Your Money or Your Life: 'Dumping' Uninsured Patients from Hospital Emergency Wards

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In his irreverent *House of God,* Samuel Shem describes "gomers" (get out of my emergency room) as "human beings who have lost what goes into being human beings."[1,2] They are elderly, demented patients, usually transferred from nursing homes, with multiple illnesses that medicine cannot cure. Law Number I of the *House of God* was that "Gomers don't die." The problem of medical residents in the 1970s, according to Shem, was to keep such patients out of the emergency room (and therefore out of the hospital) because they would make your life miserable and there was nothing you could do for them. In the mid-1980s, the incentives seem to be shifting. The new cry is to keep the uninsured and the poor (the new gomers) out of the emergency rooms based on Economic Law Number I of the House of Adam Smith: "Poor People Can't Pay."

This is a new and disturbing development that would have been completely unacceptable as recently as a decade ago. Although we remain the only industrial nation not to have a system of national health insurance, we have always considered it the responsibility of our hospitals, as the purveyors of a social good, to provide emergency care to those in need regardless of ability to pay. As one court put it in 1973, "It would shock the public conscience if a person in need of medical emergency aid would be turned down at the door of a hospital having emergency service because that person could not at that moment assure payment for the service."[3] The current efforts to transform medical care from a social good to an economic good threaten to erode this community ethic.

Princeton University economist Ewe Reinhardt has argued that because hospitals can no longer simply shift costs from one segment of their patient population to another, "the uninsured poor themselves [have] become the hot potatoes one hospital seeks to dump into the lap of another."[4] This transformation has not occurred without warning. For example, in 1980 a St. Louis man with a steak knife in his back that was wedged against his spine was transferred from an emergency room because he was uninsured and the hospital refused to take the knife out unless he could come up with $1,000 cash in advance.[5] Changes in Medicaid rules produced a significant increase in patient "dumps" to Cook County Hospital in Chicago in late 1983.[6] Also in 1983, the State of New York passed a statute aimed at curtailing economic emergency room refusals in response to the deaths of two patients, both heart attack victims who died after emergency ward treatment was refused. The statute makes denial of emergency care a misdemeanor punishable by a $1,000 fine and a year in jail for the doctor, nurse, or other hospital personnel involved.[7]

Dumps are usually made within the same city or state, but not always. The farthest dump in the United States on record involved a Florida hospital that chartered a plane to fly a terminally ill AIDS patient to San Francisco to die. A spokeswoman for the hospital said the proposal for such transport was made by the physician in a conference with social workers who were seeking outpatient discharge.[8] The patient died 16 days after transfer.

It is not just the rise of for-profit medicine that has challenged our traditional social commitment to provide emergency services to rich and poor alike, but the erosion of this social commitment on the part of government itself.[9] And it is not just public hospitals that are the recipients of economic dumps. As Emily Friedman, an early chronicler of the phenomenon notes, "Catholic institutions in many cities, and children's hospitals in a few, appear to be receiving significant numbers of economic transfers."[10]

The New Context

Current public policy places the emphasis squarely on cost-containment: quality of care and equity of access take distant second and third places. The poor and uninsured suffer. Specifically, 35 million people (15 per cent of the population) lack health insurance of any kind today—an increase of 10 million people since 1977. While many are poor and unemployed, most are not. Gail R. Wilensky of Project HOPE has noted, "In fact, the most likely to be uninsured are young adults between the ages of 18 and 24; and a third of the uninsured are children under 18."[11] Any policy of refusing emergency care or transferring emergency patients who are uninsured will thus fall hardest on those in our society least able to protect themselves: children and young adults.

