SPECIAL CONTRIBUTIONS

Ethics of Emergency Department Triage: SAEM Position Statement

SAEM Ethics Committee*

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ABSTRACT

Emergency department overcrowding, the growth of managed care, and the high cost of emergency care are creating pressures to triage patients away from U.S. EDs. Paradoxically, this pressure to limit patient access to EDs has increased in spite of federal laws that restrict patient triage and transfer. The latter regulations view EDs as the safety net for the U.S. health care system. The SAEM Ethics Committee evaluated the ethical implications of policies that triage patients out of the ED prior to complete evaluation and treatment. The committee used these implications to develop practical guidelines, which are reported.

Key words: ethics; triage; ambulatory care; emergency medicine; managed care; health maintenance organization.


In this period of rapid health care change and ED overcrowding, emergency physicians (EPs) are being pressured to help decrease the high cost of care by deflecting patients away from EDs toward supposedly “more cost-effective” venues for care. Additionally, concern has arisen about ED overcrowding, which may lead to long delays and patients’ leaving without being seen, which may compromise patient care. This paper addresses ethical issues surrounding the triaging of patients away from the ED and provides practical guidelines for this practice.

BACKGROUND

What Is “Triage”?
The French word triage originally referred to sorting coffee beans according to their quality or size. The military applied the term to the sorting of injured soldiers who could go back into battle vs those who could not. The military also used triage to determine which patients would receive the benefit of limited medical resources. This concept eventually led to nonmilitary physicians’ triaging patients in disasters and other situations associated with limited medical resources. Emergency departments now use triage to determine which patients need treatment most urgently. This triage practice assumes that adequate resources exist to treat every person requesting help, but some patients will be seen sooner than others, based on their medical needs. Some EDs have begun to take triage one step further, incorporating battlefield-like triage into the civilian sector by refusing care to some patients—sending them away untreated to find another access point into the health care system.  

**The Question**

Is triage away from the ED ethically or legally justifiable? Routinely refusing emergency care to selected patients poses a challenge to the values upon which emergency medicine (EM) rests. This behavior also may conflict with U.S. COBRA (Consolidated Omnibus Budget Reconciliation Act) laws which were enacted to prevent transfer of unstable patients to other hospitals for financial reasons. The ethical and legislative imperatives for assessing all patients are juxtaposed with subtle health care system and economic forces promoting denial of ED access.

**THE CONFLICT BETWEEN MANAGED CARE AND EM**

Managed care systems and traditional EM have their roots in different models of care. Managed care controls access to providers, attempts to prevent illness and injury, maintains a limited panel of patients with statistically foreseeable disease frequencies, and attempts to provide service in the manner most cost-effective for the managed care system. Emergency medicine traditionally provides a 24-hour-a-day open-door policy, accepts anyone in need, and is prepared to evaluate and treat even the sickest individuals at a moment’s notice. Although conscious of cost constraints, emergency care often includes expensive, high-technology-based evaluation and treatment.

Ideally, managed care represents a utilitarian model, providing the greatest good for the greatest number within a restricted budget. However, managed care clinicians are increasingly being asked to act as “gatekeepers” who determine through telephone contact whether patients should be seen either in their clinic or in the ED. If the “gatekeeper” does not agree to the ED visit, the HMO care plan will not cover the ED charges. The gatekeeper role may generate a conflict between the clinician’s responsibility as the patient’s advocate and her or his role as the steward of society’s and the HMO’s resources. In addition, the managed care incentive system may have an impact on decisions relating to referrals, admissions, transfers, diagnostic testing, confidentiality, and consultations since the gatekeeper’s own income may be diminished with each use of the system by the patient. Specifically, the best interests of the patient may be in conflict with the best interests of the provider. A system that holds sick patients accountable for getting permission each time an illness or injury brings them to the portals of the local ED may adversely affect patient health. Although patients continue to have the choice of being seen in the ED regardless of HMO payment for their care, the threat of a claim’s being denied may deter them from seeking emergency care in a timely fashion.

The goals of high-quality health care and cost-effective medicine are not mutually exclusive. Emergency physicians and HMO longitudinal care clinicians deliver different kinds of care with different goals. However, patient welfare must remain all physicians’ first priority. As the American Medical Association states, “The duty of patient advocacy is a fundamental element of the physician-
patient relationship that should not be altered by the system of health care delivery in which a physician practices." 10

COST OF EMERGENCY CARE

One of the primary arguments favoring triage of ambulatory patients away from the ED has been the high cost of ED care. However, it is unclear how this cost is defined. Cost often is defined simplistically as billings or payments by a third-party carrier. While billings for ambulatory ED care are currently high, they may not reflect the actual cost of providing care for ambulatory patients. To date, society has chosen to accept the need for a large standing army in the ED to provide care in the event of a serious emergency. The additional (marginal) cost of providing care to patients with non-urgent problems may be small. In fact, ambulatory patient care collections often offset some of the expense of having personnel and equipment available for more urgent needs. 11 The appropriateness of ED ambulatory visit charges is not addressed by a simplistic comparison of charges for similar visit diagnoses managed in other settings.

