

New Jersey's Ethical Dilemma:
Restrictive Privileges for Elective Angioplasties

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In 2006, investigators at Johns Hopkins University began the Cardiovascular Patient Outcomes Research Team Elective Angioplasty Study (C-PORT-E), to assess whether there is an increased risk of complications from elective angioplasties performed at hospitals without on-site cardiac surgery capabilities as compared with licensed cardiac surgery facilities. The C-PORT-E study tracked patient outcomes from elective angioplasties performed on more than 18,000 patients in 23 states; New Jersey authorized 11 non-cardiac surgery facilities to perform elective angioplasties under the study (Aversano, 2018). Surgical backup has been required for nonemergency angioplasties because in rare instances the procedure has led to a tear in the vessel or closing of the artery. Early national guidelines mandated surgical standby because the need for emergency coronary artery bypass grafting occurred in >5% of the cases in the early days of angioplasty. However, the use of better stents and the pretreatment with dual anti-platelet therapy reduced the need for emergency surgery fall from 2% in 1992 to 0.12% in 2005 (Belder, 2007). In 2012, the results of the C-PORT-E study were published in the New England Journal of Medicine and presented at the annual meeting of the American College of Cardiology (Aversano, Lemon, & Liu, 2012). The study concluded that there is no greater risk of death or complications when elective angioplasties are performed at non-cardiac surgery facilities as compared with licensed cardiac surgery facilities. Furthermore, the Johns Hopkins study determined that the risk for emergency bypass is less than 1-2 in every 1000 cases. Following the end of the C-PORT-E study, the Department of Health established a continuing demonstration program permitting the State facilities that participated in the C-PORT-E study to continue performing elective angioplasties; additionally, elective angioplasties may currently be

performed at any of the licensed cardiac surgery centers in New Jersey (Department of Health, 2012).

Since the publication of the C-PORT-E, the overwhelming majority of the States in the United States, such as Pennsylvania, Delaware, and New York, have [opted](#) to permit elective angioplasties to be performed at hospitals that do not have cardiac surgery services on site. Despite numerous attempts at legislative or regulatory reform over the years, New Jersey has not expanded elective angioplasty eligibility to hospitals that do not have cardiac surgery on site (Stainton, 2018). Consequently, there are still only 29 hospitals authorized to perform elective angioplasties in the State of New Jersey, including the 11 demonstration project facilities and the 18 licensed cardiac surgery centers. Unfortunately, these 29 facilities are located in just 14 of New Jersey's 21 counties (Stainton, 2017). [As a result](#), Cape May, Cumberland, Gloucester, Hunterdon, Salem, Sussex and Warren Counties, do not contain any elective angioplasty facilities. Residents in these counties, which are primarily located in the southern and northwestern regions of New Jersey, are therefore required to travel long distances or out of state at times to receive an elective angioplasty. These patients may also experience an unnecessary delay in their potentially life saving care as they await a bed in the referred hospital to be available (Hsia & Shen, 2016). In addition, patients in these counties may incur greater healthcare cost as they require admission to two separate hospitals and suffer the hardship of not being able to receive their care locally. [At times](#) the patients' physician may care for [his/her](#) patients at these remote hospitals, but more often the patients are required to be admitted to a new hospital and must be cared for by a completely new healthcare team of doctors. Ironically, the State of New Jersey permit the most critically ill patients to undergo an angioplasty and stent

placement in an emergency, but the State will not let the same procedure be performed electively in a stable patient.

In the early part of 2019, it is expected that New Jersey will need to confront current regulations. These regulations are rooted in policies that reflect the higher risk of the procedure when cardiac catheterization was first developed over 50 years ago (Stainton, 2017). The management decision that will need to be made in this case centers on whether elective angioplasties should be permitted in hospitals that do not have on-site cardiac services. There are three primary alternatives to this case. The first alternative is to only permit hospitals that have on-site cardiac surgery perform elective angioplasties. The second alternative is to permit the 29 hospitals currently authorized to perform elective angioplasties in the State of New Jersey, including the eleven demonstration project facilities and the 18 licensed cardiac surgery centers. The third alternative is to permit elective angioplasties to be performed in hospital based on patient volume and needs rather than the availability of cardiac surgery on site. In order to make an informed decision, the major stakeholders in the case study will be identified. Subsequently, the three alternative decisions will be discussed using the utilitarian and rights arguments. Based on these arguments, I will provide judgment on the current ethical dilemma that confronts the State of New Jersey.

