

More Hospitals to Be Replaced by FSEDs

If an ED is considered the “front door” to the hospital, how do we regard a free-standing emergency department (FSED) with no hospital attached to it? Fueled by continued hospital closures in the face of steadily increasing demands for emergency care, FSEDs are now replacing hospitals in previously well-served urban areas in addition to serving rural areas lacking alternative facilities.

According to *The New York Times* (<http://nyti.ms/1TB8Z44>), since 2000, 19 New York City hospitals “have either closed or overhauled how they operate.” As this issue of *Emergency Medicine* went to press, plans had been announced to replace Manhattan’s Beth Israel and Brooklyn’s Wyckoff Heights hospitals with FSEDs and expanded outpatient facilities. These hospitals and many others that have recently closed, including St Vincent’s (2010) and the Long Island College Hospital (2014), had been part of the health care landscape in New York for over 125 years.

What do FSEDs mean for emergency medicine (EM) and emergency physicians (EPs), and are they safe alternatives to traditional hospital-based EDs? Newer technologies and treatments, coupled with steadily increasing pressures to reduce inpatient stays, razor-thin hospital operating margins, and the refusal of state and local governments to bail out financially failing hospitals, have created a disconnect between the increasing need for emergency care and the decreasing number of inpatient beds.

On one end of the EM patient care spectrum, urgent care centers (UCCs) and retail pharmacy clinics—collec-

tively referred to as “convenient care” centers—are rapidly proliferating to offer care to those with urgent, episodic, and relatively minor medical and surgical problems. (See “Urgent Care and the Urgent Need for Care” at <http://bit.ly/1OSrHSA>). With little or no regulatory oversight, convenient care centers staffed by EPs, family practitioners, internists, NPs, and PAs, offer extended hour care—but not 24/7 care—to anyone with adequate health insurance or the ability to pay for the care.

On the other end of the EM patient care spectrum are the FSEDs, now divided into two types: satellite EDs of nearby hospitals, and “FS”-FSEDs with no direct hospital connections. Almost all FSEDs receive 911 ambulances, are staffed at all times by trained and certified EPs and registered nurses (RNs) provide acute care and stabilization consistent with the standards for hospital-based EDs, and are open 24/7—a hallmark that distinguishes EDs from UCCs. FSEDs code and bill both for facility and provider services in the same way hospital-based EDs do. Although organized EM has enthusiastically embraced and endorsed FSEDs, its position on UCCs has been decidedly mixed.

Are FSEDs safe for patients requiring emergency care? The lack of uniform definitions and federal and state regulatory requirements make it difficult to gather and interpret meaningful clinical data on FSEDs and convenient care centers. But a well-equipped FSED, served by state-of-the-art pre- and inter-facility ambulances, and staffed by qualified EPs and RNs, should provide



a safe alternative to hospital-based EDs for almost all patients in need of emergency care—especially when no hospital-based ED is available.

Specialty designations of qualifying area hospitals such as “Level I trauma center” will minimize but not completely eliminate bad outcomes of cases where even seconds may make the difference between life and death. In the end though, the real question may be is an FSED better than no ED at all?

Ideally, a hospital-based ED should be the epicenter of a network of both satellite convenient care centers and FSEDs, coordinating services, providing management and staffing for all parts of the network, and arranging safe, appropriate intranetwork ambulance transport.

Should you think that FSEDs are a new phenomenon, you might be surprised to discover that in 1875, after New York Hospital (now part of New York Presbyterian) closed its original lower Manhattan site to move further uptown, it opened a “House of Relief” in its old neighborhood that contained an emergency treatment center, an operating room, an isolation area, a dispensary, a reception area, examination rooms, an ambulance entrance, and wards to observe and treat patients until they could be safely transported to the new main hospital. FSEDs served 19th-century patients well, and in the 21st century may serve as a reminder that sometimes even in medicine, “everything old is new again!” (See “<http://bit.ly/1NSPIDG>.”) ■

Editor’s Note: Portions of this editorial were previously published in *Emergency Medicine*.