Specialist Shortage Shakes Emergency Rooms; More Hospitals Forced to Pay for Specialist Care

By Maureen Glabman

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Learn how hospitals are coping with a growing shortage of specialists by paying physicians to take call. It's a race to keep emergency rooms staffed.

Dr. Alex Valadka has taken emergency room call in the nation's fourth largest city, Houston, for 12 years. But only since last July did the 43 year-old neurosurgeon get paid for it.

One of two institutions where he practices, The Methodist Hospital, doles out $500 for each day he agrees to come in to treat emergency patients for cervical spine fractures, cerebral hemorrhages and more.

"Doctors brought it up. The hospital administration said, 'no,'" Valadka, says. "Eventually they realized it was a trend."

All Methodist community physicians are compensated now for covering the ER, whether or not they are called. Samplings of daily rates include $100 for pediatricians, $250 for general surgeons, topping off at $500 for cardiologists. "The stipend does not cover losses from being in your office and seeing patients, but it's better than nothing," Valadka says.

About 30 percent of the nation's hospitals report they pay some specialists for ER call, according to a 2004 American Hospital Association survey of hospital leaders. About 2 percent of that number pays all specialists.

Most began the practice within the last two years. "It is becoming more common to pay physicians for on call ER coverage," says Caroline Steinberg, vice president, trends analysis, AHA, Washington, D.C. Medical defense coverage and reimbursements for the poor are sometimes additional.

Stipends were little known only a decade ago. A confluence of changes in medicine altered what doctors provided voluntarily as a social imperative, as a means to build young practices and as a way to sustain old ones. A tide of uninsured patients, rising medical liability insurance rates and physician lifestyle issues converged to make ER call exceedingly undesirable. Doctors are demanding compensation.

"Historically, hospitals provided work shops for physicians in exchange for physicians having a responsibility to the community at large," AHA's Steinberg says. That workshop environment changed considerably when hospitalists started relieving primary care doctors of admissions in the 1990s.

At the same time, the growth of alternative practice venues, combined with technological and scientific advances that made outpatient surgeries possible, encouraged some surgical specialists, once dependent on hospitals, to reduce or drop their privileges.

Specialty coverage required

ER physicians cannot possibly know everything about every specialty. Having trauma doctors with scalpels at the ready is crucial not only for the public welfare, but for hospitals legal standing and financial viability.

Hospitals must provide specialty coverage or they risk loss of substantial federal subsidies for trauma centers. They could incur violations in EMTALA laws, revocation of their licenses and termination of Medicare and Medicaid provider agreements.

For example, if a hospital offers lucrative services like orthopedics and vascular surgery on its upper floors, it is obligated to provide the same service in its ground floor ER. A service breach in the ER can cost up to $50,000 for each infraction.

But a drought in specialists who refuse to see ER patients who come in at odd hours for medical crises has run head on into a hospital mandate to provide care, placing U.S. emergency departments on the critical list.

Physicians refusing to take call was the number one complaint found in ACPE's recent ethical behavior survey

(March/April 2005, *The Physician Executive*). Nearly 60 percent of the survey respondents said they were very concerned about the issue.

In South Florida, the problem was extreme for the North Broward Hospital District, a group of four public hospitals with two trauma centers that started paying specialists on call in November.

"Many physicians were saying they were going to drop off call because of an inherent medical malpractice risk—patients come in a more acute state where outcomes are less certain," says Mark Knight, the district's chief financial officer. "At one medical center, we had problems with virtually every specialty, though it was about 20 percent system wide."

Competing hospitals were already luring district doctors away by offering call stipends. And, hospitals in the county just to the north, Palm Beach, were transferring serious neurosurgical cases to district hospitals because of a severe shortage of that specialty. In addition, Knight says 70 percent of admissions start out as ER patients.

Using a model developed by Delray Beach, Fla.-based HealthCare Appraisers, North Broward began paying doctors fees that range from $164 per day for a pediatric surgeon to $2,500 per day for neurosurgeons and orthopedic surgeons covering trauma centers. Physicians may also bill Medicare, Medicaid and private carriers for their services.

The formula takes into account a variety of factors, such as frequency of on call events and the number of physicians participating in call. Malpractice defense insurance and guaranteed, fee-for-service payments for uninsured patients are additional. Doctors must sign two-year contracts. "It has materially relieved the coverage issue," Knight says.

New Line Item Expense

In 1999, the AMA's Council on Medical Services determined the shortage of on call specialists could be alleviated through stipends. "However it would probably be financially prohibitive for most hospitals to pay such stipends to doctors."

Six years later, it has become a major new operating expense and less of an option.

