



## SPECIAL CONTRIBUTION

# The Ethics of Health Care Reform: Impact on Emergency Medicine

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## Abstract

The recent enactment of the Patient Protection and Affordable Care Act (ACA) of 2010, and the ongoing debate over reform of the U.S. health care system, raise numerous important ethical issues. This article reviews basic provisions of the ACA; examines underlying moral and policy issues in the U.S. health care reform debate; and addresses health care reform's likely effects on access to care, emergency department (ED) crowding, and end-of-life care. The article concludes with several suggested actions that emergency physicians (EPs) should take to contribute to the success of health care reform in America.

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## BASIC PROVISIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) OF 2010, P.L. 111-148/152

The Patient Protection and Affordable Care Act (ACA) is a federal statute signed into law along with its amendment, the Health Care and Education Reconciliation Act, by President Obama in March 2010.<sup>1</sup> It is designed to take effect in stages over 8 years. The ACA contains multiple provisions designed to increase access to health insurance, including expanding Medicaid eligibility, subsidizing health insurance premiums, and providing incentives for businesses to provide

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health care benefits. It encourages states to create health insurance exchanges where uninsured adults and small businesses can buy insurance from a range of private insurers. Large businesses will have to pay penalties for their employees who receive subsidized health insurance in insurance exchanges, but businesses are not required to provide insurance for their employees. Most individuals, however, will be required to purchase health insurance, and this individual mandate for insurance purchase is the subject of a major challenge to the constitutionality of the ACA. To protect access to health insurance, the ACA also imposes a number of new requirements on health insurers. Insurance companies will be prohibited from denying coverage due to preexisting conditions, from dropping coverage when clients become ill, from imposing annual or lifetime limits on insurance payments, and from charging deductibles for most preventative care. The ACA also requires insurers to extend coverage for children up to the age of 26 years under their parents' insurance, even if the children do not live with their parents and are not dependents.

The Congressional Budget Office (CBO) has estimated that, after all the provisions of the ACA are in effect in 2019, the number of people with health insurance will have increased by 32 million over 2010 levels. This is a significant increase in health insurance coverage, but it does not achieve the goal of universal health insurance coverage for U.S. residents. Twenty-three million people will remain uncovered, including undocumented immigrants and those who choose not to purchase health insurance. People who would be paying greater than 8% of their household incomes on health insurance will be exempt from the requirement to purchase insurance. According to CBO estimates, the ACA will

raise the percentage of nonelderly U.S. citizens and legal residents with health insurance from 83% to 94%.<sup>2</sup>

The extended health insurance benefits of the ACA are funded in a variety of ways, including reductions in Medicare provider reimbursements, increased Medicare taxes on higher-income Americans, new taxes on pharmaceutical and health care device manufacturers, and an excise tax on high-value health insurance benefits. To keep health insurance affordable, the ACA also includes a variety of provisions designed to curb the steadily rising costs of U.S. health care. Among its most significant cost containment provisions are the following: 1) The ACA created a Patient-Centered Outcomes Research Institute (PCORI) to conduct and fund comparative effectiveness research.<sup>3</sup> The new information generated by PCORI should help physicians and patients choose the best available treatment options and so avoid unnecessary spending on less effective treatments. 2) The ACA establishes an incentive program for providers to form accountable care organizations, a new type of integrated health care delivery system designed to provide comprehensive care for patients at reduced costs.<sup>4</sup> 3) The ACA creates the Medicare Independent Payment Advisory Board (IPAB).<sup>5</sup> Beginning in 2013, the IPAB will annually recommend to Congress specific measures to keep Medicare spending within predetermined limits.

The ACA is widely acknowledged as the most significant piece of health care legislation since the establishment of Medicare and Medicaid almost a half-century ago.<sup>6,7</sup> Perhaps because it is such a sweeping overhaul of the U.S. health insurance system, Congressional debate over the ACA was both protracted and highly contentious. The election in November 2010 of many staunch opponents of the ACA has made it very clear that the national debate over health care reform will continue and that full implementation of the ACA is far from assured.<sup>8</sup>

