Another step might be taken to advance this critical issue beyond the point where the University of Massachusetts group and the moratorium proposers have left it. The results might be conclusive on their own, but should there be imbalances in baseline characteristics between those randomized to catheterization and those not, a basis would be established to continue further with a formal randomization of patients in predetermined categories, or, on the other hand, to leave the situation where it is at present. However, even the possibility of intrinsic harm, or at least no net benefit, from bedside pulmonary artery catheterization dictates that clarification must be undertaken—not because it is in the public domain and in the dark recesses of law firms, but rather for humanitarian and scientific reasons.

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References


Patient Dumping

The Physician's Dilemma

A dramatic increase in interhospital patient transfers (usually from private to public hospitals and predominantly for economic reasons) has been seen in this country during the recent decade of sharp cutbacks in federal and state health care funding for the poor. Although interhospital patient transfers have always been considered appropriate when there is a need for specialty or tertiary care, the patient's inability to pay for services has become a commonly accepted reason for transfer, and there is now concern that economic considerations are taking precedence over patient safety as a major determinant of hospital transfer policy. Strong economic pressures are likely to accelerate this trend, since no major improvement in the current Prospective Payment System (PPS) is expected to occur in the near future.

What should be of concern to physicians is that, despite clear guidelines and national standards regarding the physician's responsibility for ensuring patient safety during interhospital transfer, there is a growing body of literature that documents the detrimental consequences of delays in treatment resulting from this type of "social triage". There is a danger that a markedly inferior quality of care will become "the standard" for the millions of uninsured patients at risk for economic transfer while they are clinically unstable. The problem is immense, since an estimated 40 million Americans are underinsured or completely without health insurance coverage.

A simple triage system has recently been shown to accurately identify that group of severely ill pulmonary patients for whom one may confidently predict that hospital costs will greatly outstrip payments based on Diagnosis-Related Groups. The pressures from cost-conscious hospital administrators on emergency medicine and intensive care physicians involved in the care of these patients can be expected to become more intense. If current reimbursement is certain to fall short in these cases, and such patients can be quickly and easily identified, what forces will protect the patient from being exposed to the hazard of delayed treatment and the inherent risk of interhospital transfer?

This crisis presents an opportunity for physicians who practice in emergency medicine and intensive care settings and who feel the intense pressure on the modern "gatekeeper." Together, they can work with hospital managers to ensure compliance with current professional and legal requirements for patient safety during the initial hours of clinical presentation, stabilization and observation. Adequate time, staff, and resources must be devoted to emergency departments, holding and observation areas, and critical-care inpatient units. This will ensure that patients are not placed at undue risk, nor their treatment delayed, as the difficult decisions regarding hospital admission or transfer are made. Emergency and intensive care physicians must work together to be advocates for their patients and to refuse to degrade the quality of the care they provide because of business considerations. Hospital managers must be reminded of their duty to respond to community needs and their legal obligation to support the physician's judgment in admitting patients to intensive care even when the immediate economic outlook is unpromising.

There are several reasons for cautious optimism about patient dumping. Many states have begun to
extend and improve their Medicaid coverage and the Health Care Financing Administration (HCFA) has proposed changes to the DRG classification system for ventilator patients. The American College of Chest Physicians has directed its Government Liaison Committee to acquaint national legislatures with the current inequality in reimbursement policies, and the American College of Emergency Physicians has vigorously supported the anti-dumping provisions of the federal Combined Omnibus Reconciliation Act of 1985 (COBRA).

Under the provisions of COBRA, that went into effect in August, 1986, all hospitals receiving Medicare funds must adequately screen all patients seeking emergency care and refrain from inappropriately transferring “emergency” patients or women in “active” labor. The transferring facility has the further responsibility of ensuring that the receiving facility has available space and qualified personnel and has agreed to accept the transfer. What is needed now is increasing public and professional awareness of the new law, continued pressure on the HCFA to interpret and implement the law, and restraint by physicians who are tempted or pressured to violate the law.

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Tropical Lung Disease

A New Department

Social and political developments of modern times have blurred Nature’s boundaries separating the tropical, subtropical, temperate, and arctic land masses. With increasing travel and intercontinental migration, physicians everywhere can expect to face previously unfamiliar diseases, exotic medical syndromes once encountered only in tropical countries. Many of these tropical disorders involve the lungs. Pulmonologists in developed countries, particularly in the United States, must now learn to diagnose and treat tropical and subtropical pulmonary diseases.

The concept of acquiring new knowledge and learning new techniques is not foreign to pulmonologists. For centuries we were phthisiologists; later, we learned how to measure lung functions and use the information in our daily practice, along with the new developments in the field of radiology. More recently, our breathing machines have compelled us to reconcile principles of physics with new codes of ethics. The modern pulmonologist must be fully aware of imported diseases in every patient he sees—every visitor, immigrant, tourist, and jet setter he examines.

The new department of Chest, Tropical Lung Disease, will present a pragmatic and comprehensive review of tropical lung diseases that cause serious morbidity and mortality. The main objective is to help practicing pulmonologists promptly diagnose and effectively treat these exotic disorders. To start with, our first goal is to stimulate every pulmonologist to ask his overseas visitor, tourist, and immigrant patients three questions: Where have you come from? Where have you been? When did you arrive?

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