One third of the nation's hospitals already operate in the red, according to AHA. Escalating costs of supplies, Medicare cuts, rising liability expenses and private payer reimbursement reductions, are straining at their budgets. How much more can hospitals take?

"Stipends are a huge fiscal burden. Hospitals are easily spending into the millions. A lot of the time, the money is driving hospitals more in the red," says Alan Steinberg, JD, an attorney with the Pittsburgh firm of Horty Springer & Mattern who specializes in hospital work.

"I haven't heard of hospitals folding because of on call pay but it could affect equipment purchases and the opening of new services, for example. There is only so much in the red you can go," Steinberg says.

In his presentation to the American College of Surgeons Clinical Congress last fall, Winston-Salem, N.C. general surgeon, Jay Wayne Meredith, MD, estimated the total stipend cost to hospitals at an average of $1 billion annually.

Meredith determined orthopedists generally receive on call payments of $500-$2000, general surgeons $750-$1,250, and neurosurgeons, $500-$1,200. He multiplied the average fee for the three specialties by 365 days a year and by about 970 U.S. trauma centers.

"If we are going to take a billion dollars out of the health care system, someone is going to notice," he says. "Hospitals will stop having trauma coverage because they can't pay and then anyone who gets in a car, rides a bus or owns a ladder is at risk. People will die."

The Stipend Formula

HealthCare Appraisers of Delray Beach, Fla. has helped more than 100 U.S. hospitals develop on call specialty rate structures. Each hospital is unique. Here's how rates are calculated:

Factors contributing to per diem rate:

1—Typical compensation for specialty. For example, neurosurgeons earn more than neurologists.

2—Frequency of call during on call. This is hospital specific and determined by hospital data.

3—Payer mix at hospital. Large indigent population or lots of insureds? Also determined by hospital data.

4—Professional liability risks. For example, trauma and obstetrical cases versus other types.

5—The number of physicians available to participate in the call rotation.

Average Daily Specialist Stipends

Compensation varies significantly from hospital to hospital because call needs are different. These are averages for selected specialties, not lows and highs.

Specialty	Stipend
ENT	$250 to $500
General Surgeons	$300 to $600
Neurologists	$100 to $400
Neurosurgeons	$400 to $1,200
Obstetricians	$275 to $500
Orthopedists	$350 to $800
Urologists	$50 to $350

Source: HealthCare Appraisers, Delray Beach, Fla.

Moral issue

American Medical Association policies state physicians have a "moral responsibility" to provide needed emergency services to all patients, regardless of their ability to pay. And most hospital bylaws require on call ER coverage as a condition of staff privileges. However, in recent years, doctors have diminished multiple staff affiliations or reduced privileges from "active" to "courtesy" to avoid treating emergency patients.

For doctors remaining on active staff, hospitals are reticent to enforce bylaws. Half of all medical specialists report they would move some or most of their business if required to take call, according to a 2003 report by the Washington, D.C.-based research firm, The Advisory Board Company.

For a while, though, hospitals fought back by threatening to drop doctors who refused to serve on call. The situation turned ugly in 2002 for Virginia neurosurgeons Edgar Weaver, Jr. and his partner, James Vascik, MD, who practice at Carilion Roanoke Memorial Hospital.

At one time, the hospital, which has a Level 1 trauma unit, had seven neurosurgeons taking call. But in recent years, four moved away or retired, leaving Weaver, Vascik and a third partner on call every third night.

"We went to the administration and said it was untenable to be on call that often and try to maintain a practice. It was physically killing us," Weaver says of himself and Vascik. "We told them to get locum tenens physicians."

When the hospital was unable to obtain help for the physicians, Weaver and Vascik threatened to reduce their privileges from cranial and spine surgeries to just spine surgeries, which were mostly elective.

"The hospital said if we restricted privileges, they were going to kick us off staff," Weaver says. "We

had to get a good attorney." Memorial deemed it impossible for only one remaining neurosurgeon to cover cranial cases every hour of the day, seven days a week as required of Level 1 trauma centers.

Administrators resolved the problem before it went to court. They made deals with two neurosurgeons at another hospital and recruited three specialists to serve on staff, one of the relief methods used in some states where hospital employment of practicing physicians is not prohibited. The doctors who were not employees started to receive stipends of more than $2,000 per day. Weaver, 58, asked and received permission from his on call partners to be completely off call.

Increased risk

In one of the largest studies ever to evaluate on call coverage, two of every three hospital emergency department directors say they have shortages of on call specialists, such as neurosurgeons, orthopedists and obstetricians.

The study found the specialist backup is causing delays in patient treatment and increased patient transfers between emergency departments. More importantly, lack of timely access to specialists may be placing patients at risk of harm.