## **MORAL FOUNDATIONS OF HEALTH CARE REFORM**

One way to analyze the ongoing health care reform debate is to identify basic goals of the health care system and consider how reform measures serve those goals. We contend that four fundamental goals and desires have shaped the U.S. health care system.<sup>9,10</sup> First, Americans desire high (or perhaps even the highest) quality care. The reason for this desire is obvious—excellent care can provide the greatest health benefits. The goal of quality care is thus linked with the basic bioethical principle of beneficence that directs health care professionals to act for the benefit of their patients. For at least the past century, the United States has been a world leader in expanding the frontiers of medicine and improving the quality of health care. Second, Americans desire freedom of choice in health care.<sup>11–13</sup> Americans want to decide when and where they receive care, what kind of care they get, and from whom they get care. The goal of freedom of choice thus reflects the basic bioethical principle of respect for autonomy that enjoins health care professionals to honor the choices of their patients. Third, Americans

want their health care to be affordable.<sup>14,15</sup> If individual Americans, and U.S. public officials, spend too much on health care, insufficient resources will remain for all of the other things they need or want. Fourth, Americans want their fellow citizens to share in the considerable benefits of health care.<sup>16</sup> Americans are unwilling to deny health care to persons in need, and the United States has established public health insurance programs to provide care to, among others, the elderly and the indigent. The goals of affordability and universal access to care raise questions of resource allocation, namely, who should enjoy the benefits of health care and who should bear the burdens of financing the U.S. health care system. Answers to these allocation questions may appeal to a variety of ethical principles of distributive justice.

We believe that these four general health system goals are all attractive and are very widely endorsed in the United States (and elsewhere). With the rapid and relentless growth of the U.S. health care system over the past half-century, however, it has become increasingly clear that these four fundamental goals are not fully compatible—that is, they cannot all be maximized at once. So, satisfaction of one or more of the goals must be compromised to achieve the others, but Americans still resent and resist such compromises. If these four health system goals are in fact so widely embraced, observers might question why U.S. policymakers cannot seem to agree on how to structure and finance a health care system that provides a limited but acceptable level of support for each goal. The probable reason for this struggle to reach agreement is that, beneath the widespread (and perhaps rather superficial) agreement on general health system goals lie significant differences in the relative priority Americans assign to the spectrum of different goals.

Consider, for example, the fact that nearly all of the world's other highly industrialized nations, including the nations of western Europe, Canada, Japan, and Australia, have health care systems that provide universal access to care for their citizens at a per capita cost significantly lower than in the United States. Citizens of these societies typically accept significant responsibility for the material welfare of their fellow citizens, often expressed in continental Europe as a principle of solidarity.<sup>17</sup> These nations clearly place a high priority on the egalitarian goal of universal access to health care. To finance their health care systems, these nations impose a variety of constraints on other goals. For example, Germany and Japan require all citizens to obtain health insurance and all employers to contribute to insurance costs. Canada prohibits the provision of private insurance for services covered by provincial health insurance plans. The U.K.'s National Health Service restricts the adoption of high-cost therapeutic innovations, thereby limiting access to potentially beneficial new treatments. To keep health care affordable, these nations also generally impose limits on provider fees and on drug prices.<sup>18</sup>

Are Americans also willing to accept limits on health care quality and choice to finance much wider access to health care? Appeals to compassion and mutual assistance support the ACA provisions extending

health insurance to an additional 32 million people.<sup>19</sup> Support for the ACA's expansion of health insurance can also be found in arguments for a human right to health care and for access to health care based on fair equality of opportunity.<sup>20,21</sup> However, these appeals do not enjoy a clear priority in the minds of many Americans over competing claims based on individual liberty, individual responsibility, and free enterprise, values that are also deeply rooted in the American tradition. A serious constitutional challenge to the ACA, for example, is grounded on claims for individual liberty—it asserts that Americans may not be legally required to purchase health insurance. If the ACA individual mandate to purchase health insurance is overturned by the courts, and if many young and healthy Americans then choose not to insure themselves, insurers may not be able to spread their risks and costs across a large enough pool of subscribers to provide affordable coverage for the millions of new enrollees, and the entire reformed system may collapse.<sup>22</sup> The ACA's deference to the free enterprise system is evident in the prominent role given to private health insurance companies in the reformed system, and in the defeat of a public health insurance option to compete with private insurers in newly established health insurance exchanges.<sup>23</sup>

In summary, Americans desire a great deal from their health care system—more, in fact, than it can deliver. Because individuals hold different views about which goals should take priority in cases of conflict, compromise solutions for health care reform are difficult to achieve.

