

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**SPECIALTY COVERAGE IN HOSPITAL  
EMERGENCY DEPARTMENTS**



AUGUST 1992    OEI-01-91-00771

## OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services' (HHS) programs as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by three OIG operating components: the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. The OIG also informs the Secretary of HHS of program, and management problems, and recommends courses to correct them.

### OFFICE OF AUDIT SERVICES

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

### OFFICE OF INVESTIGATIONS

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil money penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

### OFFICE OF EVALUATION AND INSPECTIONS

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in these inspection reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

This report was prepared under the direction of Mark R. Yessian, Ph.D., Regional Inspector General, Office of Evaluation and Inspections, and Martha B. Kvaal, Deputy Regional Inspector General, Office of Evaluation and Inspections, Region I. Participating in this project were the following people:

#### **Boston Region**

Russell W. Hereford, Ph.D., *Project Leader*  
Lori B. Rutter

#### **Headquarters**

Alan S. Levine  
W. Mark Krushat  
Barbara R. Tedesco

For additional copies of this report, please call the Boston Regional Office at (617) 565-1050.

# EXECUTIVE SUMMARY

---

## PURPOSE

This inspection examines hospitals' capacity to provide specialty coverage in their emergency departments.

## BACKGROUND

Hospital emergency departments are the safety net of the American health care system. They provide the public's only access to around-the-clock care, 365 days per year. Under the Federal patient transfer law, Medicare-participating hospitals must meet a number of specific requirements regarding treatment of persons with emergency medical conditions, including certain women in labor. Among these requirements, hospitals must maintain a list of physicians who are on-call to provide treatment necessary to stabilize a patient with an emergency medical condition.

This report grew out of a study requested by Congress on the impact on emergency care of State laws prohibiting hospital employment of physicians. That research showed that these laws are just one of many factors limiting some hospitals' ability to provide emergency specialty services. Consequently, we expanded that study to include a separate analysis of these other factors and of hospitals' efforts to address them.

Our study uses data from (1) a mail survey of a stratified national random sample of hospital administrators; (2) a mail survey of a stratified random sample of orthopaedic surgeons, neurosurgeons, plastic surgeons, and obstetricians/gynecologists; (3) interviews with hospital administrators, directors of hospital emergency departments, medical and specialty societies, and hospital association officials; and (4) a review of literature and legislation related to hospitals' provision of emergency medical services and trauma care.

## FINDINGS

*Sixty-seven percent of hospitals report that they encounter difficulty ensuring coverage for at least one specialty service they offer in their emergency departments.*

- Certain specialties pose particular difficulty. Forty-nine percent of hospitals that offer neurosurgery in their emergency departments encounter difficulty ensuring coverage. Forty-five percent encounter difficulty ensuring coverage for plastic surgery.
- Hospitals in rural areas encounter particular difficulty staffing specialty emergency services. Seventy-two percent of rural hospitals, in contrast to 47

percent of urban hospitals, cite a shortage of specialty physicians as hindering their ability to ensure specialty coverage.

- Thirty-six percent of hospital administrators report that ensuring specialty coverage in their emergency departments has become more difficult over the past two years.

*Hospitals are likely to continue to experience difficulty obtaining specialty coverage in their emergency departments.*

- Sixty-six percent of specialty physicians responding to our survey fear increased malpractice liability as a result of covering hospital emergency departments.
- Forty-four percent of these specialty physicians believe that reimbursement for emergency services is inadequate.
- Forty-seven percent of these specialty physicians consider the Federal patient transfer law to be a serious drawback to participating in emergency care.

*Current hospital strategies to ensure emergency specialty coverage appear to be inadequate solutions to the problem.*

- Seventy-six percent of hospitals require that members of their medical staff provide emergency services. These requirements, however, do not alleviate their difficulty ensuring emergency specialty coverage.
- Twenty-six percent of hospitals report that they offer incentives for specialty physicians to participate in emergency care, but the effectiveness of these incentives is unclear.

