

Provider Misuse, Overuse and Exploitation

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Two years ago, after assuming the Presidency of CAL/AAEM, when crafting a vision for the future of the organization, I mentioned the need to address the issue of provider workload. I wrote this...

Advocacy for improvements in the healthcare work environment and reductions in the workload of the healthcare provider

The ever-increasing overload conditions that individual physicians are forced to suffer must be opposed in the interests of patients and providers. I believe we can work (perhaps with CAL/ACEP) in creating regulatory guidelines that we as an organization develop, support and promote to improve the work environment for emergency medical providers. The emphasis is to enhance the practice of emergency medicine (EM) as experienced by individual physicians and long-suffering patients in the waiting room. Recognition of the negative impact of cost cutting in healthcare on EM is the first step. Proposals to increase EM revenue and increase EM resources throughout California (such as the 911 surcharge plan in 2005 that failed due to phone companies' opposition) are necessary to promote the health of providers and optimize the healthcare system...

We should support a system in which EMS is elevated to the position of respect and financial support commensurate with the awesome responsibility we all so willingly assume. We should seek to transform EM from an overwhelmed, legislated last resort, to a fully funded, key component of an outpatient provider network growing ever more dependent on EM for patient care.

Since then many of these themes have been espoused at various board meetings I have attended as the CAL/AAEM representative to the CAL/ACEP board and as a CAL/AAEM board member.

This piece is an attempt to initiate the focused discussion of provider overuse, misuse and exploitation. While we all voluntarily step into the breach every time we go to work, what happens there often exceeds the bravado we project (and rely on), and we find ourselves overwhelmed by volume, acuity, lack of support and the messiness of it all. The impact of stop-gap measures in an increasingly imperfect system makes clinical closure for each encounter more difficult and sometimes impossible.

There seems to be no end to what will be expected of us nor has there been any meaningful resistance to the increasing burden.

Kaiser in Sacramento initiated a policy of 18 patients per shift; after that, patients wait for the next provider. Granted, they peel off the easy ones, but when I see 18 in 12 hours I feel like I've had an easy day. As the numbers grow in the more chaotic and less well-funded environments for the 95%+ of us not working at Kaiser, we suffer the mental consequences in ways overt and subtle.

The sense that we reside at the bottom of a long and efficient trough draining into a safety net that we struggle and generally succeed to manage, is not that comforting. We are the de facto last resort for medical care. Every day more people drop into that net. Yet who is talking about how to assuage the mental strain that we suffer and train others to suffer? Who will step up to regulate the flow of patients? It not us, then certainly not the people who have created the situation we are now dealing with.

Politicians, say that "everyone has access to medical care." All the uninsured have to do have to do is "go to the ER." These thoughtless and destructive lines in their theater of abdication are in sync with a rising chorus from all quarters of the medical world, including almost all of our doctor colleagues who say the same thing, "Go to the ER."

Ironically, recent studies show that insured patients, unable to connect with their primary care MDs about almost anything, are being directed to EDs at all times of the day and night in numbers that are greater than the uninsured. The patients with PMDs dutifully follow those instructions. For those with no insurance no one need give directions.

So here they come...four an hour ...six an hour per provider...overload at times ...then at all times. Each provider dealing with a full load of emergent and urgent ...and then a full load of emergent...then just sicker emergents...then more deaths and more problems ...and the strain increases. As acuity rises, more consults are needed ...and more reliance of hospital resources and back-up MDs are needed. ...these back-up systems stumble ...then there is no backup at all. No beds ...add a new problem: inpatients in the ED...gridlock. More people waiting longer and getting more perturbed. Each new patient comes pre-aggravated for the interaction with the overworked provider...too many things to do and so many people to keep track off. Just add another two hours to the night shift

for all the charts you couldn't do while you are seeing the patients. Stay over to help the next guy at the expense of your family because there are so many patients in the ED or waiting to be seen. Nurses are working at capacity or frequently beyond capacity and people are bedded and languish inside, waiting hours. Patients die in the waiting room? How could that be? This was supposed to be a good life, but now it is more nights and weekends than any other medical provider. How did that happen?

We need to address the issue of provider exploitation. We need guidelines to define our capacity and prevent the constant pressure to exceed that capacity with no regard for the consequences that are inflicted on providers. If the public outcry over the scandalous, one-in-a-million waiting room deaths is intended to address this problem, then we must act in concert. We must define and advance guidelines

that protect us from the subtle and insidious effects of being overburdened and stretched beyond our capacity while we are working because it doesn't end when the shift ends. The recovery time increases as the burden does. Our younger colleagues working 15-18 shifts a month are getting ready to work, working, or recovering from work. They're tired and also affected by the tsunami-like onslaught of problems and criticisms that seems to be enveloping our specialty. Genuine recovery time is very limited and the impact is felt with mental strain, family problems, efforts to navigate away from clinical care, early retirement or complete separation from EM for some. Leaving the ED at the end of a shift is a relief, but the fatigue and stress on home life carries over and then there is the next shift and the next night and the next weekend. Let's start a dialogue and bring this issue to the fore.

RESIDENT'S REVIEW

UCSF-SFGH Emergency Medicine Residency Opens its Doors

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A new EM residency program in California?! Yes, that's right. This summer the UCSF-San Francisco General Hospital Emergency Medicine Residency Program welcomed its first class of 12 residents. The inaugural year of the program marks the culmination of years of hard work and anticipation on the part of UCSF and SFGH's faculty and staff. As the first new program in California in three years, the UCSF-SFGH residency will train 12 residents per class in a four-year format. Among the innovative strategies featured in the program are Areas of Distinction, which allow each resident to select a niche within the specialty on which to focus their elective and research time. Thus far the program has opened two fellowships, Emergency Ultrasound and EMS/Disaster Medicine, with more on the way.

Besides food, outdoors and culture, San Francisco offers top-notch training sites. The UCSF Moffitt-Long Emergency Department serves a world-famous tertiary care facility and has an annual census of 45,000 with a 22% admission rate. San Francisco General Hospital is San Francisco's only Level I trauma center, and with an annual census of more than 50,000 it provides care to a wide variety of patients with an endless array of pathologies. Rounding out the training sites are the San Francisco VA

Medical Center, Kaiser San Francisco Medical Center, and Children's Hospital and Research Center of Oakland.

The UCSF-SFGH faculty is made up of some of the most well-respected physicians in EM today, including multiple leaders in ACEP, SAEM, and AAEM, nationally-recognized educators, and world-class EM researchers. Not to be outdone, the interns are already making waves: Several have won national academic awards, published in major journals, and are serving as resident representatives for Cal/AAEM and Cal/ACEP.

As match season approaches, the program is seeking its next class and will conduct interviews all winter. Under the leadership of Program Director Susan Promes, Associate Program Director Michelle Lin, and Assistant Program Director Barbara Kilian, the UCSF-SFGH EM residency aims to train its residents to be top-notch clinicians and ambitious leaders in our great specialty. As Michelle Lin writes on the program website, "Look out, world!"

Selected Links:

Residency Website: <http://www.emresidency.ucsf.edu/>

"MOODLE," a revolutionary online educational environment: <http://www.emresidency.ucsf.edu/moodle>.