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Business-centric healthcare's effects on the doctor-patient relationship in the emergency department

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ABSTRACT

Background: The doctor-patient relationship has always been at the core of health care, and this relationship remains of paramount importance, regardless of treatment location or the patient's condition. The hospital emergency department (ED) plays a major role in this relationship by providing access to board-certified, residency-trained emergency physicians capable of rapid diagnosis and treatment of urgent, emergent, and life-threatening conditions. U.S. EDs also serve as the nation's safety net for the care of uninsured and underinsured patients.

Discussion: As the ED has become a major profit center in the multi-trillion-dollar health care industry, business-centric pressures on ED care pose major threats to the doctor-patient relationship. This article describes and evaluates business-imposed practices that can undermine this relationship in the ED.

Conclusions: Health systems should strive to enhance relationships between emergency physicians and their patients and to avoid business practices that undermine them.

1. Introduction

The doctor-patient relationship has always been at the core of health care. Since antiquity, physicians have pledged, through oaths and ethical codes, to serve their patients' best interests. In that relationship, physicians provide services designed to maintain, restore, or enhance their patients' health and well-being. The relationship's effectiveness relies on mutual trust, communication, and respect.

While medicine remains a respected profession, it is also a multi-trillion-dollar industry in which physicians and patients are often described in more business-oriented terms like “providers” and “consumers.” Focusing primarily on the hospital emergency department (ED), this article will consider the relationship between the business model of healthcare, on the one hand, and the moral and professional dimensions of the doctor-patient relationship, on the other.

Since the advent of widespread employer-provided medical insurance in the United States after World War II, health care increasingly has become a business-oriented, revenue-generating enterprise [1]. Post-war US federal statutes like the Hill-Burton Act funded the construction of new public community hospitals that offered basic emergency medical care [2]. Yet emergency rooms (ERs), as they were then known, were a consistent financial drain on their institutions. Over the past seven decades, these hospital ERs with minimally trained physicians and scant staff have been transformed into EDs with well-trained, ED-dedicated staff, sophisticated treatment areas, and up-to-date (rather than hand-me-down) equipment [2]. As health care expanded its scope and availability, patient volume increased and EDs became major profit centers that maximized billing and quantified physician productivity [3].

EDs became a more important part of the U.S. healthcare system, providing a safety net and significant benefits to patients who can afford their services, or who fall under the limited Emergency Medical Treatment and Labor Act (EMTALA) provisions requiring evaluation and stabilization [see Table 1] [4]. These benefits include cutting-edge medications and equipment, highly trained personnel, and rapidly available emergency evaluation and procedures. The downside is that these services have high financial and social costs.

With persistent increases in ED volumes came greater administrative emphasis on reimbursement. Emergency physicians (EPs) who sought to provide effective and affordable patient care in an ethically appropriate manner began to come into conflict with their organizations’ emphasis on

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Table 1
EMTALA requirements [4].

The term "emergency medical condition" means—
(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
(ii) serious impairment to bodily functions, or
(iii) serious dysfunction of any bodily organ or part; or
(B) with respect to a pregnant woman who is having contractions—
(i) that there is inadequate time to affect a safe transfer to another hospital before delivery, or
(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.
"Stabilization" under EMTALA requires: To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (B) [a pregnant woman who is having contractions], to deliver (including the placenta).

maximizing revenue or at least minimizing expenses. A constant complaint has been that, to maximize revenue and efficiency, many EDs have cut staff and imposed unreasonable productivity standards centered around RVUs and patients per hour and other flow metrics. This emphasis on productivity has reportedly encouraged many physicians to overbill, reduce time with their patients, maximize reimbursement through unneeded tests and procedures, and otherwise modify their practice in ways that diminish the quality of ED patient care (see Table 2) [5].

To address these issues, management has routinely imposed "customer satisfaction" and similar measures to judge individual EP performance. While EPs desire that their patients have a positive experience and receive appropriate clinical interventions, over-emphasizing high scores on these blunt patient satisfaction tools may have skewed EP practice and interfered with equitable and effective care.

Table 2
Practices undermining optimal emergency physician-patient relationships.

a. Increased requirements for electronic health record (EHR) documentation leading to time drain, distracted attention, and physicians turning their backs to patients while documenting
b. Over-emphasis on documentation for billing rather than for patient care
c. Over-emphasis on active interventions (e.g., billable procedures) to improve reimbursement rather than emphasis on building trust
d. Over-emphasis on flow metrics (i.e., measures of flow efficiency, the ratio between active time and total time) that limit face time with patients and direct interactions with EPs
e. Greater dependence on less-costly providers (e.g., nurse practitioners, physician assistants, residents, students, paramedics, pharmacists, nurses, etc.) to interact with patients
f. Emphasis on using standard protocol-based care that interferes with patient autonomy and shared decision making. Unwanted protocol activation (e.g., Trauma Alerts, Sepsis Alerts, and Stroke Alerts) may also unnecessarily increase patient financial burdens
g. Proliferation of free-standing EDs in affluent suburbs to improve revenue generation rather than in medically underserved areas, such as inner city, rural, and other low-income communities
h. Referral decisions that are influenced by contractual and financial benefits to the facility rather than for optimal patient care
i. Patient admission decisions that impose substantial costs on patients, such as admitting patients to observation status or observation units when this is not reimbursed by health insurance
j. Surprise billing that occurs because the patient is transported to the nearest ED, where the patient's health insurance plan does not cover physician and hospital services
k. Excessive ED boarding of patients without initiating comprehensive treatment plans
l. For-profit health care systems and private equity investor groups that buy hospitals and physician practices, directly employ physicians, and then impose profit-generating practices that may harm patients

