# Patient dumping: the ignoble face of American medicine

Milan Korcok

It's called patient "dumping". It's the transferring or deflecting of poor or uninsured patients away from hospitals and doctors who don't want to serve them to hospitals and doctors who have no choice.

It's undignified, it's brutal and an ignoble face of American medicine.

> It's the transferring or deflecting of poor or uninsured patients away from hospitals and doctors who don't want to serve them to hospitals and doctors who have no choice. It's a stark reality of American medicine.

But it's also one of its stark realities. As more and more hospitals succumb to financial pressure, the practice of dumping looks ever more troublesome to American health care analysts.

In the Feb. 7, 1985 issue of the *New England Journal of Medicine,* Dr. Keith Wrenn, a primary care internist in the rural community of Murphy, NC, wrote eloquently of the frustration he had felt in fighting to get poor or uninsured patients (the two are not always synonomous) admitted to larger hospitals for emergency treatment. Too often, claimed Wrenn, the most crucial admission criterion seems to be whether or not the patient is insured. He gave two examples.

In May 1983, Wrenn wrote, a 26-year-old man was injured in an auto accident, receiving a bump on his head: he was brought to the emergency room of the local 50-bed hospital for observation. Though initially lucid, he began to show signs of transtentorial herniation, "presumably due to an acute subdural hematoma". Attempts were made to contact a neurosurgeon in a university setting 208 km to the south, where the patient and his family lived.

According to Wrenn: "After the case was presented to the neurosurgeon attending, the first question was 'Does the patient have insurance?' At that time no family members were present and no information other than his name was available. After much pleading, the patient was accepted in transfer and later died. As it turned out, he did have insurance".

A 35-year-old woman, a victim of an auto accident, was brought in with massive facial and head trauma. She was hypoxic, had an obvious midline mandibular fracture as well as severe bilateral orbital and eyelid hematomas. An x-ray showed skull fracture. While she was stabilized, attempts to have her transferred were confounded partly by bad weather at one centre, and by the refusal of a neurosurgeon to accept her for lack of health insurance at another centre.

Repeated attempts to transfer her to an appropriate centre were, finally, successful. But the experience left Wrenn feeling anything but a winner.

"I feel disappointed and angry", he wrote. "I also feel betrayed because the ethical principles that were imparted during training (and for that matter in growing up) seem to be just words blithely uttered in lip service to the Hippocratic oath."

Added Wrenn: "I think it is likely that the institution in question (rejecting the transfer) is not unique and that this attitude of professional 'copping out' will become increasingly prevalent in the future as more and more hospitals move to secure themselves economically and try to ward off dumps".

There are those who believe Wrenn may be right. Jack Hadley, co-director of the center for health policy studies, Georgetown University School of Medicine, has written extensively on the subject of hospital cost-shifting, patient transfers and services to the poor. He told *CMAJ* that in the past few years there does appear to have been an increase in the number of people who, because of lack of health insurance, are rejected by hospitals or transferred away to city or county tax-supported institutions that have specific mandates to handle charity care. However, he cautioned against rushing to the assumption, as is often done, that it is always the private or proprietary hospital doing the rejecting and the public hospital doing the mopping up.

It's not that simple, stated Hadley. The American health care system is really a patchwork of public and private programs, riddled with enormous gaps through which millions of Americans — poor as well as relatively affluent — often fall.

Medicaid, the joint state-federal health insurance program was established to provide a safety net of basic health care for the poor. Now, there appear to be a lot of holes in the net.

Hadley, in a 1984 paper prepared for the *Milbank Memorial Fund Quarterly**, noted that about one-third of the nation's poor lack public as well as private insurance against the costs of illness. This is so largely

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*Co-authors Judith Feder, Georgetown University; Ross Mullner, American Hospital Association.

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because eligibility criteria for Medicaid vary widely from state to state.

In addition to those who fail to qualify for Medicaid, there are also those who may have lost their coverage when they lost their jobs, whose employers do not offer health insurance, and the self-employed who through choice or circumstance are uninsured.

In America today, according the national center for health services research, there are approximately 50.7 million uninsured or underinsured persons. Though the poor make up a disproportionate segment of the uninsured, they are not the only ones "going bare".

