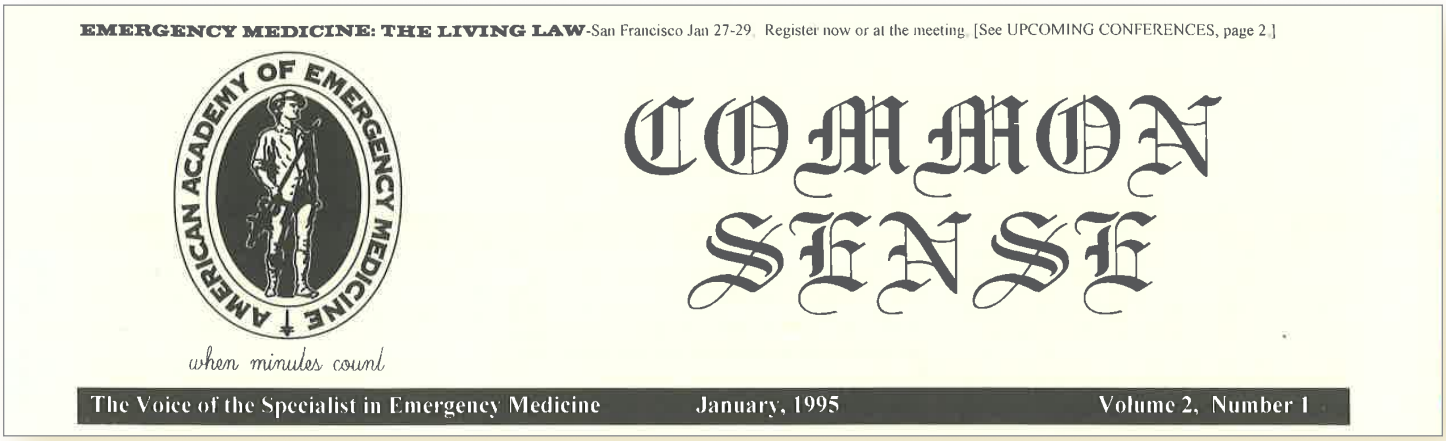
Blast from the Past

Andy Walker, MD FAAEM
Editor, *Common Sense*
AAEM Board Member

In reading this third issue of *Common Sense*, I was struck by several things. First was the news of AAEM's very first Scientific Assembly, now the best meeting in emergency medicine. Even the first one boasted some impressive speakers. It also featured the first Wagner Award, which went to Dr. David Wagner himself. Second, Coastal's lawsuit against Dr. Schwartz seems to have been going badly. Third, several issues that I thought were of recent birth were already problems 20 years ago — see the articles on burnout and physician wellness, poorly done or sham peer review, and patient satisfaction surveys.

Most interesting, even after AAEM's founding, its leaders were still trying to reform ACEP from within — and their proposals were still being rejected. Plantz, McNamara, Schwartz, and others were still trying to make ACEP more democratic; more open and transparent, especially in regard to the compensation of its leadership and staff; more of an advocate for board certification; and more protective of individual emergency physicians than of corporate interests. Resolutions calling for ACEP to lobby against restrictive covenants and for due process protections were "... soundly defeated largely due to the testimony of Dr. David Siegel, MD JD, who spoke as the Chair of NEMPAC and the ACEP Government Affairs Committee. Dr. Siegel testified that this effort would be costly and would divert funds from other lobbying efforts. *Dr. Siegel failed to disclose a major conflict of interest, that he is Chief Medical Officer for NES, a large contract management group*." (Italics original).

Last, the announcement that everyone serving AAEM as an officer or director was doing so without compensation, as a volunteer. This remains true today. ■


EMERGENCY MEDICINE: THE LIVING LAW-San Francisco Jan 27-29. Register now or at the meeting. [See UPCOMING CONFERENCES, page 2.]

AMERICAN ACADEMY OF EMERGENCY MEDICINE

when minutes count

COMMON SENSE

The Voice of the Specialist in Emergency Medicine | January, 1995 | Volume 2, Number 1

WAGNER AWARD ESTABLISHED

by Jim Keaney, MD, President, **AAEM**

The ***David K. Wagner Award***, the highest **AAEM** honor, was established at the First Annual Scientific Assembly in Philadelphia. This annual award for excellence in Emergency Medicine seemed most appropriate for none other than the award's namesake, Dr. Wagner, a pioneer in the specialty of Emergency Medicine, who, as a founding member of **AAEM**, continues to contribute enormously to the field. Originally, we chose to present an antique lantern to symbolize Dr. Wagner's career, lighting the way for others, warning of impending danger, and signifying vision for the future.

