The Emergency Room Rip-off

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The Emergency Room scene in America constitutes a national rip-off. It is an inappropriate, inadequate, and expensive way to meet the marked deficit in primary health care services. It happens because family physicians and other primary care physicians are not organized to handle the needs of the majority of patients who fill our Emergency Rooms. Consequently, some 80 percent of the patients seen in the ER are not true emergencies requiring this kind of a response system. We do need a well organized front line plus a communication and transport system which is responsive to the 20 percent of *urgent* medical situations; we do not need the present, expensive emergency system which depends on and is glutted by patients who could be cared for much better and at much less cost at home, in offices, or in clinics by organized systems of primary care.

The Emergency Room has rapidly become the doctor's alternate office. It provides his backup not only for weekends and evenings but also for unscheduled daytime patients. Overworked family physicians and other primary care physicians feel they have no alternative but to use the ER as backup. There are also many, not so overworked, who are able to approach a 40-hour week by signing out to and referring "extra" patients seeking care to the Emergency Room. Primary care physicians, as a whole, have failed to organize 24-hour coverage which would be in the best interest of their patients; theirs is a provider-controlled industry with minimum competition and little incentive for change. We as family physicians stand guilty, however, because we have not addressed total community health care needs nor have we developed alternate solutions to meet both patient needs and our own personal and professional needs.

Many weary family physicians who have spent busy lives in private practice are abandoning primary care and now work in Emergency Rooms because they find it gives them more leisure and a better personal life style. Young physicians looking at the problems of establishing practice in times of a gloomy economic climate and uncertainties and impending changes in health care frequently opt for the immediate security and limited working hours of the ER. House staff who enjoy incomes sweetened by moonlighting in the ER are attracted to this option as they compare the life of the overburdened physician in private (particularly solo) practice with the ER physician's attractive income and relative freedom from responsibility.

Many emergency care physicians are organized, aggressive businessmen who have been vocal and influential on the national scene. Their wedding with the hospital is a natural one. The ER is a feeder system for the hospital's laboratories, x-ray services, and beds, as well as assuring the hospital's accreditation. Hospital administrators are stirred on to increased activity in ambulatory care by the tighter health care dollar and their decreased bed census. Tired of the struggle for voluntary ER coverage, they are receptive to contracts with ER syndicates. A busy ER is lucrative to the hospital and relatively nonthreatening to its relations with the physicians on its staff and in the community to whom the ER makes referrals.

Physicians in private practice are sold on the policy that the ER physician takes care only of the immediate situation and refers patients to their personal physicians or to the appropriate specialty. Many specialties find this particularly attractive because it screens out the "uninteresting" patients so they can be on call only for those who need their special skills.

Medical schools are receptive to the idea of departments of Emergency Medicine because the ER provides the triage for the traditional departments of Medicine, Surgery, and Pediatrics or their subsections. Furthermore, a busy ER can help rescue the university hospital from financial starvation. This acceptance is often in contrast to the negative feelings of well established departments in medical schools towards departments of Family Practice, those newcomers who threaten to take part of their action.

The public is gradually being conditioned to look to the Emergency Room as a readily available source of health care, in spite of its inappropriateness, lack of continuity, and high cost. Third party payers often encourage ER use by paying for emergency services but not for office calls or other outpatient services. When illness strikes in a city away from home it has become a natural reaction to go to an emergency room in a hospital. Because of the obstacles in obtaining private

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care for episodic illness, this is often even true in one's own home town, rural or urban. Occasionally the patient who seeks care from his own private physician for an unscheduled illness is forced to go to the ER.

Because of our poorly organized system of providing continuing care with outreach services and close monitoring, chronically ill patients are frequent visitors to the ER with truly urgent situations, complicating their disease and its therapy. They are seen in the ER, admitted to the hospital, and given intensive care involving many physician and nursing hours and much laboratory work, all entailing great expense. When stabilized, these patients are then dumped out again into a nonsystem where little energy or money is spent to monitor their care; they return for another expensive round in the ER when their situation again becomes urgent. Better organized primary health care could prevent much of this hospitalization.

Acute life-or-death emergencies arouse public emotions. A legislator can remember his friend who died of a heart attack on a hunting trip or his own child who was injured in an automobile accident in some remote spot. These cases have much greater appeal for legislative support than the child with a sore throat or the old man suffering at home with chronic congestive heart failure or emphysema. There is great need at federal and state levels to support the development of systems to meet these less dramatic episodic illnesses, the nonurgent traumas, and the complications of chronic disease.

