The Medical-Industrial Complex

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Editor, Common Sense

“In the councils of government, we must guard against the acquisition of unwarranted influence, whether sought or unsought, by the military-industrial complex. The potential for the disastrous rise of misplaced power exists and will persist.”

President Dwight Eisenhower spoke the words above in his farewell address to the nation, three days before John Kennedy took the oath of office in 1961. Strangely enough, it was reading the April issue of Emergency Medicine News (Volume 38, Issue 4) that made me think of Eisenhower and the phrase he invented, “the military-industrial complex.” As I read EM News, I noticed a probably unintentional theme: an outcry against the medical-industrial complex, more commonly called the corporatization of medicine, and the accompanying loss of professional autonomy for physicians.

First there was the editorial “Working for Mr. Business” by Martha Roberts, who is a nurse practitioner and the daughter of one of the founders of our specialty, Dr. James Roberts. I urge you to read it in its entirety, but among her most important points is this:

“Administration is always telling us to jump, and we act like we can jump as high as their expectations require. Patients complain, administrators lecture, and sentinel events are increasing. The wait times may be improving, but is the care? Providers feel they are getting the short end of the stick while getting stuck with more complex patients daily. Their scores are dropping not because they are making poor clinical decisions, but because they did not provide the Splenda or the words a patient wanted to hear.

Hard-working ED staff are burned out, making other employment decisions, and even quitting the profession entirely.

[...] Why are we leaving the decisions to our administrators who have no role in patient care whatsoever? [...] The administration should be you and me. [...] It’s time you stop working for Mr. Business.

On the very next page is a letter to the editor from Dr. Eric Senn, which includes:

“I left emergency medicine a couple of years ago for an urgent care practice, and I am gleefully happy! The hospital system and the government succeeded in eviscerating the specialty over more than 20 years.”

Then comes another of Dr. Edwin Leap’s excellent commentaries, “Doctors and Nurses Getting in Trouble.” Dr. Leap bemoans the current corporate culture in hospitals, which makes it far more important to avoid trouble than to do good for patients:

“Me: “Patient in bed needs an ECG!” Nurse: “You have to put in the order first, or I’ll get in trouble.” In fact, this theme emerges again and again when I ask for things like dressings, splints, labs, or anything else on a busy shift. I’ve expressed my frustration about physician order entry before, and I know it’s a losing battle. When there is one of me, three or four of them, and 10 patients or more, it’s difficult to enter every order contemporaneously. But I know, “you’ll get in trouble.

[...] Now that we have given all of medicine to the control of persons trained in management, finance, and corporatism, that’s the thing they have to offer. Rules, regulations, and, ultimately, threats [...] Never mind that seeing patients in a timely manner is rendered nigh impossible by the overwhelming and growing volumes of patients coupled with the non-stop documentation of said patients for billing purposes. Keep shooting for those times! Times are easier metrics to measure. Times are easily reported to insurers and the government. Times, charts, rules followed, rules violated. The vital signs of corporate medicine in America today.”

“We physicians take an oath to put the medical needs of our patients above our financial self-interest, and nearly all emergency physicians adhere to that oath. Hospital administrators, insurers, and government bureaucrats take no such oath and feel no such ethical obligation.”

Dr. Leap also points out that we can’t turn to government for help. It has brought even more crushing bureaucracy and micromanagement to health care than corporate hospitals and insurers. In fact, it would be more accurate to label the problem the government-medical-industrial (GMI) complex, rather than the medical-industrial complex.

The casualties of the GMI (pronounced “Jimmy”) complex are hidden, buried in background noise and blamed on other things, but I have no doubt that GMI is a killer. Between the distractions, delays, and errors generated by computerized physician order entry and the electronic medical record; GMI’s obsession with metrics and customer satisfaction scores over actual medical quality; and the desire of doctors and nurses to stay out of trouble by avoiding the wrong thing, rather than being motivated mainly by a desire to do the right thing — I suspect GMI has killed hundreds, if not thousands, of Americans. In losing our professional autonomy, administrators and bureaucrats have taken control of our work space — the ED. While this is obviously bad for emergency physicians, generating burnout and driving good doctors out of the ED, it is also very bad for patients.

We physicians take an oath to put the medical needs of our patients above our financial self-interest, and nearly all emergency physicians adhere to that oath. Hospital administrators, insurers, and government
bureaucrats take no such oath and feel no such ethical obligation. But because these people have taken control of our work space, and because most emergency physicians can be fired without cause and without peer review or due process for defying such people, many of us are no longer free to exercise our hard-earned professional judgment as we think best for patients.