Those who know me wouldn't be surprised that 3 days before the assembly I phoned to notify George Schwartz that I still hadn't found an antique lantern worthy of the prestigious award. George, however, had been engaged as a key speaker at the *American Association of Physicians and Surgeons* annual meeting in Atlanta. Kathleen, his wife, and Corie Conwell, our organizational director, went into action, searching the numerous antique shops of Santa Fe for an award with a Revolutionary Era motif. Through a series of remarkable coincidences, she was led to a beautiful silver teapot made from melted coins, *that had belonged to a British colonial governor*. After engraving, she sent it to our hotel, just blocks from Independence Hall. Symbolically, the teapot, having been reclaimed by Revolutionaries from the hands of an oppressive government, was now being sent to our nation's birthplace to be presented to a modern-day revolutionary, Dr. Wagner, who ironically, a Quaker, was not a coffee drinker, but a tea lover.

I, however, was in a pickle! I'd prepared my presentation speech describing Dr. Wagner's career in context of a lantern, and on short notice found myself about to present him with a teapot! Ascending the platform I concluded, lantern or teapot, Dr. Wagner had picked up the musket a second time in his revolutionary career. Initially, he had gone up against powerful and divisive forces to create a new department, a unique set of physicians specializing in the emergency evaluation and intervention covering all disciplines. Now, years later, seeing disgraceful business practices putting the dollar above excellence, he again fearlessly picked up the musket, leading the way for others.

Dr. Wagner exhibits a rare combination of brilliance, determination and courage. For this reason the *American Academy of Emergency Medicine* proudly names its highest honor the ***David K. Wagner Award***.

COASTAL STONEWALLS AS STOCK FALLS!

Coastal vs. Schwartz and countersuit Schwartz vs. Coastal, the legal battle most closely watched by Emergency Physicians, continues to keep the specialty of Emergency Medicine hanging in the balance. Coastal, the *Goliath* of physician "*management*" services, initiated this attempt to eviscerate the movement which is currently restoring professional independence to Emergency Medicine decision-making. The economic giant is now *stonewalling* by refusing to provide critical documents, as required by law during the process of discovery. Interviewed by *COMMON SENSE*, Dr. Schwartz claims, on the other hand, he has freely and confidently provided the thousands of documents requested, stating *"I am looking forward to presenting the true facts in court!"*

Meanwhile, Coastal's stock continues to plummet from a yearly high of 42 down to a recent low of 22.5, its lowest price to date. One reason many think responsible for the plunge, is also noted by Schwartz in his answer to Coastal's attack, where reference is made to *"Increasing professional and public awareness of Coastal's poor conduct and abusive behavior."* Coastal recently moved to the more prestigious New York Stock Exchange after more than a year on the NASDAQ, and now arrogantly lists itself as **"DR"** ! The physician *"management"* service has the audacity to grant itself what would appear to the public as a professional title, the same title *you* achieved only through years of intensive labor and at great expense! According to a reliable source, Jack Page, President of Coastal Emergency Services, recently stated *the lawsuit his company initiated has become a* ***"can of worms."*** Interviewed by phone, Page, informed *COMMON SENSE he can't "confirm or not confirm" that he made such a statement.* As to the fall in stock price, he *could add nothing to "a story about anything having to deal with Dr. Schwartz" and the lawsuit.* He repeatedly stated *he desired to have corporate attorneys contact me in the morning to to answer questions,* but at press time a week later they have so far avoided my attempts for interview.

In related issues EMCARE joins InPhyNet on the NASDAQ exchange after an unusually long delay. Months had passed from the time of application and the official request by AAEM President Jim Keaney that the Securities and Exchange Commission require that blatant mistruths and serious omissions in their prospectus be corrected. However, upon final approval, millions of dollars immediately shifted into the pockets of those claiming to "manage" Emergency Physicians, the money coming from stockholders desiring to speculate on and share your professional fees. Such speculation on professional remuneration essentially has created a scenario in which stockholders may lie asleep at night in their warm beds dreaming about your ability to see as many patients as possible while minimizing expenditure. Poor medical care and the predictable injuries and deaths it can cause appear only as columns of red and black ink on the ledgers of accountants. As many of us are wearily driving home from a hard night of toil, well-rested stockholders are climbing out of bed and going to the front door for their newspapers. Over warm coffee they browse the business section to check our performance at the task they *"share"* with us. In these pages our professional concerns are translated into gains and losses in stock prices! And, realistically, how much concern could stockholders be expected to have for the welfare of our patients?!

