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

Pressures Intensify for Hospital Emergency Departments

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, according to a study conducted by the Center for Studying Health System Change (HSC).^{*} 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.^{*} 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.^{*} 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.^{*} Respondents across the 12 communities largely attributed the increase to the growing number of uninsured people, including immigrants.^{*} 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.”

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. Nationally, 73 percent of emergency departments report inadequate on-call coverage by specialist physicians.^{*} 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.

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.^{*} Hospitals enforce on-call requirements through medical staff bylaws or other contractual arrangements with physicians. With many

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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."

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.

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.

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.* 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.

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

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MARKET WATCH

Emergency Care Compensation

Specialty	All Physicians	Starting	Eastern	Western	Southern	Northern
Emergency Care	\$255,530	\$178,000	\$224,373	\$260,175	\$256,590	\$257,745

Source: 2007 Physician Compensation Survey, The American Medical Group Association (www.amga.org).

Compensation Ranges from \$272,500 to \$207,600

Source	Average*	% Change 2006–2007
Pinnacle	\$272,500	20.5%
Delta	\$261,250	0
AMGA	\$258,211	4.1
MGMA	\$257,409	3.9
Pacific	\$253,194	1.9
Jackson	\$251,500	14.8
Sullivan	\$248,457	5.8
Cejka	\$247,500	37.5
MDN	\$245,000	5.6
HHCS	\$240,399	0
Merritt	\$239,000	3.9
Martin	\$235,000	(6)
Hay	\$207,600	0

**Figures represent average total cash compensation, which includes salary and bonuses.
Source: Modern Healthcare's "By the Numbers," December 24, 2007.*

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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."

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.

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,

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What's New at NEJM?

NEW IN PRACTICE SPECIAL ISSUE ADDED FOR 2008! REACH DOCS IN PRACTICE 4 AND 5 YEARS!

In recognition of the growing shortage of physicians in the U.S., NEJM has added another special In Practice issue to help expand your reach in your search for quality physician candidates. In addition to our already popular, original In Practice issue (March 27) that is sent to physicians in practice two and three years, NEJM has added a second In Practice issue for May 1, which will be sent to thousands of physicians in practice four and five years, in an effort to help you dig deeper for the candidates you need to hire.

Call (800) 635-6991 or e-mail nejmads@nejm.org for complete In Practice promotion details and a listing of all specialties included in these issues with free, bonus reach.

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PROMOTIONAL NOTES/NEWS

**Reach Over 30,000 Final-Year Residents and Fellows for FREE
with the February 28, 2008, Resident Reach Issue!***

Run a paid advertisement in the February Resident Reach issue of the *New England Journal of Medicine*, and in addition to the 200,000 physicians that read NEJM regularly, you'll reach 30,000+ final-year residents and fellows in ALL specialties for FREE!*

Your ad will be reprinted in a special booklet and mailed to these job-seeking physicians, giving you the best access to the candidates. You can also connect to thousands of top physicians online, as your ad can also be posted to NEJM CareerCenter (nejmjobs.org).**

ISSUE	CLOSING DATE	SPECIALTIES
February 28	February 8	All Specialties — Over 100!

NEW, Added E-mail Exposure!

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**The recruitment section of the February 28, 2008, NEJM issue is reprinted and mailed to more than 30,000 final-year residents and fellows in all specialties whose address records appear in the AMA database. Counts are as of 11/13/07 and are subject to change based on data collected by the AMA.*

***Processing fees may apply to posting your ad to the searchable part of the website.*

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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.

Source: Reprinted with permission from the Center for Studying Health System Change, Washington D.C., www.hschange.org.

**Note: This article has been edited due to space constraints. To view the article in its entirety, including the footnotes, as well as complete data source information, please go to: www.hschange.org/CONTENT/956/. 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.*