C-ABC: cash before care in a private emergency department?

Stephen S Teo[1,2], Vijay Manivel[3,4]

The patient's perspective

In 2010 the American Heart Association recommended a change from ABC (airway, breathing, chest compressions) to CAB (chest compressions, airway, breathing), which was confirmed in their 2015 guidelines.[1] Interestingly, over the past 10–15 years there has also been a shift in the algorithm for trauma with the addition of "C" as a prompt for the assessment, management and resuscitation of the patient with Catastrophic haemorrhage, taking precedence over ABC and giving rise to C-ABC.[2]

I had cause to ponder this when recently I woke up with unusual pain at rest. Being of a certain vintage and, as a paediatrician, with clear deficiencies in my working knowledge of adult medicine, I made my way to a local private emergency department (ED) which I had heard about through a friend and colleague (VM). Although I have previously had cause to see specialist colleagues in rooms, this was my first adult experience as a patient in a private hospital setting. As a trainee I had worked in a private inpatient setting abroad and had a vivid recollection of needing to put a sticker from each cannula into a logbook in the ward so the patients (or proxies) could be charged accordingly. As a consultant in Australia, I had only ever worked as a staff specialist and was also intrigued from a professional viewpoint.

On starting the clerical process in the ED waiting room, I noted a sign stating that a required upfront fee could not be claimed back on private health cover. I happily paid this and felt fortunate to be able to do so without angst. During my (patient) wait to be triaged, while being attended to by both nursing and medical staff in the ED, undergoing investigations and then being seen by a specialist, I had time to reflect on my experiences of private and public acute health care.

A cynic might propose that in the private setting, the initial "C" in C-ABC could equally be applied to medical (as opposed to major trauma) patients, denoting, in decreasing frequency, Credit card, Cash and, certainly less frequently these days, Cheque, before moving on to ABC. I could not recall if PayPal was an option but in any case, I could not think of any resuscitation algorithm which extended that far down the alphabet.

So what was the reality of my private hospital experience during my (thankfully less than a day) stay? I reflect that I am very appreciative of the nursing, medical and ancillary (clerical, transport) care I received. I feel privileged to have been the recipient of the other vital "Cs": Clinical expertise and good Communication, backed by Courtesy and Compassion. My experience reminded me it does not matter whether we work in the private or the public settings, the level of care can and should be identical.

The ED clinician's perspective

While the impression that cash is the primary interest in private EDs may be common among the general public, as an emergency physician working in a private ED for over 10 years, I have a different perspective. Let us examine the pertinent background to private EDs. Australian law prohibits private health insurers from offering benefits for medical services provided out of hospital.[3] With the exception of Department of Veterans' Affairs, from the private health insurers' point of view, the ED is still considered an outpatient service; patients must therefore cover all service costs (including but not limited to facility, nursing, administrative and supply costs). It seems incongruous that private health funds cover massages but not ED expenses. Many patients who have purchased private health insurance are unaware of this and, on presenting to a private ED, are disappointed to learn of this discordance. Private hospitals work in a highly competitive market with an interesting business model, in which the competitor (public hospitals) provides the presumed free service. Despite these disadvantages, there are over half a million consultations per year in Australian private EDs,[4] where there is provision of high level care with correspondingly high patient satisfaction. Notably, around 50% of elective surgery and cancer care in Australia is undertaken in private hospitals.[4]

Although there is a paucity of research on why patients choose private over public EDs, two Australian studies have provided interesting results.[5,6] Cost may be not be perceived to be an issue for patients who elect to be seen in a private ED.[5] Incentives to present at a private ED have included convenience (both geographical and anticipated shorter wait times), and expectations of being seen by a consultant ED physician and of receiving high quality care.[6] Another possible perceived benefit may be an expectation of the option of being able to choose one's inpatient consultant, which may facilitate continuity of care.[3] However, the level of non-clinical care has also been found to be a factor in patients' decisions.[6]

Presenting to an ED with an acute medical issue can clearly be a stressful experience, and making it a positive experience is not an easy task. Cash before care in the private ED is a common misconception. In medical emergency situations, when patients without insurance do end up in a private ED, staff ensure that financial concerns are not exacerbated and that the patients receive all necessary immediate investigations and treatments. One should acknowledge that all other out-of-hospital health services (eg, private specialist rooms, physiotherapy, dental, optometry and even veterinary medicine clinics) provide care only after confirming the financial status of the patient. In private EDs, patients are seen directly by senior medical clinicians, a Fellow of the Australasian College for Emergency Medicine or an experienced career medical officer, who usually also work in a public setting and who are trained to provide the best evidence-based care possible, irrespective of the patient's financial status. There is a constant effort to reduce the agony and anguish of the patient, minimising bills and reducing the financial burden

[1]Western Sydney University, Sydney, NSW. [2]Blacktown and Mt Druitt Hospitals, Sydney, NSW. [3]Nepean Hospital, Sydney, NSW. [4]Norwest Private Hospital, Sydney, NSW.
s.teo@westernsydney.edu.au ▪ doi: 10.5694/mja18.00840 ▪ See Editorial, p. 468

whenever possible while ensuring that clinical expertise is used to deliver considered and customised care. A patient will only be transferred to another appropriate medical facility once medical stability is achieved. Additionally, there is often a lower threshold to provide prolonged observation in the ED and to admit to the hospital from a private ED compared with a public ED. Experienced emergency staff feel less time-pressured in managing a patient in a private ED, and have relatively easy and timely access to standard and advanced investigations and to specialists. The many "thank you" cards and chocolates that my colleagues and I have received from our private ED patients attest to the high quality of care.

Conclusion

We propose that good Communication, combined with expert Clinical Care by Consultants, backed by Courtesy and Compassion, followed by seamless Continuity of Care, will always supersede Cash.

Competing interests: Vijay Manivel is employed as a consultant emergency physician in a private hospital setting.

Provenance: Not commissioned; not externally peer reviewed. ■

© 2018 AMPCo Pty Ltd. Produced with Elsevier B.V. All rights reserved.

References are available online at www.mja.com.au.

1 American Heart Association. Guidelines for CPR and Emergency Cardiovascular Care. Part 5: Adult Basic Life Support and Cardiopulmonary Resuscitation Quality. https://eccguidelines.heart.org/wp-content/themes/eccstaging/dompdf-master/pdffiles/part-5-adult-basic-life-support-and-cardiopulmonary-resuscitation-quality.pdf (viewed Aug 2018).

2 Hodgetts TJ, Mahoney PF, Russell MQ, Byers M. ABC to <C>ABC: redefining the military trauma paradigm. *Emerg Med J* 2006; 23: 745-746.

3 Walker K, Ben-Meir M. Choosing public or private emergency departments in Australia. *Emerg Med Australas* 2018; 30: 122-124.

4 Australian Bureau of Statistics. 4390.0 — Private Hospitals, Australia, 2016-17. Private Acute and Psychiatric Hospitals — Summary. http://www.abs.gov.au/ausstats/abs@.nsf/mf/4390.0 (viewed Aug 2018).

5 He J, Toloo GS, Hou XY, FitzGerald G. Qualitative study of patients' choice between public and private hospital emergency departments. *Emerg Med Australas* 2016; 28: 159-163.

6 Shearer FM, Bailey PM, Hicks BL, et al. Why do patients choose to attend a private emergency department? *Emerg Med Australas* 2015; 27: 62-65. ■