

The State of Emergency Care for America: at the Breaking Point, In Need of Resuscitation and Going Nowhere

Testimony of
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INTRODUCTION

I have been a surgeon at an academic medical center for the past 27 years. My primary interest has been in trauma care and trauma services development. I have established three Level I trauma centers and helicopter programs to support regional emergency and critical care systems in three different states: Virginia, New Jersey and Pennsylvania. Additionally, I have acted as a consultant to help more than a dozen hospitals develop trauma care and trauma services. At the state level, I served on Governor advisory committees and initiatives to advance the trauma and emergency systems in the 80's, 90's and for five years served on the Board of the Pennsylvania Trauma Systems Foundation, heading a committee on standards for the state-wide trauma system in Pennsylvania. Federally, I was a member of the ad-hoc Committee on Model Trauma Systems & Plan for the Department of Health & Human Services/ Health Resources and Services Administration in 1992, and co-author of a position paper on Trauma Systems that resulted from a committee for the Center for Disease Control's "National Agenda for Injury Control in the 1990's." And lastly, from 2003-2006, I was one of two surgeons to serve on the Committee on the Future of Emergency Care for the Institute of Medicine. As an aside, Congressman Waxman, this is my second visit to your committee. In the late 80's, I testified about the escalation of gun violence and death in our cities and its effects on health. Thank you for the privilege of speaking with you again.

SUMMARY

There is a crisis in delivering emergency care to our population. Emergency care is defined to encompass the full spectrum of services involved in emergency medical care. This includes Emergency Medical Services, hospital-based emergency and trauma care, on-call specialty care, bystander care, and injury prevention and control. While the demands on emergency and trauma care have grown dramatically, the capacity to handle such demands has not kept pace. This problem is universal in the United States and the response, solutions, and willingness to put time and effort to solve this crisis seem miniscule in relation to the crisis itself. Our citizens seem better informed and more worried than our government and its leaders. In fact, the July 2007 Consumer Report identifies the emergency care crisis as the latest challenge facing U.S. consumers today.

In June of 2006, after two and a half years of interdisciplinary study, analysis and debate a group of experts delivered its report on the Future of Emergency Care for the U.S. Health System. This three-volume collection is one of the largest undertakings conducted by the IOM and represents a range of problems almost too big to tackle. For that reason,

the task force was divided into three areas: Hospital Based Emergency Care, Emergency Medical Services, and Emergency Care for Children. Each is a separate, but coordinated report with synchronized goals and recommendations. The contents of this report are sobering, and its recommendations are profound. Similar to its predecessors of 1966 and 1985 (Accidental Death and Disability: the Neglected Disease of Modern Society and Injury in America), the intent was to improve the emergency and trauma system throughout the United States. The hope was that this long overdue report would catalyze a collaborative effort by government, healthcare, taxpayers and citizens to fix a badly broken system. Unfortunately, the response has been, in my estimation, almost nothing. There has been perhaps some transient coverage in the media, several dissemination meetings in various parts of the U.S., but no response has come from our government. Despite efforts by all constituents, little seems likely to be done to begin to manage the biggest crisis in American healthcare.

The report comes in response to an epic crisis in America that is already a decade in the making. Because of other catastrophic events that have struck our country, this crisis has been put “out of sight and out of mind.” Yet the weakness, frailty and even failure of the system to function as our country’s “safety net” permeates the record of how we responded to these natural and intentional catastrophes. Both 9/11 and Katrina, and even the War in Iraq, serve as snapshots of how poorly prepared, coordinated, staffed and capable emergency and trauma care are to respond to our greatest needs. While government think-tanks and policy effectors struggle with how to design a response for the next disaster, little attention is paid to the substantial data and numerous reports that show what emergency care facilities can be on a day-to-day basis: overloaded and crowded with non-emergencies, diverting ambulances, and boarding critical patients for days to gain access to hospitals. As the basic foundation of the “safety net,” emergency care is in need of major resuscitation and an infusion of resources. To expect our emergency and trauma centers to shoulder the load in a disaster of 200, 2000, or more patients under the current conditions is unrealistic . . . and dangerous for us all.

