



Hospital Emergency On-Call Coverage: Is There a Doctor in the House?

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Ann S. O'Malley, Debra A. Draper, Laurie E. Felland

The nation's community hospitals face increasing problems obtaining emergency on-call coverage from specialist physicians, according to findings from the Center for Studying Health System Change's (HSC) 2007 site visits to 12 nationally representative metropolitan communities. The diminished willingness of specialist physicians to provide on-call coverage is occurring as hospital emergency departments confront an ever-increasing demand for services. Factors influencing physician reluctance to provide on-call coverage include decreased dependence on hospital admitting privileges as more services shift to non-hospital settings; payment for emergency care, especially for uninsured patients; and medical liability concerns. Hospital strategies to secure on-call coverage include enforcing hospital medical staff bylaws that require physicians to take call, contracting with physicians to provide coverage, paying physicians stipends, and employing physicians. Nonetheless, many hospitals continue to struggle with inadequate on-call coverage, which threatens patients' timely access to high-quality emergency care and may raise health care costs.

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Pressures Intensify for Hospital Emergency Departments

Across the 12 HSC communities, the traditional role of physicians taking emergency call as part of their obligation for hospital admitting privileges is unraveling, posing risks that insured and uninsured patients, alike, may not get timely and appropriate care (see Data Source). Emergency on-call coverage refers to having a physician with the appropriate specialty expertise available 24 hours a day to treat patients. While adequate on-call emergency coverage is predominantly an issue for hospital emergency departments (EDs), it also is increasingly a problem for inpatients requiring urgent specialist consultation.

Two years ago, HSC researchers reported on the range of pressures faced by hospital EDs—pressures that continue today and are hindering hospitals from securing adequate emergency on-call coverage.¹ Among these pressures is an increased demand for emergency services that is outpacing population growth. In the past decade, the rate of overall ED utilization rose 7 percent, increasing from 36.9 to 39.6 visits per 100

persons.² Ensuring the efficient flow of patients through the hospital—so-called throughput—also is a continuing challenge for hospitals, and delays in obtaining specialty services contribute to crowding when ED patients must wait to be seen by a specialist.

While insured people account for the vast majority of ED visits in the United States, the proportion of visits by uninsured people is rising at a relatively higher rate. The uninsured, or self-pay patients, accounted for 14 percent of ED visits in 2003, rising to 16 percent in 2005.³ Respondents across the 12 communities largely attributed the increase to the growing number of uninsured people, including immigrants.⁴ As a Cleveland hospital chief financial officer said, “The uninsured are accessing our ED more because they are finding it harder to get into private physician offices, I think because of a focus on payment in those offices.”

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Growing Reluctance to Take Call

Although a problem for the past decade, recent reports by hospital executives and other market observers in the 12 communities indicate a worsening situation around hospitals’ ability to obtain emergency on-call coverage, fueling tensions between hospitals and physicians. As one Seattle market observer noted, “I think that the ED coverage of care issue is much more salient than two years ago. We’ve had many meetings about sharing the burden around the city and the problem is getting worse.” Nationally, 73 percent of emergency departments report inadequate on-call coverage by specialist physicians.⁵ Specialists who are particularly difficult to secure for on-call coverage include orthopedic surgeons, neurosurgeons, plastic surgeons, trauma surgeons, hand surgeons, obstetrician-gynecologists, neurologists, ophthalmologists and dermatologists, according to hospital executives.

In some cases, a shortage of certain specialists contributes to inadequate on-call coverage. But physician unwillingness to take call appears to be a more pressing issue for many hospitals, compounding larger workforce issues of physicians not choosing specialties or practice locations that better align with the medical needs and geographic distribution of the population.⁶ According to a Little Rock hospital executive, for example, “There are tons of neurosurgeons. They are all trying to figure out how to not take ER call, which generates an artificial shortage.”

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Why Specialty Physicians Avoid Taking Call

Historically, physicians provided on-call emergency coverage in exchange for hospital admitting privileges, which allowed them to connect with new patients and helped build their practices. In addition, heavy public subsidization of medical education and residency training traditionally has been accompanied by an unwritten social contract for physicians to maintain the core competencies of their specialty in hospitals where they practice and to provide some emergency call.⁷ Hospitals enforce on-call requirements through medical staff bylaws or other contractual arrangements with physicians. With many specialists now shifting the focus of their practices away from hospital settings or to specialty hospitals that don’t have EDs, they are less reliant on hospital admitting privileges to care for their patients or to maintain a practice.