## KEY AREAS FOR ACTION

The issues addressed in this report reflect broad problems of cost and access that exist throughout the health care system. The challenges facing our nation's emergency care system can only be resolved through the joint efforts of physicians, hospital administrators and boards, consumers and advocacy groups, health insurers, and government officials at the Federal, State, and local levels. We urge these groups to take action to:

*Define the essential elements of an effective community-wide emergency care system.*

Parameters must be established to define what constitutes an adequate number of specialty physicians available for emergency care. Recent increases in the overall number of specialty physicians suggest that simply increasing the supply is not a solution. Rather, emphasis needs to be placed on how to ensure that specialty

physicians are available for serious emergency cases in which their special skills are required.

*Determine how hospitals can best collaborate to provide emergency specialty coverage.*

Individual hospitals cannot solve the problem of emergency specialty coverage alone. Hospitals need to devise strategies that address the imbalance between the demand for emergency specialty coverage and the supply of physicians who are willing to provide these services. Examples of such efforts include sharing lists of physicians who are available for emergency department coverage and coordinating on-call schedules with other area hospitals. The Trauma Care Systems Planning and Development Act of 1990 (P.L. 101-590) offers an opportunity for States to address regional concerns about the emergency care system.

*Determine physicians' responsibility for providing emergency specialty care.*

Hospital administrators and medical staffs need to reach consensus on how much discretion physicians should have in deciding to provide emergency service. Hospital administrators need to work with their medical staffs to develop systems for ensuring specialty coverage in their emergency departments.

*Address physician perceptions about malpractice risks associated with emergency care.*

Steps that might address their concerns include research to determine the incidence of malpractice claims arising from emergency care, educational programs directed at physicians, and effective risk management strategies.

## COMMENTS

We received written comments on the draft report from the Office of General Counsel (OGC), the Health Care Financing Administration (HCFA), and the Public Health Service (PHS), and verbal comments from the Office of the Assistant Secretary for Planning and Evaluation within the Department of Health and Human Services. We also received written comments from Public Citizen Health Research Group, the American Hospital Association, the American College of Emergency Physicians, the American College of Obstetricians and Gynecologists, the American Academy of Orthopaedic Surgeons, and the Joint Council of State Neurosurgical Societies, and verbal comments from the American Medical Association. The written comments are reproduced in full in appendix B.

Within the Department, HCFA and OGC commented that we could aid in dispelling misconceptions about the Federal Patient Transfer Law by clarifying the language that appeared in the draft text; we have clarified our description accordingly.

The PHS and OGC raised questions about our methodology, including the selection of the four specialties that we surveyed; we have clarified the methodological appendix to

explain that the reason for selecting these specialties was based on a review of the research literature. The PHS also criticized the response rate for the survey of specialty physicians, and our inclusion of pediatrics in presenting data in Figures 1 and 2, since this specialty was not included in the physician survey. We respond that two of the three findings were based on the survey of hospital administrators, which had a 75 percent response rate, and we note that Figures 1 and 2 were based on data from that survey.

While most of the organizations supported our call for local collaboration to resolve problems of emergency specialty coverage, several asked us to define the elements that such a system should contain. We reiterate our belief that these systems can be developed most appropriately at the community and State levels, rather than through a Federal mandate.

Some of the organizations representing the specialty physicians emphasized the importance of financing issues in problems of emergency care. We agree that financial issues are important, but we also recognize that these issues are part of a larger debate over the nation's health care system and cannot be resolved here. In response to concerns raised about our discussion of malpractice issues, we caution that we do not claim to have solutions to concerns raised about malpractice liability; rather, we encourage development of data to fill an informational void about malpractice risk in emergency departments. Several organizations that responded to the draft report identified a number of research topics that would further elucidate emergency specialty coverage issues. We agree that these questions deserve further research; however, they exceed the scope of this report.

