How Many Emergency Physicians Does It Take to Change a Light Bulb?

Andy Walker, MD FAAEM
Editor, *Common Sense*
AAEM Board of Directors

I will answer that question eventually, but first a warning. The words below are my personal opinion only, not the position of the American Academy of Emergency Medicine. If you think I am an idiot after reading this, I hope you will write a nasty "Letter to the Editor" and tell me so. If you agree with me, I hope you will tell me about that too. In either case, however, know that I am speaking only for myself and not our Academy.

The real question I want to address, and one far more important than the title of this column, is how many emergency physicians (EPs) does it take to staff an emergency department (ED)? A larger form of that question is how many EPs does the United States need? Serious academic papers have wrestled with this issue, formal debates have been held on it, and on page 30 in this issue of *Common Sense*, Dr. Jonathan Jones takes another thoughtful look at it. I agree with all six of his ground rules for discussing emergency medicine's workforce issue, but one particular sentence in his editorial jumps out at me: "It's time we started exploring the problem and proposing realistic solutions." Indeed.

So let's be realistic, and once again ask, "How many EPs does it take to staff an ED?" Well, that depends. On what? On how many ED patients actually need an **emergency physician**. In other words, how many have an acute injury or serious illness?

Perhaps a thought experiment will help answer the question. Assume that every single patient who comes to the ED in question has either an acute injury or serious illness. Not one has chronic back pain (or any other chronic, stable problem without any acute change at all), not one is a prescription drug addict who just wants another prescription, not one has what is obviously a simple cold, etc. Every single patient in the ED is injured or sick — really sick. In that case, obviously, the ED needs as many EPs as it takes to see every single patient quickly and efficiently, and nonEPs — whether physicians trained in other specialties, physician assistants (PAs), or nurse practitioners (NPs) — have no front line role in the ED at all.

There might have been a time when America's EDs were like that, but I don't remember it. EMTALA became law while I was a resident. It was well-intentioned and necessary. Now, as then, I am embarrassed that medical ethics had to be written into law. Unfortunately, however, by guaranteeing everyone free medical care in the ED — and if you have no intention of paying the bill and payment cannot be demanded up front, the care is free — EMTALA turned many EDs into primary care clinics. So, let's imagine the other extreme in our thought experiment. Assume that not a single patient with an acute injury or serious illness **ever** passes through the ED. Every single patient has nothing more than an obvious cold; ordinary menstrual cramps (every month, like clockwork); chronic, stable, unchanging back pain; prescription drug addiction without anything new or different going on; simple anxiety, and not even a panic attack; etc. In that case, obviously, the ED doesn't need even one emergency physician and can be staffed entirely by people with a lot less training, such as nurse practitioners.

Of course reality lies somewhere between these two extremes. The practical question we must then consider is this: **What percentage of an ED's patients must have flagrantly trivial problems, before staffing that ED entirely with emergency physicians becomes impractical — especially when few of those patients pay their bills?** Is it 30%, 60%, 75%, 90%? I have worked in a variety of EDs, ranging from academic trauma centers to community trauma centers to other busy community hospitals to very slow rural EDs. I can tell you that even in the busiest academic, urban, trauma centers at least 30% of patients have obviously minor problems. Medical problems so minor the patients themselves know they don't need emergency care — but it's easy and free, so why go anywhere else? In a low-volume, rural ED in Tennessee the percentage might be as high as 75%, or maybe even higher given the number of patients I see whose only reason for coming in is prescription drug abuse and the desire for more Xanax, Soma, and Lortab ("the Tennessee Trifecta").

Remember now, I am not talking about chief complaints that could represent serious illness but turn out to be minor problems, such as the pleuritic chest pain that turns out to be musculoskeletal instead of a PE. I am talking about flagrantly trivial medical problems, the kinds of things patients wouldn't come in for at all if they were charged just a few dollars, and from which they would never suffer any lasting ill effect. Not just the kinds of things that don't need attention in the ED, but the kinds of things that don't need any medical attention, ever.

