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Why the *Grey's Anatomy* Myth Clouds the Real Value of Emergency Care

By Dr. Jesse M. Pines and Dr. Zachary F. Meisel

A few weeks ago, the American College of Emergency Physicians (ACEP) launched a campaign to derail proposed policies to reduce the use of emergency departments (EDs). ACEP's problem with the campaign is the logic that underpins it: policymakers think that ED use, in aggregate, is a costly problem and a major driver of unnecessary health care costs in the U.S. ACEP claims that rather than delivering unnecessary care, EDs treat many patients who have no alternative when they need comprehensive medical care in a timely manner; that is, EDs deliver altogether necessary care.

ACEP has challenged reports from South Carolina and Massachusetts suggesting that a high percentage of ED us is unnecessary and that reform efforts — particularly payment incentives — will reduce "inappropriate" usage. In South Carolina, a state legislator, Representative Bill Herbkersman, even recommended that special call boxes be placed in the homes of more than 3,000 Medicaid patients to give them 24-hour access to nurses who could diagnose them over the phone and reduce costly and unnecessary ED visits. Blue Cross Blue Shield of Georgia ha also increased the co-pay on ED visits from $100 to $200 and has been steering its members away from EDs to urgent-care centers and retail clinics (with the help of a Google Maps application, soon be available as an app for members' mobile phones).

There are clearly two prevailing views on emergency care. The first is informed by emergency departments depicted on TV shows like *ER* and *Grey's Anatomy*, on which doctors and nurses dramatically and consistently (i.e., pretty much on every show) save lives. The second depicts the ED as a haven for abusers — who also make the occasional cameo on prime-time medical dramas — the dreary characters who seek primary, nonurgent medical care or drugs in the ED because it's free and convenient, dragging doctors and nurses away from the important work of saving lives. (See pictures of Brooklyn's all-volunteer ambulance corps.)

If you rummage through a tall stack of ED charts, you'll probably find both kinds of cases: the heart attacks and strokes that receive dramatic lifesaving treatment, along with the occasional unnecessary visit from a homeless man simply seeking shelter or food. But if you leaf through the rest of the charts, what you'll find is that neither o

these types of patient is representative of what really goes on in EDs.

The two most common symptoms seen in EDs are chest pain and abdominal pain — both worrisome symptoms that can potentially signal true emergencies like heart attacks or appendicitis, but in most cases do not. For many patients, the ED visit doesn't exactly save their life, but rather rules out emergencies, controls symptoms like pain, fixes problems (when possible) and provides reassurance. Mixed in is the entire cross-section of human illnesses, from infections to injuries, from psychiatric patients to substance users, from headaches to broken bones and heart failure. Characterizing the ED with any one narrative is impossible and misleading. (See why many U.S. patients opt for the ER first.)

So how can we reconcile the two extremes: emergency-physician groups advocating for patients who want convenient medical care, and policymakers and insurers who see ED visits as expensive and mostly unnecessary?

It's fair to say that some emergency care could probably be avoided if there were adequate alternatives, like clinic doctors who are responsive to their patients' urgent needs. But the fact remains that for many there are no convenient alternatives to EDs. Retail clinics are typically built in rich suburbs. Policymakers and insurers are disillusioned if they believe that driving away people with nonurgent complaints from EDs will really improve health care or save a lot of money because less than 3% of overall health care costs are spent on emergency care. The terms used by policymakers to describe emergency care are fundamentally flawed.

If unnecessary ED care is a visit that is not lifesaving, then by that standard it could be argued that most medical care is unnecessary. That includes all the unnecessary back surgeries, end-of-life chemotherapy and scopes for arthritic joints that are even more expensive than ED care. If the goal is to save lives, behavioral and social factors are proportionally greater contributors to health than medical care. If the goal is to save money, then policymakers should consider targeting the general use of expensive, questionable treatments rather than care in the ER, which is the public-health safety net. (See the top 10 nonemergency 911 calls.)

Many ED visits are also termed nonurgent after the fact. The perception of urgency after reviewing a medical chart is often different from the perception of the person seeking emergency care. Imagine a young woman with an uncomfortable urinary-tract infection on a Saturday. It is very likely that to her the ED visit felt quite urgent, while a policymaker or insurer may conclude that her problem is nonurgent and can wait until Monday when the doctor's office is open.

So how should we value of our ED system? The better approach is to view it from the various perspectives of stakeholders. Insurers — the ones that pay — would prefer that conditions that can be cared for in clinics be handled outside EDs because it costs less to do so. Patients — the ones receiving emergency care — want symptoms addressed in a timely manner and don't want to wait days or weeks for often scarce doctors' appointments. So they go to the ED because it's often the only place that's open or will admit them. And for society — for whom the goal is to minimize cost and maximize productivity — the marginal cost of an ED visit is actually lower than that of an off-hours clinic visit while getting after-hours care at an ED is more efficient than

missing work to go to a clinic.

The value of emergency care is really about which perspective you take, and actually quite different depending on where you sit. Emergency departments handle everything from treating real emergencies to providing the occasional meal for down-on-their-luck citizens. They also provide the capacity to care for people when a true public-health emergency, like a disaster, strikes.

Blunt efforts by policymakers or insurers to limit emergency care merely by limiting payments need to be reconsidered. They discount the value of EDs not only to the patients, but also to society. These efforts are potentially harmful because they run the risk of pinching a system that must be able to handle an onslaught of sick patients in a crisis and provide a health care safety net for all Americans. These misguided efforts include public-policy initiatives like the proposed South Carolina call center, which is untested and could potentially cause more problems, not to mention malpractice litigation. And what Blue Cross Blue Shield of Georgia might find is that its attempts to steer members to ED alternatives may end up driving up overall health care utilization by increasing the use of retail clinics while not really impacting ED visits. (See pictures of Cleveland's smarter approach to health care.)

But at the same time, our system should strive for greater continuity of care and prevention. Screening tests and efforts to reduce harmful behavior like smoking are not typically the role of EDs.

Much of this policy rhetoric is driven by the twin narratives of ED care, and neither really represents the reality of what goes on in the ER. The fact is that nobody knows if they are having an emergency when they go in — we all need to recognize the value of figuring it out, explaining what the problem is and providing reassurance, and the convenience of being open all the time.

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