About 1,500 hospital emergency departments were surveyed in 2004 by the American College of Emergency Physicians (ACEP), Irving, Texas, in conjunction with researchers from Johns Hopkins University. The Robert Wood Johnson Foundation funded the study. Respondents represented about a third of all U.S. acute care hospitals.

"Nearly 1,000 hospitals across the country are telling us this is a problem," wrote emergency physician Ben Vanlandingham, MD, principal investigator of the study team. "When we looked at the results across different geographic regions in the country, or with regard to hospital size, the responses were essentially the same."

A striking 15 percent of ER administrators reported they would elect to go to a facility other than their own in the event they were seriously injured in hopes of obtaining better care, mostly because of inadequate specialty backup at their own hospital. This figure comes from a 2004 study by the Lafayette, La.-based ER management firm, Schumacher Group.

The on call specialist shortage is exacerbated by several factors.

Other than neurosurgeons, many physicians can now perform some procedures in outpatient settings and gain patients through managed care networks, resulting in fewer advantages to balance the inconveniences of serving on call.

The hospital is less "the locus of focus," wrote CEO Jim Nathan, of Lee Memorial Health System, Ft. Myers, Fla. in a January memo to the medical staff. "Physicians do not utilize or practice in hospital settings in the same way they did years ago."

The first ambulatory surgery center opened in Phoenix in about 1970 by anesthesiologist Wallace Reed, MD. Today there are more than 3,000. Technology has shortened lengths of stays for hernia repair, cataract removal and more. In some states, like Oklahoma, Nebraska, Kansas and South Dakota, specialty hospitals for cardiology and orthopedics, that rarely have extensive, round-the-clock emergency facilities, attract physicians away from community facilities.

Defections on the rise

Defections to specialty hospitals can have disastrous effects on community ERs. Oklahoma University Health Sciences Center has that state's only Level 1 trauma center. Several other nearby hospitals provide Level 2 trauma coverage.

When doctors practicing in the seven local specialty hospitals elected to reduce or eliminate their participation in emergency call at the Level 2 centers, the centers started diverting patients to OUHSC, triggering a series of events that brought OUHSC's trauma center to the brink of closure. Physicians also took with them higher paying cardiac insurance cases. In 2004, the state had to step in with a $5.7 million subsidy to increase Medicaid reimbursement.

In addition to ambulatory surgery centers and specialty hospitals, doctors have also expanded office-based clinical capabilities, such as plastic surgeons' ability to do facelifts and cardiologists, thalium stress tests.

"It is reasonable to believe that, if an on call physician is able to earn a similar living without having to take hospital call, he or she would take advantage of that opportunity," says ACEP's Laura Gore.

Another contributing factor to a worsening shortage occurred in 2003, when the Centers for Medicare and Medicaid Services eased 1985 EMTALA rules. Changes permitted specialists to schedule elective surgeries and other medical procedures during on call times.

"Before, if a doctor was listed on call, he had to come in. If he didn't, it would result in an EMTALA violation, plus the hospital and doctor could have been sued for medical malpractice," says Ed Gaines, JD, board member, Emergency Department Practice Management Association, McLean, Va. "Now if hospitals can show their coverage was reasonable, they won't get an EMTALA violation."

Hospitals pushed for the flexibility because plaintiff attorneys used previous rules as an easy litigation target. If hospitals could not locate a specialist on call and patients suffered, they were shown

Potential Solutions to On Call Specialist Crisis

(One solution to call coverage will not universally apply to every situation and every market.)

1. Contract with outside multispecialty medical groups to take call.
2. Pay stipends to specialists.
3. Require managed care plans and other insurers to contribute to a state fund to be used to provide safety net compensation proportionate to the payers percentage of insured patients. Such contributions could be used to provide stipends to doctors.
4. Suggest citizens pay for emergency care as line items on their property tax bills as they do for fire and police protection.
5. Lobby lawmakers to raise local sales taxes to pay for emergency care.
6. Mandate managed care contracts with physicians include call services as part of the contractual arrangement.
7. Regionalization—multiple hospitals that have transfer agreements with different hospitals take responsibility for covering certain specific emergency services during any given day or week. Some communities are doing this but it may not be EMTALA-compliant.
8. Use hospitalists to do non-surgical ER admissions.
9. Urge medical staff leaders to come up with reasonable call policies that are EMTALA compliant.
10. Keep internal data on how much call is taken by each physician to demonstrate that the burden on any one doctor is not excessive.
11. Educate all players about EMTALA regulations—physicians and hospital management—so everyone knows rules and potential penalties.
12. Educate nearby hospital leaders about their own EMTALA liability for dumping of patients.

Source: American Medical Association and others

in violation of EMTALA, an advantage for plaintiffs.