The final decision by the State of New Jersey regarding elective angioplasties will have an implication for numerous stakeholders. The ~~hospitals which have cardiac surgery on site~~ hospitals that have cardiac surgery on site have the most to lose if the elective angioplasties are permitted at hospitals that do not have cardiac surgery on site. Consequently, several hospitals have publicly opposed expansion efforts in the past, with the most notable objections from Cooper University, Our Lady of Lourdes, and Deborah Heart & Lung (George, 2013). In

contrast, smaller hospitals in New Jersey that perform diagnostic catheterization, such as Inspira Medical Center Woodbury, that do not have on-site cardiac surgery would stand to have the most to gain if they were permitted to now perform elective angioplasties. Caught in the middle of this decision are the eleven demonstration hospitals that participated in the original New England Journal of Medicine article. These demonstration hospitals have already established in their respective communities that elective angioplasty could be performed at hospitals without cardiac surgery with no increased risk of death as compared to hospitals with on-site cardiac surgery. Additionally, the insurance companies have a major stake in the final decision from the state of New Jersey regarding elective angioplasties. In addition to the simple cost of transferring a patient from one hospital to another, the total cost is increased, as there is often a delay in treatment, [the hospital length of stay may increase and basic laboratory studies are repeated.](#) [Most transfers are based on physicians' referral preferences, which results in patients moving from one health care system to another health care system for their elective angioplasty.](#) Furthermore, transfers may require patients to migrate out-of-network and travel to neighboring states. [The ability to perform elective angioplasties would garner financial compensation while enabling direct patient care that fosters the development of the crucial physician-patient bond. For these reasons, both physicians who perform angioplasties and those who round on their patients are major stakeholders.](#) Ideally, physicians would prefer to provide comprehensive care for their own patients at their local hospital, but they [currently](#) may not have that option in the State of New Jersey. If physicians are required to transfer their patients to tertiary care facilities with cardiac surgery on-site, the physician will either need to travel to the referring hospital in order to perform the procedures or turn over their responsibility to another physician. Finally, the patients who require an elective coronary angioplasty are the

stakeholders [who](#) are the most directly affected by this decision. Although providing the highest quality of care and best outcomes to patients should always be the goal, it has been acknowledged that the decision regarding elective angioplasties has the potential to supersede quality of patient care issues (Dehmer, 2007).

From a utilitarian perspective, the decision regarding elective angioplasties would seem to be a straightforward answer. However, the complexity of the answer is only revealed when one views the decision from the standpoint of the different stakeholders. Jeremy Bentham ([1789](#)) presented the first utilitarian moral theory and he argued [that](#) the fundamental principle was to do what is necessary to produce the greatest net collective benefit for general human welfare (McCall, n.d). Intuitively, one would initially argue that any decision which increase access for elective angioplasties and allows [for](#) [life-saving](#) care to be delivered where the patients live would positively impact on the aggregate welfare of the population. In order to further understand the impact of the utilitarian theory, it is also important to understand how the stakeholders will be impacted and if the benefits will be instrumental or intrinsic (DesJardins & McCall, 2014). Improved access to elective angioplasty at hospitals [with](#) both on-site cardiac surgery and hospitals that do not have on-site cardiac surgery [would](#) be intrinsically good for patients. With standardized protocol for operating training, patient risk assessment and case selection, the Mayo Clinic [has](#) concluded that excellent outcomes for non-elective and elective angioplasties at hospitals without surgery on site can be obtained [without](#) negative impact on patients (Singh, Gersh, Lennon, Ting, Holmes, Doyle, & Rihal, 2009). However, the decision becomes complex [because](#) the instrumentally good [- which promotes some additional value, creates a financial and a utilitarian conflict between hospitals that have been providing these services and hospitals that are seeking permission to from the state to provide these services.](#)

[Inherently, the](#) hospitals that can offer on-site cardiac surgery [are in direct conflict](#) and the hospital that would like to do elective angioplasties without cardiac surgery on-site. The ability to offer and perform elective angioplasties will clearly improve a facilities financial bottom line. [In addition, the ability to do elective angioplasties without cardiac surgery on-site would add more to instrumental good to these facilities because it will improve additional services and recruit additional physicians as a byproduct.](#) In addition, this decision also has the potential [for](#) negative downstream effects to the facilities that do not reap any instrumental good. Opponents of angioplasty without on-site surgery argue the potential economic hardships from loss of business, as well as [a decrease in proficiency,](#) if the number of procedures decreased due to expansion to additional hospitals. [Furthermore,](#) hospitals that have cardiac surgery on-site, such as Deborah Heart & Lung, [cite the increased potential for unnecessary procedures based on the premise that the temptation of economic benefit will outweigh patient risk or appropriateness of the elective procedure \(Wennberg, Lucas, Siewers, Kellett, Malenka, 2004\).](#) In contrast, advocates of angioplasty without on-site surgery argue that personal, financial, and market-driven forces also exist at facilities with on-site surgery. They argue that the fear of increased competition and loss of market share have promoted unnecessarily restrictive standards and state regulations against a practice that [facilitates access to](#) early and convenient angioplasty in local communities.

