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PRESIDENT'S MESSAGE

Making Cents of Overcrowding

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The Institute of Medicine (IOM) released "The Future of Emergency Care in the United States Health System" this past summer, emphasizing the degree of patient overcrowding we are experiencing. The U.S. Department of Health and Human Services published a related report on September 28, 2006, stating that up to half of emergency departments experienced overcrowding in 2003 and 2004, defined in part as when urgent patients wait more than an hour. Both studies overlooked an important cause of overcrowding, intentional understaffing of emergency physicians by emergency services contract holders.

Understaffing is a typical consequence of fee-splitting, a common emergency medicine practice whereby the contract owner takes an excessive portion of the revenue generated from physician fees, well beyond fair market value for management expenses and overhead. Simply stated, corporate profit is derived from physician fees. By eliminating fee-splitting from the cycle of emergency patient care, more resources can be focused on care delivery at essentially no additional cost to the general public.

When you analyze how each dollar of revenue for an emergency physician group is spent, roughly 70 cents goes toward clinical salary, a composite of hourly wage and staffing levels. The next largest portion, about 12 cents, goes toward professional liability insurance. This amount is relatively fixed by market rates with some regional variability. In states without caps and high award amounts, this number increases and salary commensurately decreases. The next portion, about 8 cents, pays for coding, billing and collecting, which is also fixed by market rates with some regional variability. In my opinion, a healthy amount for administration and practice management is 10% of clinical salary, so 7 cents. Only 3 cents covers all other business expenses.

With this simple accounting model in mind, think of fee-splitting as an attempt to squeeze out a nickel or dime. In a setting with closed books, the cost of liability insurance or coding, billing and collecting can be exaggerated. More commonly however, the profit margin is "created" by a reduction in clinical salary. To secure good emergency physicians, the hourly rate must be competitive so decreased staffing levels is more prevalent. If the number of patients per physician per hour (PPH) were at two and a half, the recommended maximum for a comprehensive emergency department, a 10 cent carve out increases the PPH to about three and worsens overcrowding, with increased waits, cursory evaluations and too many handoffs to the oncoming physician.

Hard evidence of fee-splitting exists. For example, EmCare, a large provider of emergency physician services, with 329 contracts in 39 states, is responsible for over 5 million annual patient visits and employs 4,500 physicians. The primary revenue source is emergency physician fees, and the total compensation of its non-physician CEO reported in 2005 was $23M. This particular corporation, responsible for a large portion of the emergency medicine "safety net," is owned by venture capitalists.

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The following passage is found in EmCare's 2005 SEC filing. "Regulatory authorities or other parties, including our affiliated physicians, may assert that, we are engaged in the corporate practice of medicine or that our contractual arrangements with affiliated physician groups constitute unlawful fee-splitting. In this event, we could be subject to adverse judicial or administrative interpretations, to civil or criminal penalties, our contracts could be found legally invalid and unenforceable or we could be required to restructure our contractual arrangements with our affiliated physician groups."

To repair the frayed emergency medicine safety net, profit derived from fee-splitting must be reclaimed and used to fortify emergency physician staffing levels, the primary factor in patient safety. The federal government must enforce existing laws prohibiting fee-splitting and hold those contract management groups accountable. AAEM is working to focus the political spotlight on this tax-free solution to emergency department overcrowding.

AAEM Mission Statement
The American Academy of Emergency Medicine (AAEM) is *the* specialty society of emergency medicine. AAEM is a democratic organization committed to the following principles:

1. Every individual should have unencumbered access to quality emergency care provided by a specialist in emergency medicine.
2. The practice of emergency medicine is best conducted by a specialist in emergency medicine.
3. A specialist in emergency medicine is a physician who has achieved, through personal dedication and sacrifice, certification by either the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM).
4. The personal and professional welfare of the individual specialist in emergency medicine is a primary concern to the AAEM.
5. 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.
6. The Academy supports residency programs and graduate medical education, which are essential to the continued enrichment of emergency medicine, and to ensure a high quallity of care for the patients.
7. The Academy is committed to providing affordable high quality continuing medical education in emergency medicine for its members.

Membership Information
Fellow and Full Voting Member: $365 (Must be ABEM or AOBEM certified in EM or Pediatric EM)
Emeritus Member: $250 (Must 65 years old and a full voting member in good standing for 3 years)
International Member: $125
*Associate Member: $250 (Associate-voting status)
AAEM/RSA Member: $50 (Non-voting status)
Student Member: $50 (Non-voting status)
*Associate membership is limited to graduates of an ACGME or AOA approved Emergency Medicine Program

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