According to Gail R. Wilensky, director of project hope's center for health affairs, writing in the winter 1984 *Health Affairs,* two-thirds of the uninsured are not poor and one-half are families with incomes of at least twice the poverty level.

Said Wilensky: While the uninsured are disproportionately out of the labour force, over three-quarters of the uninsured are employed or are the dependents of employed workers.

How can this be? How can anyone be so negligent as to forget about buying health insurance? It's not so much a matter of forgetting, but of paying. Health insurance in America is not cheap.

Those whose health insurance is covered all or in part by their employer often don't know what it costs. Those who have to go out to buy it on their own soon learn that this is no small ticket item.

In most parts of the country, Blue Cross/Blue Shield plans are the most prevalent means of private, non-group, self-insurance. These plans do not offer first dollar coverage. There are deductibles for each user and the plans generally cover hospital and specified physicians' fees at 80% of the usual, customary and reasonable (UCR) scale in the given community. What that means is that the policyholder is left to pay 20% up to the UCR and then anything else the provider charges over and above what he considers usual, customary and reasonable.

Premiums for such coverage vary from state to state. In Florida, for example, the premium at the end of 1984 for a self-paying, non-group enrolled couple in their 40s, with no dependents was approximately $172 a month.

When that couple chose to pick up a nationally recognized "catastrophic" plan which covers all hospital and physicians' charges up to $1 million, but which specifies that each person must first satisfy a $2000 deductible, the premium went down to approximately $133 a month.

This latter plan, offered by Mutual of Omaha, is considered a "real bargain" by Florida health insurance professionals who were asked to examine it. Of course, the policyholders had to be healthy to be elig-

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ible for it in the first place.

As the number of people unable to pay for adequate health insurance has increased, so has the financial stress on hospitals that provide a significant share of their services to those who cannot pay because they are ineligible for public welfare, or those not affluent enough to afford their own self-pay insurance.

Hadley and co-authors Feder and Mullner, in their Milbank report noted that in the early 1980s, public hospitals were responsible for about 22% of all hospital care, but provided 40% of all free care. That's the reason for their tax subsidies.

They also noted that in 1982, state and local governments spent $9.5 billion for non-Medicaid charity care through public hospitals. Private hospitals, who receive no tax subsidies for indigent care and who in effect subsidize such care largely from surpluses provided by privately-insured patients, still turned up some $3.2 billion in the form of designated charity care or uncollectible charges.

The growth of such sums has made all hospitals (private, nonprofit, voluntary and publicly funded), much more aware of the fiscal status of their patient/clients. The result has been a lot of bad press.

CBS's top-ranked television documentary show *60 Minutes* called it the "Billfold Biopsy", when it presented a case history of how one major public hospital, Parkland Memorial in Dallas, TX (where President John Kennedy was taken after he was shot in 1963), is trying to serve the indigent in the Dallas-Fort Worth area and still hold on to its fiscal integrity.

What CBS's Mike Wallace contended and what seemed to be well-substantiated by taped referrals from other area hospitals to Parkland, was that unless the billfold is seen to be relatively healthy, uninsured patients are not welcome in many of the area's health facilities.

The transferring of emergency patients from private, nonprofit, voluntary or even other public facilities to an area hospital designated as a charity care centre is thought to be common in American cities. Parkland is used as a case study of this practice because it has one of the best developed databases on such transfers in the nation.

Dennis Andrulis, director of research for the National Association of Public Hospitals (the trade association of the nation's largest public hospitals) is now in the process of surveying his institutions to get precise data on the numbers of transfers and the social and economic characteristics of those who were transferred. He expects results of that survey by early summer.

Andrulis, interviewed by *CMAJ*, does believe the number of transfers is increasing, and he is concerned about the risks of such transfers to patients.

In a working paper now in progress, Andrulis and co-authors Dr. Ron J. Anderson, president of Parkland Memorial Hospital, and Karen A. Cawley, vice-president of Parkland's emergency services, contend that: "For a number of unfortunate patients, usually poor and minority, it [transferring] results in the ultimate cost, loss of life".

In trying to control transfers and cut down the risks, Parkland Memorial established, in 1983, a 24-hour emergency hotline to regulate and monitor referrals of emergency cases from other area centres.

