

Resource Utilization in the Emergency Department: The Duty of Stewardship¹

INTRODUCTION

During the 20th century, health care in the United States underwent a fundamental transformation. At the beginning of the century, health care was a cottage industry in which physicians had little to offer besides their own individual skill and time in ministering to their patients. Treatment decisions were a private matter for individual physicians and patients or their loved ones, as was modest payment for the physician's care.² By the end of the century, American health care had become a major high technology, high-cost industry, with annual expenditures exceeding one trillion dollars.³ Payment of most of this huge sum had been assumed by third party payers, largely through health insurance provided by employers and by federal, state, and local governments.⁴ During the last third of the twentieth century, these major payers made repeated attempts to control health care costs, including wage and price controls in the 1970s, prospective payment systems in the 1980s, and a variety of managed care strategies in the 1990s.⁵ None of these efforts, however, has had a lasting impact, and health spending in the late 1990s entered another period of rapid acceleration.⁶

The development of the modern hospital emergency department and the rapid growth of the specialty of emergency medicine are clear examples of American medicine's efforts to increase access to more intensive and more effective treatment. For many, if not most patients with acute illness or injury, the emergency department is the point of entry into the health care system. In the emergency department, emergency physicians make crucial decisions about how much and what kind of health care these patients will receive. Emergency physicians, therefore, play a central role in allocating the resources of the emergency department and in determining which patients require hospitalization in the United States today.

In making decisions about diagnostic and treatment modalities, emergency physicians (EPs) must attend carefully to the best interests of their patients – beneficence is a fundamental moral principle of medicine. In this paper, we contend that EPs must also attend to the need to conserve health care resources. Failure to conserve these resources will have serious consequences. Unnecessary health care spending will undermine efforts to make health insurance accessible to the more than 38 million Americans who currently have none.⁷ Even for persons who are well insured, subjecting patients to inappropriate testing or treatment wastes resources and increases the risk of iatrogenic illness or injury.

This paper proposes the concept of stewardship as a way to understand the duties of physicians, especially EPs, in the realm of prudent resource allocation. First, we compare stewardship with the more divisive concept of rationing. Next, we emphasize the central role of EPs in ensuring the availability of needed emergency services through careful cost containment efforts. Guided by the ancient virtues of prudence, temperance, courage and justice, EPs can protect both the autonomy of patients and the availability of emergency care, today and into the future.

Recognition of the duty of stewardship may also be found in the "Principles of Ethics for Emergency Physicians" adopted by the Board of Directors of the American College of Emergency Physicians in 1997 and reaffirmed in 2001.⁸ Principle 9 of this document states, "Emergency physicians shall act as responsible stewards of the health care resources entrusted to them."

STEWARDSHIP VS. RATIONING

Stewardship

In theological contexts, the term ‘stewardship’ is often used to refer to human obligations to care for God’s creation. The *American Heritage Dictionary* defines a steward as “one who manages another’s property, finances, or other affairs.”⁹ As these contexts suggest, valuable resources are entrusted to stewards for achieving specific goals. We understand stewardship, as it relates to the emergency caregiver, to be the provision of quality emergency care through the prudent management of public and private resources. Wise stewardship promotes beneficence by means of carefully reasoned, evidence-based medical decision making. As responsible stewards, EPs strive to provide excellent care for individual patients within the constraints of available societal resources. The duty of stewardship thus enjoins EPs to make effective use of the health care resources at their disposal. It implies continuing scrutiny of treatment protocols to assess whether they benefit patients, and the elimination of treatments shown to be ineffective, harmful, more costly than other, equally effective methods. Stewardship thus requires, at a minimum, an effort to prevent wasteful consumption of health care resources.

Rationing

More controversial is the issue of whether stewardship also requires limiting the provision of beneficial treatment, or the rationing of care. Rationing, as distinct from stewardship, can raise the ire of clinicians and the distrust of patients. Frequently hailed as a solution to current cost woes, rationing may be broadly defined as any method of distributing a good whose supply is limited. Three basic devices for health care rationing have been identified, and most countries use some combination of all three.¹⁰ The first is rationing based on willingness or ability to pay for health care. This type of rationing, called rationing by cost sharing or price rationing, limits access to health services for patients who are unable or unwilling to pay for those services, either directly or via insurance deductibles or co-payments. A second health care rationing device relies on explicit regulations defining eligibility or priority for health care programs or services. Examples of this type of explicit rationing are the United Network for Organ Sharing’s systems for allocating cadaver organs to waiting patients¹¹, and the comprehensive list defining which treatments are and are not covered by Oregon’s Medicaid program.¹² The third health care rationing device establishes general spending limits, for example, through global budgets or capitation systems, and relies on individual and institutional health care providers to allocate services to patients within these limits. This type of rationing, which Mechanic calls “implicit rationing,” frees providers from externally imposed regulations, but makes them responsible for decisions to deny as well as to provide care for their patients. Physician gatekeeping decisions within both private organizations such as HMOs and public systems such as the United Kingdom’s National Health Service are modern examples of implicit rationing.

