dealing with difficult consultants

1. The contrary consultant. Many consultants have an insatiable desire to prove emergency physicians wrong. When dealing with these physicians, always use child psychology. Consider the following examples.

Wrong approach:

YOU (speaking on the phone about a critically ill patient): "I have a patient in cardiogenic shock who needs to go to the CCU. Can you come and see him?"

CONSULTANT (with a condescending chuckle): "He's just anxious. We see this sometimes. Send him home and have him call my office for an appointment."

Correct approach:

YOU (regarding a patient whose chief complaint is: "My in-laws are driving me nuts."): "This patient has some weird complaints. I don't know. I think he's okay to go home, but I'm only an emergency physician and I can't be sure."

CONSULTANT: "You're obviously missing something. Get him admitted and I'll send my resident down."

2. The ego-driven consultant. Some consultants harbour the almost religious belief that emergency physicians are an inferior species with the intelligence of clay pots. These consultants have complex defence mechanisms that should not be challenged. For example, when they see a trauma victim in the ED who has an endotracheal tube, bilateral chest tubes, diagnostic peritoneal lavage fluid at the bedside, blood hanging, and 2 stabilized fractures, they typically believe: a) that patients arrive this way, b) that first-aiders performed these procedures at the scene, or (most commonly), c) that they probably resuscitated the patient themselves but, for some reason, can't remember doing so.

In such cases, emergency physicians may be tempted to take credit for their work or suggest they know what the diagnosis is. This is the ***wrong approach***, since the mere suggestion that EPs have skills or opinions may destabilize the consultant and provoke erratic or dangerous behaviour. Consider the following example.

Wrong approach:

YOU: "Hi, Bob! Listen, I have a patient who is hypotensive, cyanotic, confused and septic. I've intubated him, given 2 liters of saline, drawn cultures and started antibiotics. He's on his way to the ICU and you'll have to see him ASAP."

CONSULTANT: "Hold it, Sonny! What makes you think he needs to be admitted?"

Correct approach:

YOU: "Hi, Doctor Smith? This is the duty doctor. I have a patient who is hypotensive, cyanotic and confused. I just wondered . . . Is that normal? I've drawn a CBC. Could this be a neurological problem? Do you think I should admit him? Do you want an orthopedic surgeon involved?"

CONSULTANT: "Hold on. I'll be right down."

Note, in the latter example, that you put the consultant at ease by portraying yourself as a moron and degrading yourself ("duty doctor"). Finally, by indicating you have no idea how to manage the patient, you avoid painting the consultant into a difficult situation where he or she is forced to discontinue appropriate therapy and do something bizarre, just to prove you wrong.

3. The recalcitrant consultant. Some consultants are simply too difficult to admit to. In these cases, cut your losses by changing the diagnosis and admitting service. This need not mean a loss of face. Consider the strategy that we've found most effective.

CONSULTANT: "There's nothing wrong with this patient. I refuse to admit him."

YOU (after signalling the ED nurse to trigger the ACLS arrhythmia generator attached to the bedside monitor): "Oh dear! It looks like he's sicker than I thought. He's having runs of V tach."

CONSULTANT (humbled and speechless — shocked that your intuition was better than his): "Duh."

YOU: "Sorry to have bothered you, Dr. Smith. I'll call Cardiology."

At this point the consultant is usually transfixed by the bursts of ventricular tachycardia on the monitor. Thus far we have yet to have a consultant notice that there are no actual leads

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attached to the patient.

Conclusion

PWDP is the most difficult and stressful clinical problem facing emergency physicians today. Simpler, more effective admitting strategies for PWDP victims will help patients and physicians and prevent costly repeat ED visits by patients who should have been admitted the first time.

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