The Emergency Room system is totally inappropriate for these unmet needs. By providing access to these necessary but nonurgent services, the ER perpetuates fragmented, depersonalized care which lacks continuity and a comprehensive approach. It is a poor answer to the primary health care deficit, and if it continues to proliferate, it will compete directly with other movements such as family practice. The large fees that are necessary so the hospital can staff and maintain the facility, the excessive laboratory work, and the professional fees for the ER physician are all outrageous for most of the simple medical conditions and nonurgent injuries treated there. Similar services from a primary care physician or clinic would be much less costly. In an economy that does not have an open-ended budget for health care, the proliferation of ERs can lead to a network of ER care which acts as an extensive and costly triage system. This is in direct contrast with the philosophy of the family practice movement which, while recognizing the need for the family physician to be trained in emergency care, emphasizes comprehensive, patient-oriented, personalized health care.

The real problem, then, is the relative lack of access to such primary care services. It is not the patients' desire that takes them to the ER; it is their lack of a choice. The challenge is clear. We in family practice can keep on providing family-oriented, comprehensive care – for those who seek us out. We can continue to turn our backs on some fundamental issues of primary care, such as developing the organization necessary to permit the provision of 24-hour access for episodic, nonurgent care. I propose instead that we family physicians work together and with other health care professionals and consumers to develop improved systems to meet this challenge. If we fail in this effort the family practice movement may prove to be an experiment with a promising start but a poor future.

The Future of Physician Extenders: An Emphatically Divergent View

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In their article on the future of physician extenders (PE), Zubkoff, Reynolds, and Zubkoff seem overly ready to bury them.[1] The authors conclude that physician's assistants, Medex, and nurse practitioners possess the potential for (1) increasing physician productivity, (2) ameliorating distributional inequities, (3) offering primary care services, and (4) being accepted by physicians. Nevertheless, they predict the potential will not be realized, that PE's will be "perpetual interns" in institutional settings where they will provide "rather routine physician services . . . largely independent of direct supervision."

At best, predictions of social phenomena are hazardous. Extrapolations to the future should first of all be based on the most current and complete data available. Admittedly, no one has as much information as we need about PE's, but Zubkoff et al may not have had available to them some information critical in assessing the present status of PE's. For example, a 1974 survey[2] of 250 graduates of MEDEX programs finds 87 percent of them active in primary care (general or family practice, general pediatrics, or internal medicine); 84 percent in office-based practices, mostly fee-for-service; and 73 percent of the graduates of the six rurally oriented programs located in towns with less than 20,000 people. These initial data contradict the assumption by Zubkoff et al that PE's will necessarily distribute themselves into hospitals and into non-primary care specialties.

Gloomy about physicians' acceptance of PE's, the authors observe the bottle to be half empty, ie, they cite a survey of Wisconsin physicians[3] which reports that "only" 41 percent were then willing to employ PE's. An optimist might view the same figure enthusiastically, especially since the survey was conducted when only a handful of PE's had begun practicing. Now, when about 4,000 PE's have been trained, if "only" 41 percent of doctors wanted to employ PE's, they would find the supply severely limited. First-hand experience with PE's enhances acceptance. This is demonstrated by the fact

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that 89 percent of 292 patients who had been treated by PE's were very satisfied with their competence and 86 percent assessed PE's as very professional in their manner.[4] This degree of acceptance by consumers is much greater than when the question has been posed to inexperienced populations. For doctors as for patients, familiarity with PE's may breed even greater acceptance.

Projections for PE's must consider all factors that may impinge on their future; in their article, Zubkoff et al overlook some major ones. They do not, for instance, mention the potential and indeed the responsibility of educational institutions to influence where their graduates practice. The success of MEDEX programs in targeting their graduates to primary care practices in underserved areas is not accidental. It results from mechanisms designed to link selection and training with deployment.[5] Governmental actions to support or even mandate the training and utilization of PE's and the impact of federal programs such as national health insurance will force major adjustments of existing health manpower strategies. The coming decade may well see a reversal of the recent trend away from primary care. An auspicious sign is the renaissance of family practice.

Family medicine as a discipline is dedicated to the efficient organization of resources in behalf of patients. PE's teaming with family physicians, not independent of them, can increase the capacity to give more and better care and permit more systematic attention to prevention and health education, a direction urged by Dean DeTornyay.[6] Family physicians and PE's alike should seize the opportunities for reciprocal benefit.

This response is an attempt not only to point out the hazard of engaging in futurology with incomplete information but also to remind us that we need not be passive spectators of undesirable trends – we can affect the future. The high expectations for PE's will be realized if they, their educators, the makers of public policy and, especially, family physicians combine their efforts.

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