A good deal of attention has been paid by the current Administration to putting a price on individual lives which can be used in cost/benefit analyses of proposed health and safety regulations. The general range federal administrative agencies have been using is $400,000 to $7 million for one human life. On the other hand, even the Administration recognized in the Lebanon hostage crisis that the price we were willing to pay for the hijacked US passengers was probably at least an order of magnitude higher than what it would be willing to pay to save "statistical lives" by, for example, tightening up airport security. Emergency room patients are a mid-way case. They are "statistical lives" in

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the sense that when planning an emergency system, we do not know who they will be. On the other hand, they are not like the statistical lives that are lost in automobile crashes, industrial accidents, or because of exposure to toxic chemicals. These people, *before* they actually die, will come to a hospital emergency room seeking medical assistance from the personnel and physicians who work there. Turning them down at this point requires the physician, nurse, or clerk to make a decision to risk the life of a specific human being. More than that, if we permit the market to rule, it requires that the physician risk the patient's life at a specified price, the cost of emergency care for the condition that brought the patient to the emergency ward. Permitting hospitals and physicians to make such cost/benefit analyses from the perspective of the hospital's budget should "shock the public's conscience" and be ethically and legally unacceptable.

Dr. Arnold Relman is on target in noting that "steps necessary to ensure adequate emergency care of the indigent and uninsured are, unfortunately, at odds with the currently fashionable philosophy in Washington . . . that hospitals are basically businesses." He argues persuasively that hospitals should continue to be viewed as "community resources" with an obligation "to treat all emergency patients brought to their doors . . ."[12] Hospitals are turning away or transferring more and more indigent and uninsured from their emergency rooms. For example, in Dallas, indigent patients have recently been transferred to tax-supported Parkland Memorial Hospital at the rate of 200 a month, or three times the 1983 average.[13] Similarly, 1984 transfers to Chicago's Cook County Hospital stood at 6,000 emergency patients, five times as many as in 1980.[13] If these figures are at all representative, the problem may be growing extremely serious. A study of transfers to the major public acute care facility in Alameda County, California, Highland General Hospital, in the first six months of 1981, found 458 patient transfers to the emergency ward during this period.[14] Fifty-three per cent were admitted to the hospital. In 33 cases, transfer was judged by the four clinicians participating in the record-review study as having jeopardized the patient. Eighty-five per cent of this group was uninsured. One of these patients was a 36 year old uninsured Hispanic man who, after a beating, was taken to a private hospital where he lapsed into a coma. Two neurosurgeons refused to see him despite urgent requests to do so. He did not regain consciousness after transfer.[14]

Cases like this are, of course, the inevitable consequence of trying to make emergency care an economic good, subject to the market. As Professor Reinhardt has noted, "Unfortunately, as every freshman in economics quickly learns, the one feat the Invisible Hand usually cannot achieve is the distribution of commodities on a basis other than ability to pay." Like basic community services such as police protection, the fire department, and water purification, the attempt to convert a public good into an economic good can be accomplished only by excluding a large segment of the community from protection. What legal emergency treatment obligations do hospitals and their physicians have?

Duty of the Hospital

Courts have found that if there is a reasonable basis for suspecting that an emergency exists, a patient has a right to be examined and treated by a physician if the patient gets to a hospital emergency ward.[14,15] For example, in an Alabama case an automobile accident victim was brought to the hospital with severe back pain. A nurse could find no injury and refused to call a physician or admit the patient. The following day, at another hospital, he was diagnosed as having a broken back. The first hospital was held legally responsible for not admitting him or having him examined by a qualified physician.[16] In a similar case, a nurse in a New York hospital emergency ward refused to admit a patient or call a physician to see a patient, even though she believed he was suffering a heart attack, because the patient did not have the proper health insurance. The patient returned home and died, and the court ruled that the hospital could be found responsible for the death.[17] It is also the general rule that emergency treatment must continue until a patient can be transferred or discharged *without harm*.[14,15,18,19]

A recent case from Arizona indicates that the courts are not likely to back down from their view that public policy demands that emergency treatment be provided to *all* persons experiencing a medical emergency who make it to a hospital emergency ward.[20] The case involved Michael Thompson, a 13 year old child who was pinned against a wall by an automobile that had fallen off a jack. He was rushed by ambulance from the scene directly to the Boswell Memorial Hospital in Sun City. He arrived at 8:22 pm and was examined and treated by the emergency room physician who found that Michael's left thigh was severely lacerated. There was no pulse in the leg, the left foot and toes were dusky, cool, and clammy, and bone was visible at the lower end of the laceration near the knee. The physician administered fluids, ordered blood, and called in an orthopedic surgeon. The surgeon examined Michael, consulted by phone with a vascular surgeon, and decided surgery was needed. At some time after 9:30 pm, it was determined that Michael's condition was "stabilized" and that he was "medically transferrable." At 10:13 pm, Michael was placed in an ambulance and transferred to the County Hospital, where his condition worsened. Surgery was finally performed at about 1:00 am. He survived, but has serious residual impairment of the left leg, caused by the delay in restoring blood flow to it, which had stopped because of a transected femoral artery.[20]

The hospital agreed that the surgery could have been performed at Boswell, and that the transfer was "for financial reasons." A Boswell administrator testified that emergency "charity" patients are transferred from Boswell to County whenever a physician, in his professional judgment, determines that "a transfer could occur." The emergency room physician did so determine, and a witness for the plaintiff testified that the physician told Michael's mother, "I have the (shitty) detail of telling you that Mike will be transferred to County . . ." His mother "begged" the doctor not to send her son to County Hospital.[20]

This case can be categorized as a "premature discharge" case (rather than an emergency refusal) because the patient was seen and some treatment begun. However it is categorized, it highlights the issues involved in emergency room "dumps" or transfers. The primary question before the Arizona court was whether the hospital violated the law in transferring this 13 year old child solely because he lacked the proper insurance. The court reaffirmed Arizona law that it is public policy that a general hospital may not deny emergency care to any patient without cause. In interpreting this policy, the court noted that the state Director of Health Services had adopted regulations based in part on the emergency section of the standards of the Joint Commission on Accreditation of Hospitals which state in relevant part:

"no patient should arbitrarily be transferred if the hospital where he was initially seen has means for adequate care of his problem." The JCAH Manual makes clear that services that are "available and medically indicated" should be provided regardless of the "source of payment."

Arizona has a statutory scheme that pays private hospitals for care rendered in an emergency. But this statute does not permit private hospitals to determine whether or not to render emergency services. In this regard, they have the same duty as public hospitals:

> . . . as a matter of public policy, licensed hospitals in this state are required to accept and render emergency care to all patients who present themselves in need of such care. The patient may not be transferred until all medically indicated emergency care has been completed . . . without consideration of economic circumstances.[20]

The court concluded that the child was suffering an emergency condition, that emergency surgery was the indicated treatment, and accordingly that the hospital had a legal duty to provide Michael with that emergency surgery. All this is relatively stragithforward and consistent with most past cases on this subject.[14] But where does this leave the physician in charge of the hospital's emergency room?

The Physician's role

The physician's role is pivotal. First, it is the physician's duty to determine whether or not an emergency situation exists. If an emergency does exist, both law and medical ethics require the physician to treat the patient or find someone who can. But the definition of a medical emergency is sometimes unclear. The broadest definition is supplied by the American College of Emergency Physicians, whose view is that a patient has made an appropriate visit to an emergency department when "an unforseen condition of a pathophysiological or psychological nature develops which a prudent lay person possessing an average knowledge of health and medicine, would judge to require urgent and unscheduled medical attention most likely available, after consideration of possible alternatives, in a hospital emergency department." The group gives examples of such conditions, including relief of acute or severe pain; hemorrhage or threat of hemorrhage; and obstetrical crises and labor. This is sufficient to require a person be seen by a physician. Once seen, according to the American Hospital Association, "a true emergency is any condition clinically determined to require immediate medical care."[20]

