Emergency room care undergoes revolution

By RICK WARNER
Staff Writer

Dr. John Larson was suspicious.

"It's too quiet," he said, surveying the emergency room at Wake Medical Center during a Friday night lull. To his left, a group of nurses were huddled at a table sipping coffee and exchanging small talk. In the next room, a white-shirted technician was stretched out in a chair reading a copy of "Emergency" magazine.

Larson lit his pipe and glanced at the clock. It was 9 o'clock.

'You should have been here last night," he said. "We didn't stop for a minute. But that's the way it is with emergency rooms. You can be sitting around twiddling your thumbs one minute and the next minute, you've got a car wreck and a heart attack on your hands."

It had been a dull night so far. A man with a sprained back. A woman with chest pains. A child with a cut finger. A couple of drunks looking for a friendly place to rest. Something had to give.

"It's a code," shouted one of the nurses, as a stretcher carrying an old woman came whizzing through the door at 9:58 p.m. The woman had collapsed at a local home. The "code" meant her condition was grave.

Within seconds, the woman was surrounded by a group of doctors, technicians and nurses, all working feverishly to keep her alive. They pumped her chest. They inserted a tube down her mouth and injected fluids into a large vein below her shoulder. Four times, they sent electric shock waves directly to her heart.

But there was nothing they could do to save her. At exactly 10:21 p.m., a technician removed the tubes and needles, wiped away the blood, rinsed her mouth with water and gently pulled a white sheet over her head.

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The popular image of the hospital emergency room hasn't changed much since the days of Dr. Kildare and Ben Casey. When someone mentions the emergency room, most of us conjure up a picture of bloody bodies and screaming relatives, locked in a series of life and death situations.

Like many television shows, though, the picture is distorted. Emergency rooms are not that simple. They are expensive, highly specialized and frequently misunderstood facilities that have changed dramatically in the last 20 years.

At one time, emergency rooms were viewed as the backwater section of a hospital, where young doctors and nurses could gain some experience before moving onto greener pastures. Today, however, emergency medicine is a certified specialty that is attracting some of the best and brightest people in the medical profession.

"We used to be considered the dregs, the Black Hole of Calcutta," said Dr. Jackson Allison Jr., chief of the emergency department at Pitt County Memorial Hospital in Greenville. "Now we're the 'in' thing."

Some doctors note the excitement and variety of emergency room work but perhaps a more important reason for the new status is the growing demand for emergency care. Americans are using emergency rooms more than ever. In 1975, about 73 million cases were handled by U.S. emergency rooms, the American Hospital Association reports. By 1979, the figure was up to 81 million — an increase of 9 percent.

In North Carolina, emergency room visits have increased at a similar rate, from 1,982,217 in 1975 to 2,170,519 in 1979.

Why the increase? Part of it may be due to a general growth in population, but experts say there are other contributing factors.

One of the major reasons, they say, is the mobility of American society. Because we move around so much, many of us don't have a personal doctor. So when illness or injury strikes, no matter how minor, we go to an emergency room for treatment.

"We're like a 24-hour store," said Henry C. Scott, administrator of the emergency department at Wake Medical Center — the busiest in Eastern North Carolina. "We're always open. We get people who don't have anywhere else to go."

In many cases, though, patients are simply following doctors' orders.

Nearly one-third of all emergency room cases have been referred to the hospital by a physician, said Dr. George Podgorny of Winston-Salem, president of the American Board of Emergency Medicine, the panel that certifies emergency physicians.

"Most general practitioners just don't have the time or the equipment (to handle these cases)," Podgorny said. "They can't spend their whole day doing sutures."

Others come to emergency rooms with the notion that they are bargain basements for medical care. They are not. While basic fees are relatively low — in North Carolina, they average about $20 — separate doctor and hospital charges can easily boost the bill to more than $100.

Furthermore, insurance does not, as some people assume, automatically cover all emergency room costs. It depends on a number of conditions, including the type of injury, the type of treatment and the type of insurance the individual has.

Under most Blue Cross and Blue Shield policies, for instance, the visit must be the result of a "severe or life-threatening" ailment or an accident that requires immediate medical attention.

"If you go to an emergency room to get an aspirin for your cold, chances are we are not going to pay for it," said Scott Wallace, a spokesman for Blue Cross and Blue Shield of North Carolina. "If you use an emergency room, it's supposed to be an emergency."

Strictly speaking, "emergency room" may be a misnomer. Studies have shown that up to 80 percent of ER cases do not require immediate medical care. Though some hospitals, including Wake Medical Center, have created walk-in clinics for general care, emergency room physicians still see their share of headaches, stomach cramps and common colds.

"I know people who would call an ambulance if

they had a toothache," said Larson, who has been involved in emergency medicine for 23 years. "Some people really abuse the system. They know we're open all the time and they know we're not going to turn them away."

