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OF THE AMERICAN ACADEMY OF
EMERGENCY MEDICINE

COMMONSENSE

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INSIDE

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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.
8. The Academy supports the establishment and recognition of emergency medicine internationally as an independent specialty and is committed to its role in the advancement of emergency medicine worldwide.

Membership Information

Fellow and Full Voting Member: $425 (Must be ABEM or AOBEM certified, or have recertified for 25 years or more in EM or Pediatric EM)
Affiliate Member: $365 (Non-voting status; must have been, but is no longer ABEM or AOBEM certified in EM)
Associate Member: $250 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program)
*Fellows-in-Training Member: $75 (Must be graduates of an ACGME or AOA approved EM Program and be enrolled in a fellowship)
Emeritus Member: $250 (Must be 65 years old and a full voting member in good standing for 3 years)
International Member: $150 (Non-voting status)
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Transitional Member: $60 (voting in AAEM/RSA elections only)
International Resident Member: $30 (voting in AAEM/RSA elections only)
Student Member: $30 or $60 (voting in AAEM/RSA elections only)
International Student Member: $30 (voting in AAEM/RSA elections only)
*Fellows-in-Training membership includes Young Physicians Section (YPS) membership.

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President's Message

Hospital-Contract Management Group Joint Ventures: A Disturbing Trend

Mark Reiter, MD MBA FAAEM

In recent years the largest hospital network in the country, Hospital Corporation of America (HCA), has entered into a joint venture with the largest emergency physician contract management group (CMG) in the country, EmCare. Although not all of the details of this transaction are publicly known, under many such joint venture arrangements the hospital and the CMG own the emergency physician group and split the profits coming from emergency physician professional fees. Although many CMGs have profited handsomely from emergency physician professional fees for decades, this is new territory for hospitals. If such an arrangement is considered legal and legitimate, hospitals throughout the country will have great incentive to restructure their emergency physician agreements along these lines, so they can capture part of the emergency physicians' professional fees rather than allowing the physicians to profit fully and fairly from their own labor — joining the CMG in reaping the spoils of the emergency group's work.

Already, over the past two years, many private emergency physician groups have lost their contracts in Florida, Virginia, and Tennessee and have been told that their new employer will be the hospital-CMG joint venture. In return for being able to keep working in the same emergency department, many of these physicians are forced to take significant pay cuts and lose much of their independence and job security.

Many new hospital-CMG joint venture arrangements have many similarities to Catholic Healthcare West's (CHW) attempt in the late 1990s to force the private emergency physician groups contracting with its hospitals to join Meriten, its wholly-owned subsidiary, so that CHW would essentially own the emergency physician practices. In response, AAEM — with the support of the physician groups involved, the California Chapter of AAEM, and the California Medical Association — filed suit, citing violations of corporate practice of medicine (CPOM) and fee-splitting laws. After initial court hearings went against it, CHW sold EPMG back to the physicians, who then reorganized into a fairer, independent, physician-owned group. This was a huge win for AAEM and for the private practice of emergency medicine. However, we now see this disturbing issue recurring.

Hospital-CMG joint ventures may violate corporate practice of medicine (CPOM) laws in many states. These laws — drafted to protect the public — often prohibit non-physician lay corporations from owning or controlling physician practices, due to the potential for abuse when a corporation's fiduciary duty to its shareholders is in conflict with a physician's duty to his or her patients. Since hospitals and CMGs are typically not physician-owned corporations, having a hospital-CMG joint venture owning or controlling a physician practice may violate CPOM laws. In addition, federal fee-splitting laws prohibit the distribution of any portion of a physician's professional fee to any entity in excess of the fair market value of services provided to that physician. In situations where profits from physician professional fees are being distributed to a hospital or CMG, this raises a concern for violation of federal fee-splitting laws.

AAEM has been monitoring the recent development of hospital-CMG joint ventures and has spoken with many of the affected physician groups. AAEM is actively investigating potentially illegal activities and hopes to provoke enforcement of prohibitions on such activity. If a hospital-CMG joint venture is now affecting your group or occurring in your area, please contact AAEM to further discuss the matter. I highly encourage our members to make a donation to the AAEM Foundation, where the funds raised can be utilized by AAEM to help protect the private practice of emergency medicine. ■

AAEM Antitrust Compliance Plan:

As part of AAEM's antitrust compliance plan, we invite all readers of *Common Sense* to report any AAEM publication or activity which may restrain trade or limit competition. You may confidentially file a report at info@aaem.org or by calling 800-884-AAEM.

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?

Continued on next page

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. ■

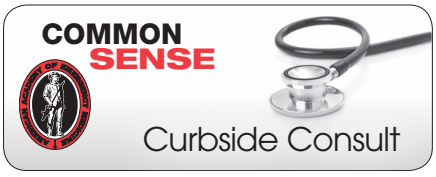
Call for Assistant Editor — Join the *Common Sense* Team

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 ■

Congress Clears Temporary "Doc Fix" Bill to Postpone Physician Cuts Until 2015; ICD-10 Compliance Delayed Again

Williams & Jensen, PLLC

At the end of March, the House and Senate acted on legislation to prevent a 24% Medicare cut for physicians from taking place on April 1, 2014. H.R. 4302, the *Protecting Access to Medicare Act of 2014*, extends current Medicare reimbursement rates until March 31, 2015, and extends for one year a number of other Medicare payment policies.

The temporary fix was criticized by the American Medical Association (AMA) and many other physician groups, which had hoped for a permanent fix. AAEM sent out an action alert in March asking members to contact their legislators in Washington, urging support for a bipartisan, permanent SGR repeal rather than another short-term patch. The House and Senate tax-writing and health committees have been working towards a long-term solution since the beginning of 2013, and leaders were mostly in agreement on a bipartisan framework that would replace the Medicare Sustainable Growth Rate (SGR) with a period of stable, positive payment updates and later a new payment system that would allow physicians to earn additional payment adjustments if they met certain performance benchmarks.

However, Republicans and Democrats were never able to coalesce around a plan to offset the cost of the permanent fix, which exceeded $150 billion once other Medicare extenders were taken into account. House Republicans passed a permanent fix in March, which was paid for by delaying the Affordable Care Act's (ACA) individual mandate through 2019. This legislation was rejected by Senate Democratic Leadership and the Administration, which claimed that the change would result in higher premiums and more uninsured Americans. The Chairman of the Senate Finance Committee floated a proposal to pay for the fix using savings from a reduction in funding for overseas war operations, but a number of key Republicans described that provision as a gimmick because it claims savings from money that would never have been spent in the first place.

When it became clear that the two sides would not reach an agreement by April 1, some of the negotiators asked for a shorter-term extension so that discussions could continue on a permanent solution, but ultimately the House and Senate advanced a proposal that would fix the rates for a full year.

The final bill included a number of provisions that impact physicians. Notably, the legislation delays for one year the transition from the International Statistical Classification of Diseases (ICD)-9 to ICD-10. The compliance date had already been delayed in 2012, when HHS decided to set the new date for October 2014. This legislation postpones ICD-10 until October 1, 2015. Some physicians and hospitals have advocated the delay, as there are concerns about the sharp increase in the number of codes when the transition is completed. They claim that the new system would impose large costs and administrative burdens on medical professionals. The bill also prevents the Centers for Medicare and Medicaid Services (CMS) from enforcing the "two-midnight" rule until April 2015. This policy was designed to prevent hospitals from abusing patient observation status and was originally scheduled to take effect in October 2013, before an earlier delay in enforcement. The rule permits Medicare coverage of admitted inpatients expected to require care that exceeds two midnights, but often denies coverage for a shorter hospital stay.

A number of provisions are included to offset the cost of the one-year fix, which the Congressional Budget Office (CBO) estimates at $20 billion. One such provision is designed to provide savings by enhancing payment accuracy, by identifying and reducing misvalued services. The data would be collected voluntarily from medical professionals and other sources, and the legislation includes a small amount of funding to compensate providers who submit data to CMS. Another cost-saving measure included in the bill would establish a program to promote the utilization of "appropriate use criteria" for certain advanced diagnostic imaging services.

Focus on Health Care Reform

With the "doc fix" off the table until 2015, Congress will likely continue its focus on health care bills that would modify or repeal parts of the ACA. While the Republican-controlled House has sought to pass legislation to change the law, the White House and the Democrat-controlled Senate has for the most part resisted significant modifications to the ACA. However, the White House has made some key changes, including adjustments to ACA enrollment deadlines and the delay of the law's employer mandate.

Continued on next page

Beyond these unilateral fixes, there have been few examples of the Administration and Congress working together to modify the ACA. Requests for additional funding to implement the law and extensions of expiring ACA policies such as the temporary Medicaid pay boost for primary care physicians are not likely to be advanced in a divided Congress.

Meanwhile, the House has already passed a number of measures in 2014 including bills to (1) repeal the ACA's definition of a full-time worker as an individual who works 30 or more hours per week; (2) delay the ACA's penalties against individuals who do not purchase health insurance; (3) prevent premium tax credits and subsidies authorized by the ACA to be granted to plans that cover elective abortion coverage; (4) allow an additional religious exemption from the ACA's minimum essential health care coverage requirements for individuals that hold religious beliefs which would cause them to object to medical health care provided under this coverage; (5) require HHS to provide notification to individuals of security breaches to federal or state health exchanges that compromised personally identifiable information; (6) establish that a volunteer providing firefighting and prevention services, emergency medical services, or ambulance services to a state or local government or tax-exempt organization is not counted as a full-time employee under the ACA's employer mandate to provide minimum essential health care coverage. House and Senate Republicans have also focused on proposals to delay or repeal the ACA's 2.3% excise tax on medical devices.

On a larger scale, key House Republicans have been preparing for the introduction of an alternative health care proposal that would replace the ACA. This bill could be introduced as a larger comprehensive bill, or it may be presented as a series of smaller bills. Either way, there is little chance of any such proposal being enacted, but the alternative would be used for messaging in advance of the 2014 elections. Similar to the framework for an alternative health reform measure introduced by several Republican Senators earlier this year, the bill would likely maintain some of the more popular provisions of the law such as allowing individuals with pre-existing conditions to remain covered and maintaining the requirement that health plans allow dependent coverage up to age 26.

The alternative is also expected to include a section on medical malpractice reform. The Senate Republican measure specifically proposed capping non-economic damages for claims under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA). It also would provide incentives for states to examine medical liability laws, promote reforms, and cite popular Republican ideas such as the establishment of special "health courts." House Republican Leadership has indicated that the House will vote on an ACA alternative before the end of the year. ■

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August 19-22, 2014
- AAEM Written Board Review Course
  Orlando, FL
  http://www.aaem.org/education/written-board-review-course

July 25-27, 2014
- 2nd International Trauma, Emergency & Critical Care Conference
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Personal finance is of extreme importance in the personal and professional lives of emergency physicians, emergency medicine residents, and medical students. "Dollars & Sense" is a new, ongoing feature of *Common Sense* that will explore the financial components of a successful medical career. In order to give readers a head start in any particular financial area they want to learn more about, I'll start with some resources that offer sound advice and can be read quickly. Let's face it, we're all busy.