Perhaps those of us climbing into bed this morning after a long night of saving lives and easing suffering can sleep peacefully dreaming that perhaps Coastal's ongoing decline in price, as well as InPhyNet stock selling for lower than expected are due to an awakening to the fact that profiteering from doctors' professional fees means ***not only bad medicine, but also bad business!***

by Drew Fenton, MD, Editor, *COMMON SENSE*

TRUTH, THE FIRST CASUALTY?

THE NEXT ISSUE OF *COMMON SENSE* WILL FOCUS ON THE ANATOMY OF A LAWSUIT AND INVESTIGATIVE REPORTING ON THE REPERCUSSIONS OF CERTAIN SPECIFIC LEGAL ACTIONS ON OUR FIRST AMENDMENT RIGHTS AND THE SPECIALTY OF EMERGENCY MEDICINE!

Scientific Assembly participants, including AAEM Officers and Board Members, convene at the ***City Tavern***, meeting place of the First Continental Congress in 1774. At this farewell luncheon the revolutionaries meet the revolutionaries.

Please keep Corie at our central office updated with current phone, and additionally, fax numbers. We are setting up a fax network to keep you informed of the latest events!

CARE FOR THE CAREGIVER

The second in a series devoted to professional wellness.

The Center for Physician Development in Brookline, Massachusetts evolved out of need. According to surveys done by the American Medical Association and the Robert Wood Johnson Foundation 35% to 50% of physicians surveyed would not choose a medical career if they had the opportunity to do so again. Such disturbing statistics indicate a national trend among physicians of dissatisfaction, burn out, and cynicism, all of which contribute to loss of self esteem and sense of life purpose. These issues have an impact on human relationships, family well being and security, and undoubtedly contribute to depression, substance abuse, and suicide in any population. For physicians there are the added factors of patient outcomes, quality of physician-patient interactions and medical malpractice, all of which are affected if the physician is not cared for. This is particularly true for Emergency Physicians who often find themselves practicing in isolation, in a specialty which does not provide for any emotional support, or even closure at the end of the work day or night. Emergency Medicine as a specialty suffers a greater than 12% attrition rate among practitioners, considerably higher than any other specialty, perhaps reflecting a common *angst*.

In 1992 the Center for Physician Development, an off-site program affiliated with Beth Israel Hospital and Harvard Medical School, was established to address the need. This program is committed to improving health care outcomes by designing support systems to maximize the clinical effectiveness, professional development, and career satisfaction of physicians. ***Caring for the care giver.***

Dr. Gigi Hirsch is the founder and director of CPD. As an internist-psychiatrist and former Emergency Physician she has taken the lessons of her personal odyssey of burn out and disillusionment to create a vehicle of support and hope for the physician. Dr. Hirsch states that *the **"culture of medicine"** encourages blaming the stressed physician for being inadequate and maladaptive, rather than addressing the sources and causes for professional unhappiness.* She goes on to say, *"The social scientists say that almost everyone, given the right set of environmental conditions will burn out."* In medicine, however, the distressed physician is the defective physician. Medicine also tends to point fingers at trends outside of the profession as the source of our discontent; for example, the insurance industry, managed care, consumer movements, and government involvement. *"It's the medical culture that makes it difficult for us to organize and communicate with each other and respond to the changes which are coming from the outside. We need to look at the cultural traits that make it hard for us to cope right now."* One cultural culprit, Dr. Hirsch says, is the concept of the *"patient comes first. But I disagree, and say that...*

"... if we don't take care of ourselves, we cannot reliably take care of our patients because of the toll that self-negligence will take on us."

It is an irony that those of us involved in EMS and rescue training programs emphasize the importance of not endangering the rescuer. The endangered paramedic or EMT adds to the casualty count as well as complicating subsequent rescue maneuvers. We physicians do not follow our own dictates. We endanger our physical and emotional well being while pursuing our *"careers."*

We all remember the **crucible of residency.** In return for temporary self denial and an altruistic goal, we were promised a life work rewarded with respect, professional status, collegiality, financial security, and autonomy. For many, particularly for Emergency Physicians, *the promise has never been fulfilled.* In confusion and disillusionment, we believe that the solution is to work harder and longer and more conscientiously. We become more alienated and more disillusioned when it is apparent that our ingrained coping skills do not produce the results we seek. Dr. Hirsch advises that we view our discontent as a career juncture rather than a career failure. This can be a signal to step back, reassess and reorient, and perhaps for the first time in our lives make conscious decisions and choices which support us as persons as well as physicians.

For every crisis there is an opportunity.

The varied crises occurring in the Emergency Department and our interest and ability to address them rapidly and effectively brought us to Emergency Medicine in the first place. The crisis of the acute myocardial infarction gives us the opportunity to use our knowledge and dexterity to save a life. The occurrence of a complication during that intervention requires that we reassess and make other management choices. So it is with our lives and our work.

The CPD offers a variety of programs and consultants for the clinician. Balint groups in continuing medical education is one such program. Balint groups bring together physicians and a psychoanalyst as group leader to discuss difficult physician-patient relationships, and emotionally disturbing cases; to provide support and feedback in relationships with administrators, families, and colleagues; to address issues of burn out and stress. Programs similar to the CPD are being developed elsewhere. Dr. John Henry Pfifferling established the Center for Professional Well Being in Durham, NC in 1979. Many managed care programs are now viewing the physician as an investment and see the value of addressing physician wellness. This is a welcome change in the attitude expressed by a medical director of a large regional HMO: *"It's not our job to provide them [doctors] with supports. The hospitals will handle those things. Or the professional societies... or the doctors themselves. If a doctor is having problems it usually shows up in our utilization review process. And then we just get rid of them."* Teaching hospitals and medical schools are now filling in this massive gap in medical training. Residents will learn how to learn from each other and how to facilitate each others work. This must occur with all physicians, for the benefit of our families, patients, and ourselves.

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Phyllis J. Troia, MD, Board of Directors
American Academy of Emergency Medicine
Emergency Medicine Relief Services

AAEM MISSION STATEMENT

The American Academy of Emergency Medicine is the specialty society of Emergency Medicine. AAEM is a democratic organization committed to the following principles:

- Every individual should have unencumbered access to quality emergency care provided by a specialist in Emergency Medicine.
- A specialist in Emergency Medicine is a physician who has achieved, through personal dedication and sacrifice, certification by the American Board of Emergency Medicine.
- The practice of Emergency Medicine is best conducted by a specialist in Emergency Medicine.
- The Academy supports the growth of residency programs and graduate medical education, which are essential to the continued enrichment of Emergency Medicine, and to ensure a high quality of care for the patient.
- The personal and professional welfare of the individual specialist in Emergency Medicine is a primary concern to the AAEM.
- The Academy supports fair and equitable practice environments necessary to allow the specialist in Emergency Medicine to deliver the highest quality of patient care. Such an environment includes provisions for due process and the absence of restrictive covenants.

AAEM ANNOUNCES ELECTIONS
A TRIUMPH FOR DEMOCRACY IN OUR SPECIALTY!

As a ***democratic organization***, we announce the opening of nominations for the officers of the ***American Academy of Emergency Medicine***, as well as for three positions on the Board of Directors. Officers will serve a two-year term and Directors, six years.

To nominate someone (including yourself) please contact the **AAEM** office to supply necessary information and send the nominee's curriculum vitae. Nominations may be made by anyone in **AAEM**, however, the nominee must be a full voting member (Board Certified in Emergency Medicine). The nominations will be closed March 15th. Within two weeks all voting members will receive the list of candidates and brief statements from each candidate declaring why they are appropriate candidates for that particular office. It is expected that candidates who are available will be at the candidates' forum at our Spring Meeting. Subsequent to that meeting, ballots will be sent to all voting members. The ballots will be closed and tabulated on August 15th. The Officers and Directors-elect will take office on April 30th, 1996.

Thank you for taking the time to make this democratic organization work.

George R. Schwartz, MD, FAAEM
Secretary, **American Academy of Emergency Medicine**

The American Academy of Emergency Medicine
invites You to participate!

Full Voting Member:_____$195
Resident or Fellow:_____$25
Lifetime Member:_____$2500
Associate Member:_____$100

AAEM
P.O. Box 1968
Santa Fe, NM 87504
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The American Academy of Emergency Medicine is a non-profit professional organization.
Our mailing list is private!

AAEM President Jim Keaney Available for Conferences

AAEM President Jim Keaney, MD, MPH is available for speaking engagements nation-wide, as are Dr. George Schwartz and other AAEM Officers and Board Members. Whether for Grand Rounds, Scientific Assemblies, or Society meetings, we are committed to quality Emergency Medical care as a public interest issue and freely commit our time and energies to achieve these most important goals. Dr. Jim Keaney, famous for his humorous and personable, and simultaneously unbridled straight-forward approach to significant contemporary issues in medicine, has been applauded at scores of Residency Programs and Medical Society Meetings, and invariably sets the stage for an insightful and fascinating debate on critical issues germane to not only Emergency Medicine, but to other fields. Current issues in Emergency Medicine are not only interesting, but, in the words of a *NEJM* reviewer,"become compelling as they predict changes in other specialties and serve as a wake-up call to physicians who remain unaware of the risks of inattention." Feel free to contact the **American Academy of Emergency Medicine**, P. O. Box 1968, Santa Fe, NM 87504 Tel:1-(800) 884-AAEM(2236) Fax: (505) 983-1733.