However, one recent study found that most patients who visit emergency rooms do need prompt medical attention. The nationwide study, sponsored by the American College of Emergency Physicians, showed that 62 percent of the patients required treatment within 12 hours. Of that group, more than half were classified as urgent — cases requiring treatment within two hours.

Statistics aside, doctors agree that everyone who enters an emergency room must be taken seriously.

"I tell my staff that when someone comes to our emergency room, we must assume it's an emergency to them," said Dr. Douglas I. Hammer, director of emergency medicine at Rex Hospital in Raleigh. "If it wasn't, they wouldn't be here.

"You can't tell a person who's having chest pains not to worry, that it's probably indigestion. To them, it's a potential heart attack. You don't have to die for it to be an emergency."

Unlike the old days, modern emergency rooms are staffed by people who are specially trained to diagnose and treat emergency cases.

Since it was officially recognized by the American Board of Medical Specialties in 1979, emergency medicine has become the fastest-growing specialty in the country. Residency programs in the field have sprung up all over the nation, and they are swamped with applications.

"We had over 400 applicants for four slots last year," said Podgorny, an associate professor of clinical surgery at Bowman Gray School of Medicine in Winston-Salem. Bowman Gray (in conjunction with Baptist Hospital in Winston-Salem) and Charlotte Memorial Hospital are the only facilities in North Carolina that offer a residency program in emergency medicine.

"Emergency medicine is now the second most popular specialty, next to family practice, and the way it's growing it could be No. 1 very shortly," said Podgorny, a former president of the American College of Emergency Physicians.

The emphasis on specialization has forced many hospitals to revamp their personnel system. Instead of borrowing doctors from other parts of the hospital or depending on interns, these hospitals have turned over their emergency rooms to companies or individuals who specialize in emergency medicine.

At least a half-dozen major medical firms now specialize in emergency care. The firms, which recruit and hire their own teams of doctors, provide a handy pool of talent to hospitals that are looking for physicians to manage and operate their emergency rooms.

The system has advantages for both sides. For the hospital, it means an instant staff of specialists who can run the day-to-day operation, manage the books and, in many cases, provide their own insurance.

For the doctors, it means an opportunity to run their own ship, steady (if long) hours and freedom from the burdens of running a private office.

"It's definitely a growing trend," said Keith Goding, a vice president of Spectrum Emergency Care Inc., the largest firm in the field with contracts at 237 hospitals in 35 states. Formed 10 years ago in St. Louis, the company now has five regional offices and employs 1,400 doctors.

"We have grown because there is a demand for our service," Goding said. "The increased patient load at emergency rooms has been hard for hospitals to handle. They can't rely just on their own doctors anymore, so they look to us."

In Raleigh, which has three major hospitals, all emergency room doctors are employed either through an emergency care firm or by individual contract. Raleigh Community Hospital gets its emergency physicians through a company in Miami. Rex Hospital uses a North Carolina firm. Emergency room doctors at Wake Medical Center are independent contractors.

At Pitt Memorial and N.C. Memorial in Chapel Hill, both university-affiliated hospitals, the facilities are staffed primarily by house doctors and medical students.

According to a recent survey by the N.C. Office of Emergency Medical Services, only 27 percent of the hospitals in North Carolina still rely exclusively on staff physicians to man their emergency departments. That compares with 32 percent that use only independent contractors. The rest use a combination of staff doctors, interns and contract physicians.

Despite a steady flow of customers, emergency rooms are rarely a money-making proposition for a hospital.

"Emergency rooms are highly visible to the public, so hospitals like to keep the rates as low as possible, even if it means losing money," explained Pete Roye, chief cost consultant with the N.C. Hospital Association. Hospital administrators often shuffle their budgets, using profits from other areas of the hospital to support emergency rooms, he said.

Scott, the emergency department administrator at Wake Medical Center, admits that emergency rooms seldom show a profit. But he says the figures are misleading.

"About 11 to 13 percent of our patients wind up being admitted to the hospital and using other services," he said. "We make money for the hospital that doesn't show up in our budget."

Hospitals say that salaries for emergency room doctors vary, but the majority make between $50,000 and $75,000 a year. In most cases, though, doctors say that money is not the primary motivation for entering the field.

"It's the excitement," said Larson, as he examined an X-ray of a fractured skull at Wake Medical Center.

"I never know what's coming next. It could be a kid with a broken finger or it could be guy with five bullet holes in his stomach. Working in an ER keeps you on your toes."

Guns, however, are not the major cause of emergency room visits, Larson said. "I'd say 80 percent of the cases I see are alcohol-related," he said.

Fights, auto accidents, even seizures can usually be traced to drinking, he said, adding, "I think if we did away with motorcycles and alcohol, there'd be very little need for emergency rooms."