Study: Emergency On-Call Coverage Is Unraveling

BY KATE JOHNSON
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Emergency on-call coverage from specialist physicians is "unraveling" at hospitals across the country, resulting in delayed treatment, patient transfers, permanent injuries, and even death, according to a study from the Center for Studying Health System Change, a nonpartisan policy research group in Washington.

While the problem is predominantly an issue for hospital emergency departments, it also is becoming increasingly problematic for inpatients who need urgent specialty care, according to the report. The findings are based on 2007 data from 12 nationally representative communities: Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; Northern New Jersey; Orange County, Calif; Phoenix; Seattle; and Syracuse, N.Y.

The picture is particularly grim given the fact that overall ED utilization rates have risen by 7% in the past decade, from 36.9 to 39.6 visits per 100 people, according to the report. While insured people account for the vast majority of ED visits, "the proportion of visits by uninsured people is rising at a relatively higher rate," the study's authors wrote.

Citing a 2006 paper from the American College of Emergency Physicians, the study reported that 73% of emergency departments in the United States report inadequate on-call coverage by specialist physicians. In particularly short supply are orthopedic surgeons, neurosurgeons, plastic surgeons, trauma surgeons, hand surgeons, obstetrician-gynecologists, neurologists, ophthalmologists, and dermatologists. While an actual shortage of such physicians may sometimes be to blame, "physician unwillingness to take call appears to be a more pressing issue for many hospitals," the study authors stated.

Although unwillingness to accept on-call duty is largely influenced by quality of life issues, the requirement to provide on-call coverage has traditionally been mandated by hospitals under the Emergency Medical Treatment and Labor Act. However, many specialists are now shifting their practices away from the hospital setting, and are no longer obligated by medical staff privileges, noted the report's authors.

Many physicians also believe payment for on-call care is inadequate, especially when they are caring for uninsured patients. Specialists are also concerned that providing emergency care may increase their exposure to medical liability and drive up the cost of their malpractice premiums, according to the report.

As a result, adverse patient outcomes are reported. One study found that 21% of patient deaths or permanent injuries related to ED treatment delays are attributed to lack of specialists' availability, noted the report. Complete lack of access to specialty care in some EDs is forcing either travel or transfer of patients. And for the physicians who continue to provide on-call coverage, increasing workload and decreasing morale may put patients further at risk.

"It's not a surprise that we're having this problem—it's a surprise to me that we have any on-call specialists at all," Dr. Todd Taylor, previously an emergency physician and speaker for the ACEP Council, said in an interview. Dr. Taylor left clinical medicine last summer to work in the computer industry, he said, because the risks of liability were more than he could justify.

For Dr. Taylor, it is these very liability risks that are at the root of the current on-call crisis. "The liability issue has become the overriding barrier to physicians being willing to put themselves at risk," he said.

More troubling than the lack of emergency on-call specialists, he added, is the lack of emergency physicians in general—a newer phenomenon reported earlier this year in the 2007 Daniel Stern & Associates Emergency Medicine Compensation and Benefits Survey.

"This has applied to on-call specialists for years, but the phenomenon is now spreading to core emergency physicians, who are increasingly seeking alternative careers," Dr. Taylor said, noting that 30% of the study's respondents said they were considering leaving medicine because of the malpractice climate. "That's what's different now compared to 2 or 3 years ago." ■

Inspector General Faults Specialty Hospital EDs

BY ALICIA AULT
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Physician-owned specialty hospitals are largely unprepared to handle emergencies and should be more closely tracked by the government to ensure that they comply with Medicare rules, according to a report from the Inspector General of the Department of Health and Human Services.

The IG's office reviewed written policies for managing medical emergencies, staffing schedules, and staffing policies for 8 days at 109 physician-owned facilities that were identified from a list provided by the Centers for Medicare and Medicaid Services. There are an unknown number of physician-owned specialty hospitals, according to the IG, which is urging the CMS to begin compiling a list.

Of the 109 hospitals surveyed, 66 were surgical, 23 were orthopedic, and 20 were cardiac hospitals. Eighteen of the cardiac hospitals had an emergency department; only 11 of the 23 orthopedic hospitals and 31 of the surgical hospitals had an ED. Thirty-three of the 109 hospitals were in Texas, 15 were in Louisiana, 9 in Oklahoma, 9 in Kansas, and 8 in South Dakota. The rest were spread across other states.

While half of the physician-owned hospitals surveyed had an emergency department, more than half of those EDs only had a single bed. Only 45% of the EDs had a physician on site at all times.

Ninety-three percent of the hospitals met Medicare staffing requirements: having a registered nurse on duty at all times, and a physician on call at all times. But seven hospitals did not have an RN on duty, and one hospital did not have a physician on call or on duty on at least 1 of the 8 days reviewed.

Two-thirds of the hospitals told staff to call 911 in case of emergency.

While transferring a patient with an emergent problem to another hospital's ED is acceptable, it might be a violation of Medicare conditions of participation if a hospital uses 911 to obtain medical assistance to stabilize a patient, according to the IG. Thirty-seven of the 109 hospitals (34%) engaged in that practice, the IG reported.

A hospital also is not in compliance if it uses 911 as a substitute for providing services required by the conditions of Medicare participation, noted the IG.

Almost 25% of the hospitals did not address in written policies the "appraisal of emergencies, initial treatment of emergencies, or referral and transfer of patients," according to the report.

The IG urged the CMS to enforce Medicare staffing requirements. Hospitals should also have information in their written policies on how to manage a medical emergency, such as how to use emergency response equipment or how to follow life-saving protocols, said the IG.

The CMS issued a written response to the IG that was included in the report. The agency said it agreed with the IG's recommendations and that it would examine current compliance through its routine hospital surveys. As many as 42% of the 109 hospitals would not have been subject to CMS oversight, however, according to the IG. Those facilities were instead accredited by the Joint Commission or the American Osteopathic Association.

Finally, the CMS said it would use its existing authority to require hospitals to have written policies and procedures on managing emergencies, but that it would also consider whether regulatory changes are needed to establish specific requirements for equipment and staff qualifications.

The report was requested by the Senate Finance Committee, whose leaders—Sen. Chuck Grassley (R-Iowa) and Sen. Max Baucus (D-Mont.)—have a history of seeking restrictions on physician-owned specialty hospitals, and have successfully implemented moratoriums on new facilities.

These senators will likely introduce a new proposal to rein in specialty hospitals this spring, Molly Sandvig, executive director of Physician Hospitals of America, said in an interview.

Ms. Sandvig said that her organization—which represents 108 physician-owned facilities—believed that all hospitals should meet Medicare conditions of participation. However, not every hospital should have an emergency department, she said.

While transfers may be acceptable, "No hospital should use 911 as a substitute for providing proper care to patients," said Ms. Sandvig. That practice is very limited, she said, alleging that the IG had misrepresented facilities' policies and practices.

Both the American Hospital Association and the Federation of American Hospitals pounced on the report, saying that it shows that physician-owned facilities are a threat to patient safety. "The report illustrates yet another reason why Congress needs to take action in the best interests of patients and ban physician self-referral to new limited-service hospitals they own and operate," AHA Executive Vice President Rick Pollack said in a statement. ■