WHY CAN'T ACEP AFFORD TO LOBBY FOR DUE PROCESS?

by Scott H. Plantz, MD, Vice President, AAEM

At the 1994 assembly, several resolutions were proposed that could have changed **ACEP**'s course. Resolutions called for democratic elections, elimination of non-compete clauses, due process, and restriction of future membership to Board Certified Emergency Physicians. Many of these resolutions were based on the AMA's Code of Ethics. All were voted down or tabled. Even fundamental due process rights for Emergency Physicians, first introduced to **ACEP** by resolution in 1985, were again defeated.

David Siegel, MD, JD, Chair of NEMPAC and the Government Affairs Committee testified that ACEP did not have the funds to lobby for these resolutions. ***Dr. Siegel is also Chief Medical Officer of NES.***

Why doesn't ACEP have the money to lobby for due process? With 17,000 members, *dues alone generate over $7 million dollars!*

At the same conference I heard that the salary and benefits of Colin Rorrie, Jr., PhD, Executive Director of ACEP, was somewhere between $300,000 - $400,000. I thought this might be excessive and decided to look into the issue.

A letter to Rorrie resulted in a referral to ACEP President Dr. Aghababian. A call and letter to Dr. Aghababian resulted in a long awaited *"I'll get back to you."* As a law student, I found Texas statutory law suggested that non-profit organizations are obligated to release executive salaries. ACEP's attorney found a loophole. The bylaws for ACEP revealed the *"books of account"* are open to member inspection. This too was found not to include Rorrie's salary. Out of frustration, my attorney threatened to sue. Rorrie responded with the *ACEP News* article titled *"ACEP Staff Salary Structure."* Although the article does not specifically state his salary, it does indicate that the range is **between $173,500 - $263,000.** This does not include benefits or *"golden parachute."* **His salary, including benefits, could easily be over $350,000!** In review of the salaries and benefits of the top five bureaucrats of ACEP, none of whom are Medical Doctors, **over $1,000,000 is spent on these individuals alone.**

No wonder ACEP can't afford to lobby for due process!

AAEM ANNUAL FINANCIAL STATEMENT

THE AMERICAN ACADEMY OF EMERGENCY MEDICINE recognizes and appreciates the value of membership dues, and is committed to use these monies in a responsible and cost-effective manner to further the goals of the Academy as delineated in the Mission Statement. As such, the 1994 financial statement is available upon request to all members. Any suggestions or concerns will be welcomed and encouraged. The Officers and Board of Directors recognize the trust bestowed upon them by the membership's overwhelming financial support and other contributions, and wish to remind you that ***no economic remuneration is received by Officers or Board Members from AAEM,*** other than reimbursement for actual expenses incurred in crucial AAEM matters. In reality, the overwhelming majority of expenses incurred by Officers and Board Members has gone unreimbursed. These unreimbursed financial and time contributions represent that individual's personal and professional commitment to the Specialty of Emergency Medicine, and at times involves significant personal sacrifice. The knowledge that our specialty and the public welfare are in trusted hands warrants such sacrifice and is payment in itself.

REPORT TO AAEM ON THE 1994 ACEP COUNCIL MEETING

Held in Orlando on September 9th and 10th, 1994, the timing of the meeting was significant for its juxtaposition to the release of the Josiah Macy Foundation Report on the Future for Emergency Medicine. **The Macy Foundation Report** decried the state of Emergency Medicine specifically pointing out the shortage of board-certified Emergency Physicians. Members of **AAEM** who also hold membership in **ACEP** actively tried to seek reform of **ACEP** by proposing council resolutions. The issues of importance to **AAEM** that were voted on are as follows:

A. Board-Certification Issues:

Resolution 15 proposed by R. McNamara, MD and P. VanDevander, MD stated *"as of January 1, 1995 all new active members will be certified in emergency medicine or an emergency medicine sub-specialty by the **American Board of Emergency Medicine**."* Despite the fact that this would not exclude current **ACEP** members and in light of the **Macy Foundation Report** this was soundly defeated. Only 8 of over 200 Councillors, and no **EMRA** Councillors voted in favor of this resolution.