General Personal Finance

If you want one book to guide you in nearly all aspects of your financial life, I'd recommend *Get a Financial Life: Personal Finance In Your Twenties and Thirties* by Beth Kobliner. It is undoubtedly the most comprehensive and useful financial book I've ever read and offers sound advice in a concise format. It covers investing, banking, insurance, real estate, taxes, and nearly every other topic you can think of. With many used copies available for under $10 on Amazon.com, this is the best money you could spend if you are in your twenties or thirties.

Another oldie but goodie is the book *25 Myths You've Got to Avoid — If You Want to Manage Your Money Right* by Jonathan Clements. It was published in 1999, but the advice is timeless. In it Clements debunks myths like:

- Stocks are risky.
- You can beat the market.
- Buy the biggest house possible.
- Life insurance is a good investment.

Investing

For investment advice I turn to two authors, Burton Malkiel and John Bogle. Malkiel is the Chemical Bank Chairman's Professor of Economics at Princeton University and is most famous for his bestselling book, *A Random Walk Down Wall Street: The Time-Tested Strategy for Successful Investing*. While I highly recommend this book and have read each of the three latest editions from cover to cover, it is 500 pages long and only for the reader who is interested in the theory behind the recommendations. His lesser known book, *The Elements of Investing: Easy Lessons for Every Investor*, would fit in the pocket of your white coat, is less than 200 pages, was published in 2013, and provides all of the advice without the in-depth theory. It's like skipping to treatment without having to learn pathophysiology, and we all know most of us hate pathophysiology. In addition, you can check out *The Random Walk Guide to Investing*, which is only 224 pages but a bit dated — the last edition is from 2007. The principles, though, remain unchanged. It is still a worthwhile read.

Bogle, founder of The Vanguard Group, is also famous for a book that I highly recommend, *Common Sense on Mutual Funds*. Again, this book is heavy on theory, but if you don't want a degree in finance, you can get the *Reader's Digest* version by reading his other book, *The Little Book of Common Sense Investing*. This book will also fit in your coat pocket, is 216 pages long, and will teach you how to get rich slowly, the only surefire way to do it.

Real Estate

Although the title makes the book sound like a late night infomercial, *The Automatic Millionaire Homeowner* by David Bach provides solid advice and can be read in a few hours. In the book he makes the case for building wealth through home ownership, provides practical advice on obtaining a mortgage, and discusses building equity by paying your mortgage off early and automatically.

If you are about to relocate and are trying to figure out whether you should rent or buy, try this new calculator: http://www.trulia.com/rent_vs_buy/. You can make calculations based on economic analysis of the top one hundred real estate markets in the United States, and use the calculator to change all sorts of variables and assumptions so that the answer you get is specific to your situation.

Contact Information

If you have ideas for future columns or have other resources you'd like to share, email me at jschofer@gmail.com.

The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense or the United States Government. ■

AAEM Announces New Position Statements

The American Academy of Emergency Medicine (AAEM) announces two new position statements approved by the board of directors at the 20th Annual Scientific Assembly, held in New York City, NY, February 11th-15th, 2014.

Joint Ventures Between a Hospital/Hospital System & CMG

AAEM opposes joint ventures between a hospital or hospital system and a corporate emergency medicine contract management group (CMG) whereby a portion of the emergency physician professional fee is distributed to the hospital or hospital system and the CMG in excess of fair market value for services performed. Such an arrangement may place the emergency physician at risk of participating in prohibited fee-splitting, kickbacks, and the corporate practice of medicine.[1]

Reference:

1. DHHS Office of Inspector General. OEI-09-89-00330 Financial Arrangements between hospitals and hospital based physicians.

The Pulmonary Embolism Rule-Out Criteria (PERC) Meets the Standard of Care for Emergency Medicine (EM)

It is the position of AAEM that, when properly applied to an individual patient for whom the clinician already has a low clinical suspicion for PE, based on a gestalt impression, the Pulmonary Embolism Rule-Out Criteria (PERC) meets the standard of care for EM. When a patient is PERC negative no further diagnostic work up for pulmonary embolism is required including D-dimer measurement and the performance of advanced imaging studies (CT pulmonary angiography and VQ scanning).

References:

1. Kline JA, et al. Prospective multicenter evaluation of the pulmonary embolism rule-out criteria. J Thromb Haemost 2008; 6:772-80.
2. Singh B, et al. Diagnostic accuracy of pulmonary embolism rule-out criteria: A systematic review and meta-analysis. Ann Emerg Med 2012; 59: 517-20.

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Medical Liability and the Emergency Physician: A State by State Comparison — Part 4

Gregory Roslund, MD FAAEM
Legal Committee

When it comes to medical malpractice law, there is immense interstate variability. Some states have passed sweeping reforms that have decreased litigation and provided increased access to medical care. Other states have been reluctant to change, and as a result malpractice insurance premiums have skyrocketed and physicians have left in droves.

This is the fourth installment of this state by state review. The initial installment, in the July-August 2013 issue of *Common Sense*, analyzed the first ten states and included a "methods" section detailing how the ratings were calculated. The second and the third installments appeared in the January-February 2014 and March-April 2014 issues, respectively.

I welcome any and all feedback. Please direct your comments or questions to the editor of Common Sense, Andy Walker, at cseditor@aaem.org. Now, let's look at the next five states, Ohio through Rhode Island.

Ohio ★★★★☆

Caps: $350,000 cap on non-economic damages per plaintiff, but up to $500,000 if multiple plaintiffs are involved (soft cap).[3]

Average 2013 premiums: $33,600 (estimated) for EM, $7,000-25,600 for IM, $23,800-78,000 for GS.[31]

Liability environment for emergency physicians: Still the seventh most populous state, this once prosperous industrial bellwether has fallen on hard times over the past decade as the majority of its manufacturing cities (Cleveland, Cincinnati, Akron, Toledo, Dayton) have continued a decline that began 50 years ago.[60] But not everything in the Buckeye State has deteriorated over the past ten years. The Cavaliers flourished under Lebron James (up until The Decision),[64] Ohio State University dominated college football (up until Tattoogate),[65] and the state's medical liability environment resurged after Ohio passed one of the country's most powerful and comprehensive tort reform packages in 2004.[66] Once designated as a crisis state by the AMA,[35] with physicians leaving in droves due to skyrocketing premiums, Ohio is now considered a welcoming safe harbor for EPs — thanks to the enactment of extensive reforms ten years ago.[66] Litigation has dropped 41% state-wide over the years following the enactment of these reforms.[66] The 2004 across-the-board package included:

- A $350,000 cap on non-economic damages.[3]
- A four-year statute of limitations — upheld by the Ohio Supreme Court in Dec 2012.[67]
- Proportionate liability reform (damages are apportioned based on the plaintiff's share of the negligence).[66]
- A required case certification signed by an expert witness actively practicing the same specialty as the defendant.[8]
- Ohio State Medical Board jurisdiction over out-of-state physician expert witnesses — which gives the board the ability to discipline any physician who provides false or baseless medical testimony.[66]
- An "apology law" making physician apologies inadmissible in court — upheld by the Ohio Supreme Court in April 2013.[46]
- Peer-review protection ensuring that any information disclosed in peer review is protected from discovery in a subsequent medical liability claim.[66]
- Prejudgment interest reform that limits calculations to when the defendant first received notice of a claim and rather than when the injury first occurred (and now prejudgment interest cannot be applied to future damages).[66]
- A Good Samaritan Law that extends liability protection to any physician who cares for indigent patients in his office.[66]
- A requirement that malpractice insurance companies both explain the reasons behind nonrenewals or premium increases and provide physicians a warning period of 60 rather than 30 days before nonrenewals or significant premium increases.[66]

The state's impressive $350,000 cap on non-economic damages does come with a few exceptions. The cap can be increased to a total of $500,000 if the case involves multiple plaintiffs, and for cases involving "catastrophic injuries" the maximum may increase to $500,000 per plaintiff or $1 million for multiple plaintiffs.[3] In addition to the broad reforms passed in 2004, the state has enacted joint and several liability reform, collateral source reform, and periodic payment reform.[3] Unfortunately for Ohio EPs, this exhaustive assortment of reforms has not included specific laws protecting physicians practicing in the emergency setting. Also, while premiums have been reduced substantially over the years (down 26%),[66] EP premiums still remain in the mid to high range when compared to EPs practicing in other parts of the country.[31] Physicians in Cuyahoga county (Cleveland) pay substantially more than their colleagues in other parts of the state.[31]

Assessment: Ohio's medical liability environment has experienced a renaissance since the state passed sweeping reforms ten years ago. Sadly, this comprehensive package did not include laws protecting docs in the emergency setting, and premiums for EPs remain relatively high.
Grade: 4.0 stars out of 5.

Oklahoma ★★★☆☆

Caps: $350,000 cap on non-economic damages (soft cap).[3]

Average 2013 premiums: $29,175 (estimated) for EM, $11,700-14,700 for IM, $39,300-51,000 for GS.[31]

Liability environment for emergency physicians: Thanks to a booming oil and gas economy, the Sooner State has recently experienced unprecedented growth and prosperity.[59] Thanks to HB 2128, passed in April 2011, the state's medical liability environment has flourished in like

Continued on next page

fashion.[35] This bill solidified a formidable cap of $350,000 on non-economic damages — regardless of the number of parties against whom the action is brought or the number of actions brought.[35] Unfortunately, a few loopholes still persist. The cap does not apply to cases involving wrongful death or cases involving "bodily injury resulting from negligence if a judge and jury find that the defendant's acts were in reckless disregard or grossly negligent or fraudulent or intentional."[35] Additional favorable Oklahoma laws include: collateral source reform,[3] partial joint and several liability reform (joint and several liability still apply if the defendant's responsibility is greater than 50%),[3] a two-year statute of limitations,[8] and a certificate of merit requirement.[8] Attorney fees are limited, but rather than the customary 30% or sliding scale, they are limited to an alarming and exceedingly attorney-friendly 50% of the plaintiff's recovery![3] Laws do exist regarding expert witnesses, but they contain notable escape clauses: "Experts must be licensed to practice medicine or have other substantial training or experience in any area of health care relevant to the claim, and must be actively practicing or retired from health care in any area of health care services relevant to the claim. The judge may allow experts who do not meet these qualifications to testify if the judge finds there is good reason to admit the expert's testimony."[8] EP premiums remain unexpectedly high in the Sooner State, with Okie EPs paying twice as much as their Kansas neighbors and substantially more than their colleagues in Texas and Arkansas.[31]

Assessment: A robust cap on non-economic damages has been upheld, but exceptions exist. Expert witness laws are dubious at best. EPs pay significantly higher premiums than their colleagues in neighboring states.
Grade: 3.0 stars out of 5.

