Responsibility and Authority

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

Later in this issue of Common Sense you will find “Metric Madness.” It was written by a member of our Academy who asked me to publish it anonymously, because “I need to keep my job for now.” As you can see, I agreed. It tells a story that is sad for several reasons, and addresses issues that are critical for our specialty, the quality of patient care in our EDs, and for the medical profession in general. I urge you to read it carefully and make it known to your colleagues who aren’t members of AAEM.

I am a simple guy, and as my IQ drops with age, my thinking gets even more simple. In reading “Metric Madness” I was thus struck by two simple, fundamental ideas. The first is duty. Whether it was the Hippocratic Oath, the Oath of Maimonides, the World Medical Association’s Declaration of Geneva, or some other oath or declaration — all of us have pledged upon our honor to do the best thing for our patients, putting their health above our own interests. Among other things, this imparts on us a duty to advise patients honestly on what is best for them, even if they don’t want to hear that — and even if it hurts our patient satisfaction scores (a good example of a bad idea).

In the modern world of emergency medicine, however, our duty to act in our patients’ best interest means much more. It means when someone — whether out of greed, stupidity, or ignorance — wants to change how we practice medicine in a way that hurts patients, we must resist. We must object. We must fight back. That is why our colleague wrote “Metric Madness.” That is why I am an active member of AAEM and its Tennessee chapter (TNAAEM). That is why I agreed to be the editor of Common Sense. These are my ways of fighting back against all the forces that interfere with my ability to exercise my professional judgment in the best interest of my patients.

For most of my career I never wanted to do anything but take care of acutely injured and seriously ill patients in the emergency department. And truly, that’s still all I want to do. I don’t want to do clinical research. I don’t want to be an administrator. I don’t really even want to be involved in organized medicine. I feel compelled by duty to be active in AAEM and organized medicine. Most of all by a duty to my patients, but also by a duty to those emergency physicians who came before me and established our specialty, and to those who will follow me.

When a hospital administrator comes up with a bad idea that will lower the quality of care in your ED, you and your colleagues have a duty to try and stop him — not by directly opposing him, but by figuring out what he really wants to accomplish and coming up with a more realistic and constructive way to get there — a way free of all the disastrous unintended consequences that administrators seem to generate. When our malfunctioning legal system pushes you to put patients through unnecessary testing and treatment for your own protection, resist by seeking tort reforms that will reduce or eliminate defensive medicine and its horrible waste of resources. When government bureaucrats or insurers want you to do things that are dangerous or wasteful, object loudly and publicly. Write your local newspapers and elected officials. Maybe even write for Common Sense. But whatever you do, when someone wants to interfere with your ability to do what you think is best for your patients, do something!

The other fundamental idea that struck me in reading “Metric Madness” is how the link between authority and responsibility has been severed in medicine. All specialties suffer from this phenomenon, but it seems most severe in emergency medicine. As usual, we are the canaries in the coal mine.

Up until as recently as the beginning of my own career, physicians were in charge of medical care. Quite fairly, we were also held responsible for the quality of that care. Both the feds and commercial insurers paid claims based on whether or not the test or treatment was ordered by a licensed physician. Except for an occasional plaintiff’s lawyer and jury, nobody but other physicians second-guessed a physician’s judgment. Hospitals were run, and sometimes even owned, by physicians. Many older physicians became hospital CEOs when they retired from clinical practice. The vast majority of physicians owned their practices and answered only to patients and to other physicians — their peers. We really were the captains of the ship. We had both responsibility and authority. Sadly, this is no longer the case. We still have all the responsibility when something goes wrong or someone is unhappy, but in many EDs we have none of the authority we need to prevent those things. Many emergency physicians are nearly powerless to influence how their ED is run, yet they are blamed when it runs badly.

“Metric Madness” describes what happened when one group of emergency physicians lost control of their ED. What the author of “Metric Madness” suffered reminds me of what I endured at the HCA hospital where I worked for many years, before similar events late in my tenure there led to my burnout and early retirement in 2012.

For most of those years I had one of the two best emergency medicine jobs in Tennessee. But then HCA forced an electronic medical record (EMR) on us that tremendously slowed patient flow. Then came computerized physician order entry (CPOE) software that was slow, inflexible, difficult to use, and dangerously error-prone. Combined, these systems forced us to spend far more time with computers than with patients. Then came a reorganization of the ED into “pods.” Instead of one large ED with roughly thirty beds and several emergency physicians working side by side, each emergency physician was assigned 8-11 beds. Instead of next seeing the patient who was sickest or had been waiting the longest, each emergency physician saw only the patients put in his or her individual pod. This reduced our flexibility and surge capacity, since one time-consuming patient (a complex wound repair or other long procedure, procedural sedation, a critically ill or unstable patient, etc.) brought

Continued on next page
patient-flow through that pod to a halt. It was like working in a ten-bed, single-coverage ED in which all ten beds were always full. Those of you who have worked in a single-coverage ED should stop and ponder that for a moment...

