

Approaching ED Call Compensation as a Negotiation

How to raise the level of dialogue between physicians and hospitals as we negotiate ED call compensation payments

WHITE PAPER



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Physicians are rapidly moving from assuming emergency department (ED) call is an obligation of medical staff membership to assuming ED call is a hospital obligation they should be paid to fulfill. Once they've made this shift, they want to know how much they will be paid for call. In fact, physicians are increasingly dictating this amount to hospitals before they commit to assuming ED call. Either the hospital meets physicians' compensation demands or physicians refuse to take call, regardless of what the bylaws require.

Physicians want to be paid for ED call for unassigned patients for many legitimate reasons, including:

- Growth in ED volumes
- Increases in uninsured patients
- Reduced physician reimbursement for other services
- Greater practice disruptions from patients acquired while on call
- Increased liability
- Desire for a better work-home balance
- Ability to earn a good living outside the hospital

There's also been a fundamental shift in how physicians coming out of training expect to build a practice. In the past, most physicians expected to put out a shingle and build a practice from scratch. Even if they were joining an existing practice, they had to be hungry for new patients to earn their keep. Hanging around the ED to scarf up ED referrals was perceived as a great way to build a practice. Today, more physicians expect to be provided a practice, either by a hospital or by a group.

Although the payer mix of unassigned ED patients isn't the best, when The Greeley Company collects data on payer mix for unassigned ED call patients, it still looks like a good way to build a practice most of the time. But physicians coming out of training aren't looking to grow a practice the old-fashioned way; they want a faster track, sometimes with a higher guaranteed salary than physicians who've been in the practice for 20 years. And given the growing physician shortage and competitive market for physician recruitment, they are likely to get that salary. They will also insist that the call requirements are reasonable—if they agree to take ED call at all.

In this environment, physicians and hospitals are struggling to determine which physicians should be paid for call and how much they should be paid, which, in essence, is a negotiation. But physicians don't approach this as such. Instead, they present an ultimatum, which all too often deteriorates into brinksmanship, with threats to stop providing call services by a specific date if their demands are not met. They also see any attempt by hospital administration to use a different process to determine which physicians should get paid and how much as a typical delaying tactic, or a way to give physicians the slow no.

The Greeley Company helps hospitals and medical staffs with ED call by handling the issue of call ownership and compensation as a negotiation. The problem is that most physicians have not been trained in negotiation, so we start by teaching them the four types of negotiations:

- Position-based
- Power-based
- Interest-based
- Principle-based

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- When physicians hear how much others in their specialty are being paid for call, they frequently go to the CEO and demand equal compensation. This launches a position-based negotiation, in which each party stakes out a position. Usually, these positions are far apart, and they make progress only when one party makes concessions on its position.

Consider buying a used car, for example. The sticker price on the car is one position. A potential buyer makes an offer below the sticker price, which is a different position. For a deal to happen, the buyer, seller, or both need to make compromises.

There are two problems with positional negotiations. First, when one party makes a concession, it often feels it's giving something up, which may lead to resentment. Both parties are afraid to give up too much, so they hold back on concessions until they are forced to give in. At the end of the day, even if a deal is struck, both parties often feel discontent about what they had to give up and may feel resentment toward the other party. Do you consider a used car dealer from whom you've bought a car a good friend you want to work with in the future? Not usually.

Second, physicians and hospital administrators have to live and work together in the same community after any deal is reached for paying for ED call. If one or both parties harbor resentment and lack of trust in the other, this frequently undermines collaboration within the hospital and in the medical community.

Other physicians approach ED call as a power-based negotiation, in which each party seeks leverage to extract as much as it can in concessions during

the negotiation. Physicians who take this approach say they believe they have the upper hand because of how much revenue they bring to the hospital, and they want to build the negotiation on the amount the hospital is willing to pay not to lose that revenue. This is especially the case in communities with two or more hospitals or systems seeking to lure physicians from their competitors.

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Physicians who use this argument often don't recognize that hospitals violate Stark and anti-kickback statutes if they consider paying physicians for ED call so they won't lose their referrals. Even if physicians aren't as blatant in trying to link ED call to the business they generate for the hospital, they may seek other sources of power to pressure the hospital to pay them for ED call.

However, hospitals are also not above using power in negotiations with physicians about ED call and may threaten to recruit or hire physicians to compete with physicians who are not perceived as being reasonable about ED call. Yet even if a deal is reached through a power-based negotiation between physicians and their hospital, low trust and resentment frequently remain.

In their groundbreaking book, *Getting to Yes*, Roger Fisher, Bruce M. Patton, and William L. Ury present the work of the Harvard Negotiation Project on how to handle negotiations in a more constructive manner than the traditional position- and power-based negotiations. They found that negotiations can be more effective if they are based on the interests of each party's position. For example, physicians demanding \$1,000 per night to provide call may have interests that include:

- Trying to make up for losses in take-home income resulting from payer cuts and rising overhead
- Having difficulty recruiting new physicians to their practice
- Feeling burned out and seeking relief
- Avoiding any exposure to additional liability after being sued for malpractice
- Resenting being forced to take call when they no longer depend on the hospital as a significant source of their income
- Seeking a better balance between work and home

You could come up with your own list of interests behind the position of \$1,000 per night for taking call, but an interest-based negotiation is not about guessing the interests of the other party. Instead, an interest-based negotiation involves each party asking questions about the other party's interests. Often, the interests can be met in other ways than simply paying \$1,000 per night.

For example, for many physicians, money is less important than the desire to reduce the burden of call, including lost sleep and practice

disruptions. In response, hospitals and medical staffs have found creative ways to reduce the burden of call, such as with a designated operating room at the start of the day for add-on cases from the night before; tuck-in service from hospitalists or ED physicians that stabilize patients and allow specialists the night off; and providing inservice training for ED physicians to expand the scope of care they can provide for patients who might otherwise require care from a specialist, such as an ENT, ophthalmologist, or urologist.

Interest-based negotiations are focused on expanding, rather than dividing, a fixed pie. They build communication and trust between parties so that working together after the negotiation is a more positive experience. And they are often less costly if the parties can be creative in brainstorming better ways to meet the interests of the physicians and the hospital.

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- Principle-based negotiations seek to identify shared values, such as fairness, between the parties that can guide decision-making on tough issues. Physicians put up with a lot in their practice and in working at the hospital, but if they feel something is unfair, it bothers them.

For example, physicians feel it is unfair when physicians in another specialty are paid for call and they are not. When a neurosurgeon is paid \$2,000 per night to carry the beeper but rarely has to come in, a gastroenterologist who is not paid for call is likely to see this as unfair. Thus, it is a good idea for physicians and the hospital to base their approach to ED call on fairness.

In our work with ED call, The Greeley Company assists physicians and hospitals with identifying these shared values and helps develop them into principles that provide guidance in determining which physicians should be paid for call and how much they should be paid. If the principles are well crafted, each party makes concessions.

But at the conclusion of the negotiation process, physicians and the hospital feel that the result is as fair as it can be. In healthcare today, that's about as good as it gets.

If you want to develop a fair and sustainable approach to ED call, the best strategy is to educate physicians and hospital leaders on the four types of negotiations: position, power, interest, and principle. Constantly seek to raise the level of the negotiation from position- and power-based to interest- and principle-based.

The Greeley Company finds that when ED call can be approached as a negotiation based on interests and principles, tempers cool, physician-hospital relations improve, and everybody is more willing to help address ED call together. ■