In 2003, the IOM brought an interdisciplinary group together and began to analyze the strengths and weaknesses of emergency care. Early on, it became apparent that the crisis we were being asked to fix was accompanied by some remarkable successes in American medicine—the most notable being the consistent dedication and commitment by professionals who unselfishly give beyond the call, night and day. Other remarkable successes include the development of Emergency Medical Services, the growth of Emergency Medicine as a specialty, and the considerable advances in biomedical research and their applications to emergency care over the past 40 years. *The other success and theme that would become central to creating the vision of the future was (and is) the regional trauma systems.* Perhaps no system in medicine better displays the comprehensive linkage of components, use of national standards and guidelines to provide consistent high-quality care, performance improvement to optimize care, and public dissemination of outcomes and verified accomplishments, as do these regional trauma systems. Despite these successes, all evidence points to a fragmented, overworked, stressed, underpaid, undervalued emergency workforce. This system and its professionals, including trauma surgeons, must cope with 24/7 readiness and an inability to limit access

to non-emergencies and minor injury. This, coupled with the increasing burden of the uninsured and underinsured, drains financial resources away from sustaining, much less improving, the real emergency system. As important, is the increasing lack of hospital-based specialists who are not available or choose not to participate in covering the emergency needs of patients. The reality of emergency care is far from what is portrayed by our television or movies. Real “emergency” is at a breaking point!

As if that is not enough, the exponential increase in demands over the next 20 years that the emergency care system will need to cope with are even more startling. They provide a compelling argument for drastic change. As the Boomers retire, some 73 million people will pass into their seventh decade. This group of individuals will live longer, be more active and demand more health care than any other group of people within a narrow older-age range that have ever occupied the earth. Their need for emergency and trauma care will also increase. If one factors this demographic into the already 114 million emergency department (2004) visits per year, the problem of assuring universal emergency care becomes daunting. One area in the report that is especially challenging is the increasing shortage of surgeons to provide emergency and trauma care. When linked with the manpower studies already documenting a profound shortage of several surgical specialties, this projects a devastating crisis for emergency patients in the near future. General surgery, neurosurgery and orthopedic surgery shoulder a large portion of the emergency and trauma care responsibility. These three specialists are the key to the surgical response for trauma care and more importantly, are the necessary surgical experts to save the life of an injured patient. General surgery, and especially trauma and surgical critical care-trained general surgeons and neurosurgeons, have the greatest shortfall in manpower production.

In two recent surveys of emergency departments nationwide, two-thirds to almost three-quarters of all ED directors or administrators report worrisome shortfalls in specialists, especially surgical specialists. Approximately one-fifth of staff said they would seek care at another hospital because of the lack of a specialist on call. A key message within the IOM report is the need for a broad-based surgical emergency specialist with skills in surgery, critical care, organization, and teamwork. This should be a surgeon who is knowledgeable of the emergency system and an expert working in and with it. The need for this acute care or emergency surgeon is apparent now and vital for any future emergency care system, as are more committed general surgeons, orthopedists and neurosurgeons.

RECOMMENDATIONS

In drafting the recommendations, the need for interdisciplinary collaboration between (and within) medicine, public safety and health, government and payers to fix the crisis is the key to success. In addition, central to the vision for the emergency and trauma care system of the future are three core principles: coordination, regionalization and accountability. Any patient, regardless of geography, environment, age or problem should expect to have a seamless “system” of components that guarantees their care and transport to the most appropriate facility. Professionals within emergency care must be well-trained across the life spectrum, especially for children and emerging special

populations. All components and resources must be coordinated throughout the system to assure concurrent availability of the necessary resources. Similar to the current regional trauma systems in some areas of our country, most hospitals will have key local roles in delivering emergency care, and after stabilization, moving patients to higher-level or special levels of care, if needed. As important, all providers and the system of emergency and trauma care will be accountable for what they do. This will require strong performance improvement and reporting to the public to demonstrate that emergency care is high-quality, safe and a good return on their investment. Each recommendation is aimed at a target group that the IOM felt had the power, authority and financial control to implement the recommendations brought forth.

The vision throughout is to create a regional, coordinated, high quality and safe emergency system that is built on evidence-based practices and meets national standards for all providers and system components. It is a system that works across all the traditional turf lines, whether geopolitical or medico-political. The report calls for changes in how we fund these systems and all emergency care. It calls for immediate action, money to offset losses from uninsured care, funding to establish pilot projects, and urges government to change EMTALA. It recognizes and embraces emergency and trauma care as a unique part of medicine and public safety, which is the key to disaster response and therefore requires a single lead agency in the federal government to coordinate all aspects. In addition, the recommendations call for Congress to immediately initiate a task force on the workforce needs to staff the emergency and trauma care system of the future and to direct CMS (Medicare) and the third-party payers to reexamine the funding for emergency care. Other recommendations call for re-evaluating and changing the current HIPAA regulations that prevent flow of patient care information in an emergency situation. The vision for the 21st Century is built on widespread implementation of information technology, training and education and assurance of core competencies for all providers throughout the system. Of great importance, it directs distinct and dedicated efforts to examine the need for funding scientific investigation in all areas of emergency and trauma research and injury control. This space does not permit a more in-depth explanation of the special needs to assure a well-coordinated, educated, and funded Emergency Medical System and the special needs to care for our young. However, those two reports are just as compelling.

REFERENCES:

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