The availability of emergency care should be a societal decision. Based on the widespread support for other emergency services such as police and fire, the maintenance of high-quality hospital-based emergency services has a high societal value. Further, voter initiatives such as California's, which limit general access to health care for illegal aliens yet permit emergency care for this population, suggest that access to emergency medical care remains a high societal value.

LEGAL ISSUES

The potential legal consequences of protocols that allow triage of patients away from the ED stem from state antidumping statutes, traditional state malpractice law, and COBRA. State antidumping statutes are unlikely to affect triage procedures. While at least 27 states have antidumping statutes, few have enforcement provisions or even clear definitions of what constitutes liability. 12 A breach of prevailing standards of care can result in liability under state malpractice law. Such a breach could occur in the triage process, but is not the main legal concern for most triage protocols.

COBRA

The main legal concern in triage decisions is COBRA, particularly since the financial penalties against physicians (up to $50,000 per violation) are not covered by malpractice insurance. In 1985, Congress passed COBRA in an attempt to end the national scandal of “rejecting patients in life-threatening situations for economic reasons alone.” 12,13 While Congress' intent was to end dumping for economic reasons, most courts now agree that failure to comply with COBRA for any reason can result in liability. 14

COBRA requires a medical screening examination, which may be more stringent than many routine triage interviews. When any person presents to the ED and makes a request for treatment, hospitals that participate in the Medicare program must provide an appropriate medical screening examination within the capability of the hospital's ED, including ancillary services routinely available to the ED, to determine whether an emergency medical condition exists. 15 This examination must be provided to every patient regardless of insurance status. If the screening examination uncovers an emergency medical condition, the patient must be stabilized (as defined by the law). A 1989 amendment provides that the hospital may not delay the screening examination or stabilizing treatment to inquire about the individual’s payment or insurance status. 1 If there is no emergency medical condition, referral is
legally permissible. If the patient does have an emergency medical condition, once she or he is stabilized, referral/transfer is also legally permissible.

It is widely acknowledged that the language of the law is vague at best. For instance, the law defines “emergency medical condition” quite broadly. Furthermore, disagreement among federal courts about “screening examination” provisions is not unusual. Some circuit courts have interpreted the same provision differently, and one circuit court has even reversed itself on the exact same issue. No court has directly addressed the question of what constitutes a legally acceptable medical screening examination.

When the 1989 amendments to COBRA were passed, many asserted that these additions meant that a medical screening examination is essentially the full physician-directed ED examination and workup, including laboratory tests and x-rays that the vast majority of patients would receive for the same condition or complaint. These commentators surmised that a superficial triage examination by a nurse or other nonphysician is not adequate to fulfill the requirements of these amendments. This has never been explicitly stated by any court, but had been asserted in some Health and Human Services (HHS) advisory opinions issued by regional Health Care Financing Administration offices. Recently published HHS regulations fail to fully clarify this issue; however, they contain no specific requirement that the screening examination be performed by a physician. It appears that the overriding consideration for an appropriate medical screening examination is whether the patient received an examination that any other patient would have received for the same condition or complaint regardless of payment status.

Some interpret the law to say that acquiescing to an HMO “denial” (allowing the HMO to act as the gatekeeper to the ED) and deferring the medical screening examination to an off-site provider are a violation of COBRA. These commentators advise that registration personnel should not request permission for treatment from the HMO “gatekeeper” prior to the screening examination, asserting that this would violate the 1989 amendment forbidding delay in treatment while determining insurance status. According to recent HHS regulations, only routine registration delays that every other similarly situated patient would encounter, regardless of insurance status, are permissible. Recent federal law also may protect HMOs from liability for triage decisions based on payment status.

In summary, 1) uncertainty remains about what constitutes a legally acceptable medical screening examination under COBRA; 2) inquiring about insurance status (other than routine registration procedures) before providing a screening examination or stabilizing treatment is a COBRA violation; 3) HMOs are often protected from liability for ED triage decisions influenced by them; 4) the adequacy of a screening examination will be scrutinized in retrospect and the burden will be on the physician and the institution to prove that all patients were treated equally and the examination was adequate; and 5) a patient may be referred out of the ED only if the medical screening examination reveals no emergency medical condition, or if the patient’s emergency medical condition has been stabilized.

