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NAVIGATING THE PATH OF CARE FOR THE COMPLEX HOSPITALIZED PATIENTS WITH DR. BHARAT BHUSHAN

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A key challenge for a hospitalist is to coordinate levels of care across multiple strata through the hospital setting. This involves evaluation of the patients in the emergency room, appropriate admission to the floor or the ICU, administering appropriate care while in the hospital and appropriately advising the patient during discharge, all of these aimed at "complete recovery" so as not to encounter an early hospital readmission. No single model of care is applicable to the patient, the hospital or the attending physician. Dr. Bharat Bhushan, an internist and hospitalist, based out of Lubbock Sound Physicians Health System, advises us to embrace the complexities that arise during the tenure of the stay in the hospital. He advocates a multipronged approach, much like the organization of tapestry. This is being feasible because Dr. Bhushan can visualize the multiple complaints of the patients on an individualized platform basis, hammering the complaints into physical, mental, social and economic domains of problems.

This makes it a valuable approach in providing highest quality care to the complex hospitalized patients. The field is currently benefitting from Dr. Bhushan's wealth of experience, resulting from a lifelong commitment to internal medicine. After completing his medical school in which he received a Certificate of Appreciation for helping victims of the Bhopal gas tragedy, he served a residency in general medicine at the prestigious Gandhi Medical College in Bhopal. He served a second residency at the Prince George County Hospital in Cheverly, Maryland. He held several leadership positions, including Program Director of the hospitalists program in community hospitals affiliated with the University of Pittsburgh Medical Center. More recently, in his hospitalists' role, he serves as the Lead Nocturnist at the Covenant Medical Center (Sound Physicians). Dr. Bhushan's envious career in medicine is dotted with examples of experience from hospitals from all over the world. He has special interests in enhancing efficiency of care of patients, unconstrained by the numerous challenges that the current healthcare setting is facing. To this, he adds his medical management expertise that he acquired as an alumnus of the Carnegie Mellon University and the Samson Academy of Leadership at the Cleveland Clinic. It is thus conceivable, how the management of the complex hospitalized patients was deconstructed into a simplistic model by Dr. Bhushan. It is an overarching concern for all of us who work in the hospital to have as much seamless care of delivery as possible. Dr. Bhushan's approaches provide us with an exceptional level of fluidity in order to make decisions in the best interest of the hospitalized patients. In fact, these contributions of Dr. Bhushan are at the helm of preventing physician burnout, one of the most pressing issues currently facing global physicians. Physician burnout has recently been identified by World Health Organization (WHO) as a distinct, significant and pervasive global healthcare problem. In this way, Dr. Bhushan has transcended in his roles as "*caring for the carer*", while keeping the interests of his patients as the main epicenter of his daily activities. I delved into the details of Dr. Bhushan's approaches in a candid interview.

Q: Welcome Dr. Bhushan. What do you mean by a "complex" patient?
BB: The definition of "complexity" of a patient is not linear. In straightforward terms, it would usually mean interplay of conditions, disorders or disease processes arising from one or more multiple organs. The conditions can arise either from a medical standpoint or organ-based complications in a surgical patient. The patients may present either in the ambulatory setting. Often, I encounter them in the hospital. The challenges of complexity are both related to the difficulties in diagnosis, as well as the nuances in optimal management.

Q: Then, how shall you define the complex hospitalized patients?
BB: The patients in the hospital obviously have a challenge which is difficult to tackle without direct supervision; thus, an executive decision is taken to request to confine within the hospital. Certain conditions

like an emergent heart attack merits immediate attention. Patients admitted for other reasons may be relatively immobile and are predisposed to formation of clots within the blood vessels. These clots can dislodge from the leg veins and cut out the circulation of the lungs. Fine thinking is required on the part of the clinician, who screens out the high-risk patients who need advanced imaging for understanding the status of the clots. These cost-benefit approaches add up to savings of precious healthcare dollars.

Q: Technically this seems like all of your patients shall have some levels of complexity.
BB: That is true to an extent. One of the first levels of things that I reconcile is the medication list. This is fundamentally important to the prevention of medication-based errors, one of the most important causes of prevention of complications arising in the hospitalized patients. These reconciliatory efforts are important both on the medical floor as well as the ICU. Superior communication skills are very important in ensuring this success. Regular rounding with the clinical pharmacists is at the heart of prevention of medication errors.

Q: What are the other conditions that can add to the medical complexity in the hospitalized patients?
BB: Chronic and unexplained pain is a frequent accompaniment of many hospitalized patients. Under some circumstances, post-operative conditions, heart attacks, chronic confinement to bed due to orthopedic problem can all cause pain. Post-bariatric surgery patients often have pain, which can reduce their ambulation. Reduction of pain allows the bariatric patients to move around, to have adequate lung aeration and prevention of lung collapse. A right balance has to be created so as to reduce pain optimally and to prevent reliance on habit forming pain medications like opioids. As we know, reliance on pain medications, especially after surgery, has been the proposed nidus for the current opioid epidemic. Another growing menace, especially among the youth population, is the abuse of clinical substances like marijuana. Marijuana contains metabolites which are soluble in the body's fat; thus, even if a person stops smoking marijuana for some time, these metabolites may still be present in the body. These may predispose the young patients to the risks of sudden cardiac rhythm disturbances and even sudden cardiac death (also called Brugada Syndrome). These unexpected complications can increase the complexity of the trajectory of the hospitalization course.