When examining the decision by the State of New Jersey regarding elective angioplasties from a rights perspective, inherent conflicts between the numerous stakeholders. Unlike the utilitarian perspective that focuses on the aggregate good, a rights theory is based on the good of the individual (DesJardins & McCall, 2014). [In order to fully consider the issue from a](#) rights theory perspective, [one must](#) distinguish between basic rights and derivative rights of the

individual stakeholders before ultimately determining the moral weights of these rights.

Amongst the stakeholders, the patient is the only one who has a basic right, as an elective angioplasty may prevent a heart attack, treat angina symptoms and preserve their health.

Consequently, once they have been informed of the pros and cons of an elective angioplasty at a facility that does or does not have cardiac surgery on-site, the patient should be able, [from a rights perspective, to](#) decide their course of treatment and where they feel the most comfortable proceeding with their care from a rights [moral](#) perspective. [When](#) given the ability to select when and where they will be treated, patients traditionally make their decision based on non-monetary factors and place a high relative value on the patient-physician relationship (Pearson & Raeke, 2000). In contrast, the economic impact of elective angioplasties is the fundamental driving force that has motivated hospitals with cardiac surgery on-site to fight to maintain their exclusive ability to perform elective angioplasties and the driving force for hospitals without cardiac surgery on-site to fight for the ability to offer elective angioplasty to their patients. [Similar to the instrumental good in the utilitarian perspective, derivative rights add a layer of complexity to the rights theory perspective argument. Elective angioplasties produce financial gains that have a positive impact on individual hospitals, which can be considered a derivative right of the respective facilities. If more hospitals are able to offer the services, then insurance providers are able to prevent out migration of patients from in-network provider. The stakeholders, insurance providers, therefore have a major derivative right that should also be taken into account from a rights moral perspective.](#) Since the ability to perform elective angioplasty has been restricted, the insurance providers are required to approve the necessary transfers to other facilities which may not be in network and often may even be in another state where the insurance plan may have limited control of financial factors.

After reviewing the utilitarian and rights arguments, it appears self evident that permitting elective angioplasties at hospitals without on-site cardiac surgery would have a positive impact not only on the aggregate population, but also the individual patients. They should have the basic right to decide where and ~~by whom their healthcare provided~~who provides their healthcare. Historically, hospitals in New Jersey with cardiac surgery on-site have essentially monopolized the elective angioplasty market for their own derivative rights and have used the “utilitarian shield” of safety for the aggregate as their justification. Likewise, hospitals that do not have cardiac surgery on-site defend their derivative rights to pursue elective angioplasties as procedures that today, with improvement in technology, can be safely performed without putting the patients’ basic rights to an excellent outcome at risk. In addition to the financial incentive and positive impact to the individual hospital, these facilities can argue from the utilitarian moral theory perspective that it would be for the aggregate good for the State of New Jersey to permit more facilities to perform elective angioplasty. Consequently, access to elective angioplasty could be extended to the seven counties in New Jersey that currently cannot perform these procedures. As a result, expanding access to elective angioplasties would afford the hospitals in these communities the opportunity to better serve their patients. The insurance providers are also major stakeholders, but current restrictions force them into a more passive role as they are seen more as the one left to “pick up the bill”. The current limit on centers that can provide elective angioplasty permits the insurance industry to negotiate contractual agreements regarding the payment for procedures directly with the individual hospitals. Yet, the derivative rights of the insurance providers because of the limited number of centers that can currently perform elective angioplasties inhibits their ability to prevent migration out-of-network. As result, organizations such as Inspira Health Network, which use a self-insuring model, must pay

the higher out of network price whenever an Inspira employee requires an elective angioplasty as none of the networks four hospitals can provide these services. [Meanwhile](#), if elective angioplasties were permitted at any one of the Inspira Health Network hospitals, the insurance underwriters for Inspira [could](#) exercise their derivative rights for a financial gain while also arguing there would be a benefit to the aggregate group of subscribers from a utilitarian viewpoint.

