The Emergency Department Dilemma: Discharge or Admit…
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**Story from the Front Lines:**
An 82 year-old man presented to the hospital with lower extremity pain and erythema. He denied fevers or chills and had normal vital signs. The patient stated the tender, warm area in his right leg had been present for 2 weeks and was not obviously worsening. In the emergency department the decision was made to admit him for treatment of cellulitis out of concern for inability to take medications reliably given a diagnosis of mild cognitive impairment (MCI) documented in the electronic medical record. Upon arriving to the medical ward, the patient admitted that while he was not able to manage his medications on his own, he lived with his wife - a retired nurse – who administers and manages his prescriptions. The patient added that he preferred outpatient treatment of his cellulitis if possible. The patient’s hospital course was uncomplicated and he was discharged the following morning after receiving oral antibiotics overnight.

**Teachable moment:**
Admitting patients to the hospital for management of acute medical conditions can be life saving. However, for some patients the decision of when to admit versus managing as an outpatient can be challenging. Several different factors (for example, patient co-morbidities and home living situations) are important in determining an optimal management plan. A better understanding of which patients are at increased risk for hospitalization is one way to help avoid unnecessary hospital admissions. Smith, et. al. conducted a study at 24 randomly chosen Veterans Affairs hospitals across the United States during a 9-month period to assess the appropriateness of acute medical, psychiatric and surgical services.\(^1\) Non-acute admissions (admissions without urgent need for inpatient monitoring or care) accounted for greater than 38% of acute medical and surgical hospitalizations. Reasons found to be associated with non-acute admissions on the medical service included practitioner “conservative practice” (32%), no alternative lower level service available (18%), administrative reasons such as transfer from another VA (18%), and lack of social support (11%). In another study conducted by Landi, et. al, an observational study of six Italian home health care agencies focused on predicting hospitalization of geriatric patients, the study concluded that a combination of both social and health issues could be used to predict those at highest risk for hospitalization.\(^2\)

Specifically, those living alone (OR 1.59), economic hardships (OR 3.01), and previous hospital admissions (OR 3.73) were most strongly correlated with incidence of hospitalization.

For our patient, there were several risks factors that ultimately resulted in his avoidable hospitalization. First was a diagnosis of MCI, a label that probably biased the emergency department physician toward the need for hospitalization. The potential harms of diagnostic labeling - the effect of telling someone who feels well that he or she is sick – are well documented.\(^3\) Also contributing was the typical insufficient time to ask the patient about his social situation (who he lived with, home health care, etc.). Though time constraints and pressures of “efficiency” can limit clinicians’ ability to perform adequate histories and assessments, we must always be attentive to the fact that hospitalization is not without its own risks. Seemingly lost in the transaction was the patient’s preference to
be treated at home if possible. In an article published by Mulley, et. al titled “Stop the silent misdiagnosis: patient’s preferences matter” they describe the importance of making not only the right medical diagnosis but also the correct “preference diagnosis.”¹ A preference diagnosis is outlined as an “inference of what a patient would choose if he or she were a fully informed decision maker.” To accomplish this clinicians must carefully explore the patient’s goals and wishes and engage them in the decision making process.

In conclusion, as physicians we must remember that hospital admission may not always be the “safer” default. Rather, determining which patients are most appropriate for admission is a challenging task requiring consideration of both the medical and social dimensions of health.

References:


