

Introduction

Annals News and Perspective explores topics relevant to emergency medicine, in particular those in which our specialty interacts with the political, ethical, sociologic, legal and business spheres of our society. Discussion of specific clinical problems and their

management will be rare. By design, it will not be a “breaking news” section with the latest (and undigested) developments, but instead a reflective investigation of recent and emerging trends. If you have any feedback about this section, please forward it to us at feedback@acep.org.

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DEBATE RAGES OVER THE “FUTURE OF EMERGENCY CARE”

Maryn McKenna

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The US emergency care system is overwhelmed, underfunded, understaffed and “at the breaking point,” the Institute of Medicine (IOM) announced on June 14 in releasing a three-part report on problems in emergency care.

Once a minute every day—501,000 times per year—an ambulance carrying a sick patient is turned away from an emergency department (ED). Treated patients wait hours or days on gurneys for admission elsewhere in the hospital. And nowhere in the country is an ED adequately equipped—with staff, technology or spare beds—to handle a mass-casualty terrorist attack or the introduction of pandemic flu.

“The Future of Emergency Care in the United States Health System,” which was prepared over 2 years by a committee of more than 40 physicians and nurses from around the country, makes a number of urgent recommendations to ease the bottlenecks. But its authors said they hope more than anything to draw the attention of the public and Congress to a situation accelerating out of control.

“In most communities there is a crisis under the surface,” Dr. Gail Warden, president emeritus of the Henry Ford Health System in Detroit and the chair of the report committee, said at a lengthy briefing at IOM headquarters in Washington.

“We have overcrowded emergency departments and hospitals with long waits for beds. We have ambulance diversions because the emergency room is overcrowded and not able to handle the volume coming to it. We have a lack of specialists available to care for emergencies. . . The transport of patients is often fragmented and disorganized.”

The crux of the problem is a mismatch between supply and demand, the report authors said. Use of EDs is rising: There were 114 million visits in 2003, up 26% from 10 years before. But the number of EDs is shrinking: Over that same decade, 425 EDs and 703 hospitals closed, and the number of hospital beds contracted by 198,000.

The remaining departments are providing more care—despite a shrinking pool of on-call specialists, a nursing shortage of more than 110,000 open positions, and cuts in federal reimbursements—because they feel a moral obligation, said Dr. A. Brent Eastman, a report co-author and the chief medical officer of ScrippsHealth in San Diego, CA.

SAFETY NET FOR SHOWING THE STRAIN

“The safety net is currently being kept afloat by incredibly dedicated professionals,” he said at the IOM briefing.

But, the experts pointed out, overloaded departments are also providing care because they are legally compelled—by EMTALA, the Emergency Medical Treatment and Active Labor Act—to treat anyone who comes through their doors.

“We value emergency care so much that it is the only medical care to which Americans have a legal right,” said Dr. Arthur Kellermann, a report co-author and professor and chair of emergency medicine at Emory University School of Medicine in Atlanta. “But we value it so little we are not willing to pay for that care. It is in Congressional parlance an unfunded mandate.”

An instant infusion of funds for emergency medical care tops the reports’ list of urgent recommendations: a one-time appropriation of \$50 million to reimburse hospitals whose EDs are used as primary care providers by the under- and uninsured; \$88 million to fund demonstration projects uniting fragmented EMS-hospital communication systems; and increases in budgets for the Emergency Medical Services for Children Program.

Those dollars will provide a short-term fix not a long-term solution, said Warden, who called the \$50 million request “a down-payment to get Congress’s attention.”

The report calls as well for an immediate increase in the proportion of funds for bioterrorism and pandemic-influenza preparedness that are being sent hospitals’ way. Since 2002, the

report committee said, emergency medical services nationwide have received only 4% of first-responder funds paid out by the Department of Homeland Security. Hospitals have received an average of \$10,000 each from the Health Resources and Services Administration's post-anthrax Bioterrorism Hospital Preparedness Program—and, to date, none of the money granted states by the Department of Health and Human Services (HHS) to prepare for pandemic flu.