The real questions it seems, are what does "immediate" mean?, and what reasons are sufficient to justify a decision to transfer a patient to another facility? All of the physicians in the Arizona case agreed that the child was suffering from an emergency condition that required emergency surgery. They seem to have believed, however, that the child was nonetheless "medically transferrable." This belief seems to have been primarily based on the fear that the hospital would not be adequately paid for the surgery. It *is* proper for a physician exercising *medical* judgment to determine, according to good and accepted medical standards, whether or not a patient is experiencing a medical emergency, if immediate treatment is indicated, and if such treatment *can* reasonably be provided at the hospital. It is *not* proper for a physician who determines that a medical emergency exists to make a decision to attempt to transfer a patient based solely or primarily on financial considerations. Physicians cannot and should not permit themselves to be used as financial hatchetmen by profit-maximizing hospital managers. They should act as conscientious objectors to hospital policies that put patients at risk, and their professional associations should vigorously support physician actions consistent with good patient care.

But what if "immediate" treatment really is not necessary, and the patient can be safely transferred without any foreseeable risk to his health or decreasing his chances for recovery, and nonetheless the County Hospital (or tertiary care center) refuses to take the patient? The physician can either make arrangements for the patient to stay at the hospital, or discharge the patient. In this regard, another 1984 Arizona case held that "since cessation of hospital care may not be medically indicated despite the cessation of the emergent condition . . . the private hospital may not simply release a seriously ill, indigent patient to perish on the streets."[21] The hospital's obligation to provide care *after* the emergency condition is stabilized *continues* until the patient is properly transferred or is medically fit for discharge from the hospital, and the physician should ensure that the hospital meets this patient care obligation.

Suggestions

For-profit hospitals and financially-strapped public and non-profit hospitals will undoubtedly attempt to redefine their legal duty toward emergency patients and attempt to influence their medical staffs to adjust their professional ethics to narrower definitions of emergencies and broader criteria justifying transfer. The public and physicians should resist these efforts vigorously. Whatever "minimum" we owe all members of our community regarding medical treatment, it must include emergency treatment or the transformation of medicine from a profession dedicated to the alleviation of illness and suffering to a business unconcerned with suffering, disability, or even death will be complete in the institutional setting. Three actions seem reasonable:

- Professional associations should reaffirm the ethical requirement of their members to assist all those needing emergency medical care, and only permit transfer for *better* care.
- States, through statutes and regulations, should define "emergency" broadly (rather than narrowly) and add criminal penalties for hospitals, physicians and nurses in emergency departments that refuse such services.
- Uninsured individuals should be encouraged to carry cards that set forth their state's law regarding emergency treatment, and contain a form for the emergency room physician to sign certifying that no emergency condition exists if he or she refuses to treat them for what they consider an emergency situation, and that transfer can be accomplished without risk and will provide superior services should transfer be ordered. Such a card has been used by the Legal Services of Middle Tennessee for years (800) 342-3317, and even when it does not help procure necessary services, it identifies the physican who determined such services were unnecessary. This type of personal physician responsibility must be maintained if institutional objectives to deny emergency services to the poor and uninsured are to be effectively combated.

Other approaches should also be explored. One suggestion has been to develop "emergency transfer protocols" and a mechanism to enforce them.[22] State departments of public health could usefully adopt such protocols as regulations, with input from the hospitals in the state, and enforce

them by retrospective review of individual emergency transfers. Noncomplying hospitals could be eliminated from emergency systems, such as a 911 network, or their emergency department's license or permit could be revoked. Noncompliant physicians and nurses could also be disciplined through the offices of state physician and nurse licensing agencies.[23]

The only nonstatutory right to medical care United States citizens have is the right to be treated in an emergency room for an emergency condition. During the 1970s, it seemed that this right was secure, and could be the basis for expanding "the right to medical care" in the country. In the mid-1980s, even this limited right is in danger of contracting significantly. All those interested in fairness, equity, and a medical care system that at least responds to emergencies without first inquiring into the patient's finances must be concerned about this trend. Of course hospitals should be paid for emergency services; but the fact that we have not yet worked out a payment mechanism that is universally acceptable is insufficient justification for physicians and hospitals to radically alter their traditional caring behavior by converting necessary emergency services into an economic commodity, available only to those able to pay. The emergency rule should remain: Treat first and ask about ability to pay later.

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