**RESEARCH ON TRIAGE AWAY FROM THE ED**

Although many claims have been made about the success of triage away from the ED based on specific screening criteria, it remains unclear how safe “triage away” is for patients. In 1988, the University of California-Davis ED personnel began to refuse to provide care to patients seeking care “inappropriately.” Specially trained emergency nurses interviewed patients and obtained their vital signs. If the vital signs were within predetermined limits, and the patient had one of 50 minor complaints, the patient was refused care and referred to a “help desk.” A t the help desk, those triaged
away were told about community resources where they might seek care. About 19% of ambulatory patients met the criteria and were sent away. After being triaged away, 59% of these individuals did not go to the help desk for advice. Follow-up of those who did obtain advice found that 22% did not seek further medical care, 42% received care elsewhere on the same day, 37% made a follow-up appointment for another day, and 2% were seen in another ED. In total, 112 of 21,069 patients who were triaged out returned to the ED because they could not obtain care elsewhere. The authors noted that they have a community with numerous county medical clinics that are available to see and treat those people who were refused ED care. In their follow-up of the patients who could be reached or their families, the authors found no one who needed emergent care or immediate hospitalization and no death as a result of their triage system. 

In 1990, Lowe et al. attempted to reproduce the UC-Davis results at the University of California-San Francisco. They retrospectively reviewed 106 patients who would have met the UC-Davis criteria for refusal of ED care. They determined that 35% of these patients had visits that were actually “appropriate” for an ED, and four patients were hospitalized. Specifically, four patients were splinted, two had wound care, 31 had diagnostic testing, 11 had specialty consultation, and four were given medications in the ED. Similarly in 1992, Birnbaum et al. found that six of 534 patients at the Bronx Municipal Hospital Medical Center who met one of ten selected UC-Davis criteria for refusal of ED care required hospitalization.

Not all communities have resources available to evaluate and treat patients who are refused ED care. It is also unclear whether accurate methods exist for determining which patients may be safely denied ED care. At this time, the risk of a patient’s being denied care who ultimately is determined to have a life-threatening condition appears small, but measurable.

**ETHICAL PRINCIPLES**

Triage away from the ED should be considered in light of the four basic principles of Western health care ethics: nonmaleficence, beneficence, respect for autonomy, and distributive justice. These values, in principle, guide our society’s health care because they represent commonly held beliefs.

**Nonmaleficence**

Any health care policy must include efforts not to harm patients, i.e., nonmaleficence. Civilian triage policies must be designed to limit, where possible, pain, suffering, disability, and death. While a woman with pain on urination, a student with a sore throat, or a toddler with an earache may be able to wait for a later appointment and not suffer any long-term harm, they will incur additional pain and suffering if treatment is delayed. We believe an obligation exists to avoid this harm to patients unless treating these patients would threaten the welfare of another identifiable patient, or unless the patient could be treated more quickly and effectively elsewhere. That is, if these patients can be quickly and efficiently seen in another location (without undue burden to the patient), harm in the form of excessive delays may be avoided. Hence, when less harm is likely with referral to other clinics, the practice may be ethically justified.

On the other hand, patients come to the ED for many reasons, including 24-hour-a-day care availability, immediate access without a preplanned appointment, ease of transportation, lack of availability of primary care providers, and because, traditionally, EDs have not turned people away regardless of their ability to pay. Most patients who come to the ED believe that they have a problem that needs immediate medical attention, and in one study half of the ambulatory patients coming to the ED had already attempted to care elsewhere.
Refusing to treat certain patients may signal to our society that EDs will no longer act as a safety net to those in need and could deter those in need of help from seeking care.

**Beneficence**

The goal of EM is not only to prevent death and disability but also to improve the patient’s well-being. Beneficence requires physicians to act in their patients’ best interests by balancing good against potential harm. This obligation, based on the physician-patient relationship, predates the Hippocratic oath and remains a fundamental part of the physician’s role. Emergency physicians have an ethical obligation to attempt to provide benefits to ED patients by taking their complaints seriously and by managing their problems according to prevailing standards of care.

Although our focus is on emergent and urgent medical problems, the role of the ED is not merely to manage medical or surgical emergencies, our mission also is to care, holistically, for patients. For example, the EP does not just diagnose noncardiac chest pain, but also reassures the patient that the pain does not represent a heart attack. We do a disservice to ourselves, our patients, and our communities, who require expert, responsive caregivers, if we neglect the caring aspect of our profession.