2. Discussion

2.1. Can these practices be beneficial?

The introduction to this article identified significant threats to the quality of ED care and the moral integrity of the doctor-patient relationship that are posed by a dominant business model that emphasizes profit generation. This section will consider whether these business-centric, revenue-generating practices may also positively influence the doctor-patient relationship and the quality of ED care. Do the practices listed in Table 2 have positive as well as negative consequences?

Although some of the listed practices divert EPs from time spent with patients, they may benefit patients in other ways. For example, reviewing the electronic health record (EHR) enables physicians to access information about prior medical experiences more quickly and efficiently, including prior ED visits, past medical history, and important medication changes. This valuable information is most accessible for patients previously seen in the same facility or in healthcare systems with accessible EHRs. Although interactions with patients by advanced practice providers (APPs) and paramedics may limit EP's direct contact with patients, these professionals also provide quality care for ED patients.

Applying business models to EM can lead to enhanced clinical efficiency, improve EPs' ability to provide care for more patients, and fulfill EPs' duties to serve as responsible stewards of the healthcare resources entrusted to them [6,7]. This may come at the expense of decreasing EP face time with individual patients, but it may facilitate timely care for ED patients, including access to consultants and to specialized tests such as MRIs.

An important benefit of the doctor-patient relationship is enabling patients to communicate with EPs about their conditions and treatment options and to make informed treatment decisions. Practices that rush patients through the system interfere with these crucial conversations. Treating ED patients using evidence-based protocols, while removing important communication opportunities that enhance the doctor-patient relationship, may also create a more quality-driven, standardized approach that has been proven to save lives [8–10]. Once patients are assigned to a treatment protocol such as sepsis, stroke or trauma, appropriate diagnostic tests and treatments are provided, and care can be more efficient and comprehensive. Yet EPs also have a responsibility to limit protocolized care when this leads to over-ordering tests (resulting in cost inefficiency) and, in the case of excessive CT scanning, causing possible harm to patients due to radiation exposure.

3. Ethical analysis

Physicians have a widely recognized, fundamental duty to act for the benefit of their patients (Table 1) [6,11]. Despite the already complex and chaotic environment in the ED, practices that further strain the doctor-patient relationship by decreasing the EPs' time with their patients (e.g., EHR and other documentation requirements that reduce EPs' time at the bedside, EP surrogates, and inappropriately applied clinical protocols) raise significant questions about EP's ability to fulfill their duty of beneficence. These practices may interfere with appropriate diagnostic evaluation or treatment and significantly reduce the quality of the EP-patient relationship by limiting the time an EP can spend with patients.

As fundamental as the EP's positive duty to benefit patients, is the negative duty to refrain from interventions that are more likely to cause harm than benefit. Protocols or interventions whose primary purpose is revenue generation or expenditure prevention may violate this duty of nonmaleficence. Inappropriate treatments provided to maximize revenue can cause significant physical, psychological, and economic harm.

Physicians also have a widely recognized, fundamental duty to respect their patients' autonomy. One way that duty is operationalized is the legal requirement to obtain patients' informed consent to treatment. Instituting extensive clinical protocols, or failure to provide information

about treatment options or refusal of treatment options, absent recognized exceptions such as immediate life or limb emergencies, is a clear violation of moral and legal obligations. Communication failures can have not only significant physical and financial consequences but can also undermine the doctor-patient relationship. (Whether withholding information about the cost of diagnostic testing or therapies violates respect for autonomy remains a matter of debate in ethics and health law.) While most ED patients have the cognitive ability, desire and right to make treatment decisions for themselves, there are also recognized moral and legal exceptions to this duty, particularly for the small percentage of ED patients who lack decision-making capacity.

Many of the practices in the Table 2 divert time from doctor-patient communication and therefore compromise the physician's ability to discuss the important information about the patient's condition and treatment options with the patient or the patient's surrogate decision maker. This threatens respect for patient autonomy, whether these time diversions result in abbreviated informed consent discussions or diminished and inadequate shared decision making.

Finally, EMTALA has established hospital EDs as the primary safety net for access to health care in the United States (Table 2) [4]. EMTALA gives EPs a central role in the distribution of the benefits and burdens of health care among patients who present to the ED, and a more indirect role in the broader distribution of care among the members of a given population.

