Failure to cope

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Physicians around the world use various terms to describe patients who present to hospitals when they cannot function at home. In the United States, the term used is "the social admission"; in Canada, we use the term "failure to cope." Of course, failure to cope is not a clinical diagnosis but a consequence of a clinical diagnosis — an ankle sprain that limits mobility or a caregiver who gets the flu.[1] These terms are shorthand language, used to transmit concisely our mental image of a patient. Unfortunately, they can take on a life of their own, often with negative connotations that lead to poor care — even blaming the patients or their families for their predicament.

Sometimes, it is the health care system, rather than the patient, that is failing to cope. In related research, Jones and colleagues use a strong case–crossover study design and show that a "task-focused, visit-based, contracted service" model of daytime home care nursing visits actually leads to increased, rather than decreased, emergency department visits in the evening.[2] These findings are disappointing but not unexpected, and serve to remind us that patients who require home-based care are complex. When community-based nurses are neither integrated into primary care teams nor equipped with resources to manage patients' problems effectively — perhaps by a limited scope of practice — patients have nowhere else to go but the emergency department.

Hospitals are built to manage medical, surgical, obstetric and psychiatric problems. However, emergency departments have become the final common pathway for some patients with social problems, who end up being cared for in hospital inpatient beds that were intended to be used to treat patients with acute medical problems. Physicians asked to care for these patients often lack expertise or interest in their management, and feel their attention is being diverted away from patients with more acute medical issues they perceive to be their priority. In teaching hospitals, trainees prefer to care for patients who need surgery or acute medical treatments, because these patients are deemed to provide more educational value. Hospital administrators may view patients with predominantly social problems as occupying beds that block other patients from receiving the care they need (e.g., preventing patients from being admitted for planned surgery). For these reasons, "social patients" are sometimes perceived to be an imposition on the core mission of the people who staff acute care hospitals.

KEY POINTS

- "Failure to cope" is a label applied to patients who cannot function at home, sometimes because of new medical problems, but often owing to unaddressed chronic medical or social issues.
- The underlying factors that lead patients to hospital emergency departments are complex, and even interventions designed to ensure they are cared for in the community sometimes fail to do so.
- Regardless of the language used to describe patients with predominantly social problems, physicians need to approach them with the same level of compassion as they do patients with acute medical issues.

When patients with mainly social problems arrive in the emergency department, there are valid reasons to avoid admitting them for their own welfare. Hospitals create an environment that can traumatize patients during their stay.[3] Physicians must weigh the risk of missing a new serious medical problem (because the label "failure to cope" engenders minimizing investigation) against the risk of worsening a patient's status by overmedicalizing their care. If no new serious medical problem is found, the ongoing care of these patients should be adjusted to meet their needs, with routine blood tests, continuous intravenous access and nighttime monitoring of vital signs avoided. Carefully balancing these risks and benefits requires conscious attention that is in itself of educational value.

What is the answer to this problem? The easy answer is that we must improve access to alternative pathways of care and get patients with functional impairment to the right place for their care. Innovations in home care, long-term care and telemedicine may help keep people out of acute care hospitals.[4] But even while these initiatives are pursued, as Jones and colleagues have shown,[2] patients who are not doing well at home will continue to arrive in our emergency departments. We must all remember that social problems are real problems and that those with "failure to cope" require compassionate and thoughtful care just as every other patient does; they are not impositions on our professional lives.

There is nothing wrong with using shorthand language to describe patients; we are not advocating abandoning the terms. But when a label becomes a metaphor for the whole person, it limits how we think about not only the patient in front of us, but about their specific care requirements.

Consider the following: we all have parents or other family members who are aging or suffer from advanced disease, and may show up in an emergency department. Think about how you would react if you learned that your mother with advanced cancer was considered less deserving of her physician's attention than other patients simply because she had nowhere else to turn for care. The next time you encounter a patient who cannot cope at home, frame the issue in this way and ask yourself the following question: What is the right thing to do for this person at this time? And then you will know how to proceed, because it is never a mistake to do the right thing.

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