**Respect for Autonomy**

Respect for autonomy provides that adults have the right to make choices regarding their own health care. Autonomy derives from two Greek root words, autos and nomos, meaning “self-rule.” Respect for patient autonomy among health care professionals has emerged only recently. Changes in our society that have encouraged the rise of respect for autonomy include the expansion of political democracy, improvement in the education of American citizens, the ascendance of informed consent in medical research, the decline of paternalism, and an increase in cultural diversity, which encourages individuals to protect their own personal values.

The American College of Emergency Physicians defines emergency services as follows:

> Emergency services are those health care services provided to evaluate and treat medical conditions of recent onset and severity that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that urgent and/or unscheduled medical care is required. 32

This definition, appropriately, leaves it to the patient to determine when an emergency severe enough to warrant emergency care exists. It implies that the patient will then receive an evaluation and appropriate treatment for the condition. This definition was written to break down any barriers to emergency treatment, to allow patients to exercise their autonomy and to have EPs respect the patient’s decision to seek care. It would be morally unjustifiable to return to a paternalistic paradigm, and refuse to accept the patient’s own definition of what constitutes a medical emergency.

**Distributive Justice**

Nonmaleficence and beneficence obligate clinicians to provide care to individual patients, while respect for autonomy allows patients to participate in their health care decisions. Distributive justice provides that, in the face of limited resources, when allocation and rationing decisions must be made, the decision must be made fairly. This does not mean that each person or group must get an equal share
equality), but rather a fair share based on needs (equity). There must be assurances that no group is unfairly penalized.

The poor and disenfranchised most often use our EDs. They often have no other choice for health care services. Denying this safety net of health care services to already disenfranchised patients without offering alternative treatment options that provide equal or better care is patently unfair. Is there really a shortage of beds, facilities, and personnel, or has our society decided that it is simply not worth expending additional resources to treat the portion of our population who are disadvantaged, disenfranchised, and dysfunctional? 24

In truth, our society, rather than individual EDs or EPs, must decide whether and how emergency care will be rationed. However, the majority in society cannot be allowed to limit care to a disenfranchised minority in an inequitable manner. It is a momentous and far-reaching decision, not to be taken lightly.

PRACTICAL CONSIDERATIONS

The ethical and legal concerns that surround the triage of patients depend on whether the person is “triaged away” or “triaged to.” Unless the situation is one of true scarcity of resources, triage can be ethically justified only if patients may be referred to other locations where they will receive care appropriate to the acuity of their problem only if:

- an examination has been performed that determines that the individual does not have an emergency condition and is medically stable for referral:
- there are assurances that the clinic or managed care facility to which people are referred has agreed to accept them without financial screening or other barriers to care;
- the patients will be seen in a timely fashion;
- either the clinic or the managed care facility is on the same campus, or the patient has or is given timely transportation to the site;
- the patient understands risks and benefits of triage and agrees to the transfer;
- all patients are treated equitably based on their personal and medical needs with the same compassion, consideration, and respect; and
- triage criteria, if any, are based on research that shows them to be safe and effective. (At present, triage criteria cannot be considered without risk.)

CONCLUSION

Patients generally present to EDs because they or others believe the person has a medical emergency. 31 No existing system based on a brief “triage” examination differentiates all patients with serious emergencies from those with lesser problems. Thus, most triage policies that refuse care to individuals meeting specific criteria put some of these patients at risk for further harm. Further, federal law suggests that patients must have an evaluation commensurate with a normal ED examination before being released. However, in some circumstances, patients presenting to the ED could, with little inconvenience, be more quickly seen in an alternative setting. Some EDs, overcrowded with life-threatening emergencies, have established such overflow or urgent care clinics. However, some EDs are sending patients away to seek care on their own or to distant clinics run by clinicians (often in a prepaid medical system) with a financial incentive to see the patient themselves. “If doctors as a healing community really want to recapture a sense of moral integrity, the most important thing they can do is to resist and to refuse to do anything that violates the promise to act in the patient’s interests.” 33 Economics will continue to change medicine. Emergency medicine, however, must remain the safety
net” of an inadequate U.S. health treatment system. Emergency physicians owe their first allegiance to their patients. In advocating virtue in medical practice Pellegrino and Thomasma state:

Today medicine, in practice and academia, is making a series of Faustian moral compacts with business, government, and even science. Fiscal survival and exigency are the usual moral justifications, although reasons of greater productivity and faster service are often advanced. As in all Faustian compacts, Mephistopheles will sooner or later show up to claim his part of the bargain – to claim many professional souls. 33

Emergency medicine must resist the temptation to allow convenience and self-interest to dictate policy. Patient welfare should be the overriding determinant of access to emergency care.

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