Resolution 26 submitted by an **ACEP Task Force** chaired by Michael Bresler, MD called for elimination of **ABEM** certification as a requirement for FACEP while opening a practice track type option for FACEP. However, despite the fact that other major specialty societies (**ACP, ACS, AAP, ACOG,** etc.) require board-certification for membership alone, *this resolution nearly passed.* Even more outstanding is the fact that *the large majority of the Councillors voted in favor of this!* Fortunately, as a By-laws amendment, this required a two-thirds majority vote to pass. The actual vote was 122 for (in favor of removing board-certification for FACEP), and 73 against. This failed to achieve a two-thirds majority *by only 8 votes.*

Dr. George Schwartz makes a point at the ACEP Assembly debate, which included Dr. John McCabe and Dr. Ian Cummings.

LETTER FROM THE SECRETARY

Let us indeed make 1995 The Year of the Emergency Physician. To do this we need your membership. We have a truly democratic organization. Perhaps some of you do not agree with one policy or another of AAEM. I understand that completely. However, as a democratic organization, change can occur every two years with the elections of officers and one-third of the Board of Directors. AAEM truly belongs to the members.

The January conference is unique and has a dazzling array of speakers. Interest is so high that some national news organizations will be in attendance. There is still time!!! We know it is "Super Bowl Weekend"and meetings have been arranged for those who do not wish to miss the big game.

Become a Founding Member or a Founding Member and Fellow in the American Academy of Emergency Medicine. Join those who will be leading the field and unifying all the elements into a concerted thrust. Unification of vision is a key phrase. We are free of debilitating third party interests and our overhead is so low we don't need to sell out or make financial compromises.

AAEM has a contract with America and a contract with American Emergency Physicians in 1995. We will focus on Resident and Colleague Education, Malpractice Reform and Surveillance, AMA liaison and the JCAH, Elements of the Anti-Profiteering Act, Managed Care and Capitation Guidelines, Due Process for Emergency Physicians, and Cost-Conscious Health Care Reform. Our committees and task forces are formidable. Don't expect wishy-washy statements or pronouncements. We are out to make a difference. JOIN US!!!

George R. Schwartz, MD, FAAEM, Secretary of AAEM

B. Practice Issues:

There were several resolutions proposed by **AAEM** members regarding restrictive covenants and due process. Resolutions 50 and 51 authored by Drs. Scott Plantz, Chris Minis, Robert McNamara and Patricia VanDevander called for **ACEP** to lobby state and federal governments for a ban on restrictive covenants. **AAEM** members testified regarding the importance of this issue to individual emergency physicians. This resolution was soundly defeated largely due to the testimony of David Siegel, MD, JD who spoke as the Chair of **NEMPAC** and the **ACEP Government Affairs Committee**. Dr. Siegel testified that this effort would be costly and would divert funds from other lobbying efforts. ***Dr. Siegel failed to disclose a major conflict of interest, that he is Chief Medical Officer for NES, a large contract management group.***

Resolutions 52 and 54 by the same authors included similar wording as the above resolutions regarding the unethical use of due process exclusion classes in Emergency Medicine. *Again Dr. Siegel's testimony led to the sound defeat of these resolutions.* Resolution 53 stated *"that the lobbying efforts of ACEP should be directed toward Federal legislation which would bar the sale of emergency department contracts."* There was no support for this and was **defeated in a near-unanimous vote.**

C. Structure Issues:

In order to make ACEP a more democratic organization **AAEM** members prepared the following resolutions:

Resolution 14 proposed by Robert McNamara, MD and Patricia VanDeVander, MD called for all state **ACEP** Chapters to only *"elect"* rather than *"elect or appoint"* their Councillors. Many states including California and Pennsylvania have the Councillors appointed by the state Board of Directors. Therefore, the *"representatives"* of the members are never elected. This resolution was defeated by a near unanimous vote. Resolution 30 originally called for the President of **ACEP** to be elected by the members. **There was no support for this**, however, a modified resolution passed that will bring up the question of election of the President by the Council for the 1995 meeting.

D. Other Issues:

Three members of the **AAEM** Board of Directors, Drs. George Schwartz, Scott Plantz, and Robert McNamara were nominated for the **ACEP** Board of Directors from the floor of the Council. They ran on the issues of board-certification, fair and equitable practice arrangements, and service to the individual practicing Emergency Physician. None of these candidates were successful in their campaigns.

AAEM members expressed concern about the wording of proposed resolutions that called for lobbying the government. Unfortunately, claiming potential anti-trust actions, **ACEP** would not allow discussion of restrictive covenants, due process and the sale of emergency department contracts unless this was worded as a call for lobbying.