Q: Is there any other issue that you would like to bring to our perspective regarding the nuances of care of these patients.
BB: Important areas which can cause downhill course are situations that malign the cognitive state of an individual. This is especially important for elderly and frail individuals. Delirium or acute mental confusion can arise from electrolyte abnormalities, adverse effects of medications or during the course of the hospital stay as an evolving feature of the primary illness. It is important to distinguish between dementia and delirium. I vigorously counsel for these issues with patients and their family members. Compounded with these are real world issues like homelessness and affordability of treatment, which significantly alters the course of the hospital stay. Coordination of care for elderly individuals with social workers is a key step in doling out the appropriate insufficiencies faced by these individuals.

Q: Does mental illness have an impact on the complexity of the hospitalized patient?
BB: Very much so. In parallel to the medical conditions of my medical and surgical patients, I take deep interest in the behavioral and the mental health issues. It is being increasingly realized that excellence of care merits a bridge to tackle both the physical and mental health aspects of an individual patient. For example, major depression sets in a majority of patients admitted in the hospitals after myocardial infarction. Depression can cause issues with medication compliance. Patients can be depressed while they are in the hospitals, could have prior mental comorbid illness or may arise from social isolation in hospital. Routinely, internists are not trained to effectively deal in the domain of consultation-liaison psychiatry. Recently, I have reviewed the impact of different anti-psychotic medications on cardiovascular health, hypertension and hyperlipidemia. Prior to hospital admissions, a lot of emergency room visits, especially at nighttime, involve drug overdose, chemical substance abuse and behavioral health issues. Being explicitly informed about these issues enhances the confidence of the managing team in order to take a step forward for the patient in the mission of healing.

Q: To an extent, any ill person admitted to the hospital will face a certain level of isolation while they are in the hospital. How do these affect the care of the patients?
BB: It is well known that social interactions influence the functioning of the bodies defense system. Stress and illness are frankly lowered when group ties are established. Theoretically, we seen this in many classic movies like "One who flew over the cuckoo's nest". The physical environment of the hospital and demands of work often preclude social interaction. Loneliness is an ancient nemesis, creating hostility to happiness. Coupled with these is an inherent sense of ill feeling associated with the sickness. Issues as simple as having to eat hospital food or sleeping on a different bed makes one "feel away from home". In creased noise and light can significantly disrupt sleep making one unnecessarily demand for pain medications, sleeping medications or even to take drugs. Many important things are affected: Quality of rest, patient's privacy, even the lack of fresh air. I endeavor to enhance the social contact of the patient, even in ICU so the individual does not feel weak, passive, dependent or powerless. Brief purposeless chat or an empathetic touch can go a long way beyond therapeutic measures can improve the physical health

and heal the patient. Many patients discharged from the ICU have a prolonged lingering "post-ICU" illness, which can significantly diminished by litigating loneliness and enhancing family visit time during the duration of the hospital/ICU stay.

Q: Neurological disorders form what percent of share of your patients?
BB: Neurological disorders pose a huge burden of disease. By 2030 it is anticipated that the burden shall escalate to 103 million disability-adjusted life years (DALY). The hospitalized neurologic patient represents the prototypia of the complex medical patient. Arriving at a diagnosis for a patient with undiagnosed neurologic condition is like working like a medical sleuth. The patient may present with sensory or motor symptoms or a combination of both. My policy is always to obtain a detailed and meticulous history, the systematic approach always almost leading to a narrowed list of differential diagnosis. The demography of the neurologic emergencies and neurologic based admissions are changing. Previously infectious diseases like tetanus, poliomyelitis, meningitis, malaria and tuberculosis commonly resulted in neurological disability. Currently vascular causes, stroke, dementia, Alzheimer's disease, nutritional deficiency related diseases form the common picture. Drugs and alcohol are also highly contributory to neurology-based hospital admissions, as are head injuries from road traffic accidents. I rely on algorithmic based approaches to arrive at reasonably focused diagnosis.

Q: You have been a passionate advocate on advanced directives. How does this impact care of patients and their families?
BB: I have demonstrated through my studies that advanced directives or "living will" influences the patients and their family and substantially impact the utilization of resources and costs of healthcare at terminal stages of life. High fidelity documentation has a significant impact on utilization of healthcare resources.

Q: Thank you Dr. Bhushan for this enlightening discussion. How does this meticulousness impact the functioning of the whole system?
BB: The hospital environment will continue to grow complex. This shall be both in terms of the models of care as well as the presentation of the patients. All of us have a narrative or an algorithmic, nearly-standardized approach, to patient care. A simple conscientious approach in order to provide holistic care and deep interest in patient welfare makes the difference. My approach is a quasiquantitative perspective into breaking things into its consequent parts, as well as not losing the vision so as to visualize the patients and their complaints as a whole. Keeping the patient at the center of my activities is my key to my daily success as a hospitalist.