Parkland is a 750-bed acute-care public teaching hospital with a specific mandate to serve the indigent population of Dallas County. The hospital receives tax revenues for this purpose. In 1983, county taxes accounted for 53% of Parkland's operating budget. Unfortunately, total uncompensated care (charity and bad debts) accounted for 71% of the same budget.

Vice-president Cawley told *CMAJ* that Parkland set up its hotline program to try to control what had been a sudden and relentless increase in emergency transfers, from an average of 70 a month to 200 — some of which resulted in grief.

Authors Cawley, Andrulis and Anderson cite several horror stories in their working paper.

A 18-year-old hispanic male presented to a Dallas emergency room with purpura, headache, stiff neck and fever. He was given two injections to "calm him down" and was then transferred to Parkland, by private car, because he had no insurance. A prescription blank provided the only physician-to-physician communication and it stated that Parkland needed to "rule out meningococcal meningitis". The patient, according to the working paper, did not receive stabilizing care before the transfer.

There was, according the authors, an "inordinate delay" of several hours before the patient arrived at the Parkland triage desk, where he collapsed and suffered a cardiopulmonary arrest and died. The postmortem confirmed the referring physician's suspicion of meningococcal meningitis with septicemia.

In setting up the hotline program, Parkland, in consultation with area hospitals and physicians, established clear medical and economic guidelines, put them into booklet form and distributed them throughout the area.

The 25-page transfer guidelines

Too often [transfer] admissions criteria are abused . . . . Sometimes referring physicians or patient's families will understate the patient's income. Other physicians or referring hospitals might claim they can't provide a given service. Still others just bluff it and send patients on. Between October 1983 and September 1984, Parkland Memorial Hospital received 537 transfers with no prior warning.

stipulate that in order to be accepted for emergency transfer, the patient must be medically stable and capable of being moved, an appropriate bed (such as ICU) and appropriate physician service must be available, the patient must be a Dallas County resident and must meet charity care income criteria as established by the country ($609 gross income per month for a single individual, $1171 a month for a family of four). They also stipulate medical indications for transfer.

Too often, however, said Cawley, the admissions criteria are abused and patients are transferred whether they fit the criteria or not. Sometimes referring physicians or patient families will understate the patient's income only to have the truth found out later. Other times physicians or referring hospitals might claim they can't provide a given service. Still other times, they may just bluff it and send the patients on anyway.

Since Parkland has a policy of not refusing emergency treatment to any patient appearing at its emergency department, the hospital ends up as the repository of a lot of "dumps" — despite its well-crafted guidelines. Still, the guidelines have eased the crisis.

Between October 1983 and September 1984, 1897 emergency patients were transferred to Parkland. Of these, 537 arrived with no prior warning from the referring institution. Of these 1897 cases, 429 or less than 23% were charity-eligible patients, 1061 cases (55%) were charity-ineligible patients with no insurance and 407 (less than 22%) were at least partially insured.

According to Parkland's guidelines, there were a lot people transferred who should not have been, who were not indigent per se, but who didn't have the health insurance to make them attractive enough patients to keep.

Cawley admits it often takes a hard-nosed administrator, manning the transfer hotline, to keep transfers within the guidelines and to keep the transfer policy from being abused. These are some of the hotline conversations CBS's *60 Minutes* reported to its viewers recently.

Referring doctor from an area medical centre: "This lady has diagnostic heart failure and she's in ICU now, but we need to transfer her over".

Parkland administrator: "Not so quickly you don't. First of all you have to tell me a little bit about her".

Referring doctor: What do you mean not so quickly?"

Parkland administrator: "Well, I mean I'm not going to take an unstable patient, basically."

Referring doctor: "I'm not going to send anybody who is not stable, you got it, paisano, capisce? Listen to me for a minute now, don't give

Referring doctor: ". . . Listen to me for a minute now, don't give me all that crap. She does not have insurance, the hospital does not want to take care of her, OK? This is a private, capitalistic, money-making hospital. They're on my back to have her transferred."

me all that crap. She does not have any insurance, the hospital does not want to take care of her, OK? This is a private, capitalistic, money-making hospital. They're on my back to have her transferred."