Right now economics is settling this issue for us. Because so many ED patients don't require the knowledge or skill of an emergency physician, and because their ED bills are paid only partially or not at all, mid-level providers and family medicine physicians are filling many ED jobs. After all, how many of you would work in an ED for $100 an hour or less? And if you could work in an ED for an entire year without intubating a single patient, would you say that ED actually needed an emergency physician?

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Our specialty's manpower issue isn't that we can't staff every ED in the country with emergency physicians. It's that so many patients in most EDs don't need an emergency physician at all, and don't pay enough to fund one. Our specialty has yet to face up to this ugly reality, and has yet to adjust the number of residency programs and slots accordingly. I believe we have two choices. We can either continue towards our goal of filling every emergency medicine job in the United States with an EP — accepting a huge cut in average pay in the process — or we can accept a future in which EPs spend most of their time supervising PAs and NPs, intervening in only the most serious or difficult cases. If we choose the latter, we are going to need far fewer emergency physicians than we thought.

I remember a time when it was hard for anesthesiologists to find a good job in this country, because their specialty didn't adapt quickly enough to the impact of nurse anesthetists. I would hate to see emergency medicine go through such a painful phase before facing reality. We must consider our workforce issues in light of how many ED patients need only the most routine kind of primary care, and in light of the charity burden we bear in the ED.

And now the answer to the question in the title, "How many EPs does it take to change a light bulb?" One — along with a good nurse — because an emergency physician with one good nurse can do anything. ■

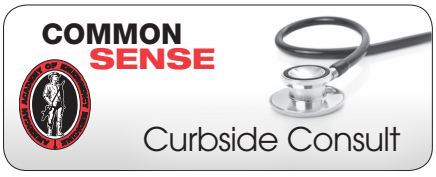
Call for Assistant Editor — Join the *Common Sense* Team

Common Sense needs an assistant editor. I am looking for someone who enjoys reading and writing, who is passionate about AAEM's values, and who is dedicated to fighting for individual emergency physicians, our specialty, and our patients by spreading news of the Academy and growing its membership. Responsibilities include editing articles for accuracy, grammar, and to some degree, for style. Our goal in editing is to make every article an easy and interesting read while leaving the author's original voice and intent intact.

The assistant editor will always edit the "Resident Journal Review," as well as anything else I need help on, and write an occasional "From the Editor's Desk" column when I need a break. An important part of the job will be to recruit authors and solicit interesting material to publish. I hope the assistant editor will also contribute ideas on how to make *Common Sense* more interesting, useful, and popular to AAEM members.

If you are interested, please contact either me (cseditor@aaem.org) or Laura Burns (lburns@aaem.org) and explain why you want the job and think you would be right for it. A sample of your writing would be appreciated. Note that this is a volunteer job, just like all AAEM leadership positions — including my own. ■

We're listening, send us your thoughts!



Letters to the Editor

Andy Walker, MD FAAEM
Editor, *Common Sense*
AAEM Board of Directors

A "Letters to the Editor" feature is now available on the *Common Sense* section of the AAEM website. Members must log in 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

Letter in response to January/February "AAEM News" feature titled "Missouri Lawmakers Relax Volunteers' Medical Malpractice Liability":

Greetings Dr. Walker!
I was encouraged when I saw on your note on the article "Missouri Lawmakers Relax Volunteers' Medical Malpractice Liability" that AAEM supports redefining malpractice as gross negligence for providers of EMTALA-mandated care. Georgia is a state which has legislated along those lines (see the article on this same issue "Medical Liability and the Emergency Physician: A State by State Comparison — Part 2").

Emergency Physicians Monthly, March 2014 issue, published the article "'Gross Negligence': A Slippery Slope for Dubious Expert Testimony" (www.epmonthly.com/features/current-features/gross-negligence-a-slippery-slope-for-dubious-expert-testimony/). Imagine my surprise and dismay when the "dubious" expert witness was identified as Dr. Peter Rosen. I do not know if this is THE Dr. Peter Rosen. However, I believe these physicians' expert testimony should be evaluated by the Academy for accuracy and veracity. If the testimony is found to be appropriate then the article in *EP Monthly* needs a response. If, on the other hand, the testimony is deemed to be appropriate, then the Academy needs to make at least a statement. Furthermore, if the expert witness is a member of the Academy, then some sort of action needs to be taken. The Academy cannot allow rogue members to sabotage and undermine its strong work.

