

Rethinking ED Call

How to balance physician, hospital, and community needs

WHITE PAPER



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As I write this, I am saddened from a recent visit with a hospital and its medical staff struggling with the challenge of physician coverage of unassigned patients for the emergency department (ED) and inpatient consultations. For that hospital, discussions between some physician groups and the hospital degenerated into anger, threats, and broken trust. The physician demands for ED call compensation easily outstrip the hospital's entire bottom line. Yet some of the physicians have said if their compensation demands aren't met, they will stop taking call at the end of the month, regardless of what the bylaws require. Why did this happen, and what can be done by hospital and medical staff leaders to prevent a similar experience in your hospital (or to turn it around if it's already happened)?

Physicians are unhappy about providing coverage for unassigned patients for many legitimate reasons, including:

- Growth in ED volumes
- An increase in the number of uninsured patients
- Reduced physician reimbursement
- Greater practice disruptions from patients acquired while on call
- Increased liability
- Desire for a better work-home balance

These and other changes have led to a dramatic shift in physician expectations regarding coverage of unassigned patients.

In the past, when a colleague called a fellow physician about a patient who needed that physician's expertise because of an emergency, the response from the other end of the phone was usually, "How soon do you want me there?" Today, the response is far more likely to be sullenness, resentment, overt anger—often directed at fellow physicians—or even a refusal to care for the patient. Every time this happens in your community, it undermines collegiality of the medical staff, creates an EMTALA compliance risk, and drives a deeper wedge between physicians and your hospital.

In response to the changes in healthcare and medical practice, physicians in many communities nationwide are demanding compensation to provide coverage services that they have previously provided for free. Given the pressures on the practice of medicine and the rising burden of ED call, this is an understandable demand. (To be fair, several other physician dissatisfiers are driving physician unhappiness that don't involve coverage of

unassigned patients, but which further fuel demands for compensation for coverage services previously provided for free.)

What has taken many by surprise is the tenor of discussions between physicians and hospitals regarding call. Physicians, especially in some surgical specialties, have presented ultimatums, demanding large sums just to carry a beeper for unassigned call. Even when these amounts are larger than the hospital's bottom line, some of these physicians respond to hospital management with harshness, anger, name-calling, and threats. What's going on?

Is ED call an unsolvable problem?

If you ask many physicians for a solution to the ED call problem, they have a simple solution. This is a hospital obligation, not a physician obligation. Therefore, if the hospital wants physicians to do this work, it should pay them.

If you ask many hospital administrators and governing board members for a solution to the ED call problem, they have an equally simple solution: Every physician on the medical staff should be required to take call as a condition of medical staff membership.

The problem is that physicians and hospital administrators can't both be right. They have fallen into the trap, well described by H.L. Menken when he said, "For every complex problem, there is an answer that is clear, simple, and wrong."

Many of us like to be challenged by problems such as crossword puzzles and the most recent craze, Sudoku, the Japanese math puzzle game. We like the challenge and satisfaction of discovering the right solution. For physicians, coming up with the right diagnosis for each patient—how they spend much of their professional time—is about solving problems. Doing this well provides great professional satisfaction. For a surgeon, solving a problem is about performing the right procedure well in order to cure the patient. For an internist, solving a problem is about selecting the right drug to cure a patient's condition.

What is the right solution to the ED call problem faced by hospitals and communities across the country?

- What is the right solution to the ED call problem faced by hospitals and communities across the country? Your physicians, hospital administrators, and board members are great problem solvers. They can't rise to the top in their fields without being great problem solvers. So why can't they solve the problem of ED call?

They've tried. Hospital CEOs have negotiated deals with each physician specialty that forced the issue of compensation for call. Does this feel like a solution? Perhaps to the physicians who secured the deals, but not to the chief financial officer, who sees a never-ending spiral of costs for ED call,

costs nobody is paying the hospital more to take on and will eventually bankrupt the hospital if allowed to continue unchecked. And even for the physicians, what felt like an acceptable solution the previous year somehow seems not enough compensation for the same work this year, so they ask for more—sometimes a lot more. And for people whose specialty didn't get in on the initial deals for compensation for call, it certainly doesn't feel like a solution, at least not until their specialty gets in on the dealing as well.