In an interview with *CMAJ*, Parkland's Cawley admitted that tensions often run high on the hotline, "But what I'm interested in is primarily why a hospital wants to transfer. If it's for financial reasons I ask the doctor . . . or family member to give me an estimate of monthly income.

"If a doctor . . . says he has a single male patient who makes $500 a month and is a Dallas County resident and the patient is stable enough to be transferred, then we take him.

"If the same doctor calls and says the patient makes $1000 a month and that hospital can provide the service the patient needs . . . those are the patients we turn down."

What about a patient earning more than the Dallas indigency guidelines but who is uninsured? "My position is that he's at your hospital, you have an emergency room, and those are the hazards of having an emergency room."

That's the theory, but it doesn't always work that way. Here's another taped conversation presented to viewers by *60 Minutes*.

Referring doctor: "Honey, we're not talking about ethical practice. We're talking about a lady that needs something done that doesn't have the money to do it with . . . and I am dead serious, sweetheart. We have had no end of problems at Irving Community Hospital with Parkland Hospital in the last 6 months, with perfectly legitimate transfers. That's what your damned


**Incidence Less than 1%**

1) Granulocytopenia (incidence about 0.5%), sometimes resulting in death
2) Thrombocytopenia
3) Immune hemolytic anemia
4) Convulsions
5) Psychosis with hallucinations
6) Confusion
7) Mental depression
8) Giddiness
9) Lightheadedness
10) Weakness
11) Bitter taste

**Rare**

1) Hypotension
2) A case was reported with fever and chills plus nausea, vomiting, abdominal pain, acute hepatomegaly, and a rise in serum glutamic oxaloacetic transaminase following a single dose of the drug.
3) Vasculitis (hypersensitivity-type).

**SYMPTOMS AND TREATMENT OF OVERDOSAGE**

Signs and symptoms of overdosage of procainamide include severe hypotension, ventricular fibrillation, widening of the QRS complex, junctional tachycardia, intraventricular conduction delay, oliguria, lethargy, confusion, nausea and vomiting.

If ingestion is recent, gastric lavage or emesis may reduce absorption. Dopamine, phenylephrine or levarterenol may be helpful in reversing severe hypotensive responses.

Management of overdosage includes symptomatic treatment with ECG and blood pressure monitoring. Procainamide toxicity can usually be treated, if necessary, by administering vasopressors after adequate fluid volume replacement. Intravenous infusion of ⅙ molar sodium lactate injection reportedly reduces the cardiotoxic effects of procainamide.

The urinary elimination of procainamide is proportional to the glomerular filtration rate but is also affected by changes in urinary pH. Procainamide is relatively lipid-soluble as a free base but the ionized form is not. Acid urine, therefore, leads to ion trapping of procainamide which enters the urine by passive diffusion from the plasma. Accordingly, renal clearance of procainamide can be considerably increased by maintaining a low urinary pH and high flow rates.

If procainamide toxicity causes severe hypotension and renal insufficiency, urinary elimination of procainamide and NAPA is decreased and hemodialysis may be required. Hemodialysis significantly reduces the serum half-life of procainamide and effectively removes procainamide and NAPA. Peritoneal dialysis is not effective.

It has been reported that one patient who ingested approximately 7 g of procainamide hydrochloride recovered after treatment consisting of i.v. levarterenol, i.v. furosemide, attempted volume expansion with albumin, and hemodialysis. Also reported is the case of an elderly patient who recovered after ingestion of approximately 19 g of procainamide hydrochloride. The patient was treated with i.v. isoproterenol and i.v. epinephrine. The latter report suggested that insertion of a ventricular pacing electrode is a reasonable precautionary measure in case high grade SV block develops.

**DOSAGE AND ADMINISTRATION**

Selection of the dose and route of administration should be made with the following facts in mind:

1) The optimum plasma level is 4 to 8 mcg/mL.
2) In elderly patients and in patients with impaired renal function (decreased creatinine clearance) excretion is delayed and reduced frequency of administration is required (see PRECAUTIONS).
3) An alkaline urine indicates a reduction in excretion rate, and the necessity for reduced frequency of administration.
4) Patients with cardiac failure, shock, low cardiac output and extrarenal azotemia should be carefully monitored and the dose or frequency of administration reduced if necessary.
5) Excretion rates appear to be unchanged by furosemide and other diuretics but are decreased by the use of acetazolamide, due to the production of alkaline urine.
6) Should toxic or sub-therapeutic levels be suspected, the patient's plasma procainamide should be determined and adjusted accordingly.