# TABLE OF CONTENTS

---

	PAGE
EXECUTIVE SUMMARY	
INTRODUCTION .....	1
FINDINGS .....	3
Hospitals encounter difficulty ensuring emergency coverage .....	3
Problems are likely to continue .....	6
Current coverage strategies are inadequate .....	9
KEY AREAS FOR ACTION .....	11
COMMENTS ON THE DRAFT REPORT .....	14
APPENDICES	
A. Methodology .....	A-1
B. Comments on the Draft Report .....	B-1
C. Endnotes .....	C-1





# INTRODUCTION

---

## PURPOSE

This inspection examines hospitals' capacity to provide specialty coverage in their emergency departments. It addresses (1) the availability of specialty physicians for emergency coverage; (2) specialty physicians' concerns about participating in emergency care; and (3) strategies that hospital administrators use to ensure that specialty coverage is available.

## BACKGROUND

Hospital emergency departments are the safety net of the American health care system. They provide the public's only access to around-the-clock care, 365 days per year. Emergency departments care for those injured in automobile accidents, casualties of violence, victims of heart attacks, children with common colds, and women in labor.

Hospitals report an array of difficulties facing their emergency departments. Recent studies cite inadequate reimbursement for emergency care, a high level of uninsured patients,<sup>1</sup> overcrowding,<sup>2</sup> high liability insurance costs,<sup>3</sup> and inappropriate use as primary care sites.<sup>4</sup>

Under the Federal patient transfer law<sup>5</sup> Medicare-participating hospitals must meet a number of specific requirements regarding treatment of persons with emergency medical conditions and certain women in labor. Hospitals must provide for an appropriate medical screening examination for any person who comes to an emergency department. If the person has an emergency medical condition, the hospital must either provide further examination and treatment to stabilize the condition or, under narrow circumstances, provide for the appropriate transfer of the patient to another medical facility. Hospitals must provide that their services ordinarily available in the hospital be made available for emergency patients. In addition to several other requirements, hospitals must maintain a list of physicians who are on-call to provide treatment to stabilize a patient with an emergency medical condition.

Hospitals usually provide emergency specialty coverage by maintaining an on-call panel: a time- and date-specific roster of specialty physicians who are available for emergency department coverage. In most hospitals the on-call panel comprises members of the medical staff who provide emergency specialty coverage on a rotating basis.

This report grew out of a study requested by Congress on the impact on emergency care of State laws prohibiting hospital employment of physicians.<sup>6</sup> Our early research for that study showed that State prohibitions were just one of many factors limiting

some hospitals' abilities to provide emergency specialty services. Consequently, we decided to expand that study to include a separate analysis of these other factors and hospitals' efforts to address them.

## METHODOLOGY

We have gathered our information from the following sources (see appendix A):

- (1) A mail survey of a stratified national random sample of 598 hospital administrators regarding hospital emergency department coverage; 447 responded (75 percent);
- (2) A mail survey of a stratified random sample of 837 specialty physicians--orthopaedic surgeons, neurosurgeons, plastic surgeons, and obstetricians/gynecologists--regarding hospital emergency department coverage; 477 responded (57 percent);
- (3) Interviews with hospital administrators, directors of hospital emergency departments, staff of medical and specialty societies, and hospital association officials; and
- (4) A review of policy literature and legislation related to hospitals' provision of emergency medical services and trauma care.

