How the Availability of Observation Status Affects Emergency Physician Decisionmaking

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Study objective: This study seeks to understand how emergency physicians decide to use observation services, and how placing a patient under observation influences physicians' subsequent decisionmaking.

Methods: We conducted detailed semistructured interviews with 24 emergency physicians, including 10 from a hospital in the US Midwest, and 14 from 2 hospitals in central and northern England. Data were extracted from the interview transcripts with open coding and analyzed with axial coding.

Results: We found that physicians used a mix of intuitive and analytic thinking in initial decisions to admit, observe, or discharge patients, depending on the physician's individual level of risk aversion. Placing patients under observation made some physicians more systematic, whereas others cautioned against overreliance on observation services in the face of uncertainty.

Conclusion: Emergency physicians routinely make decisions in a highly resource-constrained environment. Observation services can relax these constraints by providing physicians with additional time, but absent clear protocols and metacognitive reflection on physician practice patterns, this may hinder, rather than facilitate, decisionmaking. [Ann Emerg Med. 2018;■:1-9.]

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INTRODUCTION

Background

The last decade has seen a substantial increase in observation services— hospital-based ambulatory care used to evaluate and treat patients presenting at the emergency department (ED)—while a decision is made in regard to admission or discharge.[1] Although evidence from both England and the United States demonstrates that observation services can reduce unnecessary inpatient admissions, reduce inappropriate ED discharges, and improve diagnosis and treatment,[2,3] analyses of claims or medical records contribute little to our understanding of how emergency physicians think. Consequently, little is known about how physicians decide to place patients under observation, or how this influences physicians' subsequent decisionmaking. As the use of observation services continues to increase, answering these questions is important.[1,4]

Emergency physicians now have more information and options to consider in their decisionmaking. Crudely, the process has moved from binary (admit/discharge) to ternary (admit/observe/discharge), with observation affording the opportunity to gather additional information. If physicians' initial decisionmaking processes lead them to incorrect decisions, they risk discharging patients prematurely, with obvious deleterious implications for patient safety, or observing or admitting patients unnecessarily, with implications for efficient resource use, patient experience, and potential iatrogenic harm. Similarly, observation's usefulness largely depends on the degree to which it facilitates better decisionmaking: whether the extra time and opportunities for diagnostic testing it affords are used effectively for the patients who stand to benefit most.[5] Although a few studies have examined emergency physician decisionmaking, we know of none examining decisionmaking in the context of observation services.[6-11]

Goals of This Investigation

This study sought to understand how emergency physicians make decisions about observation services use. Because this decision may be influenced by health policies governing payment and care delivery—for example, the 4-hour maximum wait in the ED in England[12] and

Editor's Capsule Summary

What is already known on this topic

Emergency department patients are often transferred to observation status, but little is known about how emergency physicians make that decision or how that option affects emergency physician decisionmaking.

What question this study addressed

This qualitative study of 10 US and 14 UK emergency physicians explored how such decisions are made.

What this study adds to our knowledge

Although observation status can be used beneficially to provide additional time to sort out a patient's condition, it can also be used sloppily as a way of avoiding making a decision.

How this is relevant to clinical practice

Better understanding of how physicians use observation can help shape policies that will maximize the utility of this process.

pressures to maximize hospital reimbursement peculiar to the United States[13]—we examine emergency physicians' decisionmaking in 2 differently structured national health care systems (England and the United States). We have previously described why we selected these 2 countries and the general role observation services plays in both.[14] We hypothesize that emergency physicians rely more heavily on intuitive thinking when deciding to place patients under observation. Conversely, we hypothesize that the extra time afforded by placing patients under observation may permit physicians to increase reliance on analytic thinking.

MATERIALS AND METHODS

Study Design and Setting

We conducted detailed semistructured interviews with a convenience sample of 24 emergency physicians, including 10 from a large academic medical center in the US Midwest, and 14 from 2 large academic medical centers in central and northern England. We initially planned to sample 10 physicians at each site, but achieved thematic saturation earlier than expected because the interviewers jointly determined that no new themes had emerged during several subsequent interviews. We contacted physicians by e-mail or telephone, informed them about the study, and invited their participation. To ensure representation of various perspectives, we sought a mix of physicians by sex and practice experience. To encourage participation, interviewees received a $50 Amazon gift card.

Data Collection and Processing

Physicians agreeing to participate received a follow-up e-mail or telephone call to schedule an interview time. We conducted and digitally recorded all interviews in person. One interviewer was American and the other was English, and both conducted approximately half of the interviews in each country to balance any cultural biases that might otherwise occur in a cross-national study. Interviewers used a guide containing fixed-response and open-ended questions developed from the observation literature in consultation with our emergency physician coinvestigators (Appendix E1, available online at http://www.annemergmed.com). Questions specific to the decisionmaking process were guided conceptually by dual-process theory. We allowed discussions to evolve naturally, not asking all questions in every instance, altering question order, and asking unscripted questions as appropriate to probe emerging topics of interest. Then we had the audio files professionally transcribed.

Primary Data Analysis

Initially, a trained research assistant read all transcripts to gain familiarity with the data, note any emerging themes, and ensure that respondents' remarks were accurately captured. Then she manually coded the interviews in Microsoft Word (version 16.0.4690.1000; Microsoft, Redmond, WA), beginning with codes derived from the interview guide and creating additional codes as suggested by the data, ensuring that unanticipated themes were incorporated into the analysis. Two coauthors from different disciplinary backgrounds conducted a nonblinded review of the coded transcripts to verify their accuracy and discussed coding discrepancies (which were minimal) until they reached consensus. Finally, we used axial coding to develop an integrative understanding of the connections between codes that explained our data and provided a conceptual framework for presenting our results.[15] We also shared results with clinical members of the research team and sought their feedback to ensure face validity. The study was approved by the University of Iowa institutional review board.

RESULTS

Characteristics of Study Subjects

Our sample of 24 emergency physicians consisted of 5 women and 19 men in full-time practice and covered a wide range of experience levels in both countries. The US physicians averaged 7.8 years' postresidency practice experience in emergency medicine (range 2 to 17 years).

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