Patients vary in response to a dose of procainamide. Nevertheless, the following **guidelines** should be considered when deciding upon the patient's actual requirements.

PRONESTYL-SR Tablets (procainamide hydrochloride tablets) are a sustained release dosage form not intended for initial therapy. For initial therapy by oral administration, conventional oral formulations of PRONESTYL (procainamide hydrochloride) are recommended. Patients stabilized to an appropriate dosage level can be transferred to an equivalent daily dosage regimen of PRONESTYL-SR tablets. The duration of action of procainamide hydrochloride supplied in this sustained release form allows dosing at intervals of every 6 hours, which may encourage patient compliance.

**Ventricular Tachycardia and Premature Ventricular Contractions** — The suggested maintenance dosage of PRONESTYL-SR Sustained Release Tablets is 50 mg/kg of body weight daily given in divided doses at six hour intervals.

To provide approximately 50 mg per kg per day:*

Give patients weighing less than 55 kg — 500 mg q6h

Give patients weighing between 55 and 91 kg — 500 mg or 1 g q6h

Give patients over 91 kg — 1 g q6h

*This dosage schedule is for use as a guide for treating the average patient; however, each patient must be considered on an individual basis.

**Atrial Fibrillation and Paroxysmal Atrial Tachycardia** — The suggested maintenance dosage of PRONESTYL-SR Sustained Release Tablets is 0.5 to 1 g every six hours.

**Administration:**

Patients should be advised not to break or chew the sustained-release tablet, as this would interfere with designed dissolution characteristics.

**AVAILABILITY**

Each greenish-yellow, biconvex, oral, veneer-coated sustained release tablet contains 500 mg of procainamide hydrochloride. Available in bottles of 100 and 500 tablets.

**Storage:** Store at room temperature; avoid excessive heat.

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**Actions**
Hydralazine hydrochloride exerts its hypotensive action by reducing vascular resistance through direct relaxation of vascular smooth muscle.

**Indications**
APRESOLINE Oral: Essential hypertension.
APRESOLINE is used in conjunction with a diuretic and/or other antihypertensive drugs but may be used as the initial agent in those patients in whom, in the judgment of the physician, treatment should be started with a vasodilator.
APRESOLINE Parenteral: Severe hypertension when the drug cannot be given orally or when there is an urgent need to lower blood pressure (e.g. toxemia of pregnancy or acute glomerulonephritis). It should be used with caution in patients with cerebral vascular accidents.

**Contraindications**
Hypersensitivity to hydralazine, coronary artery disease, mitral valvular rheumatic heart disease, and acute dissecting aneurysm of the aorta.

**Warnings**
Hydralazine may produce in a few patients a clinical picture simulating systemic lupus erythematosus, in such cases treatment should be discontinued immediately. Long-term treatment with adrenocorticosteroids may be necessary. Complete blood counts, L.E. cell preparations, and antinuclear antibody titer determinations are indicated before and periodically during prolonged therapy with hydralazine and if patient develops arthralgia, fever, chest pain, continued malaise or other unexplained signs or symptoms. If the results of these tests are abnormal, treatment should be discontinued.
Usage in Pregnancy
Animal studies indicate that high doses of hydralazine are teratogenic. Although there is no positive evidence of adverse effects on the human fetus, hydralazine should be used during pregnancy only if the benefit clearly justifies the potential risk to the fetus.

**Precautions**
Caution is advised in patients with suspected coronary-artery disease, as it may precipitate angina pectoris or congestive heart failure, and it has been implicated in the production of myocardial infarction. The "hyperdynamic" circulation caused by APRESOLINE may accentuate specific cardiovascular inadequacies, e.g. may increase pulmonary artery pressure in patients with mitral valvular disease. May reduce the pressor responses to epinephrine. Postural hypotension may result.
Use with caution in patients with cerebral vascular accidents and in patients with advanced renal damage. Peripheral neuritis has been observed and published evidence suggests an antipyridoxine effect and the addition of pyridoxine to the regimen if symptoms develop.
Blood dyscrasias consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis and purpura have been reported. In such cases the drug should be withdrawn. Periodic blood counts are advised during therapy. MAO inhibitors should be used with caution in patients receiving hydralazine. Slow acetylators should probably receive no more than 200 mg of APRESOLINE per day. When a higher dose is contemplated, and, whenever possible, it may be advisable to determine the patient's acetylation phenotype.

