ETHICS IN ACTION

Affordable Care Act could make for more complex interactions for emergency physicians

By Torben K. Becker, MD, PhD

Recent changes in the healthcare environment have been interpreted by many emergency physicians (EPs) as a possible threat to the mission of their specialty. The majority of these concerns have centered on the Affordable Care Act and new, but typically related, CMS regulations.

EPs are questioning how the perceived new mandate of Emergency Departments (EDs) as a center of acute-care needs, but not necessarily true emergencies, will be balanced with the ground rules regulating ED use such as the EMTALA legislation. Other areas of concern include an apparent encroachment on how to actually practice medicine and the role of healthcare providers who are not physicians, as well as patient expectations and satisfaction. The transformation of existing, diverse healthcare institutions into more unified accountable-care organizations has raised questions about physician practice models, profit sharing and healthcare rationing.

The following cases illustrate the potential for complex interactions, unanticipated and unintended consequences and possible solutions. One of the most important concerns shared by many physicians is that government regulations could push them toward practicing medicine in a way that may not be appropriate for an individual patient or not be based on sound scientific data.

Case 1

Consider an elderly patient who presents to the ED with symptoms that suggest a diagnosis of transient ischemic attack (TIA). This diagnosis is confirmed after an evaluation by the treating EP. In this theoretical scenario, new guidelines from the patient's public insurance recommend an outpatient work-up for patients with a diagnosis of TIA if certain criteria are met. The hospital's administration recently urged all emergency physicians to carefully assess the need for admission for such patients, as payment will typically be denied.

The patient has good outpatient follow up with his primary care physician. However, the patient and his family feel that inpatient care would best fit their expectations and comfort level with this diagnosis, and leaving the hospital without a definite work-up would cause them significant discomfort and anxiety. The EP feels that both outpatient and inpatient management would be reasonable for this patient. However, she finds herself caught between the expectations of her administration and the patient.

A patient's physical and emotional needs should always be the treating physician's primary concern. However, since healthcare resources are not infinite, the costly decision to admit a patient needs to be balanced with the needs and expectations of society as a whole. The EP should ensure that the patient and his family understand the diagnosis, the care plan, and typical management options for this disease, including their risks and benefits. They should be made aware of the insurance regulations and that outpatient management of TIA patients is an option that is being supported by current research. If the patient does not change his mind, alternative options could include the involvement of other healthcare professionals, such as the patient's primary care physician or medical social workers. The patient may also wish to contact his insurer directly. The patient could be offered to pay for his hospital stay himself, though a reasonable estimate of expected costs should be given.

Case 2

Readmission penalties have received particular attention amongst the general public and physicians alike. Consider the case of a patient with severe congestive heart failure (CHF) who presents to the ED complaining of shortness of breath with an obvious exacerbation of his disease.

The EP initiates treatment with nitrates and diuretics and the patient's condition improves. He is now much more comfortable and has normal vital signs. The EP feels the patient will require ongoing monitoring and treatment in the hospital. However, the hospital administration requests the patient be kept in the ED's observation unit because the patient was just discharged from the hospital after another CHF exacerbation two weeks ago. The EP does not feel comfortable with this plan, because the observation unit is not equipped to provide the close clinical monitoring and treatment that seems necessary. On the other hand, the hospital would incur a penalty associated with this early re-admission for CHF.

Continued on Page 10

Ethics, continued from Page 7

Though the patient's safety and well-being should, again, remain the physician's priority, institutional policies and close and early cooperation between the administration and clinicians will be required to resolve such conflicts. Federal regulations that affect the hospital as a system will continue to lead to challenging clinical situations on a regular basis, and EPs will need to advocate for the needs of their patients, and be involved in all related decision- and policy-making.

Case 3

Finally, consider a 70-year-old smoker with a past medical history of hypertension and diabetes who presents to the ED complaining of chest pain. The patient has been evaluated for similar complaints in this and other EDs in the area at least three times within in the last two months.

The patient's public insurance deemed these prior visits non-emergent because the patient was discharged from the ED each time with a diagnosis of musculoskeletal pain. Based on new regulations, payment was therefore denied. The hospital administration has urged the ED to limit extensive medical work-ups for complaints that are likely to be result in the diagnosis of a non-emergent condition.

After evaluating the patient, the EP feels that serial cardiac enzymes and observation in the ED are indicated. However, the EP is concerned that payment may again be denied, leading to further tensions between hospital administrators and ED clinicians. Nonetheless, the emergency physician's ethical and legal responsibility to provide good medical care and to rule out life-threatening diseases remains unchanged.

A multidisciplinary approach may help to decrease the number of repeat ED visits for non-emergent complaints. Physicians should work with medical social workers, the hospital administration, primary care physicians and other hospital leaders to explore alternative possibilities. What are the reasons for the patient's frequent ED visits? Is he unable or unwilling to afford his medication? Is it the lack of access to primary care services? Alternative care models that have been studied could include evaluation in an adjacent clinic for non-urgent complaints or same-day referral to a primary care physician.

Final thoughts

Ignoring these challenges will not help and will place EPs in a position where they are forced to react, instead of being given the opportunity to help define standard procedures and processes in a way that benefits patients and physicians. Most EPs feel that they are increasingly expected to consider healthcare system resources beyond an individual patient encounter, whether they have asked for this role or not. New strategies will be required to address this challenge, and to help EPs become stewards of a balanced healthcare system. ◗

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Reflections, continued from Page 9

Seeking advice

While your duties have grown to include care for patients and provide supervision, it is important to remember you are not alone. You can and should ask for help from your co-workers and your attending physician when appropriate. It is better to ask for assistance before becoming overwhelmed, rather than when it is too late. While the second year may not feel as isolating as intern year, there will be difficult moments. Speak to your friends, colleagues, mentors and attendings and jointly work through the challenges. It is helpful to develop your clinical judgment by taking counsel from those around you.

An important aspect of your second year of residency is deciding your career path. You must first decide whether you are interested in a fellowship or wish to finish residency and begin practicing. There are a plethora of fellowships available to emergency medicine residency graduates and they are competitive. Popular choices include ICU, toxicology and ultrasound, but other available opportunities include sports medicine, research, disaster medicine, emergency medicine services and more. SAEM has a fellowship directory on its website that provides the information on available training programs.

If you are considering a fellowship, it is best to start collecting resources early. Speak to fellowship trained physicians and find a mentor. Research is an important component of your CV and application, and it is best to start working on projects as early as possible. Attending and presenting at national conferences can be beneficial. Conference information such as abstract submission dates is listed on various organization websites. For more information, including a complete application timeline and other invaluable resources, visit the Electronic Residency Application Service website at aamc.org/students/medstudents/eras/fellowship_applicants

If you decide fellowship is not for you, there are still decisions to be made, including the type and setting of the ED where you will practice. Do you desire an academic position, a community-based position or a combination? What are the job opportunities in the location you wish to reside? These are factors that must be considered while planning your future. Talk to your advisors and mentors to formulate the career path that is best for you.

The most important piece of advice I can offer is to be courteous to your co-workers: be polite and have a smile on your face. This creates a positive working atmosphere and learning environment. Continue to build friendships with the nurses and other staff members. They are an invaluable resource and source of knowledge.

The second year of residency is the time to hone your skills and formulate a plan for your future medical career. ◗

SAEM appreciates the contributions from the Resident Student Advisory Committee. This column presents advice, insights and suggestions for other residents and students.

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