"We are definitely not prepared for the onslaught of patients we would receive today in a disaster, whether it is a hurricane Katrina, whether it is a terrorist attack which conventional wisdom would suggest may well be explosive, or a pandemic," Eastman said.

Along with funds, the committee recommended Congress create a new federal agency, preferably within HHS, that would unite under one roof programs now scattered among several departments.

"If we are calling for real integration of a very fragmented system of emergency care, regionally and locally, that has to flow all the way up to the federal level also," said Robert Giffen, PhD, an IOM senior program officer and the study's co-director. Currently, "there are some redundancies and lots of gaps," he said. "The system does not have good representation at budget time. Every organization is an orphan."

But the committee called on EDs, EMS and hospitals to make changes as well, on initiatives that range from cooperating with local and regional rivals, to gathering data to make evidence-based decisions, to implementing operational and technological improvements.

THE MARRIOTT MODEL OF BED CONTROL

"Marriott knows a lot more about the status of the rooms in their hotels than the vast majority of hospitals have any clue about in this country today," said Dr. Brent Asplin, associate professor of emergency medicine at the University of Minneapolis and a report co-author. "Even though most hospitals have electronic bed-capacity monitoring systems, we all know the real information in many hospitals is on a paper clipboard, and only the house supervisor knows where the patients are and where they are not."

Crucially, the committee said, hospitals must abandon the chokehold on inpatient bed space that forces EDs to board patients, and turn ambulances away.

"I didn't say, 'Work on it'—we said they must end it," Kellermann said at the IOM. "They need the resources and support to do that, but this is simply unacceptable. We cannot let the most time-critical form of entry into the health care system be gridlocked."

The 3 report sections released Wednesday focus on critical aspects of the emergency medical care system: in-hospital care, prehospital services and pediatric emergency care. Their titles give a flavor of the committee's sense of urgency: "Hospital-Based Emergency Care: At the Breaking Point"; "Emergency Medical Services: At the Crossroads"; and "Emergency Care for Children: Growing Pains."

Immediately after their release, the constituencies whom the reports touched responded—mostly positively—to their urgent calls for change.

"The IOM report . . . is a much needed wake-up call for all Americans," said Dr. Thomas R. Russell, executive director of the American College of Surgeons.

"The Emergency Nurses Association agrees with the general recommendations put forth today by the IOM," said Nancy Bonalumi, ENA president and director of emergency nursing at Children's Hospital of Philadelphia.

A CALL FOR CONGRESSIONAL ACTION

The American College of Emergency Physicians (ACEP) called for immediate Congressional hearings.

"Hospitals must be reimbursed for the significant amounts of uncompensated emergency care they provide," said Dr. Frederick Blum, ACEP president. "To do otherwise threatens to destroy the critical emergency care infrastructure that all Americans depend on."

Senator Richard Burr (R-NC), chairman of the Subcommittee on Bioterrorism and Public Health Preparedness, backed the call for action. Burr is leading a bipartisan effort to reauthorize the Public Health Security and Bioterrorism Preparedness and Response Act, first passed after the 2001 anthrax-letter attacks.

The IOM report "shows that across the nation our emergency care system has difficulty meeting the current pressures it must contend with," Burr said. "If our emergency rooms are strapped now, how will they provide emergency care in the event of a medical disaster? We must restructure the federal programs that affect emergency medical response and make sure there is one person in charge at HHS."

HHS itself—envisioned by the IOM committee as the home of the new federal agency for emergency medicine—responded conservatively.

"HHS will be reviewing the findings and recommendations in the Institute of Medicine reports on 'The Future of Emergency Care in the United States,'" the agency said in a prepared statement. "By and large, it is consistent with our understanding of the problems that currently exist, and it notes some of the actions we are currently taking to ensure that our emergency health care system provides safe and high quality healthcare."