Often outside an EP's direct purview but within their area of influence, the health system's decisions can result in clear disparities in access to ED care and to health care generally. For example, opening profit-making, free-standing EDs in the suburbs may benefit patients residing in those communities, but limit care for indigent urban patients whose only ready access to care is at crowded inner-city EDs. Similarly, contractual relationships can result in patients bypassing the closest EDs in favor of others for purely economic reasons.

Additional concerns that business-centric approaches could threaten the doctor-patient relationship include the recent proliferation of residency training programs within for-profit hospitals and of contract management groups that are dependent on private equity. Overemphasis on flow metrics and patient throughput by private equity investors could also devalue the contribution of EPs to ED care, thus decreasing demand for EPs and contributing to the projected oversupply of EPs [12]. Although private equity firms and venture capitalists have played a major role in bankrolling the US technological revolution since the 1970s, the net value of their healthcare investments (including hospitals and physician practices) remains unclear. Moreover, the fact that some of the major contributions to private equity revenue are from healthcare management and performance fees, could easily be construed as leading to an overemphasis on many of the practices listed in Table 2 [13].

4. Conclusion

The introduction of business models and practices into emergency medicine can have significant negative effects on the doctor-patient relationship and lead to ethical lapses. It is, therefore, critically important that practices that compromise the doctor-patient relationship be addressed to minimize those adverse effects. For example, although APPs have become a significant part of ED practice, preserving adequate time for patient interaction with a supervising EP can help preserve and enhance the doctor-patient relationship in the ED. Evaluation of incentives, including RVUs, patients-per-hour quotas, and flow metrics, should consider their effects on the safety and quality of care in order to strengthen the doctor-patient relationship rather than detract from it. EDs can be configured to improve patient encounters, as, for example, having computers positioned so that clinicians always face the patient. EPs can also reduce errors and improve patient satisfaction by minimizing interruptions while they are seeing patients. Enhancing the doctor-patient relationship will improve rapport, trust, and respect, and that will, in turn, enhance the value of and future demand for ED services. Health systems should, therefore, strive to enhance relationships between EPs and their patients and to avoid business practices that undermine them.

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References

[1] Starr P. The social transformation of American medicine. New York: Basic Books; 1982.
[2] Zink BJ. Anyone, anything, anytime: a history of emergency medicine. Philadelphia: Mosby; 2006. p. 10–6.
[3] McConnell KJ, Gray D, Lindrooth RC. The financing of hospital-based emergency departments. J Health Care Finance 2007;33(4):31–52. PMID: 19172961.
[4] Examination and treatment for emergency medical conditions and women in labor. 42 USC 1395dd. www.medlaw.com/statute.htm. [Accessed 14 March 2023].
[5] Lemley DE. Too conscientious: *the Evolution of ethical Challenges to Professionalism in the American medical marketplace*. Cham, Switzerland: Springer; 2022.
[6] American College of Emergency Physicians. Principles of ethics for emergency physicians. In: Code of Ethics for Emergency Physicians. Available at: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/viewer.html?pdfurl=https%3A%2F%2Fwww.acep.org%2Fglobalassets%2Fnew-pdfs%2Fpolicy-statements%2Fcode-of-ethics-for-emergency-physicians.pdf&clen=404748. Accessed December 21, 2021.
[7] Moskop JC. Resource stewardship. In: Moskop JC. *Ethics and health care: an introduction*. Cambridge, UK: Cambridge University Press; 2016. p. 138–57.
[8] Choi J, Carlos G, Nassar AK, Knowlton LM, Spain DA. The impact of trauma systems on patient outcomes. Curr Probl Surg 2021;58:1–21.
[9] Alberts MJ, Hademenos G, Latchaw RE, Jagoda A, Marler JR, Mayberg MR, Starke RD, Todd HW, Viste KM, Girgus M, Shephard T, Emr M, Shwayder P, Walker MD. Recommendations for the establishment of primary stroke centers. Brain Attack Coalition. JAMA 2000;283:3102–9.
[10] Uffen JW, Oosterheert JJ, Schweitzer VA, Thursky K, Kaasjager HAH, Ekkelenkamp MB. Interventions for rapid recognition and treatment of sepsis in the emergency department: a narrative review. Clin Microbiol Infection 2021;27:192–203.
[11] ABIM Foundation, ACP-ASIM Foundation. European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician covenant. Ann Intern Med 2002;136:243–6.
[12] Marco CA, Courtney DM, Ling LJ, et al. The emergency physician workforce: projections for 2030. Ann Emerg Med 2021;78:726–37.
[13] Anrnsdorf I. How rich investors, not doctors, profit from marking up ER bills. https://www.propublica.org/article/how-rich-investors-not-doctors-profit-from-marking-up-er-bills. [Accessed 28 April 2022].