Emergency medicine always seems to be “the canary in the coal mine” when it comes to problems facing the medical profession, and this issue is no exception. As a hospital-based specialty — except for the growing free-standing ED movement — we are dependent on largely non-physician hospital administrators for our livelihood, and our specialty has been dominated by predatory staffing corporations (contract management groups, or CMGs) from its founding.

In fact, as I finished the April issue of EM News and came to the classified ads at the back, I was jarred to find them dominated by CMGs like EmCare,* which routinely include a clause allowing termination without cause in their employment contracts — denying emergency physicians peer review and due process, even after some post-hiring probationary period has expired. The issue was full of warnings against the GMI complex, but then full of ads from the worst practitioners of corporate medicine.

To use Eisenhower’s words, we have indeed seen the “disastrous rise of misplaced power.” But what can we do about it? Although extremely wealthy and powerful forces make up the GMI complex, we can mitigate the damage done and moderate the danger to our patients by reclaiming some of our professional autonomy. AAEM is working primarily on two fronts to accomplish this. 1) The Academy and its lobbyists in Washington are working hard to obtain guaranteed peer review and due process for emergency physicians. This would give us the protection we (unfortunately) so often need in order to do the right thing for our patients, who are often looked on as difficult and undesirable by hospital administrators and even other physicians, and the protection we need to point out and correct situations in our EDs that endanger patients or administrators and even other physicians, and the protection we need.

2) The Academy recently launched the AAEM Physician Group, to support existing physician-owned, democratic groups that comply with Academy principles and to found new ones. Such groups guarantee due process and peer review to their physicians.

As more and more emergency physicians and other hospital-based specialists become employees, I predict the Academy will eventually open a third front in the war to protect doctors and patients: unionization. But that’s a topic for another column...

* ACEP’s president-elect, Rebecca Parker, is part of upper management at EmCare and its parent company, Envision Healthcare. From the EmCare website:

“Dr. Rebecca Parker [...] serves as Senior Vice President of Practice and Payment Integration for Envision Healthcare and Executive Vice President for Leadership Development and Education for EmCare. Dr. Parker serves on the Board of Directors for the American College of Emergency Physicians and was elected to the position of president elect by the ACEP Council in October 2015.”

Below are two things from the Nov/Dec 2013 issue of Common Sense that relate to Dr. Parker and EmCare, and Dr. Bob McNamara’s editorial from that issue appears in its entirety immediately following this installment of “From the Editor’s Desk.”

“Emergency medicine always seems to be ‘the canary in the coal mine’ when it comes to problems facing the medical profession, and this issue is no exception.”

1) From “Lake Emergency Services and the Road Less Traveled,” by Carol Cunningham, MD FAAEM:

“In September of 2010, we learned that Lake Health had awarded a three-year contract to EmCare, and Lake Health’s administration had instructed EmCare to offer all of us employment. We attended an informational dinner sponsored by EmCare. Dr. Rebecca Parker, EmCare’s regional medical director and a member of ACEP’s board of directors, presented EmCare’s compensation proposal and encouraged us to complete applications for employment. The quality of the compensation package was, in our opinion, woefully inferior to what we earned as physician-owners of LES. We left the EmCare folders on the table or tossed them in the garbage on our way to the parking lot. In subsequent weeks our suspicions were confirmed, when phone calls from EmCare indicated that the expected number of clinical hours per month was more than many of us worked during residency. In addition, the compensated time set aside for administrative duties was one third to one half of that LES had provided. Attempts by some to negotiate changes in the EmCare offer were stonewalled by Dr. Parker, who declined to present some of our requests to her corporate superiors. LES physicians who were members of ACEP were left stunned and scratching their heads, wondering what happened to the claim from ACEP’s mission statement that it was “the leading advocate for emergency physicians.

Continued on next page
The LES contractual definition of a full-time physician was 120 hours per month, while EmCare offered us contracts mandating 160 hours per month. The double and triple physician coverage and PA that LES provided during the busiest parts of the day were reduced to single physician coverage, with sporadic double physician coverage. The 8-hour shifts that LES instituted in 1992, to promote the faster delivery of better patient care, support physician wellness, and prevent burnout were replaced by EmCare with 12-hour shifts.

At the request of Lake Health’s CEO, I met with her in January of 2011 to discuss Lake Health’s emergency medical services, since I had served as EMS medical director since 1995. During our conversation she expressed surprise that nearly everyone in LES refused to work for EmCare. She thought that working for a corporation whose regional medical director was on ACEP’s board of directors would be attractive to us.

