



# THE EMERGENCY DEPARTMENT: EVERYTHING TO EVERYONE OR RESTRICTED RESOURCE?

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Every emergency department (ED) in the United States that participates in Medicare is held to the Emergency Medical Treatment and Labor Act (EMTALA). Enacted in 1986, EMTALA is a federal law that mandates a medical screening exam of all patients that present to the hospital regardless of their ability to pay (*ACEP.org*). A medical screening exam occurs when a health professional evaluates a patient and determines there is not a life threatening condition or that a pregnant woman is not in active labor. EMTALA is often referred to as an “anti-patient dumping” law. “Patient dumping” occurs when one hospital transfers a patient who is uninsured or unable to pay for care to another hospital prior to stabilizing any emergent medical condition. In addition to “dumping” patients to other hospitals, EMTALA also attempted to address the issue of limiting or denying access to the hospital for the poor and uninsured. Prior to this law, this practice was a significant issue that included several high profile cases receiving national media attention and public outrage.

In an effort to maximize profit, hospitals and doctors took unethical steps to avoid treating the poor and uninsured. Patients were often transferred with “knives still in their back” and some women were forced to give birth in hospital parking lots (Friedman). While the motivation for this law was the protection of the poor and indigent, there have been significant financial burdens placed on hospitals and emergency departments. This federal mandate is unfunded. As a result, emergency physicians provide more free care than any other type of doctor. Despite the fact EMTALA is unfunded, there are significant financial penalties for violating the law. This has resulted in the closure of emergency departments throughout the US. In fact, the number of EDs has decreased by 27% between 1990 and 2011 (Hsia). The basis of these closures are multifactorial but the vast majority of causes are economic. A major factor in

the amount of closures has been the mandate to provide uncompensated services under EMTALA.

There are three examples in which physicians and /or hospitals have attempted to limit the impact of EMTALA using debatable practices (Bitterman). The first method is demanding payment for further services after an emergent medical condition is excluded. Patients would be asked to leave if they could not pay for care. The second example is through limiting the role of the consultant after a patient is stabilized. For example, a patient with a complicated fracture is stabilized in a splint and further treatment would require payment. Lastly, large receiving hospitals would refuse transfer of an admitted patient (not in the ER) from another hospital that has been found to require treatment outside the scope of the initial hospital. The receiving hospitals claim the patient has been medically screened and the receiving hospital has no EMTALA obligation. This stance by the receiving hospital often occurs after the patient's insurance status has been forwarded and reviewed. This last example has been addressed by CMS (Center for Medicare and Medicaid Services) and an amendment has been made to the original law requiring the receiving facility to accept such cases.

The ED is often referred to as a healthcare "safety net" where uninsured patients can receive care. Often, this is primary care that most insured people receive at their doctor's office. Due to numerous factors, the poor and underserved often don't have the resources to get primary care. That need is somewhat fulfilled in the emergency department (Siegel). In most circumstances, the ED will continue to evaluate a patient's complaint after an emergent condition has been excluded regardless of insurance or ability to pay. For example, a patient without insurance presenting with an ankle sprain is briefly evaluated and this injury is determined not to be causing a life or limb threatening condition. This patient is still evaluated by a provider and

the necessary x-rays and treatment are ordered. Due to financial pressures, there has been a trend in some EDs to request upfront payment to continue the evaluation of non-emergent conditions. Using the previous ankle injury patient as an example, after the emergent medical condition was ruled out advance payment would be required to continue the evaluation. If the patient was unable to pay, they would not be seen. To be clear, there are limits to the testing done in emergency departments regardless of the patient's finances. For example, an MRI will not be obtained for a person concerned about a ligament injury to their ankle. There are some patient requests that go beyond the acceptable resources of an emergency department. This practice is not an ethical conundrum since this limitation of evaluation is done regardless of insurance or ability to pay.

A concern with the practice of requiring payment is once one hospital in a region begins this, there is pressure for other hospitals in the same area to do the same, eroding the safety net for these patients. As indigent patients are turned away by one hospital, they travel to nearby hospitals that will still see them. As a result, these hospitals have a sharp increase in the number of uninsured and unreimbursed care while increasing the number of patients seen resulting in a strain on their resources.

As our health system in the United States continues to face increasing financial tensions and increasing demands for limited resources, healthcare managers and leaders need to make policy decisions to guide daily operations. The management decision that needs to be made in this case centers around what should happen to nonpaying patients after a medical screening examine is performed in the ED. The alternatives are to continue to treat them regardless of the ability to pay or to demand payment after an emergent medical condition has been excluded. I

will first identify the major stakeholders in this decision. Then, using utilitarian and rights arguments, I will argue both decision alternatives prior to making a decision.