After considering the utilitarian and rights arguments, the basic rights of the patient to receive the best care and to make their own informed decisions must be respected. Determining the moral weights of the stakeholders' rights is crucial in resolving the conflict when there are several different alternative managerial decisions and [among](#) stakeholders with opposing interests. Limiting elective angioplasty to hospitals that have cardiac surgery may financially benefit those individual facilities; but [it](#) is too restrictive [and](#) not in the best interest of the aggregate [because](#) it infringes on the patient's right to be part of the decision process. Continuing the current policy of permitting the 18 licensed cardiac surgery centers and the 11 demonstration hospitals is based more on simply maintaining the status quo rather than deciding on what is in the best interests of the stakeholders. The demonstration hospitals could argue it would be immoral to restrict their ability to provide therapeutic interventions for their patients. [They concluded, on the basis of the C-PORT-E study, that elective angioplasties could be safely performed with today's technology at facilities that do not have on-site cardiac surgery.](#) Consequently, the [ethics](#) decision from a utilitarian and rights perspective [is](#) to remove the restriction that requires elective angioplasties be performed at centers with cardiac surgery on site and to make the decision regarding privileges based on volumes of procedures and the patients' needs.

References

- Aversano, T.(2018) John Hopkins launches study to determine if heart angioplasty is safe in community hospitals. *American Association for the Advancement of Science*. Retrieved from https://www.eurekalert.org/pub_releases/2005-09/jhmi-jhl090805.php
- Aversano, T., Lemmon, C.C., & Liu, L. (2012). Outcomes of PCI at hospitals with or without on-site cardiac surgery. *The New England Journal of Medicine*, 366, 1792-1802
- [Bentham, J. \(1789\). An Introduction to the Principles of Morals and Legislation. UCL Bentham Project. Retrieved from https://www.ucl.ac.uk/bentham-project](https://www.ucl.ac.uk/bentham-project)
- Belder, M. A. (2007). On-site surgical standby for percutaneous coronary intervention: a thing of the past? *Heart*, 93(3), 281-283.
- Dehmer, G, Blankenship, J (2007) The Current Status and Future Direction of Percutaneous Coronary Intervention Without On-Site Surgical Backup. *Catheterization and Cardiovascular Intervention*
- Department of Health. (2012). *HealthFacilities evaluation and Licensing Division. Amendments: N.J.A.C. 8:33-3.11(e)*. Retrieved from https://web.doh.state.nj.us/apps2/documents/bc/hcab_rule_proposal_cport_extension_revised_10182012_1212.pdf
- DesJardins, J. & McCall, J. (2014). *Contemporary Issues in Business Ethics (6th edition)*. Stamford, CT: Cengage Learning
- George, J. (2013). Heart-care battle resumes in New Jersey. *Philadelphia Business Journal*. Retrieved from <https://www.bizjournals.com/philadelphia/news/2013/03/29/heart-care-battle-resumes-in-new-jersey.html>

- Hsia, R. & Shen, Y. (2016). Percutaneous coronary intervention in the United States: Risk factors for untimely access. *Health Services Research, 51(2): 592-609.*
- Pearson, S & Raeke, L. (2000). Patients' trust in Physicians: Many theories, few measures, and little data. *Journal of General Internal Medicine, 15(7): 509-513.*
- McCall, J.J. A General Introduction to Moral Theory.
- Singh, M., Gersh, B.J., Lennon, R.J., Ting, H., Holmes, D.R., Doyle, B.J. & Rihal, C.S. (2009). Outcomes of system-wide protocol for elective and nonelective coronary angioplasty at sites without on-site surgery: The Mayo Clinic experience. *Mayo Clinic Proceedings, 84(6), 501-508.*
- Stainton, L.H. (2017) Renewed push to expand elective angioplasty to more hospitals in New Jersey. *NJ Spotlight*. Retrieved from <https://www.njspotlight.com/stories/17/06/01/renewed-push-to-expand-elective-angioplasty-to-more-hospitals-in-new-jersey/>
- Stainton, L.H. (2018) New drive for more elective angioplasty, community hospitals say long overdue. *NJ Spotlight*. Retrieved from <https://www.njspotlight.com/stories/18/04/10/new-push-to-expand-elective-angioplasty-community-hospitals-say-it-s-long-overdue/>
- Wennberg, D.E., Lucas, F.L., Siewers, A.E., Kellett, M.A, & Malenka, D.J. (2004). Outcomes of percutaneous coronary interventions performed at centers without and with onsite coronary artery bypass graft surgery. *Journal of American Medical Association, 292, 1961-1968.*