The contract between Lake Health and EmCare was abruptly terminated in March of 2013, almost a year before its expiration date. When they learned that the contract had been canceled, several members of Lake Health’s medical staff contacted us and begged us to return as an independent group. However, the administrators who initiated our departure remained in place.”

[[...]] note the role a member of ACEP’s board of directors played in EmCare acquiring the Lake Health contract. A similar story is unfolding now in Tennessee, where EmCare has launched a joint venture with HCA, which is taking over the ED contracts at several HCA hospitals in the state...The CEO of EmCare’s South Division is Dr. Terry Meadows, a member of ACEP and one of the directors of its Florida chapter. Other EmCare leaders also play leadership roles in ACEP. Dr. Russell Harris, CEO of the North Division, is a past president of ACEP’s New Jersey chapter. Dr. Angel Iscovich, West Division CEO, is “an active member of ACEP” according to EmCare’s website. Dr. Thom Mayer, EmCare’s executive vice president, is a member of ACEP and winner of its Speaker of the Year award. EmCare’s chief medical officer, Dr. Kirk Jensen, is also a member of ACEP and another winner of its Speaker of the Year award. Dr. Dighton Packard, CMO of Envision Healthcare — EmCare’s parent company — is a past-president of ACEP’s Texas chapter.

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Our Opinion
Robert McNamara, MD FAAEM
CEO, AAEM Physician Group

Reprinted from the November/December 2013 issue of Common Sense. Dr. Bob McNamara offers editorial commentary on Dr. Cunningham’s story.

The upbeat tone of Dr. Cunningham’s message inspires admiration for her and her colleagues, and their resolute action. However, if you take a step back you will see that this story encompasses much of what is wrong with emergency medicine, and why it was necessary to create AAEM. In my opinion, the facts are clear. A leader of ACEP helped destroy an independent, democratic emergency medicine group. What purpose did that serve? What these emergency physicians built and nurtured over the course of 25 years was ruined. Dr. Parker was a principal agent in disrupting the careers of the LES emergency physicians. Can any EmCare bonus justify that?

At the time this story was unfolding, Dr. Cunningham and her colleagues sought AAEM’s support. We quickly responded with letters to the hospital Board of Trustees and leaders of the medical staff, questioning why they would threaten the integrity of patient care by bringing in a for-profit corporation. We went further and sent a request to the Ohio State Medical Board, asking for a review of the planned EmCare arrangement based on our concern over fee-splitting. Sadly, the group lost the contract anyway. LES probably never had a chance to retain the contract because the hospital CEO believed EmCare’s pitch that the docs would roll over, stay, accept their loss of independence, and work for EmCare — a pitch made more credible by the fact that Dr. Parker was on ACEP’s board of directors at the time. As Dr. Cunningham suggests, subsequent reports indicate that this decision not only affected the LES emergency physicians, but also the patients they left behind.

What we are left with is another cautionary tale for administrators who listen to the Dr. Parkers and EmCares of the world. On September 24, 2013, a story by Matt Skrajner in The News Herald reported that EmCare has lost its contract to staff Lake Health’s three EDs, replaced by EMP (Emergency Medicine Physicians) of Canton, Ohio. As in many other cases — such as Methodist Hospital in St. Louis Park, MN* — hiring a corporate group to replace a stable and proven physician-owned group has proven risky. More importantly, the population served by Lake Health has moved further away from the essential component of AAEM’s Vision Statement: A physician’s primary duty is to the patient. The integrity of this doctor-patient relationship requires that emergency physicians control their own practices free of outside interference.

What should you do? If you are part of an independent democratic group now, consider sending this article to your administrator — being fully aware that your contract is always being pursued by contract management groups. Second, applaud Dr. Cunningham, her colleagues, and yourself for supporting AAEM in its quest to protect individual emergency physicians and their patients rather than corporations — and ask yourself why you would support any professional society that doesn’t share those values.