E. Summary

The earnest attempt of **AAEM** members to bring **ACEP**'s structure and philosophy more in line with **AAEM** was met with overwhelming rejection by the **ACEP** Council. The issues of board certification as a defining characteristic of a specialist in Emergency Medicine, provision of due process for Emergency Physicians and limiting the use of restrictive covenants at present remain a priority focus of only one organization in Emergency Medicine, **The American Academy of Emergency Medicine.**

Submitted by Robert McNamara, MD, AAEM Board of Directors

PEER REVIEW - IS IT ALWAYS DUE PROCESS?

by John Libby, MD
AAEM Board of Directors

"A procedure which permits the prosecutor to select the evidence which it will divulge, determine whether legal representation will be permitted, shift the burden of proof, permit a witness for the prosecution to participate in the jury deliberations, and limit judicial review to a search for substantial evidence supporting the verdict is neither fair nor reasonably calculated to determine the truth." (California Medical Association, April 1988)

In keeping with AAEM's Mission statement, access to ***equitable*** peer review is germane. We cannot provide *"highest quality of care and optimally serve our patient populations"* unless we are provided equal and affordable access to the protection of the laws and precedents that govern professional conduct. There is no discipline of medical practice that has a more circuitous path to obtain protection of existing laws than Emergency Medicine.

The Semmelweis Society is a group of multi-disciplined physicians dedicated to educating physicians and other health care professionals about unbiased peer review and how to establish such a process to maintain high professional standards while protecting the rights of all physicians who become involved in the process. Founded in 1986, it has over 400 members nationwide who believe that good faith peer review is essential to promoting and maintaining professionally recognized standards of health care. The accompanying text of an editorial in the American Journal of Surgery, July 1994, by Dr. Verner S. Waite, MD and Robert Walker, JD is a concise and critical review that warrants the close attention, understanding, and serious contemplation of all engaged in medical practice. Dr. Waite has agreed to make a presentation at our AAEM conference in San Francisco, January 27-29, 1995.

MEDICAL AND SURGICAL PEER REVIEW

by Verner S. Waite, MD, FACS, Robert Walker, JD

In medicine it is commonly found that asking 10 doctors for an opinion on medical care will result in at least 5 different suggestions. Peer review in medicine is conducted where validated guidelines often do not exist. There is still an ongoing study about tonsillectomy indications, with confusing ideas after many decades. Validated criteria are rare. With such lack of medical agreement, it is not surprising that peer review is often a contest of opinions. Unfortunately, it often has severe effects on a doctor's career. An adverse peer review is far more serious than a large malpractice award. The process has several sources for serious bias.

First, doctors on the same staff act as a jury in the case of another physician about whom they may have heard a great deal. Those bringing the charges often have enough influence within a hospital that finding against their view may be like committing professional hara-kiri. Second, the entity involved, usually the hospital or its medical staff, appoints the hearing officer. This person often has very warm feelings for the entity or does regular work for the entity and is compensated handsomely. Third, hearsay evidence is allowed. Opinions, and perhaps "facts" that can not be substantiated, are treated as legal fact. Fourth, there is no ability to overcome a hospital's refusal to provide supporting evidence or a comparison of habits and results of colleagues not under review. Fifth, the reasons for the hearing do not have to be specific.

In summation, one may be faced with a jury selected by one's accuser, as is the judge; prohibited access to evidence; vague charges; and a controversial opinion. No one should have trouble identifying this kangaroo court!

Now contrast this process with a malpractice trial. Here the judge is not selected by either party, and the jury is composed of strangers. No hearsay evidence is allowed. Both sides have a right to discovery, and subpoena powers exist. Crucially important, the charges are very specific.

Our forefathers formed the Constitution and the Bill of Rights when the Inquisition was still affecting the daily lives of many. After 200 years we no longer appreciate how very important these concepts were. Exceptions now are the over 1,000 doctors who have been expelled from a medical staff. Many have been suspended for trivial reasons, such as standing on the patient's left when doing a cholecystectomy, when the chief favored the right. Surgeons who have uneventfully, and safely, done vascular procedures using techniques that include trivial differences have lost privileges. Doctors may be denied privileges because they have not done a newly selected number of cases. Of course, those determining the critical numbers often did not fulfill that requirement either. Turf is more dear day by day!

Fortunately, the federal courts are not allowing the immunity that perpetuated the Inquisition that lasted 700 years. One physician's shabby, unprincipled, and unprofessional review was exposed. Another was not forced to sign a sham contract and his "143 cases of substandard care" were found exemplary. A pathologist was not forced to give 11% of his gross income to the hospital administrator, and his colleague's false testimony was exposed. These are three examples from 400 with which we have been directly involved.

Currently, 1 in 20 physicians will undergo the peer review process. One in 5 will serve on such a committee. Contract physicians will often be asked to serve, for their contract is at risk with no peer review rights. Hospitals are using peer review as the tool to serve their business interest more and more. Ethical and excellent medical practices can be at risk.