Oregon ★★½☆☆

Caps: $500,000 cap on non-economic damages in wrongful death actions (hard cap).[3]

Average 2013 premiums: $20,200 (estimated) for EM, $6,700-10,250 for IM, $26,400-37,500 for GS.[31]

Liability environment for emergency physicians: Unfortunately for Oregon EPs, the state's medical liability environment is not as stunning as it's windswept Pacific coastline. The Beaver State is known for breathtaking waterfalls, majestic forests, and volcano-studded mountains. It is not known for tort reform, which is barely perceptible in this otherwise beautiful state. In fact, Oregon was identified as a crisis state by the AMA in 2003.[35] In keeping with this designation, the state lacks a certificate of merit requirement and there are no laws of any kind in regard to expert witnesses.[8] The statute of limitations is generally two years, but can be extended up to five years in certain cases.[8] There are no significant limits on attorney fees, but attorney fees recovered from an award for punitive damages are limited to 20% of the punitive damages.[3] The state's constitution specifically prohibits caps on non-economic damages in personal injury actions, but a $500,000 cap is applied to wrongful death cases.[3] The state has enacted joint and several liability reform and collateral source reform.[3] EP premiums are inexplicably reasonable (low to mid-range), despite the state's lack of meaningful reform.[31] In keeping with its cutting-edge image, the state recently adopted an early arbitration initiative.[22] Senate Bill 683 (2013) is similar to the Michigan Model and Massachusetts' Disclosure, Apology, and Offering Initiative.[58] This innovative process emphasizes early discussion and mediation, including early settlement offers, under the authority of the Oregon Patient Safety Commission.[22] This bill was supported by both the Oregon Medical Association and the Oregon Trial Lawyers Association, as a way to improve patient safety and reduce costly litigation while still offering fair compensation.[22] While this bill has received overwhelming support, its ultimate impact remains uncertain. As it stands, these "adverse outcomes" will be reported confidentially to the Oregon Patient Safety Commission rather than the National Practitioner Databank (compensation negotiated through mediation does not have to be reported to the NPDB).[61] Patient advocacy groups are concerned that this lack of transparency will have a negative impact on patient safety.[61]

Assessment: A gorgeous state with reasonably fine looking premiums and unsightly tort reform. Its early arbitration initiative is promising.
Grade: 2.5 stars out of 5.

Pennsylvania ★½☆☆☆

Caps: Punitive damages are capped at twice the actual damages (hard cap).[3]

Average 2013 premiums: $48,175 (estimated) for EM, $13,600-30,700 for IM, $45,400-103,000 for GS.[31]

Liability environment for emergency physicians: As the U.S. was gearing up for its bicentennial celebration in 1976, Elton John sang "Cause I live and breathe this Philadelphia Freedom. From the day that I was

Continued on next page

born I waved the flag." This song, originally about tennis, became an anthem for the Keystone State and its City of Brotherly Love. Philadelphia will always be synonymous with flag-waving patriotism, liberty, and the signing of the Declaration of independence. To this end, the state's constitution contains specific language protecting the people's right to sue and prohibiting caps on damages of any kind.[62] While this degree of "liberty" may be advantageous to some, for well-meaning EPs taking care of patients in the trenches, the situation is an absolute nightmare. For many years Pennsylvania undoubtedly had the worst medical liability environment in the country. It was an AMA-designated crisis state,[35] with Philadelphia **ATRA's top-ranked Judicial Hellhole**.[63] At the peak of the state's catastrophe, from 2000 to 2004, general surgery premiums increased from $33,600 to $128,500 per year and OB-GYN premiums increased from $37,500 to $161,000 per year.[35] In 2002, medical malpractice plaintiffs whose cases were heard in Philadelphia courts were more than twice as likely to win jury trials as the national average, and more than half the awards were for $1 million or more.[63] Reforms were passed in 2003, including a case certification requirement and venue reform — a law mandating that liability legal proceedings take place in the county where the alleged negligence took place, to prevent "venue shopping" for sympathetic juries.[63] Over the past ten years medical malpractice case filings have decreased 44% in the state, and they're down 65% in Philadelphia.[63] So times have changed — or have they? Let's just say things have gone from "horrendous" to "barely tolerable." Keystone State EPs still pay some of the highest premiums in the country.[31] Furthermore, surgeons and OB-GYNs can expect to pay over $100,000 per year in Philadelphia — almost double the premiums paid by their colleagues in the remainder of the state.[31] Pennsylvania's per capita malpractice payout of $24.77 per year is the second highest of any state in the nation.[36] Also, the state has failed to enact significant caps. Punitive damages are capped at two times actual damages, but this is rarely relevant since there are no limits on attorney fees,[3] and the statute of limitations can be extended up to seven years from the date of the incident.[8] Expert witnesses must be in the same specialty and "actively engaged in clinical practice or teaching," but two loopholes exist: 1)"Expert testimony is required to establish the requisite standard of care, unless negligence is obvious to a lay person" and 2) "The court can waive this requirement if the expert has sufficient training, experience, or knowledge as a result of active practice or teaching within five years prior to the incident." On a positive note, the state has enacted collateral source reform and partial joint liability reform, and the defendant may be fully responsible for damages if it is proved that he is at least 60% at fault.[8] Finally, the state's recent enactment of "Apology Legislation" has received significant attention — after the bill required eight years to get through the legislature![61] Similar to "apology laws" that have been established in 35 other states, SB 379 makes physician apologies inadmissible in court.[61] While "I'm sorry laws" are well meaning, their overall impact on litigation remains unclear. The disclosure process remains a challenge for physicians, and laws such as this one undoubtedly lend added support. After all, according to the legendary Elton John, "Sorry seems to be the hardest word."

Assessment: This highly litigious state has made some progress over the years, but with sky high premiums and a state constitution specifically prohibiting caps, this medical liability environment remains a mine field for EPs. **Grade:** 0.5 stars out of 5.

Rhode Island ★☆☆☆☆

Caps: None.[3]

Average 2013 premiums: $32,375 (estimated) for EM, $12,300-16,000 for IM, $44,200-57,000 for GS.[31]

Liability environment for emergency physicians: Measuring just 1,212 square miles, the Ocean State is the smallest in the union. And unfortunately for Rhode Island EPs, the state's negligible medical liability reforms are commensurate with its minuscule size. Following in

Continued on next page

the footsteps of its New England neighbors, this tiny island state in the Northeast has failed to enact meaningful reform of any kind. Rhode Island has no caps on damages,[3] no joint liability reform,[3] no periodic payment reform,[3] no case certification requirement,[8] and no limits on attorney fees.[3] While "expert witness testimony is required", thanks to ambiguous legalese trial attorneys can essentially call upon any hired gun with "health care experience" to serve in this capacity.[8] The state's statute of limitations is three years[8] and its per capita malpractice payout of $17.35 per year is the eighth highest in the nation.[36] With a paucity of laws protecting physicians, it is no surprise that the AMA identified Rhode Island as a crisis state.[35] However, the state's mid-range malpractice premiums are a pleasant surprise.[31] Despite the negativity surrounding the state's liability environment, Rhode Island EPs actually pay substantially less for malpractice coverage than their colleagues in neighboring states.[31]

Assessment: An undersized state with undersized medical liability reforms. Premiums are slightly lower than expected. **Grade:** 1.0 star out of 5.

Look for this series to continue in future issues!

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Through the Patient's Eyes: Our Expectations vs. Theirs

Craig Norquist, MD FAAEM
Chair, Practice Management Committee

If patients do not tell us what matters to them, we will continue to work them up the way we already do or that we want to. Take, for instance, the chest pain work up. Patients want to know what is causing their symptoms; we continue to do our "chest pain rule out" to ensure that they are not having a cardiac event. When our test results return showing a normal troponin, we may need to admit to ensure that they are not having an event, but have not come any closer to getting an answer to **their** question.

It is the same with abdominal pain. We listen for clues to what type of scan to get and what part to focus on, rather than what patients are concerned about or why they have come to see us. We put patients into our boxes and do the tests that we have, then try to explain that we didn't find what **we** were concerned about, but haven't answered the question or concern that **they** had in the first place.

Perhaps by asking "What concerns you the most today?," we can better understand how to take care of people. Of course there will always be people who have unreasonable expectations, but then we can do our best to adjust or reset those expectations. If we do not ask and do not offer what we are able, people will continue to be confused as to what we are actually doing for them.

For example, a friend of mine has had terrible back pain and spasms for the last several weeks, leading him to the emergency department and his primary care doctor on several occasions. During one episode he also had SVT that broke with adenosine. On several of the visits he was admitted to the hospital for further workup, not for his back pain but for incidental findings that were uncovered during his initial visit. He wound up getting a liver biopsy for a lesion noted on his abdominal CT scan, then a cardiac rule out after the SVT. After six weeks of excruciating pain, many sleepless nights, and multiple visits to his PCP and the ED, he eventually went to a chiropractor because he was not getting any answers to his initial complaint. He remembers his visit to the chiropractor as the first time anyone actually touched his back and pressed on his vertebrae. Now, this might not be completely truthful and could be an exaggeration of memory, but it says that we (the allopathic medicine community) failed him, at least in his mind. He still had no relief after chiropractic treatment, but he had the peace of mind that his complaint was being heard and addressed.

I am not saying that what happened to him was wrong, or that I would have treated him any differently, but he is an educated man who, after several visits to the hospital and various doctors, states quite honestly that nothing was done for him — at least not for his back pain. Perhaps we are spending too much time worrying about what concerns **us** and not enough about what concerns **the patient**. Can you imagine if this was the case at a restaurant? If the waiter had the ability to change your order based on what he felt you needed, without an understandable explanation? Sure, people come to us for our expertise and skill, but don't we have an obligation to address the actual reason the patient wants to be seen in the first place? Maybe we could address **their** concerns while taking care of our concerns with a better explanation than "Your back pain won't kill you, but your heart being damaged might."

When I go to see my oncologist, we talk about how I am feeling and what my concerns are, and based on that and my scans and lab results we decide if and when I will need chemotherapy. If I went there expecting him to fix my back pain and never even told him that was my concern, of course I am going to leave unsatisfied. The major difference there is that I know what to expect from the oncologist. In the emergency department we are expected to be able to figure out and fix everything: illness, pain, lacerations, fractures, and even psychiatric issues. We know what our limitations are and what the limitations of the system are, but often our patients do not. We do not know what they expect, and instead of asking them for the real reason they have sought our care and attention, we place them into one of our pre-existing workups and move on to the next patient. When we give them the results of their tests without a clear explanation of what is going on, of course they are going to be unsatisfied. With abdominal pain we often need to adjust these expectations. If a patient wants to know what is going on, we often need to let them know that we might not come to a diagnosis or exact cause, but we can help them feel better while making sure there isn't a condition that requires immediate attention. This doesn't mean we are ignoring the complaint, but we are addressing it within the confines and limitations of our abilities.

Headaches are a perfect example of how I want negative test results when I work up someone for the worst headache of his life. If I find the cause, it will probably mean that he will need neurosurgical intervention and be in the hospital for some time, while his bleed or infection or whatever is treated. If I do not find the cause, then I can give him peace of mind, nausea medicine, and pain medications as needed.

Many patients don't understand our job or role as emergency physicians. They expect that we have the ability to diagnose everything for everyone. If we do not take a second to set expectations, we will continue to fail in caring for them and continue to be frustrated on a daily basis.

As for me, I continue to do relatively well. My Non-Hodgkins Lymphoma is at stage IV but I am still in the watch and wait phase. If I have B symptoms, such as fevers, night sweats, or weight loss, then I may need chemotherapy. Until that time comes, I am doing the best I can to become a better husband, doctor, son, brother, and friend. ■

In The Pit

Scribes: How Did We Ever Live Without Them?

Mark Foppe, DO FAAEM FACOEP

Does the quality of your EMR affect not only the quality of your patient care, but of your lifestyle? As one who experienced the transition from a "best of breed" system to a DOS-based "enterprise system," I can tell you that the transition was difficult. To put it mildly, it almost killed me.

When you are in a high volume, high acuity emergency department seeing 40 patients a shift, the last thing you need is 10,000 added computer clicks per shift. When you do 20 shifts a month, as I do, that is 2,400,000 clicks a year. Want to know what that will do to your body? Ask to look at my wrist when you see me next year at the AAEM Scientific Assembly in Austin, TX. No golf, no tennis, no fishing: all of it hurts too much. I know it takes 10,000 hours to become expert at something, but data entry is not my profession. Emergency medicine is.

Many emergency departments have faced the same dilemma. A solution many are going to is scribes. Medical scribes provide a means by which data can be inputted in real time with attention to quality control, patient safety, and billing. Their role is to meet the data entry requirements of charting the patient encounter, including the clinical exam and all care provided. Their role should not be exclusively clerical, however, since they may provide other services such as getting patients water, blankets, etc.

In ancient times only a select few were literate, and a society of scribes developed. It has now become necessary to resurrect this trade, as the data entry requirements of some EMRs have become so burdensome. When emergency physicians spend 80% of their time in front of a computer, we are in danger of becoming specialists in data entry rather than specialists in emergency medicine. For emergency physicians to focus on patient care, where our attention belongs, a new member has to be added to our health care team.

Scribes are a way to relieve us of the burden of data entry. Specialists in emergency medicine are highly trained clinicians, and clerical activity, like data entry, is a waste of our time and expertise — and contributes to burnout. Scribes may just save our sanity and help prevent burnout. When I reached out to EDs that already used scribes for feedback on the results, one phrase was repeated over and over: "I don't know how we ever lived without them."

Scribes assist emergency physicians by entering the entire history and physical exam, by running down and entering radiology reports and lab results, by documenting medical decision making, and by recording clinical impressions. They provide detailed accounts of time-stamped events and procedures such as cardiac cath lab alerts, eligibility for tPA, CPR, intubations, central line placements, lumbar punctures, etc. They also enter disposition/admission data. All information obtained by the clinician is recorded by the scribe. Order entry and discharge instructions, however, should be done by the emergency physician (EP) or mid-level clinician. Depending on the facility, scribes may independently gather and document clinical information regarding the ROS, PMHX, FMHX, and SOCHX using a standardized template. They may also obtain old medical records and previous studies. All information regarding this history must be reviewed and verified for accuracy by the EP. Scribes should never interject their own opinions or impressions and should never interpret clinical information. Scribes serve strictly in a clerical role that never involves physical contact with patients.

The medical scribe's note should include:

The name of the scribe and a legible signature or electronic signature.
The name of the patient's emergency physician or mid-level provider.
The name of the patient.

The EP's note should indicate:

Affirmation of the provider's presence during the patient encounter.
Verification that the provider reviewed that chart.
Verification of the accuracy of the information.

Scribes may be "home grown" or outsourced — provided by scribe companies. In either case they should be trained for and competent in:

1. Real time documentation. The scribe documents interactively with the EP or mid-level as they interact with the patient. This provides a means to document without barriers between EPs and their patients.

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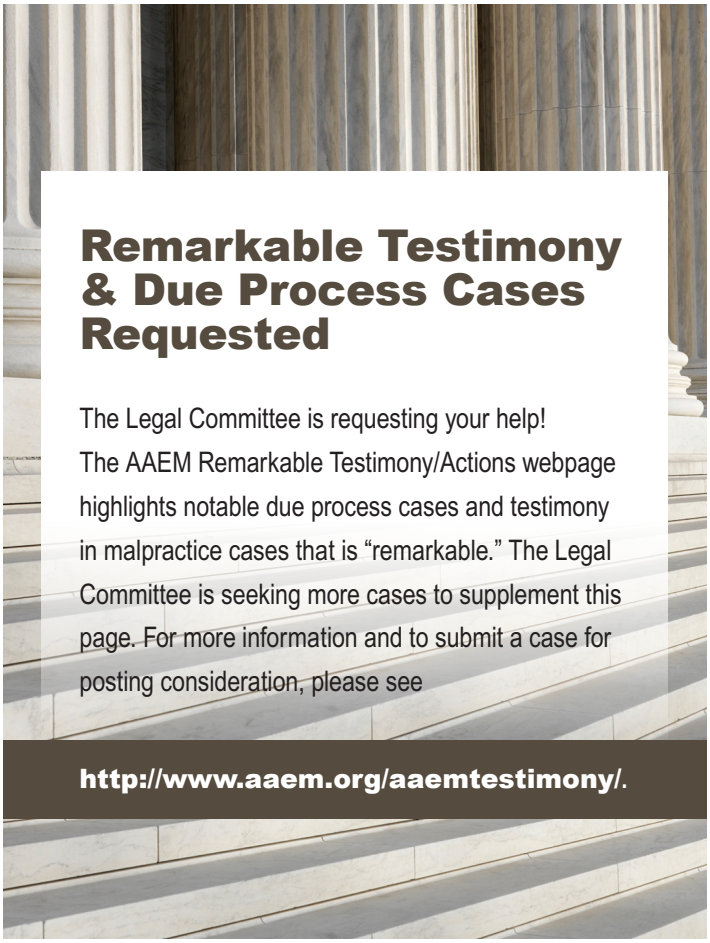

2. Communication. Examples include answering telephone calls for the EP, scanning documents into the EMR, assisting with printing or faxing data, and communicating with other health care providers.
3. Test Collation. Locating diagnostic information including lab and radiology results and recording the interpretation of the provider.
4. Focused health record compilation. Locating and organizing disparate parts of each patient's medical record, including past medical records from the EMR as well as written charts and past diagnostic studies.
5. Advocacy. Acting as a patient advocate by communicating the patient's needs and requests to the appropriate provider.
6. Notification. Notifying the clinician when relevant patient information is available or a patient is available to be seen.
7. Privacy. Depending on the medical facility, serving as a chaperone for sensitive portions of the medical history and physical examination.
8. Boundary Management. Scribes do not physically touch patients, nor should they assist in procedures.

Medical Scribe Credentials

A July 12, 2011, memo from the Joint Commission states that a scribe's position should comply with the institution's human resources requirements. Although scribes are in the patient care area, they do not have direct patient contact. Hiring requirements should thus be limited to what is required of nonclinical personnel, such as unit clerks. Examples of such requirements are a background check, PPD, immunization history (qualitative not quantitative titers), and N95 mask fit-testing.

Many believe that medical scribes should not hold a license; they are acting as living recorders and are not acting independently of a licensed clinician. However, independent credentialing of medical scribes via a national examination, verifying that minimal performance standards have been met, is a valid and reasonable approach. There is currently only one nonprofit professional organization in the industry, the American College of Medical Scribe Specialists, that offers an independent medical scribe credentialing pathway.

Computerized Physician Order Entry (CPOE)

The Joint Commission's memo on May 18, 2010, indicated that scribes could be allowed to enter orders. They reversed that position on July 12, 2011, stating that order entry by scribes was not a supported action. The Joint Commission has not explicitly recognized the difference between pending (entering an order into the computer that is pending approval from the EP, and isn't executed until that approval) and entering orders, however. Thus, with respect to the Joint Commission's opinion on scribe order entry, there is ambiguity regarding whether a scribe will be allowed to "pend" an order, since pending was not specifically mentioned.

There is no ambiguity in regard to CMS and "meaningful use." In Stage 1, CMS indicated that only licensed health care personnel were allowed to enter orders. In contrast to the Joint Commission, CMS did indeed comment on whether scribes would be allowed to pend orders. For Stage 2, CMS stated that scribes cannot pend orders in order to qualify for "meaningful use," because EMRs are presently unable to provide clinical decision support beyond initial order entry. In other words, clinical decision support such as alerts to drug-drug interactions, allergies, etc., only pop-up on order entry and do not appear when an order is pended. Based on this reasoning, one anticipates that when EMRs enable clinical decision support on both the pending and execution pages, CMS will allow scribes to pend orders. CMS did make an exception to its rule and stated that Certified Medical Assistants can place orders. This is a loophole that many practices are using to have others place orders on behalf of physicians.

Are Medical Scribes Worth the Investment?

A major issue in modern health care is cost, and hospitals, EM groups, and individual physicians are being forced to do more with less. That makes the provider to patient ratio critical. Too many groups do not pay enough attention to this, and then wonder why they have to request increased subsidies from their hospitals. With the increased collections and provider productivity that scribes allow, hospitals and EM groups can improve their provider to patient ratios by 15-25%, becoming more efficient and profitable.

Scribes are a part of the ED team in thousands of hospitals in the United States. They are a means to alleviate approximately 80% of our documentation burden, thus allowing emergency physicians to become re-engaged in patient care by devoting more time to patients and medical decision making. And scribes often increase collections enough to pay for themselves! ■

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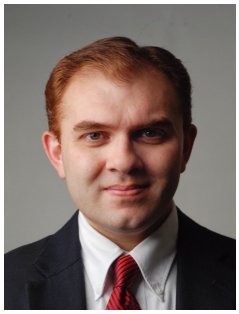

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Setu Mazumdar, MD, CFP®
President, Financial Planner, and
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ABEM Board of Directors Elects Two New Members

At its winter 2014 meeting, the board of directors (BOD) of the American Board of Emergency Medicine (ABEM) elected two new directors: Carl R. Chudnofsky, MD, and Marianne Gausche-Hill, MD. Both were nominated by the emergency medicine community-at-large.

Dr. Chudnofsky is a Professor in the Department of Emergency Medicine at Jefferson Medical College in Philadelphia, Pennsylvania. His clinical practice is with the Einstein Healthcare Network, for which he serves as Chair of the Department of Emergency Medicine and a member of the Board of Overseers and Board of Trustees. Dr. Chudnofsky has over 16 years of service as an ABEM volunteer, having served as an examiner, senior examiner, team leader, and senior case reviewer for the oral certification examination. He currently is chair of the eOral Multiple-Encounter Case Development Panel, and a member of eOral Case Development Panel and eOral Field Test Development Working Group. He also served as chair of the Initial Certification Task Force (ICTF) eOral Pilot Advisory Panel.

Dr. Gausche-Hill is Vice Chair of the Department of Emergency Medicine, and Chief of the Division of Pediatric Emergency Medicine at Harbor-UCLA Medical Center in Torrance, California; and Professor of Clinical Medicine and Pediatrics at the David Geffen School of Medicine at the University of California, Los Angeles. She was an ABEM appointee to the Pediatric Emergency Medicine Subboard, for which she served as chair from 1999 to 2001; chair to ABEM and American Board of Pediatrics Committee for Self-Assessment from 2004 to 2006; and member of the ABEM Emergency Medical Services Examination Task Force from 2011-2013. Dr. Gausche Hill is currently a member of the EMS Examination Committee.

Dr. Chudnofsky and Dr. Gausche-Hill will attend the 2014 summer BOD meeting as observers and begin their terms as ABEM directors at the close of that meeting. The ABEM Board of Directors is comprised solely of volunteer, board-certified, emergency physicians who are actively participating in ABEM Maintenance of Certification, a program of continuous learning and periodic assessment and are practicing physicians in emergency medicine.

About ABEM

Founded in 1976, the American Board of Emergency Medicine (ABEM) develops and administers the emergency medicine certification examination for physicians who have met the ABEM credentialing requirements. ABEM has over 31,000 emergency physicians currently certified. ABEM is not a membership organization, but a non-profit, independent, physician assessment and standard-setting organization. ABEM is one of 24 Member Boards of the American Board of Medical Specialties. ■

JOIN A Committee!

The ACCME Subcommittee, a branch of the Education Committee that maintains AAEM's CME Program, is actively recruiting members.

Subcommittee activities include:

- Ensuring that each educational activity meets the criteria set forth by the Accreditation Council for Continuing Medical Education (ACCME)
- Reviewing applications, faculty disclosures, presentations, and content for all the direct and jointly sponsored activities to ensure all ACCME guidelines are met and the appropriate number of CME credits are determined

To learn more about the responsibilities of all of our committees and to complete an application, visit:
www.aaem.org/about-aaem/leadership/committees

COMMITTEE UPDATE: Practice Management

At this year's Scientific Assembly in New York, the Practice Management Committee met to discuss how to increase participation and work more closely with other committees that share common themes/goals, such as the Operations Management Committee. Dr. David Lawhorn's book on emergency medicine practice continues to move along and he hopes to have it ready very soon.

In an effort to become more proactive and less reactive, the committee is moving forward with a database of existing democratic groups in the country. This endeavor will take some time and effort, but will help us identify groups that may need our help before it becomes too late to save them. We will be reaching out to state chapters and other committees to assist in gathering information from each state.

Other items on the agenda included the possible formation of an AAEM practice management agency, which could provide needed services to members for a fee. Many more details need to be worked out, but we agreed that it is an interesting idea.

Craig Norquist, MD FAAEM
Chair, Practice Management Committee ■

COMMITTEE UPDATE: State Chapter

The AAEM State Chapter Committee held our most recent meeting in New York during the Scientific Assembly. We had great attendance for the meeting, with representation from virtually every state chapter. Each representative presented their chapter reports to the committee. We also discussed recent activity over the last few months, as well as chapter development and membership growth strategies.

In Tennessee, members have sponsored AAEM membership for a local EM residency (Vanderbilt). We encourage other chapters and other AAEM members to consider supporting AAEM membership for residencies in their state.

Delaware Valley continues to hold their highly successful annual Residents Day, drawing over 200 attendees, with the morning containing resident-focused lectures and the afternoon consisting of an LLSA review for attendings and community physicians.

Virginia chapter leadership has been actively working with the state legislature to eliminate Virginia's PEND program, a Medicaid program that decreases reimbursement for ED care determined in retrospect to be "nonemergency."

California chapter will be working with CAL/ACEP and other California medical associations on the pending 2014 ballot initiative (and a possible legislative initiative too) from trial lawyers to overturn MICRA — California's medical liability reform law establishing caps on non-economic damages, limiting attorney fees, and preserving access to care. They also held their Third Annual San Francisco Speaker Series in the fall as an educational and networking event for members.

The Florida chapter is planning to coordinate more activities with local medical schools and their student emergency medicine interest groups, in order to drive membership growth.

In Louisiana, we are currently working with AAEM leadership and members in Louisiana to reorganize and reactivate that chapter later this year.

The reorganized New York chapter held its first in-person board meeting during Scientific Assembly. The board looks forward to growing chapter membership and developing more membership benefits. They are also looking into extending membership in their chapter to the Tri-state area, which would include Connecticut and New Jersey.

Texas chapter has held regular meetings and is working to promote the 2015 Scientific Assembly, which will be held in Austin. There was a discussion about psychiatric care issues in their state, and ED boarding of psychiatric patients, which prompted a great discussion about similar issues in EDs throughout the country. Texas members also spoke of how the passage of significant tort reform has led to a much improved practice environment for emergency physicians, with an increasing number of physicians entering the state to practice.

The Great Lakes chapter (Indiana, Illinois, Iowa, Michigan, Minnesota, Ohio, and Wisconsin) held its first in-person board meeting in New York, and its leadership has done a great job of recruiting representatives from each state for the board.

Finally, Dr. Brian Drummond, an AAEM member from Arizona, is working to start an Arizona state chapter. We will continue to work with him to support a new state chapter there.

I encourage AAEM members to get involved in their state chapter. If you live in a state that doesn't have a state chapter, get involved to help form one. Having two regional chapters, we are considering a plan to replicate this strategy of pooling membership, resources, and leadership to form regional chapters in other parts of the country. AAEM will provide significant support to help you through this process. I would especially encourage other past AAEM board, YPS, or RSA leaders to get re-involved with AAEM by joining your state chapter leadership or getting involved in starting a new chapter. We would also like to find AAEM supporters on faculties, who could serve as residency program liaisons with their state chapters. If you are an AAEM member and interested in becoming more involved in a state chapter, please contact me at brianpottsmd@gmail.com.

Brian Potts, MD MBA FAAEM
Chair, State Chapter Committee ■

CHAPTER REPORT: Florida AAEM

The following press release was sent to media outlets on March 17, 2014.

AAEM and FLAAEM Concerned Over Florida Supreme Court Ruling Removing Cap on Non-Economic Damages for Medical Malpractice

MILWAUKEE — The American Academy of Emergency Medicine (AAEM) and the Florida state chapter of AAEM (FLAAEM) are concerned about the effect of Thursday's ruling by the Florida Supreme Court and its implications for the emergency medicine community.

The court's 5-2 ruling will remove caps of $500,000 on non-economic damages and $1 million on damages on wrongful death claims, originally set in place in 2003. In response to the ruling, the president of the Florida Medical Association, Alan Harmon, MD, noted that the caps were originally enacted "to counter the out-of-control litigation that was driving physicians out of the state and discouraging new physicians to locate in Florida. The caps have helped begin to stabilize the medical liability climate in Florida. Insurance premiums, while still high compared to other states, have started to level off since the caps were put into place."[1]

David A. Farcy, MD FAAEM FCCM FACEP, president of FLAAEM, echoes concerns that the ruling may increase costs and limit access to care stating, "Physicians will return to practicing a more defensive type medicine by ordering more tests to protect themselves, resulting in increased health care costs, longer wait times and length of stay in the emergency department." Dr. Farcy also noted that the decision may discourage new medical graduates and other specialists, such as OB-GYNs and General Surgeons, from remaining in Florida due to the high cost of medical malpractice premiums.

Mark Reiter, MD MBA FAAEM, president of AAEM, added that "AAEM is committed to a future where all patients presenting to our emergency departments are cared for by emergency medicine specialists. This ruling is a major step back as many emergency physicians in Florida may now choose to leave what has now become one of the worst medicolegal environments in the country."

1. Press Release, Florida Medical Association "Supreme Court Invalidates Medical Liability Caps" http://www.flmedical.org/Supreme_Court_invalidates_caps.aspx.

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YPS Vice President's Message

Why Don't EM Physicians Reproduce?

Jonathan Jones, MD FAAEM
YPS Vice President

OK, maybe that's not the exact question that we need to answer, but it's better at getting your attention than "Currently, there are not enough emergency physicians (EPs) in the United States to adequately staff the country's emergency departments, and the rate of growth of the specialty is not going to remedy the situation anytime soon." Basically, our country needs more of us and we're just not helping out enough.

Let's start with some facts. Per the most recent CDC data, there are 129.8 million ED visits annually.[1] Per the most recent data from ABEM, there are about 30,000 board certified emergency physicians.[2] Simple math shows each ABEM-certified physician needing to treat 4,327 patients annually. There is debate over the number of patients an EP can or should see per hour, but most agree that the number is somewhere between 1.8 and 2.8 depending on patient complexity, boarding times, and a multitude of other factors. Complexity and boarding have been increasing, which makes us less productive in terms of patients per hour. These numbers mean that the average EP would need to work from 1,545-2,404 hours per year. Almost all emergency physicians work fewer hours than this — an average may be around 1,440 hours per year. So, we have a problem.

The problem is that there are high-acuity, highly complex patients who are not being treated by a qualified, board-certified specialist in emergency medicine. So — blah, blah blah, we all know there is a shortage of emergency physicians. We've known about it for years. We hate to admit it, but we haven't really done much about it because, well, nothing is **too** broken — or at least there hasn't been a huge news exposé on the problem yet.

Do you know who is responsible for this problem? We are. Why are we, the hard working EPs, responsible? We're responsible because we are the only ones with the knowledge and expertise to understand the problem and its potential solutions. Do you know why idiots in the big bad government legislate fixes to problems they don't understand? Because the people with expertise did nothing for so long that the public finally took notice and demanded something be done.

It's time we started exploring the problem and proposing realistic solutions. To start the conversation, let me propose some ground rules on which I believe our discussion should be based.

- All Americans — not just those is large population centers — deserve expert emergency care.
- Emergency medicine is a complex specialty which requires specialized residency training.
- Expert emergency care is only provided by ABEM or AOBEM-certified emergency physicians.
- Emergency care provided by physicians from other specialties who have experience in emergency medicine is not expert care.
- Emergency care provided by moonlighting EM residents is not expert care.
- Emergency care provided by non-physicians is not expert care.

What do you think? Are these statements true? Think about them and their repercussions in depth. They sound good, but are we really prepared to address the problems facing Americans in need of emergency care if we agree with the above?

Where will we get all the new experts needed? Can residencies expand fast enough? Do we even have enough qualified teachers to expand residencies? Are we willing to work more hours? Would it be safe if we did? Should we work faster? Would it be safe if we did? Are we willing to work in rural settings? Are we ready to eliminate mid-level practitioners from the ED?

If the six assertions listed sound good, but the answers to the above questions are not easily and immediately answered, then we have a disconnect. My hope is that I've given you something to think about on your next slow night shift — you know, the shift were you are only seeing 1.8 patients an hour. I'll share some of my ideas for answers in the next issue of *Common Sense*. What are yours? Share them in a "Letter to the Editor" or shoot me an email at jsjones3@umc.edu.

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2014-2015 Elections: Young Physicians Section

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Vice President
Jonathan Jones, MD FAAEM*

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Megan Healy, MD
Mimi Lu, MD FAAEM**
Sarah Terez Malka, MD

YPS Director
Michael Ybarra, MD FAAEM

*Elected as At-Large, appointed to Vice President
**Appointed

2014-2015 Elections: Resident & Student Association (AAEM/RSA)

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Ex Officio: Mark Tschirhart — St. George's University

AAEM/RSA President's Message

AAEM/RSA — With You All the Way

Meaghan Mercer, DO
AAEM/RSA President

Emergency medicine is a specialty known for high burnout. Professional burnout is described and measured in many different ways, but it encompasses a loss of enthusiasm for work, emotional exhaustion, disparagement, depersonalization, a loss of empathy, and feeling a lack personal accomplishment. A study done in the 1990s showed that, of surveyed emergency physicians, 77-80% of physicians said that EM had met or exceeded their career expectations but 31-33% still noted that burnout was a significant problem in their work life. We have a dichotomous emotional response to our work: a love of what we do and a component of exhaustion from it. We can have large swings of daily highs and lows, or a day full of benign abdominal pains. We often present ourselves as emotionally open and able to look at all things objectively, but with burnout we can become emotionally blunted. How do we prevent this? There have been many proposals on how to prevent burnout, but fundamentally the answer is in rediscovering what drew us to EM initially and letting that continue to motivate us day to day.

As residents we have numerous motivations: reward, punishment, acknowledgment, evaluations, pride, and peers; but Dan Pink makes a compelling argument in his book *Drive* that the greatest motivators are autonomy, mastery, and purpose. These intrinsic factors sustain our creativity, passion, and enhanced performance. As we enter the post-residency world, our intrinsic motivation is what keeps the spark going.

Autonomy is the ability to be self-directed, and when this is allowed in the workplace it leads to engagement in tasks. This is seen in teaching institutions. As residents progress through their training they begin to take control of their education, challenging ideas and testing themselves. New graduates often express much higher job satisfaction, unrelated to the sudden increase in their free time, because of their new ability to be self-directed in medical decision-making. Mastery motivation is the impetus to achieve and improve your skills in the absence of any physical reward. When external forces are no longer looming over us, telling us we have to keep learning, we have an innate desire to know and do more. We want to be masters of our field. This is the same force that often drives our hobbies. Playing an instrument, climbing the difficult route, and finishing an art piece, all fulfill our need to master a subject or task. Purpose is the challenge and desire to contribute. This is an obvious motivation in the FOAM movement. The brightest minds in our field have endless demands on their time, yet they use their free time to create materials to educate and advance the field and then give it away for free.

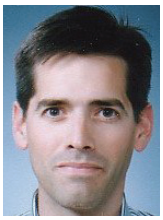
We are intrinsically motivated when we are doing an activity for ourselves and extrinsically motivated when we are doing it for a reward. Residency is the time to find out what motivates you. We take for granted this environment, where we have a great safety net of nurturing individuals that want us to succeed. Seize the opportunity to interrogate yourself, to find what drives you forward, and what will allow a life-long fulfilling career. Discover what gives you the deepest reward — do a fellowship so you can master a specific realm of our field, contribute to the ever growing FOAM movement to add purpose to your research or self study, or find something you love outside of medicine so that you have balance and passion all areas of life.

I would love to hear what motivates you and any comments on my column. Please email me at mercer.meaghan@gmail.com. ■

RSA Editor's Letter

Calling Back, Checking Up, Finding Out

Edward Siegel, MD MBA
AAEM/RSA Publications Committee Chair



With the exception of occasional resident research projects, most RSA members are insulated from efforts to improve efficiency, patient satisfaction, and the other dollars-and-cents concerns of running an emergency department (ED) that dog administrators. There is, however, a team in almost every ED that is focused solely on those things. These teams are constantly trying new innovations, methods, and systems to gain efficiency and improve (or reach) profitability.

Our hospital recently initiated a patient call-back system, following in the footsteps of many other EDs nationwide. This system was implemented with several goals in mind, with improved patient care chief among them. Our program is young, but it may interest those looking for ways to improve their own emergency departments.

The program starts with the attending physician who sees the patient on the initial visit. He or she earmarks the patient for callback. There are no hard-and-fast criteria for who is added to the callback list, but most patients either don't have a cut-and-dried diagnosis, or made the doctor concerned about adequate follow-up or pain control at home.

Determining who makes the calls is usually a choice between in-house and out-sourced systems. In-house systems have the benefits of ready access to patient records, faster access to members of the patient's treatment team, quicker referrals to in-hospital providers, and brand reinforcement. Shortcomings of in-house systems include lack of adequate staffing, the need for job-specific training, and possible conflicts-of-interest between personnel who may be working together. Out-sourced programs have the ability to run day or night, avoid draining hospital personnel resources, utilize employees who are specifically trained for the task, and have systems in place to quickly synthesize the collected data. Out-sourced systems have greater cost, utilize personnel who are not familiar with the hospital or care system, and bear the burdens that come with sharing confidential patient information with a third party. At our institution the call-back system is run by an in-house group that is tangentially involved in ED operations, but no ED physicians make calls themselves.

The calls focus on three questions: did the doctor listen effectively, did the doctor explain treatment, and did the doctor address concerns? Each answer is given a numerical score. The patient is also given the opportunity to express problems such as worsening symptoms, inability to obtain prescriptions, etc.

The two benefits that I see from this program are improved patient care and improved patient satisfaction. From a care standpoint, the follow-up calls are an opportunity to re-address a complaint if the working diagnosis and treatment appear incorrect. Try as we might, our diagnostic and clinical abilities are not perfect. A 2007 study of missed/delayed diagnoses showed myriad causes — many of which are beyond the control of the doctor or require proper follow-up and compliance on the part of the patient. A call-back program gives us another bite at the apple, another opportunity to properly diagnose and care for our patients, and one last chance to avoid breakdowns in the chain of diagnostic steps listed in the table,1 compiled from 79 malpractice suits in which an error could be identified.Patient satisfaction is addressed in two ways. First, the call-back enables patients to directly rate their physicians, thereby alerting a practice to a physician who may be perceived as uncaring or detached. Second, it shows patients that we continue to care about their health even after they have left the ED. The hope is that more satisfied patients are more willing to follow the advice of their ED doctor/nurse, and are less likely to pursue punitive measures if they are displeased with the level of service they obtained.

The pros of such a program become obvious with every missed diagnosis that is caught. It is hoped that the program will reduce malpractice suits and earn the ED a reputation for caring about the members of its community.

The cons lie in some of the rougher edges of the program, which may be smoothed over time. A large percentage of patients on our call-back list cannot be reached, either because they gave incorrect demographic

Continued on next page

information or chose never to return phone messages. Potential for bias in selecting patients for call-back could be mitigated by relying on diagnosis, rather than attending physician choice.

Table 2. Diagnostic steps and frequency of breakdowns at each step.

Step	No.	%*
Patient notes problem and seeks care	3	4
Provider performs medical history and physical examination	33	42
Provider orders appropriate tests	46	58
Ordered tests performed in a timely manner	3	4
Ordered tests performed correctly	1	1
Test results transmitted to and received by the provider	13	16
Test results transmitted to and received by the patient	6	8
Interpretation of test results	29	37
Provider orders consultation (or referral)†	26	33
Requested consultation (or referral) occurs†	1	1
Creation of proper follow-up plan	21	27
Patient adherence with plan	6	8

*Calculated as a percentage of 79 claims with identified errors.

As discussed in my last editorial, we live in a world where we doctors often play the role of salesmen: selling ourselves as competent professionals, selling our recommendations as credible avenues toward better health, and selling ourselves as caring and active members of the community in which we practice. A call-back program is one method for reaching out to our customer-patients, in the hope that more dialogue will lead to better health and greater satisfaction on both sides of the health care system.

Thanks to Thomas Kurtz, Associated Hospital Director of Emergency Services, Logistics, and Specialty Care Transport at Temple University Hospital, who provided me with information and research sources about the call-back program which he helped implement at our hospital.

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Resident Journal Review

Updates in Emergency Department Management of Sepsis

Authors: Eli Brown, MD; Allison Regan, MD; Kaycie Corburn, MD; Jacqueline Shibata, MD
Edited by: Jay Khadpe, MD FAAEM; Michael C. Bond, MD FAAEM

Severe sepsis is responsible for more than 750,000 hospitalizations each year in the United States, and treatment will be initiated in the emergency department (ED) for about 500,000 of these patients. The significant mortality associated with sepsis and septic shock, and the substantial cost and utilization of resources associated with this illness, has prompted the development of the Surviving Sepsis Campaign (SSC). The SSC is an international collaboration with the objective of reducing mortality due to sepsis and stimulating research. The SSC has made recommendations for the management of severe sepsis and septic shock that focus on identification of high-risk patients, early antibiotics and cultures, and early goal-directed therapy. This review addresses the evidence behind early antibiotics in sepsis as well as sepsis severity scores, sepsis biomarkers such as procalcitonin, and resuscitation endpoints such as lactate clearance and central venous oxygen saturation ($ScvO_2$).

Zhao Y, Li C, Jia Y. Evaluation of the mortality in emergency department sepsis score combined with procalcitonin in septic patients. *American Journal of Emergency Medicine.* 2013 Jul;31(7):1086-91.

The Mortality in Emergency Department Sepsis (MEDS) score is used to evaluate the severity of disease and to predict the mortality of patients with suspected infection in the ED. It was derived from 2,070 patients using nine historical, examination, and laboratory findings to form a score ranging from 0 to 27. It was validated in 2008 as an accurate prediction tool for 28-day mortality in patients who present to the ED with systemic inflammatory response syndrome (SIRS) (Sankoff 2008).

Biomarkers such as procalcitonin (PCT), Interleukin-6 (IL-6), and C-reactive protein (CRP) are commonly used for diagnosis and prognosis of sepsis. The authors of this study hypothesized that the combination of the MEDS score with biomarkers would enhance the ability of risk stratification and prognostic evaluation for patients presenting to the ED with sepsis.

This was a prospective, blinded study that included 570 patients presenting to a single tertiary care hospital with suspected infection and at least two SIRS criteria. All enrolled patients had blood collected for CRP, PCT, and IL-6 analysis. In addition, the MEDS score for each patient was calculated. The primary outcome was the presence of severe sepsis or septic shock. The secondary outcome was 28-day mortality. Hospital records were followed for 28 days after ED admission or until death.

Of the 501 enrolled patients, 319 (63.7%) had sepsis, 155 (30.9%) had severe sepsis, and 27 (5.4%) had septic shock. A total of 134 patients failed to survive, for a 28-day mortality of 26.7%. The MEDS score had the largest area under the curve (AUC) (0.793 for severity of sepsis and 0.776 for 28-day mortality). It also had the highest specificity, positive predictive value (PPV), and negative predictive value (NPV) (85.3%, 70.4%, and 79.5% for severity of sepsis and 81.7%, 55.6%, and 85.7% for 28-day mortality). Logistic regression found that the MEDS score and PCT were the only relevant variables that were statistically significant ($P<0.05$). A new combination of the MEDS score and PCT was compared with the MEDS score and PCT alone, and found that there was a significant difference in the severity of sepsis (AUC, 0.8952 vs. 0.793; $p < 0.001$) and in 28-day mortality (AUC, 0.813 vs. 0.776; $p = 0.008$). The new combination also had better sensitivity, specificity, PPV, and NPV for both evaluating severity and for predicting mortality.

One limitation of this study is that only one biomarker concentration, rather than serial levels, was obtained at the time of ED evaluation. Additionally, this was a relatively small study and was carried out at a single institution. A broader clinical trial with multiple centers is required to prove that these results are applicable to all ED patients presenting with sepsis.

Puskarich MA, Trzeciak S, Shapiro NI, Arnold RC, Horton JM, Studnek JR, Kline JA, Jones AE; on behalf of the Emergency Medicine Shock Research Network (EMSHOCKNET). Association between timing of antibiotic administration and mortality from septic shock in patients treated with a quantitative resuscitation protocol. *Crit Care Med.* 2011 Sep;39(9):2066-2071.

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The SSC guidelines recommend initiating broad-spectrum antibiotics within one hour of recognizing severe sepsis and septic shock. The objective of this prospective study was to assess if there is an association between the timing of initial antibiotics and mortality in patients presenting to three U.S. EDs with septic shock.

The study was an analysis of a previously completed prospective, non-blinded, randomized clinical trial comparing lactate clearance to $ScvO_2$ as a tool for assessing resuscitation of sepsis. The trial took place at three urban tertiary care hospitals and included patients with age greater than 17 years with suspected infection, at least two SIRS criteria, and evidence of hypoperfusion (either hypotension after fluid challenge or lactate >4mmol/L). All patients received broad-spectrum antibiotic coverage according to hospital guidelines. The primary outcome evaluated was in-hospital mortality. The study compared outcomes of subjects who received an initial dose of antibiotics to those receiving antibiotics before each hourly increment. The study also assessed for differences before each hourly increment after shock recognition.

Of the 300 patients enrolled in the study, nine were excluded due to receiving a first dose of antibiotics prior to hospital arrival. One hundred seventy-two (172) out of 291 (59%) patients received the initial dose of antibiotics after recognition of shock. Overall mortality was 55 of 291 (18.9%) patients. One hundred (100) out of 291 (34.4%) patients grew positive blood cultures for pathologic organisms, with a mortality rate of 26.0%. The mortality rate for those with blood culture negative septic shock was 29/191 (15.2%).

The median time from triage to initial antibiotic administration was 115 minutes. The odds ratio (OR) for inpatient mortality was 1.18 (95% CI 0.57-2.46) for the group who received antibiotics within one hour of presentation and 0.71 (95% CI 0.39-1.30), for the group receiving antibiotics between one and two hours from triage. No association was found between in-hospital mortality and the time from ED triage to antibiotic administration. The median time to shock recognition was 89 minutes, and 172 (59%) patients received antibiotics after shock recognition. Those patients who received antibiotics after shock recognition were more likely to die with an OR of 2.35 (95% CI, 1.12-4.53).

This study found no association between mortality and time from triage to initial antibiotic administration. However, the data do suggest an increase in mortality if antibiotics are delayed until after shock recognition, though there was no increase in mortality if they were administered within three hours of shock recognition. A major limitation, however, is the near impossible nature of identifying the exact time for onset of septic shock. In addition, the timing of antibiotics was not randomized in this study, but retrospectively analyzed. To demonstrate a true benefit from early antibiotic administration, additional randomized control trials are necessary.

Brunkhorst, F, et al. Effect of empirical treatment with moxifloxacin and meropenem vs meropenem on sepsis-related organ dysfunction in patients with severe sepsis. *JAMA.* 2012;307(22):2390-2399.

Antibiotics are a mainstay of therapy for patients with severe sepsis. Choosing inappropriate antibiotics can have deleterious effects on patient outcomes. Recent sepsis guidelines have encouraged empiric combination therapy to cover gram-negative organisms despite a lack of evidence to support improved outcomes over monotherapy.

This particular study set out to compare combination therapy with two broad-spectrum antibiotics to monotherapy on sepsis related organ dysfunction. Subjects for the study were randomized to either meropenem/moxifloxacin or meropenem alone for a total of seven to eight days. Of note, administration of the medications was not blinded. There was also co-administration of other medications such as activated protein C, hydrocortisone, selenium, and prednisolone to some of the study subjects based on clinician discretion.

The primary outcome was sepsis-related organ dysfunction, which was measured using the Sequential Organ Failure Assessment (SOFA). A SOFA score is based on subscores for six organ systems ranging from 0-4. Therefore, the overall SOFA score ranges from 0 to 24, with higher scores indicating increasing organ dysfunction. Patients had a calculated mean daily SOFA score over a period of 14 days or until the end of their ICU stay. Secondary end points included 28-day and 90-day all cause mortality.

Six hundred patients were randomized into the study from 44 academic ICUs in Germany. Forty-nine patients were excluded due to inability to obtain informed consent. There was no significant difference in overall SOFA score for the combination therapy group compared to the monotherapy group: 8.3 and 7.9, respectively (7.9 and 7.6, respectively in the per-protocol analysis). There was also no difference in rates of 28-day

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and 90-day mortality. At day 28, there were 66 deaths in the combination group and 58 deaths in the monotherapy group. At day 90, there were 96 deaths in the combination group and 84 deaths in the monotherapy group.

Overall, there was no benefit to combination therapy of meropenem/moxifloxacin versus meropenem monotherapy in regard to 14-day mean SOFA score or any secondary end-point in this study. It is important to keep in mind that this particular study tested specific antibiotics and cannot be generalized to the efficacy of other antibiotics. In addition, most participants received antibiotics within 1.5 hours and this may not be a standard that can be met in clinical practice. More data are needed to determine the best antimicrobial treatment for severe sepsis.

Jones AE, Shapiro NI, Trzeciak S, Arnold RC, Claremont HA, Kline JA. Lactate clearance vs central venous oxygen saturation as goals of early sepsis therapy. *JAMA.* 2010;303(8):739-746.

The SSC guidelines recommend monitoring $ScvO_2$ as a marker of tissue oxygen delivery. However, this is controversial since the recommendation was based on a single center study and because $ScvO_2$ testing requires time, expertise, and special equipment that complicates its use in many EDs.

This study is a multicenter, randomized, non-inferiority trial comparing the change in lactate levels vs. $ScvO_2$ for monitoring tissue oxygen delivery in sepsis patients in the ED. The trial enrolled 300 patients from EDs of three large U.S. urban medical centers. Included patients were older than 17 years who met SIRS criteria with hypoperfusion (defined as SBP<90mmHg after a 20cc/kg volume challenge) or had a lactate of >4mmol/L. Both groups had mean arterial pressure (MAP) and central venous pressure (CVP) measured and were randomly assigned to either $ScvO_2$ or lactate measurement. The primary outcome measured was in-hospital mortality rate. Secondary outcomes were ICU length of stay, hospital length of stay, ventilator-free days and new onset multiple organ failure.

All patients received CVCs that could monitor $ScvO_2$. Patients in both groups were given crystalloid boluses to achieve a goal CVP >8mmHg. The next goal was to keep MAP >65mmHg by giving fluids and, if unsuccessful, vasopressors. In the $ScvO_2$ group, if $ScvO_2$ was less 70% and hematocrit (Hct) was <30%, then packed red blood cells (pRBCs) were transfused. If $ScvO_2$ was still low after achieving Hct >30% then dobutamine was administered. In the lactate clearance group, lactate was measured at least every two hours and if <10% clearance and Hct <30%,

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pRBCs were transfused. If Hct >30%, dobutamine was titrated to lactate clearance of 10% when measured each hour. Patients were treated until all treatment goals were achieved or until six hours had elapsed.
The CVP goal was achieved in 133 patients in both groups and the MAP goal in 142 patients in both groups. The lactate clearance goal was met in 139 patients and the $ScvO_2$ goal met in 136 patients. In-hospital mortality was 23% in the $ScvO_2$ group with 17% in the lactate clearance group. There was no statistically significant difference in-hospital mortality between the two treatment arms. There was also no significant difference in adverse outcomes.

The authors conclude that lactate clearance goals should be used as a substitute for attempts to normalize $ScvO_2$ in early goal-directed therapy for sepsis, as lactate measurements are easier to perform in the ED. However, the study was limited in that it was not blinded. In the future it would be interesting to see how these various goal-directed therapies compare to placebo. In the meantime, it appears lactate monitoring is, at a minimum, non-inferior to $ScvO_2$ monitoring in the guidance of early sepsis therapy.

Puskarich MA, Trzeciak S, Shapiro NI, Albers AB, Heffner AC, Kline JA, Jones AE. Whole blood lactate kinetics in patients undergoing quantitative resuscitation for severe sepsis and septic shock. *Chest.* 2013;143(6):1548-1553.

Despite significant morbidity and mortality due to sepsis, the endpoints of adequate resuscitation remain unclear. As discussed above, two possible markers that have been proposed are lactate clearance and $ScvO_2$. Elevated lactate in septic patients has been associated with increased mortality, and previous studies have demonstrated that a lactate clearance of 10% or more in sepsis resuscitations has been associated with improved outcomes.

