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PRIORITY ACCESS TO CARE IN THE EMERGENCY DEPARTMENT

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ABSTRACT

"Very important persons" (VIPs), "friends of physicians" and Emergency Department (ED) staff and family members often receive care in front of other patients who may be critically ill waiting for care in the ED lobby. This paper explores the organizational ethics of these three select groups of patients who often obtain priority access to care in the busy ED. A specific case is provided to highlight the challenges of these complicated encounters. The organizational ethics are then explored and potential solutions are identified. This is an important ethical and operational issue that requires exploration by emergency department and hospital leaders because of the potential harm it may cause other patients and the strong negative emotional reactions by employees that can lead to decreased staff morale.

KEYWORDS

healthcare organizational ethics, Emergency Department, VIP patients, access to Care

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Introduction

In many health care systems, a select group of donors, celebrities and influential individuals get "very important person" (VIP) treatment, which consists of access to services not available to the general population. Some ethics literature on this issue refers to VIPs as "very influential patients" to reflect the ways these patients may alter the system of care (Alfandre, Clever, Farber, Hughes, Redstone, & Soleymani, 2014). There are formal programs within some health care systems that identify the VIPs in advance so as to ensure these patients obtain priority access and experience excellent service with the health system. In addition to VIPs, two other groups of patients — those with connections to emergency department staff and those with connections to physicians in other hospital departments — also obtain priority access to emergency departments (EDs). These three groups of patients often move to the front of the emergency department waiting line regardless of their illness severity. They access the emergency provider in front of others who may have undiagnosed yet life-threatening medical conditions.

VIPs are the patients most likely to upset employees and staff in the ED. Members of this group have premium access because of their financial and/or political influence. They often also receive enhanced care compared to other patients. This may include a dedicated nurse who stays with them in the ED or others in the health care system who speak directly with their physicians to facilitate expedited or special care experiences.

The second group of patients is the "friends of physicians." This group, composed of friends and family members of non-emergency department physicians, also elicits a strong negative emotional reaction from ED staff. They obtain priority access when their physician friend or family member speaks with the emergency physician, who in turn helps facilitate priority access in the ED.

The third group of patients is the "take care of your own" group and usually does not evoke a negative emotional reaction from ED staff. This group includes individuals (both physicians and non-physicians) who work in the ED and their family members. Interestingly, this third group is very similar to the second group, but since there is closer personal connection there seem to be fewer complaints by ED staff.

A specific case example illuminates the types of problems caused by VIP treatment. A patient arrives at the emergency department on a busy Friday night. There are eight other patients when she arrives in the waiting room. The ED is full, with one room about to become available in five minutes. The patient is triaged by the nurse and appears to be in moderate pain. She has a history of migraines and states this migraine is one of her worst. She has been unable to obtain relief with home medications. She rates her pain as 9 out of 10 and she looks uncomfortable. Her vital signs are within normal limits. She is triaged as an Emergency Severity Index (ESI) level 3. The ESI levels are a triaging system. An ESI level 1 patient requires immediate life-saving intervention, while an ESI level 5 patient presents will low acuity needs such as toe pain or a medication refill request (Gilboy, Tanabe, Travers, & Rosenau, 2012).

At the time this patient checks in to the ED, there are three patients triaged as ESI level 2, one with chest pain, one with severe abdominal pain and the third with suicidal thoughts and psychotic symptoms. The remaining five patients are all triaged as ESI level 3, the same as the woman who just checked in. As she is walking back into the waiting room after triage, the emergency physician on duty comes out and calls her back into the one available room in front of the other eight patients.

The patient is a close friend of one of the vascular surgeons at the hospital. The surgeon called the ED attending when after learning the patient was coming to the emergency department. The surgeon politely asked the ED attending to take good care of her friend, explaining the friend has a long history of severe migraines that are sometimes debilitating. This emergency physician informed the charge nurse that this patient needed the next room, ahead of other more acute patients, and personally went to the waiting room and roomed the patient in the last available room. The ED attending is also good

friends with the vascular surgeon and works with her on a routine basis in the ED. He considered this favor "professional courtesy," permissible in light of the fact the patient had real pain that required IV medications.

