

From the Editor's Desk

The Hamster Wheel

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Do you ever feel like a hamster running endlessly on a wheel while you are working a shift in the emergency department? What should you do next? Should you rush to the stroke activation on the 25-year-old with tingling? Should you rush to see another new patient first, to keep your door-to-doctor time down? Did you remember to add the lactate level on that dialysis patient with a fever? I hope you didn't forget to chart

the TIMI score on that rule out MI who is heading upstairs.

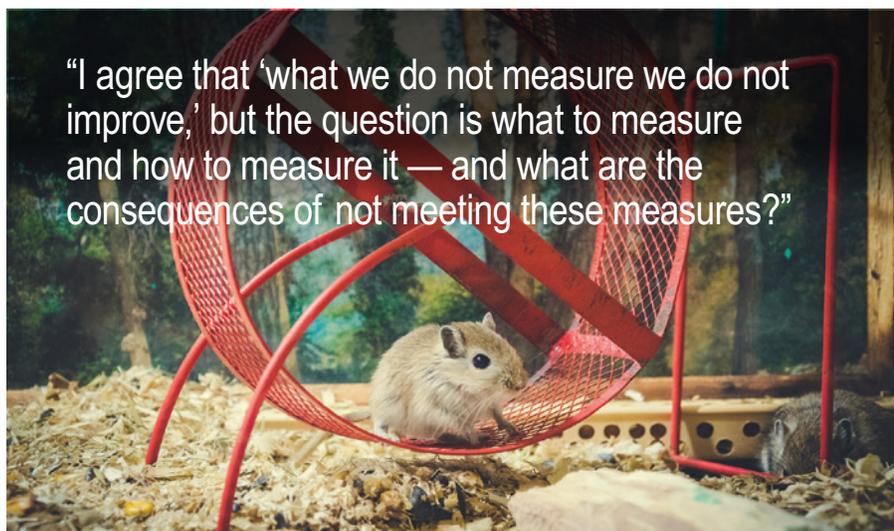
Sadly, while trying to decide on your next move the tech shoves two more triage EKGs into your face, so you can write "NO STEMI" on them while you try to talk to the nurse practitioner at a local urgent care about another patient they are sending over "because he needs to see a doctor." Emergency physicians are highly trained to handle multiple sick patients at once, but is the next action you decide to take the "right" one in relation to metrics?

Each emergency medicine practice setting has its own unique set of obstacles, but sometimes it seems that the game is rigged against us. Should we accept the fact that metrics are here to stay? I agree that "what we do not measure we do not improve," but the question is what to measure and how to measure it — and what are the consequences of not meeting these measures? Adding more and more metrics in order to monitor an emergency physician's "quality" can lead to feelings of helplessness and burnout. It is not the hamster's fault if he or she has to keep running faster and faster on the wheel to nowhere, suddenly falls off, and then gets a threatening email from deep in the bowels of the hospital. It sometimes seems that the rapidly enlarging team of "clipboard nurses" is the new military-industrial complex.

I recently became the medical director of my independent group, and the members of my group are my partners. All quality issue emails now come to me. Now I see not only my own falls off of the wheel but also those of my partners. There is certainly frustration in having to defend the clinical decisions of one of my partners when they were working alone at 4:00am. Why didn't they give the 30 cc/kg fluid bolus to the volume-overloaded dialysis patient with pneumonia and a mildly elevated lactate? This metric transgression occurred when all the quality reviewers were safely tucked into their beds at home, and discovered on Monday morning. Discussing these cases with the tired emergency physician brings out the "rage against the machine" eyes. There is that sullen quiet or loudly angry response to questioning their care, when their only crime was to decide on a course of action, which was medically correct but did not "meet the measure."

I had a partner several years ago, when "metrics" were in their infancy, who never let these measures of quality bother him. When confronted

by a reported lapse of quality he expressed a nonchalant attitude. His explanation was that he was just trying to do the right thing and that was enough. In the early days of metric-driven medicine this may have worked, but no longer. The idea that it is enough to use your best medical judgment to do what you think is right may be gone. Now we go to national meetings where we are told to order the 30 cc/kg bolus but then quickly cancel it, as this will meet the metric while still preventing harm to the patient. How did we come to this and where do we go from here?



