


Unconditional Care in Academic Emergency Departments

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Recent news stories have explicitly stated that Rpatients with symptoms of COVID-19 were “turned away” from emergency departments. This commentary addresses these serious allegations, with an attempt to provide the perspective of academic emergency departments (EDs) around the Nation. The overarching point we wish to make is that academic EDs never deny emergency care to any person.

All academic EDs receive payments from Medicaid and Medicare. Under the Federal Emergency Medical Treatment and Labor Act (EMTALA), no ED that receives funding from Medicaid or Medicare can “turn away” any patient. In fact, every patient must receive a medical screening examination to determine that no emergent medical condition exists prior to discharge. At a minimum, this requires vital signs, an interview, and a physical examination by a physician or qualified designee—sometimes a physician assistant or nurse practitioner, collectively referred to as advanced practice providers (APPs). From the moment of presentation to the triage area, he or she becomes a patient of that ED, and unless he or she leaves willingly prior to being examined, that patient will receive this screening

examination and any medical care that is deemed necessary. This applies for all 120 million patients who visit an ED each year regardless of the ability to pay, race, ethnicity, creed, gender, sexual orientation, physical ability, or any other human factor.¹

In the COVID-19 environment, uncertainties surrounding access to diagnostic testing, accuracy of this testing, available therapies, and mortality estimates, coupled with unprecedented social isolation policies may generate understandable fear that can quickly transform to anger.^{2,3} This epidemic has illuminated long-standing flaws and stress points in the U.S. healthcare system, and African-Americans have suffered disproportionately higher COVID-19 mortality.⁴ Hospital responses designed to protect patients from COVID-19 might give patients the impression that less was done in the emergency care setting. Around the world, many hospitals have implemented COVID-19 triage systems in tents or auxiliary areas outside of the ED to provide rapid screening examinations.⁵ Emergency care is also leading the use of telemedicine for initial evaluation of persons with COVID-19 symptoms.⁶ These systems are designed to quickly make

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patient-centered decisions for stable, ambulatory patients, and also limit their exposure to possibly more vulnerable patients receiving care in the ED. Many hospitals still lack adequate resources for rapid SARS-CoV-2 testing for all symptomatic patients. Even if testing availability were unlimited, the reverse transcriptase polymerase chain reaction test requires a remarkably unpleasant nasopharyngeal swab, and results require at least an hour up to many hours depending on the test, increasing the patient's length of stay and potential to become infected, infect other patients, or providers. Moreover, when done, the swab results almost never change any final patient care decisions for patients who are stable and are likely to not require hospital admission. Recognizing the possible high rate of false negative results, providers will offer the exact same precautions to limit contagion, and new or worsened symptoms that warrant return to the ED, even if a swab test fails to identify SARS-CoV-2 nucleic acid from the patient's nasopharynx.⁷⁻⁹

Patients who enter the ED can expect evidence-based policies that will protect them, other patients, and providers.⁸ The best defense against spread of COVID-19 is double masking, the masking of both patient and provider, particularly for symptomatic patients. For their entire stay, patients should expect to be reminded, constantly, to wear their masks over their mouth and nose.¹⁰ Additionally, to reduce potential for spread of COVID-19, many EDs restrict visitors and family from being physically present with patients.

Academic EDs are always open to all who need care. Academic emergency care clinician-scientists and clinician-educators have committed their lives to reducing disparities by creating new knowledge about how to care for people during times of emergency and by training compassionate emergency providers. Many physicians, APPs, nurses, and staff work in academic

hospitals, under conscious choices that sometimes include lower salaries, and potentially more challenging working conditions than in private settings, in exchange for the privilege of providing unconditional emergency care to all people.

References

1. Riu P, Kang K. National Hospital Ambulatory Medical Care Survey: 2015 Emergency Department Summary Tables. 2015. http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2015_ed_web_tables.pdf. Accessed May 7, 2020.
2. Morrow-Howell N, Galucia N, Swinford E. Recovering from the COVID-19 pandemic: a focus on older adults. *J Aging Soc Policy* 2020;1-9.
3. Butler SM 2020. <https://jamanetwork.com/channels/health-forum/fullarticle/2765238>. Accessed May 7, 2020.
4. Wadhwa RK, Wadhwa P, Gaba P, et al. Variation in COVID-19 Hospitalizations and Deaths Across New York City Boroughs. *JAMA* 2020;e207197. <https://doi.org/10.1001/jama.2020.7197>
5. Wee LE, Fua TP, Chua YY, et al. Containing COVID-19 in the emergency room: the role of improved case detection and segregation of suspect cases. *Acad Emerg Med* 2020; 27:379-384.
6. Hollander JE, Carr BG. Virtually Perfect? Telemedicine for Covid-19. *N Engl J Med* 2020; 382:1679-81.
7. West CP, Montori VM, Sampathkumar P. COVID-19 testing: the threat of false-negative results. *Mayo Clin Proc* 2020. <https://doi.org/10.1016/j.mayocp.2020.04.004>
8. Desai AN, Patel P. Stopping the spread of COVID-19. *JAMA* 2020;323:1516. <https://doi.org/10.1001/jama.2020.4269>.
9. Wang W, Xu Y, Gao R, et al. Detection of SARS-CoV-2 in Different Types of Clinical Specimens. *JAMA* 2020; 323:1843-1844.
10. Desai AN, Aronoff DM. Masks and coronavirus disease 2019 (COVID-19). *JAMA* 2020. <https://doi.org/10.1001/jama.2020.643>.