**Adverse Reactions**
Within the first day or two: headache, palpitations, tachycardia, anorexia, nausea, vomiting, diarrhea, and angina pectoris. They are usually reversible when dosage is reduced or can be prevented or minimized by administering reserpine or a beta-blocker together with hydralazine.
Less Frequent: nasal congestion; flushing; lacrimation; conjunctivitis; peripheral neuritis, evidenced by paresthesias, numbness, and tingling; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity (including rash, urticaria, pruritus, fever, chills, arthralgia, eosinophilia, and, rarely hepatitis); constipation; difficulty in micturition; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly; blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, thrombocytopenia with or without purpura; hypotension; paradoxical pressor response.
Late Adverse Reactions: Long-term administration at relatively high doses may produce an acute rheumatoid state. When fully developed a syndrome resembling disseminated lupus erythematosus occurs. The frequency of these untoward effects increases with dosage and duration of exposure to the drug and is higher in slow than in fast acetylators. Antinuclear antibody and positive L.E.-cell tests occur.

**Symptoms and Treatment of Overdosage**
Symptoms: hypotension, tachycardia, headache, generalized skin flushing, myocardial ischemia and cardiac arrhythmia can develop. Profound shock can occur in severe overdosage.
Treatment: No known specific antidote. Evacuate gastric content, taking adequate precautions against aspiration and for protection of the airway; if general conditions permit, activated charcoal slurry is instilled. These procedures may have to be omitted or carried out after cardiovascular status has been stabilized, since they might precipitate cardiac arrhythmias or increase the depth of shock.
Support of the cardiovascular system is of primary importance. Shock should be treated with volume expanders without resorting to use of vasopressors, if possible.
If a vasopressor is required, a type that is least likely to precipitate or aggravate cardiac arrhythmia should be used, and the E.C.G. should be monitored while they are being administered.
Digitalization may be necessary. Renal function must be monitored and supported as required.
No experience has been reported with extracorporeal or peritoneal dialysis.

**Dosage and Administration**
Adjust dosage according to individual blood pressure response.
Orally: Initial: 10 mg 4 times daily for the first 2 to 4 days, 25 mg 4 times daily for the remainder of the first week, 50 mg 4 times daily for the second and subsequent weeks of treatment.
Maintenance: adjust dosage to lowest effective levels. Following titration, some patients may be maintained on a twice daily schedule.
Usual maximum daily dose is 200 mg, up to 300 mg daily may be required in some patients. In such cases a lower dosage of APRESOLINE combined with a thiazide, reserpine or both, or with a beta-adrenergic-blocking agent may be considered. When combining therapy, individual titration is essential to ensure that the lowest possible therapeutic dose of each drug is administered.
Parenterally: patients should be hospitalized. Usual dose is 20-40 mg I.M. or by slow I.V. injection or I.V. drip, repeated as necessary. Patients with marked renal damage may require a lower dosage.
For I.V. drip, the ampoule(s) should be added to 5% sorbitol solution, physiological saline or Ringer solution; glucose solution is not suitable for this purpose. Blood pressure levels should be monitored. It may begin to fall within a few minutes after injection, with an average maximal decrease occurring in 10 to 80 minutes. In cases with a previously existing increased intracranial pressure, lowering the blood pressure may increase cerebral ischemia.
Most patients can be transferred to oral APRESOLINE within 24 to 48 hours.

**Availability**
Tablets of 10 mg: yellow, uncoated, biconvex, scored, and imprinted "FA" on one side and "CIBA" on the other.
Bottles of 100 and 500.
Tablets of 25 mg: blue, coated, printed "GF" on one side and "CIBA" on the other.
Bottles of 100 and 500.
Tablets of 50 mg: pink, coated, printed "HG" on one side and "CIBA" on the other.
Bottles of 100 and 500.
Ampoules: 1 ml, each containing 20 mg hydralazine hydrochloride, 103.6 mg propylene glycol, 0.65 mg of methyl-p-hydroxybenzoate and 0.35 mg of propyl-p-hydroxybenzoate in water for injection.
Boxes of 10.
Complete Prescribing Information available on request.

