Cost Containment in Emergency Medicine
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Recognize the Problem

Although we all say that a problem exists, most of us feel that it is for the "other" guy to cut the cost of his/her care, not for me. Until we all acknowledge that a problem exists and that the solution rests with each and every one of us, there is little personal motivation to make important and difficult changes in established practice patterns. I, myself, have often said, "They pay me to be right, not cheap." In the long run we need to be right and cheap. Cost containment will eventually effect us all. The way we practice medicine in the future depends on what we collectively do today.

We must learn what the minimum appropriate work-up is for every illness and discipline ourselves to order only those tests or interventions absolutely necessary. If we are used to ordering a CT scan for every patient in the ED with a headache, eventually, there will be no place for us in the modern health care system! However, it is also true that the tests ordered in the ED are small change when compared to the cost of an inappropriate or unnecessary admission to the hospital. We are seeing increasing use of outpatient therapy and intermediate interventions- like observations units to cut the cost of care. We daily face pressures to discharge patients today who would have been admitted a few years ago. I can easily remember when every patient with pyelonephritis or a kidney stone or undiagnosed abdominal pain was admitted to the hospital for observation.

* Many wasteful practice patterns are learned in medical school and during residency training. These patterns are then carried and nurtured during years of clinical practice and lead physicians to order tests that they neither need nor want. Some of the pressures and misconceptions contributing to the wide array and high volume of laboratory and X-ray procedures ordered in the ED are familiar:
  A. Fear of criticism by other physicians for not ordering a test
  B. Fear of legal liability
  C. A need to discover as many things possible wrong with the patient in as short a period of times as possible
  D. Pressure from the patient or his family
  E. Hospital policies mandating certain "routine" admission tests
  F. The feeling that we must "do it all" during the current visit because many ED patients may not seek follow-up

Know specific strategies useful in limiting the use of ancillary tests and procedures.

1. Be selective and avoid ordering tests by reflex.
   The ordering of "baseline" tests is usually inappropriate. Question your motives when you think to order "baseline" tests.

2. Ask the "Golden Question"
   The "Golden Question" should be asked before any tests or X-rays are ordered. "How useful will the results of this test be in establishing a diagnosis or influencing a therapeutic decision?" A good example of this is the routine ordering of a CBC, SMA-7 and abdominal X-rays on patients with suspected appendicitis. It is well documented and scientifically proven that appendicitis is a “clinical” diagnosis and that no test or intervention is sufficiently sensitive or specific to make the diagnosis. Clinical impression is still the standard as it was 50 years ago.

3. Don't order a test just to satisfy your own intellectual curiosity.
4. Allow time to be a diagnostic aid. Observe and reassess patients.

5. Reevaluate protocols that call for the automatic ordering of tests.

6. Develop and use a systematic approach when deciding to order newer diagnostic procedures.

7. Avoid ordering a test for purely "medicolegal" reasons. 
   Remember- "If it's not medically indicated- it's not legally needed"

8. Involve your patient in your reasons for not ordering inappropriate tests.

9. When you do decide to order certain tests, don't "dribble", that is, don't add the tests to the order sheet a little at a time. This requires the nurses and clerks to take your orders off the chart repeatedly and prolongs the patient stay. Order all you need at the beginning of your evaluation, if possible. Note: in most ED's, patients are charged according to the length of their stay.

One final way to think about the ordering of tests is to imagine the Physician’s Orders sheets as a stack of blank checks which the patient has signed. Every time you order a test, you are making a withdrawal from the patient’s bank account. How much do you need to drain the account?

* Excerpted with changes by W. Kuhn, M.D. from Cost Containment: Guidelines for Cost Containment in Emergency Medicine, ACEP, 1983.