The new rule provided hospitals with stronger defenses. Hospitals are still required to maintain lists of on call physician specialists but the specialists are permitted to be on call at more than one hospital simultaneously and can limit the amounts of call they are willing to take.

The upshot is that "ER docs spend hours 'smiling and dialing', trying to get a specialist to come in or trying to get a hospital to accept a patient," Gaines says.

True emergency

San Antonio ER physician Robert Kottman, MD tells the story of what can happen. A man in his 20s came into a hospital with a vascular injury to his leg artery from a gunshot wound. "We had six hours to repair vascular circulation or risk losing the limb. There was a doctor on call but he was tied up in surgery. Another surgeon on call was in another operation. The patient was uninsured and no hospital wanted to take him. Ultimately he was transferred to a city hundreds of miles away. By the time he arrived, his leg was dead and had to be amputated," Kottman recalls.

A shortage of on call specialists is also due to poor distribution of physicians and a reduction in the scope of practices because of liability concerns. Kentucky neurosurgeon James Bean, MD, of The Alliance of Specialty Medicine, a consortium of more than a dozen specialty societies, reported to Congress in February that based on its surveys:

- One in seven obstetricians has stopped delivering babies
- 55 percent of orthopedic surgeons avoid certain high-risk procedures

- 75 percent of neurosurgeons no longer operate on children
- 41 percent of urologists refer complex cases

Half of all hospitals in the 20 states identified by the American Medical Association as having a liability crisis say their communities lost doctors because of increased professional liability expenses. At the same time, cardiologists and other specialists are being consulted more frequently as doctors practice defensive medicine.

Still, the number of emergency patients keeps rising as the number of emergency departments diminishes. "Because of hospitals either closing their emergency departments or going out of business, the number of emergency departments decreased about 15 percent between 1992-2002, resulting in those emergency departments still open taking on an increasingly larger volume of patient encounters," according to a March 2004 Centers for Disease Control report. "The result is longer wait times and increased diversion."

Add to this the Council on Graduate Medical Education's prediction that by 2020, the nation will be short 85,000 physicians.

Perhaps the most severe specialist shortage is already occurring among neurosurgeons, whose ranks are sued every two years, according to Richard Anderson, MD, chairman of the Napa, Calif., liability insurer, The Doctors Company. ERs are a major source of liability, he says. Legal pressures have forced so many brain specialists to retire that in 2003, there were same number of U.S. neurosurgeons as in 1994, even though the country's population increased during that period.

"My partner was 57 when he retired," says Kentucky neurosurgeon Bean. "He said there is no future in this. I could lose my life savings in one lawsuit."

Because of liability concerns, more than one-third of neurosurgeons have altered emergency and/or trauma call and more than 21 percent of orthopedic surgeons have done the same, according to the Alliance.

Lawsuits and reimbursement

Emergency physicians provide countless examples where a shortage of brain specialists affected outcomes. At least two middle-aged patients who arrived at Wheeling Hospital in West Virginia with hypertension-related brain hemorrhages likely died from lack of prompt care, says Geoffrey Ruben, MD, an ER physician, at the 250-bed hospital.

"They didn't make it through the 55-mile trip to Pittsburgh, the nearest facility with neurosurgeons," he says. "The transfers were necessary because between 2000-2003, Wheeling lost all three of its neurosurgeons because of the liability insurance crisis. Two retired, one moved to Minnesota."

In California, the shortage of on call specialists is more related to reimbursement than lawsuits. Specialists asked to treat managed care patients on whose panels they do not serve have trouble obtaining payment.

And, one third of the state's population is uninsured, according to Jack Lewin, MD, CEO, California Medical Association. "Society is exceeding the good will of doctors to be able to cope financially," Lewin says. "Many doctors would just as soon quit practicing than continue to work for free."

The issue has impeded access to care. A 2003 California Senate Office of Research report cited an example of a middle-aged man with upper gastrointestinal bleeding that came to a hospital ER on a Saturday night.

In the next three hours, six gastroenterologists refused to come to the hospital to treat him. The patient was at risk of bleeding to death. At last, the ER director lured a specialist he knew to the hospital with a promise of $500 cash. The specialist performed the procedure and stopped the bleeding.

"Why would anyone is his right mind want to suffer liability exposure for no pay? It rubs salt in the wound," says San Antonio emergency physician Kottman.

In inner cities like East Los Angeles, the percentage of self-pay or non-paying patients is well over 50 percent, compared to more affluent communities of western Connecticut and the Washington, D.C. suburbs where it could be 5 percent self-pay," says Ruben, the emergency physician who is a past president of the Association of Emergency Physicians, Mars, Pa.

Even at Methodist in Houston, a large, private 920-bed hospital, neurosurgeon Valadka says half of his emergency cases are freebies.

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