Your comments on this matter will be greatly appreciated.

Hector Peniston Feliciano, MD FAAEM

Thank you for your letter. I not only enjoy hearing from AAEM members, by contributing your voice you make our Academy stronger and *Common Sense* a better read. The case you mention is an important one.

Obviously important for emergency physicians and others who provide EMTALA-mandated care in Georgia, but important for such doctors across the country because of its implications for fundamental tort reform everywhere. And tort reform doesn't get any more fundamental than redefining malpractice for government-mandated care as gross negligence rather than ordinary negligence. Properly understood and traditionally defined in common law, gross negligence is the kind of mistake all of us would agree is malpractice — the kind of thing an injured patient should indeed be fairly compensated for, and often the kind of thing that should attract the attention of a hospital's Peer Review/Quality Assurance Committee and a state licensing board. While in theory ordinary negligence is defined as behavior that is unreasonable under the circumstances, in reality it is too often defined in America's courtrooms as any bad medical outcome, even when the medical care in question was perfect. And that isn't just my jaded opinion. Studdert, et al. (*New Engl J Med* 2006;354:2024-33) showed that 40% of malpractice claims involve either no injury at all or no error at all — not just no negligence, but no error of any kind. Yet 16% of no injury claims and 28% of no error claims still result in a payment to the plaintiff and for the latter those payments average over $313,000. And since that was a decade ago, the average payment is certainly higher now. In practical terms this means that any bad outcome can result in a lawsuit that has a reasonable chance of ending with a payment to the plaintiff — and that is the problem. That is what drives us to waste untold resources on defensive medicine — tests and treatment designed to protect us rather than our patients.

Caps on noneconomic damages, which seem to be the most popular tort reform, won't fix that problem. Other reforms, such as expert witness reforms and a "loser pays" rule (known as the English Rule and in effect in every country in the world but the U.S.) might help, but they won't eliminate the problem either. Only redefining malpractice as gross rather than ordinary negligence has the potential to truly correct the problem, and to allow us to practice emergency medicine with the knowledge that we cannot be successfully sued unless we have actually done something wrong.

In the case you cite, news reports (including the article in *Emergency Physicians' Monthly* that you mention) make it appear that the plaintiff's experts called the defendant emergency physician grossly negligent, when I think most of us would argue about whether he was even guilty of ordinary negligence. If expert witnesses successfully redefine ordinary negligence as gross negligence, this profound tort reform will be completely undone. That is why this case is so important.

AAEM cannot publicly comment on any active case until after the conclusion of litigation. During litigation we can get involved by writing an amicus curiae brief or by offering our own expert testimony. The case has been reported to the AAEM Legal Committee as a possible example of remarkable testimony, and the Legal Committee will evaluate the case to decide if the experts' testimony should be posted on the Academy's

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Remarkable Testimony website after the conclusion of litigation. As always, if their testimony is deemed remarkable the expert witnesses will be invited to post an explanation of their testimony or rebuttal to the Legal Committee's findings on the same website.

— The Editor

Letter in response to March/April "From the Editor's Desk" article titled "Malpractice":

Dear Dr. Walker,

I am a recent EM graduate and current critical care fellow and was reading your article on malpractice in the current issue of *Common Sense*. Overall I very much enjoyed reading it and wanted to thank you. I also wanted to say that I was struck by your comment that academic physicians are likely not appropriate as expert witnesses for many community cases. I've simply never heard this idea proposed before of having academics separated from community providers as expert witnesses in malpractice cases, but I am both curious by it and think that it deserves more consideration. The risk, as I see it, is that the attitude starts to subcategorize EM physicians into such small subspecialties that it may be eventually detrimental in urban settings to our breadth of competence (such as we see with many urban anesthesiologists or general surgeons not being able to practice in cases where they are not subspecialty certified [peds, thoracic] because a subspecialist could be obtained), I think overall we are so far from even having specialty specific rules for expert witnesses across the board that we have a while to go.