In the age of patient satisfaction scores and metrics, I think a major reason for burnout is that the emergency physician is seemingly responsible for everything but has authority for nothing. Did anyone ask you if the stroke team measures were useful, helped patient care, or if you wanted to participate in them? These measures and metrics add layers of anxiety and frustration to the emergency physician's day, in return for highly questionable patient benefit.

What should we do? How do we prevent burnout in this new environment? This is a key question which we as a specialty need to address, so that each of us can survive and try to craft a fulfilling career. There are many activities that do not involve organized medicine, which I wholeheartedly encourage. I fish and talk about fishing. Travel with my wife and family and seeing other cultures is also one of my ways of staying sane. I would, however, like to emphasize the role which organized emergency medical organizations can play in supporting individual emergency physicians.

The idea that an organization can keep you sane or protect your career is not realistic, but the values and ideals which an organization projects and the personal support it gives to its members can be of important help. AAEM's president and board are willing to advocate directly for a

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member or a group, clearly illustrating AAEM's mission. The happiness and security of the "pit doctor" have always been a fundamental goal of the Academy.

Organized medicine, including AAEM, has a duty to advocate for physicians and the patients we treat. AAEM certainly does this at an individual and group level, but also on a national level. Our executive committee and board members advocate on your behalf. Our president-elect, Dr. David Farcy, has been trying to educate our federal regulators on more rational clinical requirements for sepsis care. AAEM has a strong lobbying presence on capitol hill. The latest advocacy day was an excellent experience and one I recommend for all of you. Do I think speaking to a congressional staffer will suddenly change American health care? No, but seeing the process and having a personal sense of trying to make things better might make you feel better about your career and personal well-being, while doing good for the country in the long run.

I also encourage each of you to attend the Scientific Assembly. The content is first-rate and the locations are great. However, one of the main reasons I think you should go is the sense of community you will feel. Seeing such a gathering of "pit docs" in one place, and realizing that we all face similar challenges and metrics, might restore the sense of professionalism and community that you lost in your metric-driven ED. Everyone attending walks in your shoes and is there to refresh, learn, and reconnect with old friends, partners, and residency classmates. I always head home feeling a renewed sense of having a profession instead of a job. You might remember what drew you to emergency medicine in the first place. Will this make your first shift back easier, dealing with the frequent-flyer complaining about his dose of Dilaudid? I really do hope so.

AAEM now has a Wellness Committee, which wants to help you flourish in our profession. This committee held several events in Orlando, which

were very well received. *Common Sense* is starting a regular column from our Wellness Committee named "Resuscitating Resilience." I hope you will find it a useful resource in our quest to prevent burnout and promote wellness.

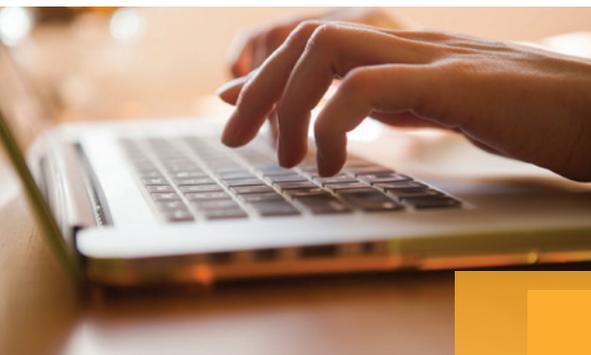
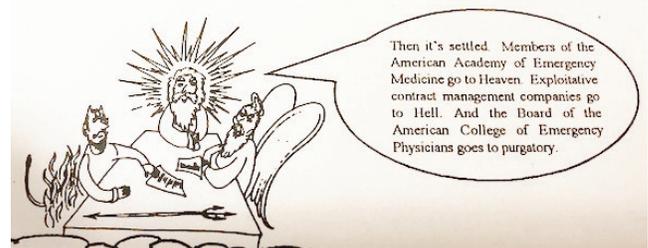
Finally, I ask you to engage in this process. Please let AAEM and *Common Sense* know your thoughts and ideas. The free flow of ideas in the pursuit of improving our professional lives might be a way to help. Letters to the editor on your ideas about the hamster wheel, or any other issue on your mind, will be appreciated. ●

Call for Cartoon Submissions

"Humor is just another defense against the universe."

— Mel Brooks

Here's a comic from the premiere issue of *Common Sense* in 1994. Emergency medicine is moving forward, but issues remain. Maybe some humor would help? Are there any aspiring artists out there who would like to submit cartoons for publication in *Common Sense*? Send your submission to lburns@aaem.org.



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