Jejunostomy tubes: A solution in search of the problem

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The article by Kidane and colleagues,¹ entitled “Emergency Department Use Is High After Esophagectomy and Feeding Tube Problems Are the Biggest Culprit,” identifies an inanimate object as the cause of a very human problem. This article demonstrated how a “trivial” part of the operation resulted in significant expense of health care resources and a loss of quality time for many patients. Of the approximately 30% of patients who visited the emergency department (ED), J-tube issues accounted for approximately 40%, with another 13% visiting for dysphagia, together accounting for more than half of these “acute care” visits. We now live in a practice culture in which ownership of the patient and the after care of the “case” are controlled by phone triage or “if this is an emergency please call 911 or go to the nearest ED.”

I learned to provide a patient care experience from a Kelley, a Lori, or a Sharon who spent endless hours on the phone before, during, and after the operation to create a bond with patients and families to provide a lifeline so that years later patients would stop to visit, call to check in, or call for help with a dental appointment because they could not navigate the system without the help of these nurse coordinators who calmed their fears, brought them into the office, or made me make calls to resolve issues for them.

This is now known as “concierge” medicine and is what was provided for my patients by these nurse coordinators. The ED almost never saw the esophagectomy cases unless it was for another problem, and then we almost always knew about it because they would call our nurse coordinators to let them know. However, the importance of these numbers for ED visits for trivial problems is lost on those who have not worked in a system in which the face of our programs and practices is seen in the pictures of our nurse coordinators. In fact, access to care is not as important as the coordination of this care in determining delays in care or ED visits.²

Patients with a complex operation, without the active involvement of a nurse coordinator, will seek their own solution for care, which often is the ED. Experienced nurse clinicians can reliably predict those patients who will

Care, communication, and compassion cannot be replaced no matter how small the incision.

Central Message

Health care economics has resulted in a loss of ownership and constancy for patients and families. The unintended consequence of increased resource use is now being seen by increasing ED visits.

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require readmission and ED visits that could have been preventable.³

One of the biggest limitations of the study by Kidane and colleagues¹ was the lack of knowledge of other visits to outside EDs or providers. A care coordinator dedicated to these patients would know from frequent contact how the patients were doing and avoid these visits in many cases. Use of this care coordinator model at the Gunderson Clinic reduced the length of stay by 46% and unplanned admissions by 64%.⁴

The article demonstrates that there was a large group of patients who had issues that required an ED visit, which is costly both in health care dollars and in patient time. However, I would argue that the real culprit is our system that has allowed us to move away from a culture of patient-centric coordinated nursing to “if this is an emergency please hang up and dial....”

Thank you Sharon, Lori, Kelley, Melissa, and Amy for teaching me and my residents how it is done.

References

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