Overall your proposal is interesting and thought provoking and I wanted to thank you for it and am curious to see where it goes. Do you plan on writing further about it or advocating for this?

Thank you also for your work as Editor. I thoroughly enjoy reading the magazine.

Sincerely,
Joseph

Joseph Tonna, MD
Critical Care Fellow
University of Washington

Thank you for your letter, and I understand your concern. I felt the same way years ago as I watched the rise of pediatric emergency medicine. After all, emergency physicians are experts in pediatric emergencies — just as they are in adult emergencies, medical emergencies, surgical emergencies, etc. If it's an emergency — whether it occurs in a man, woman, adult, infant, child, or octogenarian — it's part of our specialty. If we have been properly trained in emergency medicine, then we have been properly trained in pediatric emergency medicine. Now, however, in some quarters even board-certified emergency physicians are looked on as second class providers of emergency care to children — a completely ridiculous and unjustified position. I definitely don't want to further fragment our specialty so that individual emergency physicians are allowed to do less and less, limiting their practices more and more — which, as you pointed out, is what happened to general surgeons. I do indeed see the risk that worries you.

I would not have thought academic physicians were unqualified to comment on the standard of care in community hospitals, had I not seen it with my own eyes. Since becoming an expert witness myself, both deposition and trial testimony from academic physicians has convinced me that most of these experts have no idea what it is like to practice in a small, community hospital ED. They have wildly unrealistic expectations in regard to the time and difficulty involved in getting a consultant to come in or admit a patient, in transferring a patient, in getting a CT scan interpreted, in obtaining an ultrasound or MRI, in obtaining rarely used or expensive drugs, etc. I believe the reason for this is that most academic emergency physicians go straight from residency into an academic attending job, never leaving the academic cocoon. They never practice "in the real world" of a community hospital ED where they don't have multispecialty back-up 24/7. Since the standard of care is what a reasonable physician would do under similar circumstances, not understanding the circumstances makes most academic physicians unqualified to testify on the standard of care in a small, community hospital. I am not saying they couldn't have taken excellent and proper care of the patient, or that they are inadequately trained, so I hope I am not furthering the fragmentation of our specialty — a problem that worries me as much as you. I am saying that if they do not regularly experience the circumstances then they don't understand the circumstances — and thus do not understand what the standard of care is in those circumstances.

In the infantry every general started off as a soldier in the trenches, usually a platoon leader, so he knows what is involved in leading 30 men against a machine gun nest. In emergency medicine, however, few of our academic leaders have ever been by themselves in that lonely outpost, the single-coverage ED where the emergency physician isn't just the only doctor in the ED, but the only doctor in the entire hospital - caught between caring for the ED patient with chest pain and answering a code on the floor at the same time. Those who haven't been there don't know what it is like, and aren't qualified to criticize those who are there.

In answer to your final question, I do plan to seek tort reform in my state so that only board-certified emergency physicians can testify on the standard of care in emergency medicine. Even now I counsel any attorney who retains me that he should attempt to have expert witnesses who are radiologists, cardiologists, neurologists, etc. barred by the court when they are seeking to testify on the standard of care for an emergency physician. That attempt is usually unsuccessful. On the other hand, I have seen more than one case in which an academic expert was barred from testifying because of his lack of understanding on the standard of care in a small, nonacademic ED. It all depends on the judge involved, and the quality of the lawyers' arguments. Thanks again for your letter and your kind words for me and *Common Sense*.

— The Editor

Letter in response to March/April "From the Editor's Desk" article titled "Malpractice":

Wow. Loved your piece in *Common Sense* on malpractice. Right on.

Judith E. Tintinalli, MD MS FAAEM ■