Payment for emergency care, and physician services in general, is another factor in specialists' reluctance to provide on-call coverage. Many physicians believe payment for care provided while on call is inadequate, and when they are required to care for uninsured patients, the situation becomes untenable. Time spent by a physician seeing ED patients has an opportunity cost in terms of time away from insured patients in their office practice. According to a Syracuse hospital executive, "They [physicians] look at ED call as a burden. It affects quality of life and finances in a negative way."

Specialists also are concerned that providing ED care increases exposure to medical liability and may result in higher malpractice premiums. A Lansing physician noted, "All over the country there is an unwillingness of physicians to take ER call. It does have to do with the lack of reimbursement, but also the malpractice issue. Usually big trauma cases and more challenging cases carry more risk—that's the perception, at least."

Moreover, so-called microspecialization among physicians—for example, an orthopedist who focuses only on hand surgery—has added to the reluctance of surgeons to provide on-call coverage for more routine emergency conditions they believe are outside of their narrow subspecialty. A Phoenix market observer lamented, "Now, we have very specialized specialists and, because of liability, they don't want to go outside of their area." Given training requirements, however, most specialists possess the core competencies that qualify them to provide care for the majority of routine, but urgent, conditions that present in a general hospital.⁸

Physicians' reluctance to provide emergency on-call coverage also is influenced by quality-of-life issues. Many physicians dislike providing coverage because it requires them to be available 24 hours a day. During the day, this may oblige physicians to leave their practice to respond to an emergency call. In the evening or on weekends, call coverage may interfere with family or other personal obligations.

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Adverse Patient Outcomes

There is evidence that specialist physicians' reluctance to provide emergency on-call coverage is contributing to adverse patient outcomes. Twenty-one percent of patient deaths or permanent injuries related to ED treatment delays are attributed to lack of availability of physician specialists.⁹ Across the 12 communities, market observers said that ED patients are waiting longer for specialty care.

In some communities, there is a complete lack of access to routine specialty care in the emergency department, forcing patients to either travel long distances or be transferred to another hospital for fairly routine but urgent needs, such as uncomplicated fractures. In Little Rock, a hospital respondent gave the example of a patient with hand injuries being transported to another state for care because a specialist was not readily accessible. Such situations can result in prolonged patient suffering and inconvenience, and in some cases a second ED visit and ambulance bill. Two-thirds of ED directors in level I and II trauma centers say that more than half of all patient transfers they receive stem from lack of timely access to specialist physicians at the referring hospital.¹⁰

Finally, the specialist on-call coverage issue places a disproportionate burden on physicians willing to provide coverage, increasing the potential for adverse patient outcomes as the workload increases and morale declines. As fewer physicians agree to take call, specialists who provide on-call coverage in some areas must

cover multiple hospitals on the same night. One Seattle ED director described this as “a huge stress” [on physicians]: “Specialists feel that they signed up to cover one hospital and now they’ve got all of them.”

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How Hospitals Secure Emergency Coverage

Hospitals are pursuing a variety of strategies to secure specialist emergency on-call coverage, including enforcement of hospital bylaws requiring call, payment for on-call coverage, paying professional fees for patients who are unable to pay, and other administrative arrangements aimed at improving the physician work environment.

Advances in medical technology, coupled with the development of physician-owned surgery, imaging, diagnostic and other facilities, have prompted the movement of many services to non-hospital settings. Consequently, many specialists no longer need general hospital admitting privileges to maintain a viable practice. Still, in some markets, there remains sufficient leverage for hospitals to enforce medical staff bylaws that require physicians to provide on-call coverage. A Little Rock health plan, for example, requires physicians, as a condition of participating in its network, to maintain the highest level of hospital privileges, including providing on-call emergency coverage, unless the physician is mainly an office-based primary care practitioner. A plan respondent said, “We still believe in call coverage with specialties. We believe that the oversight in the hospital setting, peer review and rubbing elbows with peers is good for quality.” A Miami hospital ED director reported that his hospital’s medical staff bylaws require physicians to come in within an hour for a consult, otherwise, the CEO calls them.

Some hospitals are securing emergency on-call coverage via contracts with physician groups that take responsibility for ensuring emergency coverage. This is a model used in some areas of high population growth and few medical training programs, such as Phoenix, but it is also used in smaller cities, such as Syracuse, where direct employment of specialists may not be feasible.