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hospital is there for. That's what I pay my taxes for."

Despite such fractious encounters, Parkland's hotline/transfer program, with its clearly defined criteria has smoothed out the transfer process in Dallas County. It has improved patient stabilization and the flow of information and record keeping between institutions. It has also reduced the flow of transfers from an average of 200 per month to a current rate of about 170 a month.

But what of other areas? How is this dumping practice going to develop in other hospitals where the local tax subsidy for indigent care is not nearly as generous as it is in Dallas?

As might be expected, the courts are beginning to have something to say about dumping. Medical-legal expert William J. Curran, writing in the Feb. 7, 1985 *New England Journal of Medicine* cited a recent decision by the Arizona Supreme Court which sought to clarify the law governing obligations of physicians and hospitals in rendering emergency care to indigent patients.

The case at issue had to do with a 13-year-old Arizona boy who was injured in an accident and was rushed by ambulance to a nearby private hospital. The patient suffered a full or partial transection of the femoral artery high in the left thigh. It was agreed that he required immediate emergency surgery. His family was indigent.

It was then decided to transfer him to the county hospital on the basis of what the hospital administrators themselves admitted were financial reasons.

The patient was stabilized and transferred. One hour after the transfer, the boy's condition deteriorated. A few hours later, he underwent surgery and repair of the femoral artery. He was, however, left with a permanent impairment of the left leg, limiting his growth and development. His mother sued.

The Supreme Court declared that the physicians who rendered the services before the transfer had met all of their obligations in treating and evaluating the patient, and neither they nor the consultants could have prevented the hospital from making the economic transfer to the county institution.

The joint commission on the accreditation of hospitals manual states that "No patient should arbitrarily be transferred if the hospital where he was initially seen has means for adequate care of his problem". This may take the risk out of emergency transfers but it doesn't cut down on the growing numbers of indigent patients requiring care in the next decade.

The court was not that lenient with the hospital. It held that a private institution has the same legal obligation as a public hospital to render all needed care to emergency patients.

In ruling so, it cited the standards of the joint commission on the accreditation of hospitals (JCAH) concerning emergency services. The JCAH manual says: "No patient should arbitrarily be transferred if the hospital where he was initially seen has means for adequate care of his problem".

Perhaps if such a criterion were to become more widespread it would take some of the risk out of emergency transfers. But it's not going to do much to cut down on the growing numbers of indigent patients requiring care in the next decade. Those numbers appear to be getting larger.

The Milbank report noted that between 1980 and 1982, the number of people with family incomes below 150% of the poverty line increased by 13.5%, and the number of people who were both poor and inadequately insured increased by almost 21%.

That kind of increase is more than public hospitals, already straining, will be able to bear. This means that private (both for-profit and non-profit) as well as voluntary institutions will have to pick up their share. Some already have.

Virtually every large hospital corporation has announced plans to get into the business of managing large, urban teaching hospitals. Their legacy will be the indigent.

For example, Humana Heart Institute International, as part of its contract to manage the University of Louisville medical school's main teaching hospital has agreed to assume responsibility for all indigent residents of Jefferson County presenting at the hospital for emergency care.

Others are cutting similar deals in return for the teaching hospital business. No one expects that private hospitals will ever assume the same open door policy for indigents that some public institutions have in the past. They're just not set up that way.

As the administrator of a large privately-owned Dallas-Fort Worth medical centre has emphasized: "This hospital's policy is no different from any other . . . in the metropolitan area, with regard to indigent folks. We are not in the business of caring for large numbers of people who do not have the ability to pay. We do not have the money to do that".

Of course he's right, his argument is rational and he has to take care of business.

That's what worries Parkland President Anderson. "They're taking what is a businesslike, rational approach, which scares the hell out of me because medicine is not just business, it's caring for people.

"We've got to be businesslike", said Anderson, "but those boardrooms are a long way from my emergency room."■


DON'T LEAVE HOME WITHOUT IT

IMODIUM*

(loperamide)

For travellers diarrhea

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