At the end of a busy night, the ED triage nurse was very upset that this patient was placed in the one remaining bed when the waiting room contained both patients triaged at a higher level and patients triaged at the same level that had been waiting longer. She completes a Patient Safety Intelligence (PSI) report and writes separately to the quality medical director of the ED to explain the situation and requests an investigation.

Considerations

According to Dr. Robert Potter, there are three central questions to consider in evaluating a hospital organizational ethics problem (Potter, 1996). The first is the discovery of the issue or "what is going on here?". The underlying organizational ethics question in this situation is: should the hospital determine patient priority and level of care based on factors other than clinical acuity? If yes, who should be given special priority? In what circumstances should they be allowed this enhanced access?

Second, we need to consider "what ought we to care about?" as an organization in this situation. The Providence Health System and Services model for ethical discernments is a useful framework (Providence, 2010). It outlines four principles to consider as an organization when examining an ethical question: the mission of the organization, the common good, stakeholders and tradition.

Many health care delivery system mission statements contain phrases such as "respect," "clinical quality," "responsibility" and "community service" (Legacy, 2016; Providence, 2016; OHSU, 2016). Hospitals are generally seen as institutions that serve the community. This commitment to service provides a sense of fair access to all who seek care, especially in their emergency department.

With respect to the common good, one element to consider is whether there is a way to develop a system that gives special privileges to VIP patients yet does not cause harm to non-VIP patients. A quotation from an article exploring this issue in emergency departments nicely summarizes the underlying issues: "Nobody deserves more or better or faster care. But while ethically you cannot do that . . . you *can* give different care under an ethical framework if it's in the best interests of the patient and doesn't harm another patient" (Geiderman & Goldwag, 2006). For example, the emergency department may be obligated to take special steps to protect the privacy of well-known individuals, such as the CEO of the hospital. Having this person wait in the lobby as a patient may compromise their privacy since many staff members at the hospital would recognize them.

Priority treatment of certain patients implicates a complex set of stakeholders and partners. VIP programs serve an important institutional goal: securing continued support for the organization, usually in the form of monetary donations. That support helps to fund programs that increase access and improve quality of care across the board. Furthermore, providers, nursing directors and nurses may face serious repercussions if they offend or do not go above and beyond for these individuals.

Examining the tradition or historical precedence in the organization, there is often an established history of providing certain individuals special treatment. Physicians have long held positions of power in hospitals and are able to pull resources from the system to provide special care for families and friends.

The organization's mission statement should act as the compass. If the health care system wishes to address the issue of priority access to the ED for VIPs, there are several options to explore. The first option is obtaining more information by tracking how often the ED grants VIP access, attempting to specifically track and identify negative harm to other patients or the system. The Cleveland Clinic has published "nine principles" for health care

providers to follow when caring for VIP patients in their organization to help minimize the negative impact on their health care system (Guzman, Sasidhar, & Stoller 2011). These principles could help organize an effort to gather more information.

The second option is to increase transparency internally. Informing key stakeholders, such as hospital staff, that these VIP programs exist and the criteria for determining membership would elicit valuable feedback. This could have the benefit of helping to determine the extent of the problem, viz., harm to other patients as a result of VIP treatment, and brainstorm potential solutions to this problem.

The third option is to develop an organization-wide policy on VIP access, with specific guidelines. An alternative course of action is for the emergency department to write a department-specific policy, if the hospital was not willing to adopt a hospital-wide policy. This would help tether VIP treatment to the core mission of the hospital. In addition, a consistent policy would help respond to ED staff concerns about fairness and safety, particularly if staff were involved in developing the policy.

Recommendation

In conclusion, priority access to medical care based on non-clinical factors in the emergency department is an ethical issue all EDs face. This ethical dilemma should be explored because of the potential harm it may cause other patients in the emergency department. Furthermore, this issue causes strong emotional reactions from staff members and can lead to decreased staff morale. Health care systems should consider creating a hospital-wide VIP policy if they do not currently have one and make this process transparent within the organization and to the general public.

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