Rationing as a Means to Responsible Stewardship

When resources are scarce, limiting the availability of certain types of beneficial care is an appropriate part of stewardship. Whether today’s difficult economic circumstances compel austerity measures such as rationing is an important question. For most of the world’s population, the answer to this question has long been an unequivocal *yes*; many types of technologically advanced and emergency health care services are simply unavailable outside the industrialized world. In the U.S., the adoption of steadfast resource stewardship may avert the need for explicit rationing on a large scale; however, triage-trained EPs will need to carefully manage the increasingly limited human and material resources at their disposal. As in times of disaster, patient requests for unnecessary, marginally beneficial, and burdensome care may sometimes be forgone. Depending on the context, responsible stewardship may, at least occasionally, involve rationing decisions.^{13,14}

WHY STEWARDSHIP?

Economic Justification

U.S. health care spending has increased steadily for the past thirty years. After a period of relative stability and slower growth in the mid-1990s, health spending began to accelerate again, reaching double-digit rates of increase by 2001.⁵ The cost of health care in the U.S. is projected to reach 2.8 trillion dollars per year by the year 2011.³ The population of elderly Americans requiring health care resources continues to grow, accounting for nearly 40% of health care expenditures.¹⁵ Finally, 85 million Americans are uninsured or underinsured in today's health care system.¹⁶ All of these factors, high cost, rapid growth, and increasing demand, highlight the need for effective stewardship of our health care resources.

EPs must participate in efforts to provide high quality and affordable health care so that the emergency department (ED) can remain a viable source of health care for millions of needy Americans. Despite the still-common misperception that care in the ED is expensive and often unnecessary, recent data strongly suggest that emergency departments provide timely, good quality care at a low marginal cost.¹⁷ Unless EPs take an active role in providing a solution to the current cost increases, we will continue to be perceived as part of the problem. As "stewards" of the health care safety net, EPs routinely make allocation decisions that set in motion the dominoes of diagnostic testing and treatment. Prudent decisions to pursue testing in the ED can, for example, prevent unnecessary hospital admissions and reduce the length of hospital stays. Dealing fairly and rationally with finite resources is an important skill for which EPs are specifically trained, whether planning for natural or manmade disasters, directing EMS, supervising triage, or orchestrating ED referrals and admissions.

Socio-Legal Justification

Legislative and judicial mandates have placed the EP in the forefront of the legal and social challenges of acute resource utilization. EPs have a legal duty to provide mandated medical screening and acute stabilization of any patient in need, without regard to financial or health insurance status.¹⁸ From a social standpoint, EPs care for *all* patients, regardless of their ability to pay or station in life. The office-based physician generally serves a more discrete patient population and may refuse care to those who do not have the appropriate insurance or means to pay for services.¹⁹ Finally, EPs have many social and public health duties, including direction of emergency medical service resources, orchestration of hazardous material exposures, toxicological decontamination, casualty planning and treatment, forensic data collection, and the reporting of criminally inflicted, sexually transmitted, and communicable diseases. Since all strata of society are represented in the ED population, the EP is well positioned to serve as both gateway and gatekeeper to hospital and prehospital resources for all.

ETHICAL JUSTIFICATION

Beneficence and Nonmaleficence

Stewardship honors the fundamental ethical principles of beneficence, nonmaleficence, justice, and respect for autonomy. Physicians should, for example, refrain from overtreatment that could cause patients harm (e.g., medications with potential side effects). The utilization of more costly but unnecessary technology (e.g., nasal radiographs) does not guarantee improved patient outcomes, and the beneficent physician should not provide care without reasonable expectation of patient benefit. As moral professionals, EPs' obligation to preserve societal trust and ultimately patient welfare is honored when they allocate resources wisely and equitably, guarding the good of the patient.

Justice

The concepts of justice and stewardship are complementary. Justice and stewardship both imply equitable, but not necessarily equal, care. Justice requires that resources be allocated fairly, rationally, honestly, and consistently.²⁰ Resource allocation based on individual judgments of worthiness, social standing, or ability to pay should be avoided, since they propagate distrust and impede patient care. Methods of stewardship are just in so far as they strive to preserve health care resources for all and optimize outcomes for individual patients.