Whether or not the reforms of the ACA withstand the strong political challenges mounted against them, we believe that effective cost containment will be the most difficult problem for the U.S. health care system in the foreseeable future. Currently, the United States is

the world's highest spender on health care per capita.<sup>24</sup> Americans enjoy many benefits from higher spending, including shorter wait times for procedures, easier access to primary and specialty care, and more advanced diagnostic and therapeutic technologies and pharmaceutical agents when compared to many other countries. Ideally, Americans would like to see cost containment without reduction of services or quality.<sup>25,26</sup> The strong professional and public backlash against managed care cost containment strategies in the 1990s was directed against perceived erosion of access to and quality of care. The subsequent retreat from tightly managed care, however, brought with it a return to steep annual increases in health care spending in the new millennium. An important challenge for the sustainability of the ACA, therefore, will be its ability to control health care spending.

### AMERICAN COLLEGE OF EMERGENCY PHYSICIANS CODE OF ETHICS AS A GUIDING DOCUMENT

For guidance regarding the ethical dimensions of the health care reform debate, emergency physicians (EPs) might first consult foundational statements like the "Principles of Ethics for Emergency Physicians" of the American College of Emergency Physicians (ACEP;<sup>27</sup> Table 1). The "fundamental moral responsibilities of EPs" expressed in these principles lend support to the basic goals of the health care system described in Table 1 (Table 2).

#### Goal One: Quality Care

Principle 1 states that EPs shall embrace patient welfare as their primary professional responsibility. Principle 8 enjoins EPs to pursue continuing education to provide high-quality care.

Table 1  
ACEP Principles of Ethics for Emergency Physicians

The basic professional obligation of beneficent service to humanity is expressed in various physicians' oaths and codes of ethics. In addition to this general obligation, emergency physicians accept specific ethical obligations that arise out of the special features of emergency medical practice. The principles listed below express fundamental moral responsibilities of emergency physicians.

*Emergency physicians shall:*

1. Embrace patient welfare as their primary professional responsibility.
2. Respond promptly and expertly, without prejudice or partiality, to the need for emergency medical care.
3. Respect the rights and strive to protect the best interests of their patients, particularly the most vulnerable and those unable to make treatment choices due to diminished decision-making capacity.
4. Communicate truthfully with patients and secure their informed consent for treatment, unless the urgency of the patient's condition demands an immediate response.
5. Respect patient privacy and disclose confidential information only with consent of the patient or when required by an overriding duty such as the duty to protect others or to obey the law.
6. Deal fairly and honestly with colleagues and take appropriate action to protect patients from health care providers who are impaired or incompetent or who engage in fraud or deception.
7. Work cooperatively with others who care for, and about, emergency patients.
8. Engage in continuing study to maintain the knowledge and skills necessary to provide high-quality care for emergency patients.
9. Act as responsible stewards of the health care resources entrusted to them.
10. Support societal efforts to improve public health and safety, reduce the effects of injury and illness, and secure access to emergency and other basic health care for all.

Table 2  
Basic Goals of Health Care: Alignment with the ACEP Principles of Ethics for Emergency Physicians

Goal of Health Care		ACEP's Principle of Ethics
Quality care	1	EPs shall embrace patient welfare as their primary professional responsibility.
Freedom of choice	3,4	EPs shall respect the rights and strive to protect the best interests of their patients, particularly the most vulnerable and those unable to make treatment choices due to diminished decision-making capacity. EPs shall communicate truthfully with patients and secure their informed consent for treatment, unless the urgency of the patient's condition demands an immediate response.
Affordability	9	EPs shall act as responsible stewards of the health care resources entrusted to them.
Universal access to care	2,10	EPs shall respond promptly and expertly, without prejudice or partiality, to the need for emergency medical care. EPs shall support societal efforts to improve public health and safety, reduce the effects of injury and illness, and secure access to emergency and other basic health care for all.

ACEP = American College of Emergency Physicians.

**Goal Two: Freedom of Choice**

Principles 3 and 4 require EPs to respect patient rights, including the right to informed consent that gives patients substantial control over their own treatment.

**Goal Three: Affordability**

Principle 9 calls on EPs to act as responsible stewards of health care resources, thus recognizing the importance of conserving resources to keep health care affordable.