The possibility that HHS could become the federal home of all emergency care oversight—rather than the Department of Transportation, which oversees the National Highway Traffic Safety Administration, federal home of EMS—was not universally applauded. During the IOM briefing, the National Association of Emergency Medical Technicians (NAEMT) released poll results showing that, while 93% of 3,000 NAEMT members agreed they are health care workers, 85% also see themselves as public safety responders.

Outside Washington, emergency medical professionals supported the IOM report.

"The committee got it right, pretty much across the board," said Dr. Brent King, chairman of the department of emergency medicine at The University of Texas Medical School at Houston. "There's no question in my mind that we absolutely must address the issue of the unfunded mandate."

Dr. Jeff Kalina, medical director of Houston's Methodist Hospital's ED and chair of the Texas Medical Center's disaster preparedness committee, added: "Despite the fact that over and over it has been discussed that emergency preparedness is key, a lot of the money goes to fire, police. Those are the squeaky wheels, and they have the political clout to get the funding." The committee focused some of its deepest concern on the participation of those outside the emergency medical community: the physicians whom EDs and hospitals rely on to provide on-call subspecialty care, but who have withdrawn in droves due to the cost of uncompensated care and the increased risk of medical liability.

PITFALLS IN PEDIATRIC CARE

In addition to all the above, the experts concluded, there are also problems with the emergency care of children. Very few of the nation's emergency departments have all the specialized equipment, technology or staff to care for the child patients who make up one-fourth of their patient load. Although pediatric skills deteriorate quickly without practice, continuing education in pediatric care is not required or is extremely limited for many prehospital emergency medical technicians (EMTs).

Many medications given to children have not been reviewed or approved for that use by the FDA. Disaster preparedness plans often overlook the needs of children, even though their needs differ from those of adults. Even a bus crash that badly injures a dozen children could overtax a department, they said.

"When you look at surge capacity, the checklists say, do you have a 3-0 tube, not do you have 15 of them," said Kathi Huddleston, a Virginia transport nurse in the IOM briefing's audience. "In this area of 6 million, we have less than 40 pediatric ICU beds."

REPORTS AS A SECOND LANDMARK

By accident or design, the IOM report comes on the 40th anniversary of another National Academy of Sciences publication —the report "Accidental Death and Disability: The Neglected Diseases of Modern Society," which triggered the passage of federal legislation, the creation of NHTSA and the Office of EMS and the rapid growth of US trauma care.

There was a palpable sense at the IOM briefing that committee members hungered for a similar second surge of public and political will.

"We transformed EMS and trauma care in the United States in less than a decade, and then we kind of ran out of momentum," Kellermann said. "We substituted, for some sense of strategy and direction, a lot of goodwill and talent and individual effort. We have run on that for 30 years—but that is a terrible way to make public policy."

"Imagine what we could do if we could harness good thinking, careful planning and the talent we have in the emergency care system, today . . . We could have a system that deserves the confidence of the American people that they still give us, and certainly that they deserve."

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BREAKING POINT: REPORT CALLS FOR CONGRESSIONAL RESCUE OF HOSPITAL EMERGENCY DEPARTMENTS

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The trends in patient demand and bed availability bode ill for US emergency departments (EDs), leading an influential panel of medical experts to call for Congressional aid.

Between 1993 and 2003 ED visits rose by 26%, from 90.3 to 113.9 million. During the same period the US lost 703 hospitals, 198,000 hospital beds and 425 hospital EDs.

It's no surprise, then, that by the year 2001 some 60% of US hospitals were operating at their capacities, or exceeding them.

The results of such trends are clear and painful: ED crowding and diversion.

In recognition of these challenges, and a changing world in which EDs may find themselves on the front lines during terrorist attacks and natural disasters like Hurricane Katrina, the Institute of Medicine devoted a subcommittee to *Hospital-Based Emergency Care: At the Breaking Point*. In this committee's own words: