FROM THE EDITOR'S DESK

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

At the Academy’s upcoming Scientific Assembly in Austin next February, I will conclude nine years of service on AAEM’s board of directors. While I hope to continue to serve our Academy beyond that date as editor of Common Sense, which would make me an ex officio board member, I will no longer be representing the membership at large, voting, or actively guiding AAEM. Though I will miss helping direct the course of our Academy, nine years is more than enough time for anyone to make their mark and move on, giving someone else a chance to serve. None of us are indispensable, and there is much to be said for new blood.

Whether you are practicing emergency medicine, teaching it, or just learning it — you are smart, steady, creative, adaptable, and interested in the welfare of your fellow man. You earn your living by making good decisions quickly with limited information, and then acting decisively. And, since you have chosen to join the Academy, I know you are a fair and honest person and an ethical physician. You have all the skills you need to be an excellent leader. Not putting that ability to maximum use would be a terrible waste. Our specialty needs you, and AAEM needs you.

Five positions on the Academy’s board of directors will be up for grabs in the next election, and you might be perfect for one of those seats. Even if you run and lose you will have contributed to the health of our Academy, because AAEM is stronger when every election is contested. Of course there are other ways to be an active part of AAEM: you can serve on a committee, chair a committee, lead a state chapter, or help lead AAEM/RSA if you are a resident or student. (And don’t forget that you can also help by writing for Common Sense!) However, nothing puts you in a position to do more good for emergency medicine than being an officer or director of the American Academy of Emergency Medicine.

Without AAEM, board certification in our specialty might not have the meaning or value it does now. Without AAEM, corporations would control even more emergency departments. Without AAEM, fewer emergency physicians would own and control their own practices in equitable, democratic groups. Neither ACEP nor any other organization puts the interests of individual emergency physicians over corporate interests the way the Academy does, and fights the battles AAEM fights. For a few concrete examples of that, go back to the Jan/Feb 2014 issue of Common Sense (Vol. 21, Issue 1) and reread “Highlights of AAEM’s Legal Advocacy for Emergency Physician’s” or my two editorials in that same issue, “Why AAEM?” and “Legitimate.” Even now the Academy is working to protect independent, physician-owned, emergency medicine groups in ways that cannot yet be made public, but which will eventually make you proud of how AAEM differs from other professional societies — again.

I know what you are thinking: “I already have too much to do, and there are plenty of other people willing to do that job. They’ll be fine without me.” Wrong! While the Academy does have over 8,000 members, including residents, it is relatively small compared to most professional societies. An even smaller number of people drive AAEM and get its work done — work that benefits all board-certified emergency physicians and their patients. I believe that, at both the national and state levels, too few Academy members are actively involved. We need new blood in leadership positions at both levels.

When too few people are behind a state chapter, no matter how many members are actually on the rolls, that chapter is in danger of collapse when those few tire and move on. To ensure long-term stability, the leadership of each state chapter must make cultivating the next generation of leaders a priority. Even at the national level, there is risk in drawing leaders from too small a pool. New blood brings fresh perspectives, new ideas, and a different way of approaching things.

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We’re listening, send us your thoughts!

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.
The medical profession is in trouble, and emergency medicine is more threatened than most specialties. We are subject to more regulations than other specialties, such as EMTALA and balance billing laws; we take care of everyone, including patients other doctors actively shun, regardless of the patient’s ability or willingness to pay for that care; we depend largely on hospitals, and thus on hospital administrators, for the quality of our tools and work environment; for-profit, layperson-owned, publicly traded corporations like EmCare and Team Health control many of the jobs in our specialty — and now they are launching joint ventures with hospital chains and driving even more emergency physician groups out of business; and finally, even in 2014 there are still those who say EM isn’t a legitimate specialty and residency training in EM isn’t necessary. Battles I thought we won and put behind us in the 1980s and ’90s go on, while new threats continue to arise. These things don’t take care of themselves; they must be actively addressed by knowledgeable and dedicated people. People like those who have led AAEM over the past 21 years — people like you. I know you are busy. All of us are busy. But trust me — you can find a way, and you will be glad you did.

In my time on the Academy’s board of directors, I have had my share of disagreements. I won some arguments and lost others. I have watched AAEM go down the road I chose for it, and seen it take other paths. What I have never seen is an Academy officer or director act with anything but the sincerest and most passionate desire to do the best thing for emergency medicine and the board-certified specialists who practice it. I have never seen dishonesty, self-interest, vanity, or loyalty to another entity influence the action of a single person on the board. I have never felt anything but proud of my fellow directors and the Academy’s officers, and that should make you proud too. I hope that also inspires you to serve and fills you with hope that we can make AAEM’s Vision Statement a reality:

A physician’s primary duty is to the patient. The integrity of this doctor-patient relationship requires that emergency physicians control their own practices free of outside interference.

We aspire to a future in which all patients have access to board-certified emergency physicians.
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.aаем.org/publications/common-sense). If necessary, you may request that we post your letter anonymously and such requests will be reviewed on a case-by-case basis. The letters that I think are interesting, entertaining, educational, provocative, or of general interest, will be printed in Common Sense.

I hope to hear from many of you, even if you are criticizing me. I need your feedback to make Common Sense an interesting read and a good use of your time. I also want it to attract new members to the Academy. If you like something you see, let me know. If I make you mad, let me know. Especially if I make you mad. I want the “Letters to the Editor” feature to become a forum for civilized but vigorous argument, and the more vigorous the better.

— The Editor

Letter in response to the July/August 2014 “AAEM News” article titled “Metric Madness”: The Dying of the Light

I would like to thank the author of “Metric Madness” for clarity and courage, and the editors of Common Sense for sharing it and safeguarding its source. May simple words spark a fire of frank talk about serious issues.

The following perspectives come from 33 years as a single coverage ER Doc (one strand of our so-called Safety Net). Work means prioritizing urgent needs, juggling information, clinical status, and a Gatling-gun of communications. An array of problems and drama converge on the ED: threatening trauma and illness, minor trauma and complaints, chronic recurrent symptoms, the indigent and uninsured, those with no other timely access to medical care, the intoxicated, the drug-seeking, the worried well, those plagued by voices or suicidal thoughts, the frail elderly, unmanageable teenagers and foster kids, and anyone dragged in by police, handcuffed and cursing.

Applying door-to-doc metrics is an unreasonable approach. Stable presentations and non-urgent issues fall into a different category. Human dynamics are complicated, often disorderly. It’s not a question of how fast you get your burger or the oil changed.

Length of Stay (LOS) is only partially (and inconsistently) under an ER Doc’s control. Want my metrics to shine? Give me a shift with evenly-paced, straightforward encounters and a savvy, hustling team for support. Entangle me with intractable system problems, spotty specialty coverage, nursing shortages, inefficient inpatient limits, and an overwhelmed hospitalist; and the admissions — the sickest patients — will linger for hours and hours on uncomfortable ED beds.

The electronic medical record has improved access to information, but the EMR’s cost/benefit ratio was never seriously studied. Computers were touted as safer and more efficient when they are neither. They’ve only changed the form of hectic-shift errors. They are less efficient: ask any veteran ER doc or nurse if triage and flow were better before or after. The system of software, upgrades, training, and IT handlers is also very, very expensive. Policymakers banking on EMRs saving health care dollars are in for a rude awakening.

Here’s more uncomfortable truth: navigating an EMR’s various fields, checkpoints, detours, glitches, and obstacles fragments attention, scrambles clear thinking, and drains mental energy. Critical analysis is a physician’s most important asset. Since time is a closed system, every minute struggling with a machine (entering data, orders, prescriptions, discharge instructions) is time siphoned away from good patient care (such as a detailed history and a thorough exam), from answering questions and alleviating concerns, from comforting someone in distress.

EMRs control the data that feed metric madness and support belief in false accomplishment and misunderstanding of what quality really means. This foolishness is destroying morale by adding more stress to an already stressful job. Caregiver health suffers under its impact. All this in the context of a growing physician shortage! A sizeable percentage of ED groups are already understaffed, meaning overtime for the harried few carrying the load. Requests for locum tenens help are drastically increasing.