**Goal Four: Universal Access to Care**

Principle 2 calls on EPs to provide emergency care for all who need it. Principle 10 endorses the goal of access to basic health care for all.

This endorsement of all four of the basic goals of health care systems reinforces our claim that these goals are fundamental and widely embraced. The Principles of Ethics remain very general, however, because the ACEP statement does not rank these principles or consider conflicts among them. Further, it does not provide clear guidance about how to resolve conflicts based on appeals to different principles.

The ACEP Principles of Ethics do, however, offer at least two valuable suggestions. First, they endorse the goal of universal access to basic care. This concept of basic care suggests inevitable limits on the goals of quality and individual choice to achieve the goals of equity and affordability. Precisely what constitutes basic care is an important point of debate that has not yet been resolved on a national level. Second, the ACEP principles explicitly endorse the role of EPs as “responsible stewards of the health care resources entrusted to them.” This is also a clear recognition of the conclusion that claims to health care resources cannot be unlimited and that EPs must play a role in setting appropriate limits. Note, however, that this stewardship role may pose ethical dilemmas for EPs who also embrace patient welfare as their primary responsibility.<sup>28</sup>

In a recent commentary, Brody<sup>29</sup> offers a promising suggestion regarding how physicians can contribute to reducing unnecessary health care spending. Brody

proposes that each medical specialty society identify a “top five list” of “diagnostic tests or treatments that are very commonly ordered by members of that specialty, that are among the most expensive services provided, and that have been shown by the currently available evidence not to provide any meaningful benefit to at least some major categories of patients for whom they are commonly ordered.” Brody then suggests, “each specialty society should come up with an implementation plan for educating its members as quickly as possible to discourage the use of the listed tests or treatments for specified categories of patients.” Brody’s proposal offers one way for physicians to become more responsible stewards of health care resources. It is our recommendation that emergency medicine (EM) as a specialty should rise to Brody’s challenge to create and disseminate a “top five list” for EM.

Even after the passage of the ACA, much of the hard work of balancing the specific claims of the four basic health care system goals remains to be done. This work should be guided by moral principles, but it also requires good empirical information about treatment outcomes and costs and an effective political process.

**IMPACT OF THE ACA ON EMERGENCY MEDICINE: ACCESS TO CARE AND HOSPITAL CROWDING**

**ED Trends**

Guaranteed access to health care is currently available in the United States in only one setting, the hospital emergency department (ED). The federal Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 established an unfunded mandate to provide medical evaluation and emergent treatment for anyone presenting to an ED, regardless of his or her ability to pay. Not all visits to the ED are emergent or urgent, however. According to the recent National Ambulatory Medical Care Survey, 4.5% were triaged as needing immediate evaluation, 11.3% emergent, 38.5% urgent, 21% semiurgent (defined as needing to be seen within 1 to 2 hours or later), and 7.9% nonurgent (needing to be seen within 2 to 24 hours).<sup>30</sup>

Due in part to the fact that the ED provides the only guaranteed access to health care in the United States, the number of ED visits has risen steadily over recent years to 116.8 million in 2007, an increase of 23% since 1997.<sup>24</sup> Eighty-one percent to 88% of patients currently seen in EDs have medical insurance, with a disproportionate number being covered by public insurance, such as Medicare and Medicaid plans, that have lower reimbursement rates than private insurance. The medical costs associated with treating the 12% to 19% of patients without any health insurance are largely absorbed by hospitals, as required by EMTALA. Over the two decades from 1990 to 2009, the number of hospital EDs has decreased by 27%. An increased risk of ED closure is associated with for-profit ownership, a competitive market, safety-net status, and low profit margin.<sup>31</sup> These trends suggest that the burden on EDs of providing safety-net health care for uninsured patients has increased significantly over several decades.

### The ACA and Access to Health Care

As noted above, the ACA will enable some 32 million U.S. citizens and legal residents to enjoy health insurance for the first time. This represents a significant addition to the estimated 254 million insured Americans.<sup>32</sup> In theory, those who will receive first-time health insurance coverage under the ACA will no longer need to rely on EDs for routine health care and will prefer to establish therapeutic relationships with primary care physicians (PCPs). In practice, however, many of these patients may continue to present to EDs, often because they cannot find PCPs. Many PCPs will not accept these newly insured patients, because their practices are already full or because they are unwilling to accept Medicaid's low reimbursement rates. Overall, the increased number of insured Americans may be expected to improve their access to health care, which is congruent with the fourth moral foundation discussed above—that Americans want their fellow citizens to share in the considerable benefits of health care. However, the effect on already strained EDs must be considered. If many of the newly insured continue to depend on EDs as their primary source of health care, will this be a significant change from the prereform system? And, how will the expansion of health insurance coverage affect the volume and quality of ED care?