The difficulty is that ED call is not, at least at this time, a solvable problem. Instead of finding one right answer, it is about understanding, honoring, and finding a way to support the needs of physicians, the hospital, and the community at the same time. This is not a problem to solve, but a dilemma that must be managed, even if it has no solution. Problem-solving thinking, which is about "either/or" thinking, is not designed to manage a dilemma of this nature. A dilemma such as ED call requires "yes/and" thinking. In fact, applying typical problem solving to managing a dilemma fulfills H.L. Menken's observation and eventually makes the problem worse.

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● There is not enough money in healthcare today to reimburse every physician for every night on call, even if he or she deserves it. Until recently, especially in the eyes of many physicians, the situation regarding ED call has been unbalanced. Physician needs have been disproportionately sacrificed by the rising burden of call, and hospitals and communities have not taken on their fair share of this burden. Requesting or demanding reimbursement for coverage services they've been providing for free is one way to redress this imbalance. This is not an unreasonable request. It can become unreasonable if it is expressed with the level of physician hostility seen in many medical staffs. It can also become unreasonable if the physicians' demands come at the expense of the hospital's ability to meet the challenges faced by hospitals. In The Greeley Company's work with hospitals and medical staffs, it has found that the most constructive and effective way to address ED call is to ask physicians and hospital leaders, "How can we best balance the need to achieve physician success, hospital success, and good care to our community at the same time?"

Einstein said a difficult problem cannot be solved at the same level of thinking that created it. So developing a practical, fair, and sustainable approach to ED call requires bringing physicians and hospital leaders together to develop fair and balanced strategies that will help physicians and the hospital succeed. Do all physicians owe some amount of uncompensated ED call, or must every physician be paid for every moment of ED call? How should we establish the value of what physicians do when on call (fair market value) across specialties in a way physicians will think is fair and equitable? How can we establish the criteria for which physicians will be paid for call and how much they will be paid in a manner that is fiscally responsible and sustainable for the hospital, rather than using a quick-fix approach that puts the hospital on a slippery slope.

There is no solution to these difficult questions that will make all parties happy. In fact, the best framework for tackling ED call might be the wisdom of a marriage and family counselor who said, “Couples fight over one thing and one thing only: How will we share the pain?”

Whether couples are fighting over money, kids, sex, or the house, the underlying problem is that there is pain on both sides. They are arguing over how much of this pain each of them will take. That is exactly what is happening regarding ED call. For physicians, the pain of ED call is personal. They have disrupted sleep, fatigue, lost income, increased liability, lost time with families, and significant practice disruptions. For the hospital, they have the pain of potential EMTALA violations, investigations and fines, the cost of paying up to millions of dollars for call that will have to be carved out from other important and worthy expenses, and the problems resulting from poor physician-hospital relations with some of their most important and busiest doctors.

In The Greeley Company’s work with physicians and hospitals on ED call, we have found that physicians and hospital leaders respond well to this language of sharing the pain. This allows us to facilitate the crucial conversations. How much pain will be taken on by the hospital and how much by each specialty? How will we value what physicians in different specialties do when on call? At the end of the process, we still have to answer the question every physician wants to know: How much will I be paid for ED call? When this question is asked and answered through a process that helps physicians and the hospital agree on how to share the pain, a fair and sustainable outcome is possible. We can then focus on gathering data to measure what physicians do when on call to establish the true burden of call, which provides the most accurate picture of their pain. The data are also critical for establishing fair market value for physician ED call services and creating fairness in compensation levels across the different specialties. At the end of the day, each physician, each specialty, and the hospital has to take on some of the pain, usually more than they want to. But that’s what healthcare requires of us today.

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- Many forces, including the pressures around ED call, are pulling medical communities apart. A thoughtful and effective process to address ED call can start to bring your medical community together.

One of the lessons we can learn from understanding ED call as an unsolvable problem is that if we overfocus on one side (e.g., physician success at the expense of the hospital, or hospital success at the expense of physicians), bad things will happen. For healthcare to work for everybody, we must come together and find ways to manage ED call that help physicians succeed and hospitals succeed while giving good care to our communities. ■