Those who took an oath to serve humanity need to take a hard look at what is at stake. Then, putting aside labels and political affiliations, we must join forces and command the high ground of what is truly best for patient care — enlisting strong voices and fearless leadership. Maybe we need a march on Washington, crying out, “Unshackle our EDs, support hard-working doctors & nurses, supply them with adequate resources!”

As an endangered canary in the mine, I sing the words of the poet Dylan Thomas: “Rage, rage against the dying of the light.”

Tom Moskalewicz, MD

Letter to the Editor Regarding: Academics for the Community Based Emergency Group:

I work for an independent democratic group in the mountain states. Our city has relied on physicians coming to practice from other places as there is currently no formal training program in the city. To this end, the city is embarking on a progressive program in medical education that includes a branch campus of the university medical school. As this program develops, there is currently a drive for recruiting physicians

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practicing in the community to participate in the clinical education of medical students. This developing program has created two questions for me. Whose duty is medical education? How can a program function to the benefit of the community-based practicing emergency physician and the medical student?

The concept of emergency medical education in the community is not a new one. There are many benefits to participating in medical education in a community setting. For the students, most physicians practice in a community settings for most of their careers. What better setting to prepare for their future careers than in a busy community practice? The community setting has different resources and challenges for emergency physicians. Students can see first-hand how these interactions play out no matter what specialty they eventually pursue. Community physicians, on the other hand, have the opportunity to participate in positive learning experiences for students that will eventually shape how future colleagues perceive, appreciate or dismiss the practice of emergency medicine and their interactions with it in the future. As many physicians eventually practice in the area where they trained or went to medical school, physicians that participate in medical education may see the fruit of their labor in future colleagues practicing in their community within their career.

The challenge for the community-based emergency physician is teaching when time is a scarce resource. Our time is consumed with documentation and order entry in electronic medical records, meeting performance-based metrics and downward trending reimbursements that force us to see more patients in less time to stay afloat. Time for education affects the bottom line at the end of a shift. Can education and productivity find a happy balance in a busy community emergency department? What are the successful models for

democratic groups to implement a medical education program that is fair to all practicing physicians? Is it fair to ask some physicians to contribute financially to balance the productivity of those physicians whose time is consumed with education? Editor and readers, I need your help in this regard.

Respectfully,
Robert Lam, MD FAAEM

Thank you for writing. I hope our readers can answer your questions and give you sound advice on making this new program work, because I cannot. I do believe all physicians have an ethical duty to further medical education when they have the opportunity, and having taught medical students myself I understand how they can reduce flow through an ED. However, now that the EMR/EHR has taken hold and slowed patient flow more than any gang of medical students ever could, perhaps medical students might improve flow by acting as scribes rather than just standing and watching you perform an H&P? Whether entering data, collecting test results, or keeping patients informed, surely medical students can be made useful enough to offset the time it takes to teach them. And they are bound to improve customer satisfaction scores. Medical students may not have the entirely negative impact on an emergency physician’s bottom line that you anticipate.

I am confident that you will find a way to make this program work. Perhaps such programs will help lure graduating emergency medicine residents out of big cities and major trauma centers and into smaller communities and rural areas, where they are so desperately needed. I hope you will eventually write back, whether in a letter to the editor or a full-size article, and let us know how the program turned out and what you learned along the way In the meantime: readers, Dr. Lam needs your help and advice! Either contact him directly or reply with your own letter to the editor. — The Editor

### AAEM 100% ED Groups

**AAEM 100% ED Group Membership**

AAEM instituted group memberships to allow hospitals/groups to pay for the memberships of all their EM board certified and board eligible physicians. Each hospital/group that participates in the group program will now have the option of two ED Group Memberships.

- **100% ED Group Membership** — receives a 10% discount on membership dues. All board certified and board eligible physicians at your hospital/group must be members.
- **ED Group Membership** — receives a 5% discount on membership dues. Two-thirds of all board certified and board eligible physicians at your hospital/group must be members.

For these group memberships, we will invoice the group directly. If you are interested in learning more about the benefits of belonging to an AAEM ED group, please visit us at www.aaem.org or contact our membership manager at info@aaem.org or (800) 884-2236.

For a complete listing of 2014 100% ED Group members, go to www.aaem.org/membership/aaem-ed-group-membership.