The Massachusetts health care reform experience can serve as an example of how the ACA may affect EDs and emergency medical practice. By enacting an individual mandate to purchase health insurance, Massachusetts created virtually universal health insurance for state residents in 2006.<sup>33</sup> Following the implementation of this statewide insurance mandate, there has been a dramatic increase in ED visits.<sup>34,35</sup> Of those presenting to the ED due to inadequate access to PCPs, there was a disproportionate representation of sicker, more disabled, chronically ill, and socioeconomically disadvantaged patients. The statewide network of PCPs did not increase with increased numbers of insured patients, and one in five patients could not get in to see their physician when needed. Thus, increased access to health insurance in Massachusetts did not always

guarantee timely access to a PCP, and the ED continued to serve as a safety net provider.

Hospital crowding is an important issue with significant effects on ED operations. Crowding is a growing national problem, as EDs and inpatient hospital beds decrease and the ED population increases. An additional growing burden to EDs is the growing population of elderly patients with multiple comorbidities. If the effects of the ACA are similar to what transpired in Massachusetts, the Act may exacerbate the problem of ED crowding by an influx of many newly insured patients who have poor or no access to primary care.<sup>36</sup> Compounding the problem is lack of outpatient follow-up after ED care, which will cause these patients to return to the ED for continuing care, further exacerbating ED crowding. Although many authors have debated the costs and merits of ED visits for nonurgent conditions, EDs remain a convenient and accessible source of health care for many patients with nonurgent conditions. This aspect of ED care may continue to rise in the foreseeable future, and EPs should advocate for strategies to provide timely and appropriate care for ED patients with nonurgent conditions.<sup>37</sup>

If ED crowding worsens as a result of the inability of newly insured patients to access primary care services, many EDs may be inclined to implement protocols for “deferring” or refusing ED care for nonurgent conditions. Referral of nonurgent patients to another location is already in place at some institutions. A key question is the identification of nonurgent conditions, as patients and providers often disagree about the urgency of the medical condition.<sup>38–40</sup> Published studies have reached conflicting conclusions regarding whether nonurgent patients can be safely identified and refused ED care. Several early studies argued that triage criteria and predictive models are inadequate to identify patients who may be safely refused ED care.<sup>41,42</sup> Three more recent studies, however, have concluded that select nonurgent patients can be safely triaged out of the ED.<sup>43–45</sup> ACEP's policy on medical screening of ED patients strongly opposes deferral of care for patients presenting to the ED. ACEP believes that deferring care for patients presenting to the ED reflects a void in the health care system and recommends that in situations where patients are deferred, very specific and concrete standards be adopted by the hospital to ensure patient access to timely, appropriate treatment in an alternative setting.<sup>46</sup> Thus, deferral of care may have negative effects on emergency medical care, in the face of already difficult access to primary care. Furthermore, we believe that turning patients away can create moral distress for both patients and emergency providers.

Emergency medicine has been responding to primary care constraints for years, offering both acute care and preventative services. President Obama's assertion that increasing the numbers of primary care providers and providing health care insurance for nearly everyone lacking it will naturally redirect patients with minor complaints away from the ED seems questionable.<sup>47</sup> Early projections are for worsening of crowding in the ED, as newly insured patients seek care. In 10 years, when the positive downstream effects have a chance to catch up, there may be an easing of the total patient

flow, permitting more rapid management of the remaining acutely ill patients from triage to treatment. Unfortunately, it may prove more difficult to effect a cultural change in patients who have relied on convenient and local hospital-based ED resources for several decades. Certainly the link between insurance availability and reducing ED visits has not been convincingly made.