Some hospitals pay particular specialists a monthly or daily stipend for being on call. A recent national survey found that 36 percent of hospitals paid at least one type of specialist, most often a general surgeon, to take ED call.¹¹ Some hospital respondents find that it is politically more expedient to pay stipends or provide other compensation in a competitive marketplace than to enforce medical staff bylaws. One Miami hospital used an external consultant to determine a fair-market stipend rate for physicians to provide emergency on-call coverage. The hospital dropped physicians who wanted more than that prevailing rate and, instead, employed physicians in those particular specialties directly. A Little Rock hospital pays trauma surgeons \$1,000 a night for coverage. Hospitals in many of the other 12 communities report similar experiences for particular specialists, most often orthopedic, trauma and general surgeons. Paying specialists for on-call emergency coverage reportedly costs one Miami hospital \$10 million a year.

Along with the additional costs associated with paying physicians to take emergency call, some hospitals are concerned about running afoul of the federal anti-kickback law that prohibits any inducement for referrals of items or services reimbursable by a federal health care program. In a recent advisory opinion, the U.S. Health and Human Services Office of Inspector General indicated that hospital payments to physicians to provide emergency on-call coverage could potentially violate the anti-kickback law. In the particular situation

described in the advisory opinion, however, the Office of Inspector General found that adequate safeguards were in place to protect against the arrangement being used to induce referrals.[12](#)

In lieu of stipends, and increasingly in addition to stipends, some hospitals pay physicians for each uninsured patient they treat when on call. For example, some hospitals in Little Rock and Miami reported reimbursing physicians at least at Medicare rates for patients with no coverage. An Orange County hospital guarantees physicians Medicare rates plus 20 percent for treating certain uninsured patients.

An increasing number of hospitals are moving beyond contractual or stipend arrangements toward a direct employment model with specialist physicians. Along with securing on-call coverage, hospital employment of specialists may be part of a larger service-line competitive strategy. An Indianapolis hospital chief medical officer said, “I suspect that most large hospital systems will employ more specialists...I think that the hospital systems would rather employ than subsidize.” But in doing so, hospitals must be mindful of tensions with community-based specialists, who are still a significant source of referrals. As one Boston physician noted, “Hospitals are employing physicians, who [in turn] are taking patients from physicians in private-practice. And then they are asking private practice docs to cover the ER at high risk with no compensation.” One Phoenix hospital employs neurosurgeons, plastic surgeons and trauma surgeons directly, but for political reasons, first offered emergency on call to private physicians and allowed them to decline. Because public hospitals and large academic medical centers with training programs often have many employed physicians, including residents and fellows who can provide emergency coverage, the ED coverage issue tends not to be as large a problem for these institutions as for community hospitals.

A few hospitals in the 12 communities are pursuing other administrative arrangements to encourage physicians to take ED call. A Little Rock hospital offers practice management support and tries to identify other “win-win arrangements” to get physicians to take call rather than providing additional payment. An example of such an arrangement is working with orthopedic surgeons to develop more surgeon-friendly operating room schedules in return for ED call. One Miami hospital puts payment for physicians’ time spent providing on-call coverage into a tax-deferred investment account that is vested after five years as life insurance. Other hospitals are paying for physicians’ malpractice premiums in return for on-call coverage or are cross-subsidizing premiums as a way to keep on-call specialty services available.

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Implications

Hospitals’ growing difficulty in securing emergency on-call coverage by specialist physicians threatens all patients’ access to high-quality emergency care in local communities, regardless of whether or not patients are insured. Inadequate on-call coverage creates the potential for poor quality of care leading to adverse patient outcomes. And, some approaches to addressing inadequate on-call emergency coverage—such as stipends—add considerable cost.

Hospitals’ varied strategies to alleviate the on-call coverage issue are not a panacea. Failure to address key factors contributing to the problem—market changes that discourage specialist physicians from providing emergency on-call coverage, including reimbursement incentives that encourage them to seek the higher revenues available in the outpatient and specialty hospital settings, the rising number of uninsured people, and the high costs of medical malpractice insurance—are likely to further aggravate the situation, creating

additional quality and cost pressures for the health care system.

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Notes

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Data Source

Every two years, HSC conducts site visits in 12 nationally representative metropolitan communities as part of the Community Tracking Study to interview health care leaders about the local health care market and how it has changed. The communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. Approximately 500 interviews were conducted between February and June 2007 in the 12 communities with representatives of health plan, hospitals, physician organizations, major employers, benefit consultants, insurance brokers, community health centers, consumer advocates and state and local policy makers. In each community, representatives from at least two of the larger hospitals were interviewed. Hospital representatives included the chief executive officer, chief financial officer, chief medical officer, medical staff president, and for some hospitals, the emergency department director.

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600 Maryland Avenue, SW, Suite 550

Washington, DC 20024-2512

Tel: (202) 484-5261

Fax: (202) 484-9258

www.hschange.org

President: Paul B. Ginsburg