Then came the final blow that made this bad-enough situation unbearable: metrics. At the same time we were saddled with bad EMR and CPOE systems and our ED was reorganized into pods, HCA began to put tremendous emphasis on metrics — especially the door-to-doctor (DTD) time. More complete measures of physician productivity, such as patient/hour or RVU/hour, didn’t seem to matter to all of our corporate administrators. It was all about door-to-doctor time, and one time-consuming patient in your pod would ruin your DTD metric for the day. A few would ruin your metric for the entire month, and that brought unpleasant attention from the hospital administrator. That kind of pressure takes all the joy out of work. Alcoholics, drug addicts, psychotic patients, critically ill patients — that’s not pressure. An administrator breathing down your neck about something you can’t control, because he has taken from you all decision-making authority for your own ED — that’s pressure!

In fact, that goes beyond just destroying morale. That is a perfect set-up for inducing an experimental neurosis, and might explain some of the learned helplessness that now seems to afflict so many physicians, including emergency physicians. As defined by Psychology Wiki:

**Experimental neurosis** is produced in the laboratory by putting subjects in a situation where they are required to make discriminations or produce problem solving responses that are beyond their capacity to produce. This is a learned helplessness paradigm when aversive stimulation consistently follows their inevitable failures.³

There are all kinds of “aversive stimuli” short of losing a job, but being fired for not meeting a metric certainly qualifies as aversive. The author of “Metric Madness” tells of a physician who lost his job because of bad length-of-stay (LOS) metrics. That metric didn’t seem to matter to my corporate administrators — all they cared about was the DTD time — but I am not surprised their emphasis has shifted. Many of the administrators and managers I have known over the years seemed to have the attention span of a gerbil on crack. One thing is critically important during one quarter, just to be cast aside the next quarter when something else becomes the Holy Grail of management.

I happen to know the emergency physician who lost his job to metric madness. He is clinically excellent, ethical, and compassionate. I would happily have him as my own or my wife’s emergency physician, and I would hire him if I were an ED director. Like all of us, he is a unique combination of personal and professional strengths and weaknesses. He has bad LOS metrics but goes years between patient complaints, because he spends lots of time with patients and they love him for it. On the other hand, I have great LOS metrics but bad DTD times, because emptying ED beds and making dispositions — whether through discharges or admissions — is my first priority. The point is, once metric madness infects an ED any of us can be fired anytime, depending on which metric is in fashion at the moment.

All of us will face this kind of senseless and intolerable situation if we don’t find a way to regain control of our EDs and our practices — restoring the link between responsibility and authority so that physicians decide what ought to be measured and how, and what ought to be done with the data. If we cannot take back control of our departments from non-physician administrators and bureaucrats, then we should find a way to shift onto them the responsibility we currently bear for ED performance. **Responsibility should follow authority.**

**References**


---

**We’re listening, send us your thoughts!**

---

**Thank you for being part of the AAEM family.**

Have you renewed with AAEM for 2014?

Visit www.aaem.org/renew today!
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 the March/April “From the Editor’s Desk” article titled “Malpractice”:

I am writing in response to Dr. Andy Walker’s excellent piece titled “Malpractice” in the March/April issue of Common Sense. Although I never was a fan of Shakespeare, the quote from Julius Caesar at the start of his editorial is right on the money (pun intended — see below). Dr. Phil has always been more on my level than Shakespeare. Dr. Phil frequently deals with two people in terrible conflict with each other. One of his common tactics is to challenge each of them to stop pointing the finger at the other one and to stop spending all of their energy taking the other person’s inventory. He then challenges each of them to examine what part of the conflict they themselves own and what they can each do from their own side to help the situation. If we look for things that we can do in a positive or constructive way to help the lawsuit problem that we have, this Dr. Phil strategy relates to one of the important points in Dr. Walker’s editorial: the only thing you can control is your own behavior.

Along those lines, I wanted to share with your readers and my fellow AAEM members something that we did a few years ago in our Rhode Island ACEP Chapter. I have been a proud AAEM member for many years, but there is no Rhode Island AAEM chapter. We adopted a non-binding and voluntary resolution in our chapter that tried to take a positive step against the problem of the big-money, hired-gun expert witnesses that so willingly slurp from the trough of the malpractice litigation system. As everyone knows, expert witnesses on both sides in malpractice actions frequently demand an hourly rate of compensation significantly higher than the hourly rate that they receive for practicing medicine (assuming that they do actually practice medicine). The Rhode Island ACEP Resolution is as follows:

“The Rhode Island Chapter of the American College of Emergency Physicians recommends that its members consider accepting compensation for medical expert legal work equal to the approximate hourly compensation rate that they earn working as practicing emergency medicine physicians. Medical expert legal work includes all medical expert case review and testimony.”

