



Another View on Health Care Inflation in the ER



By Loren A. Johnson, MD

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Recently, David Gibson, MD, wrote a highly critical article in the Sacramento Bee about the high cost of his daughter's care in an emergency room. He did this without allowing appropriate time for hospital quality review and without requesting peer review by our medical society. In addition, he wrote an article entitled, "My Experience with Health Care Inflation in the ER," published in Sierra Sacramento Valley Medicine, January/February 2002, in which he addressed the same concerns. Unfortunately, in this article he went on to make false and unfair allegations about hospitals and emergency physicians rather than simply airing a legitimate grievance about our health care system.

It appears that Dr. Gibson wasn't present during the visit, but he used medical terminology to infer that his daughter had a minor illness and was overtreated and overcharged in an emergency department. Obviously, the treating physicians must respect patient confidentiality and are not at liberty to argue their case. However, if we could imagine a hypothetical peer review process, consider the possibility that, based on objective findings, the patient's condition might have been substantially worse than described. Very likely then, the reviewer might find the referral and care by each of the physicians to be appropriate.

Given our rigorous governmental compliance standards and the high risk exposure of emergency departments, one could also imagine that the services were coded and billed accurately in accordance with Medicare coding and documentation standards, and that the actual payments for these services were made under deeply discounted insurance contracts at a small fraction of the charges. Now, extend this hypothetical scenario to the realm of exaggerated complaints and ulterior motives, a phenomenon that most doctors occasionally encounter in their clinical practice. And, consider that in this case, the complainant might be a health care professional with his own agenda.

Skeptical that a member of our society would say unkind and potentially damaging things about his colleagues if they weren't true? Let's take a closer look at Dr. Gibson's statements and see if we can gain some additional insights. He infers that "the ER physician inappropriately inserted himself into the case, then opportunistically up-coded his fees." As chief medical officer for an ER group, I can categorically state that we have never and will never "upcode" our fees. Further, Like all emergency physicians, this physician had an absolute duty to screen and treat the patient under federal law, regardless of the circumstances of the referral. Dr. Gibson also states, "By just walking into the ER, my daughter was charged \$1063.53." In doing so, he ignores the legitimacy of nursing and facility costs, and how they translate into actual payment. He wrongly presumes that

there was no referral from the private physician's office and that lab results from the office are available to the emergency physician. He makes the assertion that an emergency department E&M level IV code requires continuous patient attendance, a criterion not applicable to emergency medicine. He makes unwarranted conclusions regarding non-urgent ED utilization based on flawed data from OSHPD, and he goes on to make degrading references about ER groups needing close supervision by the medical staff and "inmates running the asylum," and even worse infers fraudulent activity, warning that "for these hospitals' long term well being, future investigations had better not reveal an incentive clause with profit sharing for ordering diagnostic tests."

Finally, Dr. Gibson ascribes the ED overcrowding problem to some monopolistic plot in which Sutter and Catholic Healthcare West (CHW) "conspired with managed care to eliminate competition for ambulatory services," and uses this to establish his argument for physician economic empowerment. No surprise then that he offers no evidence for these outrageous assumptions, and that he fails to acknowledge that ED overcrowding is a national problem in which hospitals and medical staffs are struggling to care for aging and underinsured populations. (Reference: Emergency Departments Under Stress, Center for Health System Change, May 2001).

In reality, cost containment is a major theme in emergency medicine. Local emergency physician groups use evidence-based guidelines to control laboratory, x-ray and pharmacy costs. Our coding and billing functions have no connection to the hospital's business activities. We maintain rigorous compliance programs and conduct honest peer review. We honor the corporate practice bar, and zealously guard our clinical autonomy from administrative intrusions, such as those implied in the article. As for the role of the hospitals, I personally know of numerous planning sessions to facilitate cooperation with community clinics, both at Sutter and Mercy facilities where I've been active. All of us suffered through a painful period of consolidation due to managed care. However, it's obvious that hospitals are no longer "acquiring medical practices." We should also know that the Sacramento Sierra Hospital Conference is working to reduce ED overcrowding and non-urgent utilization under the constraints of federal law.

Ordinarily, Dr. Gibson writes well-reasoned articles on private sector health reform. He cites some ED loss data and some hospital charges that are hard to justify, and most of us would support his general view that we need more competition and physician clout in the marketplace. However, he fails to acknowledge that in caring for the poor, 60 percent of California's hospitals continue to operate in the red, with CHW being no exception. Neither Sutter nor CHW operate at high profit margins and neither charge the highest rates in Sacramento.

Given the above, consider the feelings any of our colleagues would have on reading these statements in our own society magazine, and consider that after the initial shock, comes the realization that there might be another purpose behind these hurtful allegations. Dr. Gibson's conclusions show that he is a strong advocate for physician entrepreneurial ventures, and it's no secret that there is great interest in new physician business ventures in our area.

What better time for hospital bashing and depicting emergency physicians as modern day pawns and indentured servants? In the long-run, such tactics will sully our profession and we should not engage in them.

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