This managerial decision has implications for numerous stakeholders. The uninsured who lose access to needed healthcare have the most negative impact if payment for care is required. On the other side, there are administrators of the health systems who wish to maximize hospital income. There are also the doctors, nurses and other healthcare staff who need a financially successful hospital in order to maintain their jobs. Other hospital departments would feel the crunch from the downstream effects of allowing charity care. As more patients are entering the hospital through the ED, there will be a strain on many of the other departments in the hospital since more x-rays and labs would be ordered. There are also implications for policy makers from professional societies (American College of Emergency Physicians or the Emergency Nurses Association) who would have to make policy recommendations based on this trend. These policy makers have traditionally made recommendations favoring patient care over financial concerns. Additionally, insurance companies have a stake in this decision. As the amount of unreimbursed care increases for a health system, there will be pressure from hospitals and physicians on insurance companies to increase reimbursement for insured individuals who will offset some of the financial loss. Similarly, patients who are insured or can pay for their care will be effected. Not only will their wait times for emergency treatment increase due to an increase in patients, they will likely bear some of the burden of the unreimbursed care through higher charges and increased insurance premiums. Health systems could be opposing stakeholders depending on their position on this issue. If a health system demands payment, other local health systems will have an influx of uninsured patients.

From a utilitarian perspective, policy decisions will be evaluated on the impact to the aggregate welfare to the population. The decision is influenced by evaluating the impact on stakeholders as well as determining if the benefits are instrumental or intrinsic (DesJardins & McCall). An intrinsic good is necessary to live a proper life while instrumental goods depend on their impact on some other good. The maintenance of health is an intrinsic good that assures the well-being of the population. The financial gains and health system efficiencies are more likely instrumental goods that promote gainful employment as well as a successful healthcare business. While the number of uninsured and indigent patients is quite large, the number of stakeholders negatively impacted by uncompensated care is likely larger. Doctors and hospitals not only will be providing free care but also the emergency department as well as other areas of the hospital will be busier due to the need for resources. Also negatively affected are patients who go the ED for a true emergency. As a result of the strain on the system from non-emergent patients, the care of true emergencies has the potential to be delayed or sub-optimal. The potential for other EDs to follow suit and charge for non-emergent visits weigh into the impact on the aggregate welfare. As more EDs turn away indigent patients, the number of people who are unable to receive care increases. With uncompensated care, the cost of healthcare is shifted to those who are insured or can pay leading to increased premiums and higher healthcare bills.

The key to this utilitarian argument is the evaluation and treatment of patients who present to the emergency department requires limits. The additional strain on the system could lead to a point where additional health systems close or consolidate leading to a reduction of healthcare resources. While a cursory utilitarian evaluation suggests all comers should have a medical evaluation in the ED, consideration of the downstream consequences may lead to a different conclusion. Emergency departments are designed to evaluate and treat patients with a

potential emergency medical condition. The operations of the ED are not designed for routine care.

There are several examples of how utilizing the emergency department for routine care is not optimal for the population. Health maintenance programs such as blood pressure and diabetes control are not performed in the ED. Similarly, disease screening such as referral for colonoscopy or mammography are not done. Most vaccines for disease prevention are not administered through the ED. While a tetanus booster is part of routine acute wound care, crucial vaccinations such as flu shots or measles vaccinations to assure population health are not performed. Similar to the issues identified with disease prevention, the usage of a limited resource will eventually lead to reduced capacity of the emergency system to care for all patients, even those with true emergencies. As with any finite resource, there are only so many nurses, doctors and emergency department space for patients presenting for care. Allowing everyone to have a near complete evaluation for their complaint, emergent or not, will put a strain on the system. Even with triage processes in place, the extra patients would overwhelm the emergency system.

On the surface, it would seem allowing everyone who presents to the ED to have an evaluation would lead to the greatest aggregate happiness. Only after considering some downstream effects of this policy does one appreciate that there are detriments to the greater good. Patients would receive suboptimal primary care simply due to the fact that the ED was not designed to monitor chronic diseases and perform disease screening and prevention. Likewise, the emergency system would be quickly overwhelmed if all patients were offered complete evaluations for their non-emergent complaints. To ensure that there is high quality emergency care for the entire population, the expectation of treatment in an emergency department needs to

have limits. The ED can't be everything to everyone. Utilitarian thought urges healthcare policy makers limit the role of the emergency department to assure that efficient lifesaving care is available to the population when needed. *Appropriate* use of the ED would lead to the greatest aggregate happiness using utilitarian arguments. The corollary to this from a utilitarian is the need to increase funding and resources to primary care services.

When examining this decision from a rights perspective, the opposing stakeholders in this case would have conflict over the right to healthcare and the right for alleviation of suffering versus the right to payment for services rendered and the right to fairness to the other patients who are expected to pay. Determining the moral weight of these rights is needed to help resolve this rights conflict (DesJardins & McCall). The right to healthcare is a basic right that is required for living a decent human life. The right to fairness as well as payment for services are derivative rights. They are important rights but it can be argued that they are not basic rights. Access to healthcare is required to honor a person's humanity and to treat them with dignity and respect. To further detail this rights argument, the right to this healthcare is a positive right requiring the resources of a healthcare system. Similarly, the requirement to pay for non-emergent services for the right to payment for services rendered is also a positive right. As previously stated, the scope of this right to healthcare needs to be limited. It is not reasonable to present to an emergency department and demand an MRI for a nagging injury regardless of the ability to pay. The right to healthcare can be separated into legal and moral arguments. EMTALA does set the legal rights of patients presenting to the ED in the US. The minimal requirement is assessing and stabilizing any emergent medical condition. The letter of the law does allow patients to be turned away if it is determined they do not have an emergent medical condition. There is also a moral right to receive lifesaving treatment when you present to an ER.

That is the purpose of an emergency department. However, there is no such moral right to have chronic or trivial conditions treated utilizing an ER.

The challenge with any right is the required duty of another party to provide that right. The positive right of healthcare is at the expense of others who have a right to receive payment for their services. Healthcare providers also have the right not be servants to the population. Doctors do have the right to refuse medical care to patients. Only in the case of a life-threatening emergency are doctors obligated to provide care. As a result, there needs to be a distinction then between healthcare as a right versus the right to life saving medical care. An EMTALA expert who is also an emergency physician argues that healthcare in the US is not a right but rather a need (Bitterman). He maintains that in the US, no one has the right to take services from another person without consent and paraphrases the Declaration of Independence and the Thirteenth Amendment stating “it should be self-evident that all people are endowed with certain unalienable rights, including liberty and the freedom from indentured servitude.”

Given that **utilitarian and rights** arguments agree there needs to be limits on the scope of services and expectations of the emergency department, there is a need for a national dialogue to reach a consensus on the appropriate use of the ED. Likewise, there is a need for additional resources for primary care services and urgent cares. While certain urgent cares take some Medicaid patients, most urgent cares don't take all patients with state insurance. These patients are often directed to the nearest emergency department. In order to support health of the population, there needs to be education to the public regarding the appropriate use of the emergency department while also lobbying our government to increasing funding for primary care services. The notion of restricting the emergency department to just the sickest of patients is not unique to the US. Currently, the United Kingdom is experiencing a crisis delivering

**Commented [H1]:** Trivial requests should be refused regardless of the ability to pay.

emergency care and has advised the population to go the accident and emergency (A&E) department only for true emergencies ([BBC.com](http://BBC.com)). Due to overcrowding and cuts in funding, British doctors and nurses have gone on record stating current conditions are like practicing medicine in a third world country.

There is a recent example of the national consciousness shifting on a healthcare issue. In the 1990s, it was argued that physicians do a poor job assessing and treating pain, particularly patients in chronic pain. Pharmaceutical companies made claims that newly developed pain medications such as OxyContin demonstrated little to no risk of addiction. Unfortunately, these claims were false and the result of deliberate misinformation in an effort to increase sales for newly developed narcotic medications. As a result, our nation is experiencing an epidemic of addiction to prescription pain medications. This addiction often transitions to heroin abuse. According the CDC, 91 Americans die each day from opiate overdoses and half a million people have died in the past 15 years. ([CDC.gov](http://CDC.gov)). As a nation, we have begun to experience a shift in the attitude towards treating pain. Locally in New Jersey, outgoing governor Chris Christie has spent the waning days of his term focusing on this issue as well as directing government funds to address the problem. Similar national discourse needs to occur for our underserved patients to assure they receive the appropriate primary care in the appropriate setting.

After considering utilitarian and rights arguments, patients ought to be evaluated and treated for a medical emergency when they present to the emergency department regardless of the ability to pay. There should be restrictions on the scope of a patient's evaluation once a life threat has been ruled out. This opinion is congruent with utilitarian and rights perspectives. The populous requires an emergency system that can treat emergencies competently. In addition to developing policies delineating the appropriate use of the ED, leaders need to educate future

patients what is appropriate use of an emergency department. We cannot leave the poor and uninsured without access to quality and affordable healthcare. Healthcare leaders and our governmental representatives must address the issue of adequate primary care for all Americans.

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