## HEALTH CARE REFORM AND END-OF-LIFE CARE

Health care at the end of life represents a large fraction of health care expenditures in the United States. It has been estimated that end-of-life care utilizes 10% of the U.S. health care budget and 27% of the Medicare budget.<sup>48</sup> Improved access to care, determination and documentation of patient wishes, and following those wishes are important elements of improved cost-effective end-of-life care. Care for patients approaching the end of life is the subject of increasing attention in the U.S. health care system, as evidenced by the growth of hospice care and recognition of the new specialty of palliative medicine.<sup>49,50</sup> End-of-life issues arise in the ED when patients present with end-of-life symptoms, with terminal conditions requiring palliative care, or in cardiac arrest. Over 139,000 patients die in EDs annually (0.12% of ED visits).<sup>24,51</sup> Emergency care of patients near the end of life and support for family and friends present unique challenges to EPs. The ACEP policy statement “Ethical Issues at the End of Life” asserts that “Emergency physicians should respect the dying patient’s needs for care, comfort, and compassion.”<sup>52</sup>

Many patients have strong personal preferences regarding end-of-life care. In the absence of advance directives expressing those preferences, providers and families often are unable to state the patient’s end-of-life wishes accurately.<sup>53–55</sup> Although advance directives can be effective communication tools when they exist, there are significant challenges to their universal application, including inaccurate public knowledge, low rates of completion, and lack of understanding of implications.<sup>53,54,56–58</sup> The original ACA provision authorizing Medicare funding of advance directive discussions was written to help overcome barriers of ignorance and fear of advance care planning. This provision passed in the House of Representatives in November 2009, but was not included in the final version. Public controversy regarding the intention and potential consequences of this provision (i.e. “death panels”) led to its removal from the final bill. The provision was reinserted in regulations implementing the ACA in December 2010, but was dropped once again in January 2011.<sup>59</sup>

Critics of this provision claimed that it would permit the unbridled use of “death panels” to deny life-sustaining treatment for vulnerable patients. This claim, however, misrepresented the purpose and effects of advance care planning and of this provision. Previous studies have demonstrated that advance directive discussions are not associated with hastened death<sup>60</sup> and that advance directives are strongly associated with care that best meets the patient wishes, whether for life-sustaining measures or for palliative care.<sup>61</sup> Despite its omission from the ACA, we contend that proactive

personal planning for end of life care is a valuable component of comprehensive health care reform.<sup>62</sup> Funding for advance care planning consultations would enhance ethical care by helping patients to formulate and communicate their own preferences regarding end-of-life care, and helping others to understand and honor those preferences, thereby promoting patient autonomy and well-being.

## ACTIONS FOR EMERGENCY PHYSICIANS

Guided by the call of the ACEP Principles of Ethics for Emergency Physicians for universal access to basic health care,<sup>27</sup> we believe that EPs should support efforts to expand access to health care in a reformed U.S. health care system. To achieve effective access to care for the millions of newly insured patients, EPs should advocate for increasing the health professional work force, including both emergency and PCPs, and expanding health care institutions, including hospitals, clinics, and urgent care centers. Along with other physicians and health care professionals, EPs must act as responsible stewards of health care resources by helping to establish and implement reasonable limits to the services they provide. In this way, EPs can contribute their unique perspective to the task of balancing the four fundamental health system goals of quality care, patient choice, affordability, and universal access.

## CONCLUSIONS

Reform of the health care system will have significant influence on the practice of emergency medicine. The recently enacted Patient Protection and Affordable Care Act of 2010 has fueled, and will continue to fuel, ethical debate of several topics. This article reflects on the moral and policy issues underlying the health care reform debate, explores the likely consequences of health care reform on expanding access to health care, contributing to ED crowding and end-of-life care, and suggests actions for emergency physicians to help contribute to the success of health care reform.

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### Call for Papers

The Evidence-based Diagnostics section is seeking submissions. These manuscripts will evaluate a single emergency medicine-relevant diagnosis using a systematic review and meta-analysis to summarize high quality clinical research focusing on history, physical exam, readily available lab tests, and common imaging strategies. Evidence quality will be graded using the Quality Assessment Tool for Diagnostic Accuracy Studies. The highest quality evidence will then be summarized to report point-estimates or ranges for pre-test probability, diagnostic accuracy including interval likelihood ratios, and test-treatment thresholds for definitive tests. Authors are encouraged to contact the section editor, Christopher Carpenter, MD ([carpenterc@wusm.wustl.edu](mailto:carpenterc@wusm.wustl.edu)) with specific questions for this series.