*In 2004 EmCare acquired the ED contract at Methodist Hospital in St. Louis Park, Minnesota. EPPA, a private democratic group serving the hospital since 1969, was not told the contract was up for bid until after it had been awarded to EmCare. No request for proposals was issued. EPPA asked AAEM for assistance. The Academy offered legal counsel, made an argument on EPPA’s behalf to the hospital, filed a complaint with the state attorney general, and with EPPA jointly filed suit against both EmCare for violating corporate practice of medicine and fee-splitting laws and the hospital for breach of contract. Three weeks later Methodist Hospital terminated its relationship with EmCare and re-contracted with EPPA. EPPA continues to serve Methodist Hospital and several other local hospitals. This case had a chilling effect on corporate groups’ plans to move into Minnesota, and they have so far been unable to establish a significant foothold there. (This footnote is taken from a review of AAEM legal actions on behalf of independent emergency medicine groups by Dr. Mark Reiter and others, which appeared in the Jan/Feb 2014 issue of Common Sense.)
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Letters to the Editor

Andy Walker, MD FAAEM
Editor, Common Sense

A “Letters to the Editor” feature is now available on the Common Sense section of the AAEM website. Members must login with their AAEM username and password to read or post letters, or to comment on letters (www.aaem.org/publications/common-sense). If necessary, you may request that we post your letter anonymously and such requests will be reviewed on a case-by-case basis. The letters that I think are interesting, entertaining, educational, provocative, or of general interest, will be printed in Common Sense.

I hope to hear from many of you, even if you are criticizing me. I need your feedback to make Common Sense an interesting read and a good use of your time. I also want it to attract new members to the Academy. If you like something you see, let me know. If I make you mad, let me know. Especially if I make you mad. I want the letters to the editor feature to become a forum for civilized but vigorous argument, and the more vigorous the better.

— The Editor

Bemoaning the eHarmony Mentality of Job Applicants

We’ve all seen the ads. You know, the dating site that strives to pair you with the perfect mate based on “29 dimensions of compatibility.” It seems like there are a lot of matching services out there and not just for dating. A few clicks and setting of parameters and you can find the perfect hotel, the perfect travel itinerary and the perfect car. Does the same apply to the perfect job?

I’ve been very fortunate to have the opportunity to lead a group of physicians at a once small, but now much larger, community hospital in Texas. Our group has grown with the hospital and we’ve even added on a sister hospitalist group to help expand our services and improve patient flow on the inpatient side. Our two groups employ just under 30 full and part-time physicians. But as with most groups in our area we continue to expand and could stand to add a few more docs.

I’ve placed recruiting ads online with some success but of late have been seeing a somewhat disturbing trend with our applicants. Or maybe I should say with our applicants’ spouses. Yes, I said spouses. It first started with our hospitalists when we formed that group about 4 years ago. I interviewed an internist who wanted to bring her husband along. I thought this was a little odd but we were meeting at a restaurant offsite, he was a nice guy, and I recognize that this can be a family decision so why not? And maybe this was one of those “medicine things we ER doctors don’t quite understand. My wife is triple-boarded in internal medicine, pulmonary and critical care so I recognize some quirks exist across specialties.

But then we started getting calls from spouses making initial contact and screening positions based on what they could glean from our practice manager over the phone. And then it happened. The phenomenon crossed over to the ER side. What began as husbands tagging along for lunch, then husbands calling about jobs (and yes, it’s almost always the husbands), a wife called about a job for her ER spouse. And she was very aggressive. We provided some basic information and I politely declined to do a phone interview with the wife, offering instead an interview with the candidate himself. Not only did she decline on her husband’s behalf, but she wrote a lengthy nastygram to my practice manager saying that unless they knew the “hourly expectations, volume, compensation, benefits and so on” upfront then “we can’t know whether it’s a good fit for us” and “we can’t commit to spending the day on an interview” without this information.

Not once did I ever have any direct contact with the candidate.

Call me old fashioned, and I may very well be, but it seems to me that the natural sequence of events is that you identify a job opening, you make some general inquiries, then you interview for the job and gather the bulk of your information during the interview. Maybe some follow up questions or clarifications thereafter but most of what you would learn about the job would happen onsite where you get an opportunity to see and meet people, tour the facility, watch doctors and staff in action, etc. Try to get a feel for the place firsthand.

Now, I recognize some applicants live a long way away. It’s a big state, much less a big country. Many applicants are residents with limited resources. We’ve all been there. As much as I am not a fan of the telephone interview, we’ve relaxed our approach a little bit and have been more accommodating. Several of our physicians have volunteered to talk with prospective candidates by phone. We’ve even utilized newer technologies and have had a few FaceTime chats.

But the candidate I never met and whose wife dismissed us outright, sight unseen? He lives 55 miles away from our hospital. I Googled it. Fifty-five miles! Even with traffic would it be such a burden to come out for a face-to-face?

I regret that there is such a push to extract as much information as possible without an interview and to gauge agreeableness with the “29 dimensions of compatibility” that candidates and employers alike are missing out on opportunity for a meaningful in-person interaction.

— Patrick Woods, MD MBA FAAEM