We felt that, as emergency physicians, our greatest value to society comes from the expert care that we give our patients and from our research, teaching, and administrative activities that advance the specialty (and thereby advance patient care). We recognized that one thing that physicians have direct control over is their own medical expert compensation rate. First, we hoped that if physicians voluntarily limited medical expert fees, it might contribute positively, even if only in a small way, to controlling our rising malpractice insurance rates. Second, and more importantly, we hoped that a move from within the medical community to control costs to the system by reducing medical expert fees would demonstrate to the public and to the legislature that we were willing to take the first step toward reform ourselves. Rhode Island ACEP recommended that its members should take the lead in this area to do the right thing from an ethical, an economic, and a political perspective.

Our resolution could certainly be criticized because it is a voluntary resolution and has no actual teeth for enforcement. The lawyers told us that it had to be that way and that we could not make specific recommendations about compensation rates. Although it is mostly a symbolic move, if the practice of accepting a compensation rate for medical expert work similar to what you receive for actually being a practicing physician caught on across the country and in other specialties, we might actually see some positive change, even if it is in just a small way.

Glenn Hebel, MD FAAEM FACEP

Thank you for writing. Your feedback makes Common Sense a better newsletter. Your expert witness reform proposal is interesting, and if it could be enforced would certainly get rid of those unethical experts who are in it purely for profit and will say anything for money. From what I have seen, that would mean a lot fewer plaintiff’s experts. Unfortunately it would take the passage of new laws to institute your idea, and since your reform idea would hurt plaintiffs far more than defendants, that ain’t gonna happen.

There is another way to accomplish your goal of taking most of money out of being an expert witness, however. Although this too would require new laws, tort lawyers might be more likely to go along with it because it involves equal risk for both the plaintiff and defendant.

Instead of each side retaining its own experts — and paying them — the court would appoint a panel of three board-certified physicians in the same specialty as the defendant to agree on one expert opinion. They

Continued on next page
What we need is a less cumbersome way to chart. Charts now do not reflect our care of patients. Just try reading a chart from an EMR; it is easier to read JAMA. Everything is centered around billing and CMS metrics. Had this been left to market forces, we might have something better than Pong. However, the federal government is adept at taking technology and making it dysfunctional. So, I know how we survived before scribes ... we had a better charting system. Paper ... How sad is that?

Dave Bryant, DO FAAEM

I appreciate your letter, and I agree with you. No EMR I have seen — especially the one without voice recognition that HCA forced on me and my colleagues — is as fast, flexible, accurate, legally protective, and descriptive as dictation. An ED chart should be as unique as the patient encounter that generated it, and a point-and-click EMR can't get anywhere close. You are right about the reason for this mistake: the technology and the market for it were not allowed to evolve naturally — the federal government, with the HITECH Act, forced EMRs on us before they were ready.

As you point out, good technology doesn't require the creation of a whole new class of workers (scribes) to accomplish something that was already getting done. On the contrary, that is a sign of bad technology — very, very bad. In this case, so bad it would disappear if the doctors and nurses who are forced to use it had any choice in the matter.

There is one other thing that bothers me about scribes, and I pointed this out to my colleagues soon after we realized just how bad our EMR was. When a hospital takes dictation away from its emergency physicians and substitutes an EMR so bad that scribes are necessary, it shifts the cost of generating medical records from itself to its emergency physicians — and those records are the property of the hospital and are used by the hospital for billing, just as much as by emergency physicians. That is wrong.

— The Editor

Letter in response to the May/June 2014 “In the Pit” article titled “Scribes: How Did We Ever Live Without Them?”:

When road-blocks are placed in our paths, most of us are good at finding workarounds. Physicians are being forced to pay for the privilege of beta-testing software for the profits of second tier companies that have ingratiated themselves with the federal government. Thus, I would not describe being forced to pay for a scribe to make the use of a poorly designed product as a win-win situation. Charting is the responsibility of the physician. That record is the only real link you have to prior patient encounters. You may choose to use a scribe or a dictation service, but in the end you must proof-read and correct every piece of information placed in the chart under your name. We cannot simply delegate that responsibility and assume that it is carried out properly.

I tried using a scribe. I measured, with a stopwatch, the time charting versus a chart done by a scribe. I found that I spent longer proof-reading and correcting the note than if I had done it right the first time myself. I have trouble getting third year residents to document properly, let alone someone with no medical training. If you use a scribe, you generally need to see an extra three to four patients a shift to make a scribe pay for themselves. If you are relatively slow using an EMR, then this may make since. However, if I am already seeing three to four patients an hour, there is not a lot of room left to safely increase productivity. When I compare the time I am able to spend at the bedside against my colleagues using scribes, there is no difference. To boot, CPOE takes longer than charting and scribes cannot enter orders.

— The Editor