The Semmelweis Society simply supports peer review with "clean hands." We believe the jury should be wholly comprised of outside peers. Evidence never presented during the examination is not to be considered and given weight during the deliberation phase of the hearing. This occurs when the accused is known to those sitting in judgment. The shadows raised by commonly known, but untrue, malicious gossip are hard to fight even if never identified. They should not influence the outcome. We wish written, agreed upon guidelines for practice recommendations, in contrast to ex post facto rules that reflect the whim of the reviewers. Our bylaws are the only shield to protect a doctor from abuses we see in over 50% of medical peer reviews. Most are based on economic concerns, not bad medicine! Bylaws may be boring but are crucial to one's well being. There should be national standard bylaws rather than differences that favor the maintenance of monopolies. We wish data-driven peer review, thus there should be access to the computer data on unidentified colleagues on the staff. Physicians should not be second class citizens, but should have the same rights as those guaranteed by a malpractice trial. An adverse peer review often leads to progressive expulsion from all hospital staffs; a "domino" effect. This is based on an "extended liability" concept that allows a flawed peer review, at only one hospital, to be used as the sole reason for expulsion at all hospitals.

This process is expensive, averaging $100,000, that is if one wins in the hospital! Physicians making the charge spend no money, but much time.

The profession of medicine is under attack. In the process no physician is safe from the abuse of peer review. We encourage physicians to examine their bylaws and to look at our collegial behavior. Who is brave enough to stand against an opinionated chief of any department, when the bylaws give minimal rights and state laws give the accuser immunity?

We need to draw together behind the bulwarks of the Constitution, and good bylaws, in these economic hard times. Splitting into warring camps plays into the hands of the many business and economic interests attacking quality medicine and surgery.

AAEM booth at ACEP meeting in Orlando, FL, with supporters, (from left) Minas, Schwartz, Buffaloe, Troia, and unsung heroine Gail Hubbel, MD, whose efforts made the display happen.

EDITORIAL COMMENTARY

"Popularity Contest"

by Christopher J. Minas, MD
Board of Directors
American Academy of Emergency Medicine

In my wildest dreams, I would never have imagined that a physician's professional abilities would be judged as a *"popularity contest!"* Let me explain.

Many hospitals are employing lay people to phone patients who have been seen in the Emergency Department to ask how they "liked" their doctor. They often use a questionnaire similar to what one would expect from a restaurant chain soliciting comments about the service. *"Was your food served promptly? Was the waiter courteous? Did your waiter identify him/herself? Did you enjoy your food?*

The physician is being evaluated as a ***"waiter"*** emphasizing the philosophy that *"the customer is always right,"* overlooking the critically more important *"doctor-patient"* relationship, with its inherent primary obligation to the patient's well-being. Physicians are being rated primarily on the basis of their popularity, often completely disregarding their level of medical expertise. This philosophy should not be employed in such a manner because a patient's desires may, at times, directly oppose the provision of quality medical care. For example, if a patient presents to the Emergency Department seeking narcotics, the physician *may* feel the request is inappropriate and should then refuse it. Is the patient satisfied? Substance abusers and patients with psychiatric disorders may complain (sometimes with little or no merit) about their treatment, but the physician should exercise his medical judgment. Circumstances may dictate that the Emergency Physician cannot devote his full attention to any one patient at a given moment. A patient may feel neglected, while the physician is doing his best to differentiate true emergencies from non-emergent and minor cases and treat them accordingly. Simply put, the average patient is not unbiased as relates to medical treatment and understanding of the Emergency Department and is not qualified to review the appropriateness of medical care.

And yet, this *"popularity contest"* is used by some hospitals to help evaluate the physicians practicing in the Emergency Department. Many hospital administrators are inappropriately using customer relations questionnaires to monitor and supervise Emergency Physicians, and are thereby interfering with the practice of medicine. This business practice undermines the autonomy of the physician and intrudes upon the doctor-patient relationship.

A physician's primary concern must be to provide the highest degree of medical care and to do what is best for the patient. *"Satisfying the customer"* is an important goal, but a physician's primary obligation is to treat and protect the patient and to relieve pain and suffering. This is what society expects of us; this is the oath we have sworn to uphold. Primary emphasis on *"popularity"* and *"customer relations"*, over the physician's more important obligations to the patient is sophomoric, unprofessional, and dispiriting, and undermines the honored traditions of medicine. I maintain that only physicians are qualified to evaluate their peers and to determine how medicine is best delivered to the public. Complaints specific to medical care should be evaluated in a peer review setting by the Emergency Department medical staff.

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