This study is derived from the larger parent study by Jones, et al., discussed above. It is a prospective, non-blinded, randomized trial that enrolled 187 patients. Inclusion criteria were as follows: age >17 years, confirmed or suspected infection, two or more SIRS criteria, and hypotension after a fluid challenge or blood lactate of $\geq$4mM or initial lactate $\geq$2mM. All patients were resuscitated in the ED with intravenous crystalloid with a goal CVP >8mmHg, followed by vasopressors to maintain MAP >65mmHg. Patients were then transfused pRBCs and/or given inotropes, with one group having a goal of lactate clearance of $\geq$10% and the other group having a goal of $ScvO_2$ $\geq$70%.

The primary outcome of the study was in-hospital survival. Overall survival was 143 of 187 patients (76.5%). The lactate clearance arm included 98 patients, while the other 89 patients were randomized to the $ScvO_2$ arm. Lactate normalization was the best predictor of survival (OR, 6.3; 95% CI, 2.4-17.0), followed by lactate clearance of 50% (OR, 4.3; 95% CI, 1.8-10.2). Differences in mortality rates for patients with initial lactate of 2-4mM compared with >4mM and lactate clearance of 10% were not statistically significant.

This study found that normalization of lactate to $\leq$2mM and lactate clearance of 50% were the best independent predictors of survival in septic shock. In particular, lactate normalization was more closely associated with a favorable prognosis when compared to absolute clearance, relative clearance, and rate of clearance.

The authors cite several weaknesses to this study and its results. For example, the centers from which patients were enrolled had resuscitation protocols in place prior to initiation of the study; therefore the results may not be generalizable to other institutions where such protocols do not exist. Finally, lactate measurements were made at variable times, about two hours apart (median of 133 minutes). Therefore lactate clearance rates may underestimate actual rates.

Conclusion

Severe sepsis and septic shock represent a considerable burden on the health care system in the U.S. and worldwide. With about 500 deaths per day in the U.S. due to septic shock, mortality rates due to sepsis now nearly surpass those of out-of-hospital myocardial infarction. The Surviving Sepsis Campaign emphasizes timely identification of high-risk

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patients, early administration of antibiotics, and goal-directed interventions. Despite these recommendations, there are many unanswered questions in the literature regarding methods of identifying these patients, which antibiotics should be administered and within what period of time, and which objective measurements should be used to guide resuscitation.

For early identification of sepsis, the Mortality in Emergency Department Sepsis (MEDS) score, particularly when used in combination with the biomarker procalcitonin, appears to aid in risk stratification as well as prognostic estimation.

Although the literature reviewed found no association between mortality and time from triage to initial antibiotic administration, an increase in mortality was associated with administration of antibiotics after the recognition of shock. Another study which compared dual therapy with meropenem and moxifloxacin to monotherapy with meropenem demonstrated a lack of benefit of combination therapy with regards to sepsis-related organ dysfunction and mortality rates.

Finally, lactate clearance of 10% was found to be equivalent to the achievement of a $ScvO_2$ of 70% as a resuscitation goal in septic shock with respect to in-hospital mortality rates. Additional literature suggests that a higher lactate clearance of 50% as well as using lactate normalization as a goal may be more accurate predictors of survival. ■

Medical Student Council President's Message

El Campo

Mary Calderone, MS4

As I sat staring at the snow-capped mountains of Bolivia through the tiny window of my plane, my excitement fueled a steadfast surge of energy despite the arduous voyage from snowy Chicago. This marked my first international health experience, something I had anticipated since my first year of medical school and would finally realize in February of my fourth year. Escaping the frantic Match rank-list deadline frenzy, I set out to explore a long-standing interest in global health with Elise Heeringa, one of my best friends and fellow EM-bound classmates.

I first became interested in working at Centro Medico Humberto Para, our ultimate destination, when I met Dr. Susan Hou during my first year of medical school. Dr. Hou is a nephrologist at Loyola who made headlines when she donated a kidney to a patient. She founded the clinic in 2001 with her husband, Dr. Mark Moltich, an endocrinologist at Northwestern. A significant amount of the clinic's funding comes from the salaries of Dr. Hou and Dr. Moltich. Dr. Hou's altruism made her an obvious candidate for the Arnold P. Gold Humanism in Medicine Award. As one of my school's AAMC OSR representatives, I had the privilege of writing her nomination letter and in the process became wholly inspired by her passion for social justice and global health. Dr. Hou's examples of extreme altruism were provocative, inevitably inviting me to reflect on my own capacity for selflessness and humanism and how that might play out in my career. Having always enjoyed participation in community service activities with the Latin-American community in Chicago, I hoped one day to travel to Bolivia to see her brainchild in action.

Before this trip, I approached my interest in global health with a mixed bag of idealism and skepticism. Undoubtedly, I believed in the importance of taking responsibility for the health of humanity and deeply admired and respected what leaders in this area have accomplished. However, I questioned the impact a senior medical student could have. Would the resources required to send me on a service trip be better utilized funding surgery or medications for a patient? Would I contribute in a way that could be sustained even after I boarded the plane to return home? Could I adapt my medical knowledge and skills to an entirely new health system and cultural paradigm? I also struggled with guilt over the suspicion that I might be gaining more out of this experience than the patients I hoped to serve. Ultimately, I knew real-world experience was required to settle this internal dialogue.

Arriving in the airport on our first day, we met the volunteer coordinators who drove us in a trusty white SUV through the muddy roads, evidence that rainy season had arrived with force. We eventually reached the volunteer house in Santa Cruz, where we would spend Sundays through Tuesdays exploring the city or using it as a launch-point for regional travel. Santa Cruz is one of the largest and wealthiest cities in Bolivia, a stark contrast to the community of Palacios, where we would spend Wednesdays through Saturdays working at the clinic. The environment of Palacios is a hybrid rural/rainforest setting, which we affectionately referred to as el campo in Spanish. Despite the remoteness of its location, the clinic is modern and functional, with several private examination rooms, visual aids for teaching, wound care supplies, an air-conditioned closet for storing pharmaceuticals, a lab that performs most basic blood, urine, and stool studies, and even an EMR system.

In the clinic, students see patients independently and then staff with resident and attending volunteers from the U.S. or with native Bolivian physicians. The history, physical, presentation, and note writing all occur in Spanish. Every day of the week at least one specific community travels by bus to the clinic, with patients in need of acute medical attention or follow-up for chronic issues such as diabetes and hypertension. Most patients we saw mirrored typical cases encountered in a primary care setting (sometimes with a tropical twist to the pathology and nearly always with unique barriers to care). Occasionally, however, a few emergent situations arose and required immediate attention, requiring us to transport patients to the hospital and advocate for them as they sought further care.

In the process of transporting these acutely ill patients to local hospitals, I learned about some of the differences between the American and Bolivian health care systems. Patients are first brought to the hospital, seen by a physician, and given a list of orders and medications. A patient's family member must then leave the patient at the hospital and travel to a separate pharmacy to purchase all of the medications and supplies needed to complete the orders. Only after the patient's caretaker returns with these purchases can the orders be carried out. If the patient cannot afford the medications or supplies, the orders are not fulfilled. Some emergency care can be extended in certain situations as an exception, but that is limited. I've always understood EMTALA to be an important cornerstone to the profession of emergency medicine, but witnessing its absence gave me an even deeper appreciation of its need and purpose.

Among the many lessons I learned during my first global health trip, the concept of adaptability as a clinical skill was the most important. For one thing, in a setting like the campo imaging is not easily accessible. For another, even though the clinic contained a rather sophisticated lab, due to changes in the laboratory staff many of basic labs were not available. What I did have was a stethoscope, my senses, and the knowledge and skills I've learned in medical school. Although the lack of additional information from labs and imaging could be frustrating, I enjoyed the added motivation to perform a thorough physical exam and reaped benefits as that had an impact on our management of patients. When I encountered a patient with shortness of breath, an S3, and an irregular rhythm on palpation, it led to ordering an EKG — the kind without the interpretation written neatly on the top of the paper. We crowded around it and read it in a step-wise manner, finding evidence of an old inferior infarct, atrial fibrillation, and a brief run of V-tach — leading us to

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transport him to a nearby hospital for an ACS and CHF work-up. Although I acknowledge that having an EKG machine is a luxury, it was liberating to utilize skills that are often taken for granted when technology so readily replaces them.

A certain adaptability is also required when it comes to deciding when labs and imaging are necessary. When developing a plan I constantly asked myself, "Does the potential impact of this test warrant obtaining it?" With every decision that seems minute at home, comes a palpable debate about its benefit relative to its cost. Dr. Hou once confided that this concept has invaded even her personal decisions about resource utilization: "Our dilemma is not that the problems are so big, but that they are so small. $280 is the cost of a life saving hysterectomy for a woman with cervical cancer. Now, every time I spend $280 I feel like I'm deciding between buying a gown or saving a life. You begin to count money in Bolivian hysterectomy equivalents." I began to question the value of some common practices in the U.S., like the daily electrolytes and CBCs performed on admitted patients.

Mary Calderone, MS4 (right), and Elise Heeringa, MS4 (left).

The need for adaptability also confronted me during the time I spent counseling patients with obesity, hypertension, and diabetes. Patients from the *campo* don't always have access to a wide variety of foods. Most of the time they are simply trying to make the most of what is readily available, which happens to include many carbohydrate-heavy staples like yucca, potatoes, rice, and corn. Needless to say, the typical diet counseling I offer to patients in the U.S. didn't always work. What did work, for instance, was suggesting that a patient substitute beans for potatoes and rice, which are heavy in protein and fiber and are also relatively easy to obtain and grow. It requires an effort to know the culture of your patients and spend some time thinking about practical suggestions. In fact, it's arrogant and ineffective to assume advice that works in one setting can function equally as well in one of lesser resources.

Even my differential diagnoses had to be adaptable. In a setting and season where Chagas disease and dengue are a threat, I learned to approach symptoms like constipation and fever differently.

As I write this article, the plane buzzes back home from Santa Cruz to Miami. Soon I will set foot on American soil again, leaving behind the foreign and beautiful world of Palacios and transitioning back into my everyday routine. The lessons I will take back with me are invaluable. As for the internal dialogue I hoped to respond to with a fresh perspective, I've made some progress but still have a long way to go. As I anticipated, my patients had an immensely positive impact on me, at least equal to and likely greater than what I was able to do for them. What now surprises me, though, is the fact that I don't feel guilty for this, but grateful. I will utilize the growth I have gained for the benefit of my future patients — locally and abroad.

If you are interested in learning more about Centro Medico Humberto Parra and supporting its initiatives, you can visit the website: http://centromedicohumbertoparra.org/. ■

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