Respect for Autonomy

Proper stewardship must guard patient autonomy and can be realized only after careful assessment of a patient's medical needs and expectations. However, stewardship may be construed as paternalistic and at odds with patient autonomy, for example, when patients request medically nonbeneficial care. As a prudent steward, the EP should understand and acknowledge patient wishes while recognizing that there are limits to patient autonomy, and that demands for harmful or excessive care need not be honored. The EP must always attempt to place patient requests first while routinely considering other alternatives. Respecting autonomy requires excellent communication and patient education so that informed and interested patients may participate fully in the medical decision-making process. EPs must also recognize that patients do not always possess the capacity or insight to know their best interest as, for example, when they are intoxicated, mentally ill, or demented. The EP's role, therefore, includes protecting the vulnerable from unnecessary and potentially harmful diagnostic tests and treatments.

STEWARDSHIP: MEETING THE CHALLENGE

Proper stewardship involves the integration of social, medical, economic, and moral considerations. This integration may well be realized by the adoption of the four cardinal virtues of antiquity: prudence, courage, temperance and justice.

Plato and Aristotle both emphasized the importance of prudence or *phronesis*, a Greek concept that connotes discernment, judiciousness, and proper discrimination. This type of practical wisdom is essential to weigh properly the interests of multiple parties, particularly when the EP must apportion time in an ED bustling with patients. Balancing burdens and benefits, deciding where to triage, choosing whom to refer, and understanding the limits of technology are all manifestations of prudent stewardship.

A second important virtue in the exercise of stewardship is courage. Moral courage is a type of fortitude that helps physicians remain steadfast advocates for patients against utilization reviewers, managed care gatekeepers, insurers, and others. Courageous stewardship also demands that we help patients make reasoned, socially responsible health care and lifestyle choices. Emergency physicians may, for example, have to stand fast in resisting the demands of insistent patients for inappropriate tests or treatments. Although we must have the moral resolve to consistently place patient welfare ahead of fiscal concerns, we also must have the courage to monitor ourselves and resist the temptation of blaming society, attorneys, bureaucrats, insurers and others for our own moral blemishes.

A third cardinal virtue that captures the spirit of stewardship is temperance. Temperance reflects the self-control necessary to employ therapeutic parsimony and self-restraint when tempted toward over- or undertreating a patient. Unbridled enthusiasm for or rejection of technology, arrogant proclamation or condemnation of new ideas, or too quick a rush to judgment of any sort serves neither the patient nor the profession. Temperance requires humility and self-control, without which proper ED stewardship could not be effectively practiced.

Another quality that helps EPs shepherd resources and employ therapeutic parsimony is justice. Justice is both a principle and a virtue, aligned with fairness. It is the central theme of Plato's *Republic*, and it remains one of the four key principles of medical ethics today. With increasing discussion of unequal access and runaway costs, justice may replace autonomy as the ordering principle of bioethics in the 21st century. Although distributive and social justice seem like more appropriate concerns for the electorate, EPs may be guided to refuse marginally beneficial medical care to some, while guaranteeing a basic level of care to all.

Cultivation of the virtues bolsters the moral authority of physicians in their role as stewards of health care resources for both patients and the greater community of which they are a part. In making difficult allocation decisions at the bedside, EPs cannot shirk their responsibilities to patients, profession, and society. As just stewards, EPs must act as a fulcrum, balancing the obligations of society to the individual, on the one hand, and the obligation of the individual to society, on the other. Otherwise, EPs may be perceived as either wasteful providers or agents of social control, thereby undermining the trust of both patients and society.

CONCLUSION

Growing health care expenditures account for some 14.7% of the domestic GNP in 2002.³ New fiscal constraints in health care challenge all physicians, including EPs, to do more with less. Change and opportunity are invariably linked, and responsible EP stewardship provides an opportunity to benefit patients, profession, and society. While resource scarcity demands prioritization of health services on a societal basis, EPs can help society determine how services are to be distributed. EPs must remain advocates of both the societal need for universal access and the individual needs of patients. Although it is not possible to provide comprehensive protocols that address all the allocation decisions that EPs make on a daily basis, the prudent EP must consider the likelihood, magnitude, and duration of benefits to patients, the urgency of the condition, and the cost and burdens of treatment to patients, payers, and society.

¹ This paper is based in part on Larkin GL, Weber JE, Moskop JC. Resource utilization in the emergency department: the duty of stewardship. *J Emerg Med* 1998;16:499-503.

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⁸ American College of Emergency Physicians. Code of ethics for emergency physicians. www.acep.org/1,1118,0.html (accessed 25 July 2002).

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