We conducted our study in accordance with the *Interim Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

# FINDINGS

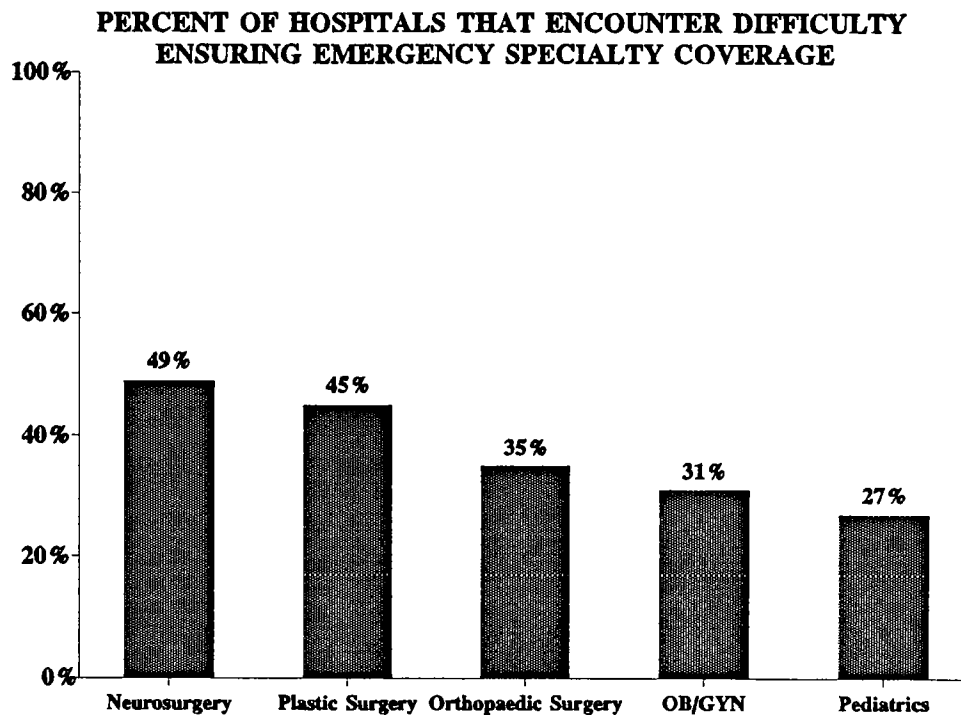
---

**SIXTY-SEVEN PERCENT OF HOSPITALS REPORT THAT THEY ENCOUNTER DIFFICULTY ENSURING COVERAGE FOR AT LEAST ONE SPECIALTY SERVICE THEY OFFER IN THEIR EMERGENCY DEPARTMENTS.**

*Certain specialties pose particular difficulty. Forty-nine percent of hospitals that offer neurosurgery in their emergency departments encounter difficulty ensuring coverage. Forty-five percent encounter difficulty ensuring coverage for plastic surgery.*

The demand for specialty physicians who provide emergency care far exceeds the supply. Hospital administrators responding to our survey cited a shortage of specialty physicians as the leading factor contributing to their inability to meet this demand.

**FIGURE 1**



Source: OIG/OEI national mail survey of hospital administrators, May 1991. N=447

Sheer numbers provide one reason for the shortage in certain specialties. The shortage is most severe among neurosurgeons, who provide specialized treatment for head and spinal injuries, and for plastic and reconstructive surgeons. Fewer than 4,500 physicians practice in either of these two specialties.<sup>7</sup>

The number of specialty physicians who actually are available to provide emergency coverage is reduced even further when other factors are considered. For example, in most hospitals specialty physicians are exempt from emergency service after age 55 or 60, or after they have provided a certain number of years of emergency care. In addition, even among those physicians who report that they provide emergency care, it is unclear how often they are on-call.

Furthermore, some specialty physicians do not participate in emergency service at all. These physicians engage in more lucrative practice options, such as private practice with elective surgery only, further constricting the supply of specialists available to take calls in emergency departments. Administrators have told us that this situation gives the few specialists who are willing to take emergency calls a great deal of economic leverage, and their financial demands can be very difficult for hospitals to meet.

*Hospitals in rural areas encounter particular difficulty staffing specialty emergency services. Seventy-two percent of rural hospitals, in contrast to 47 percent of urban hospitals, cite a shortage of specialty physicians as hindering their ability to ensure specialty coverage.*

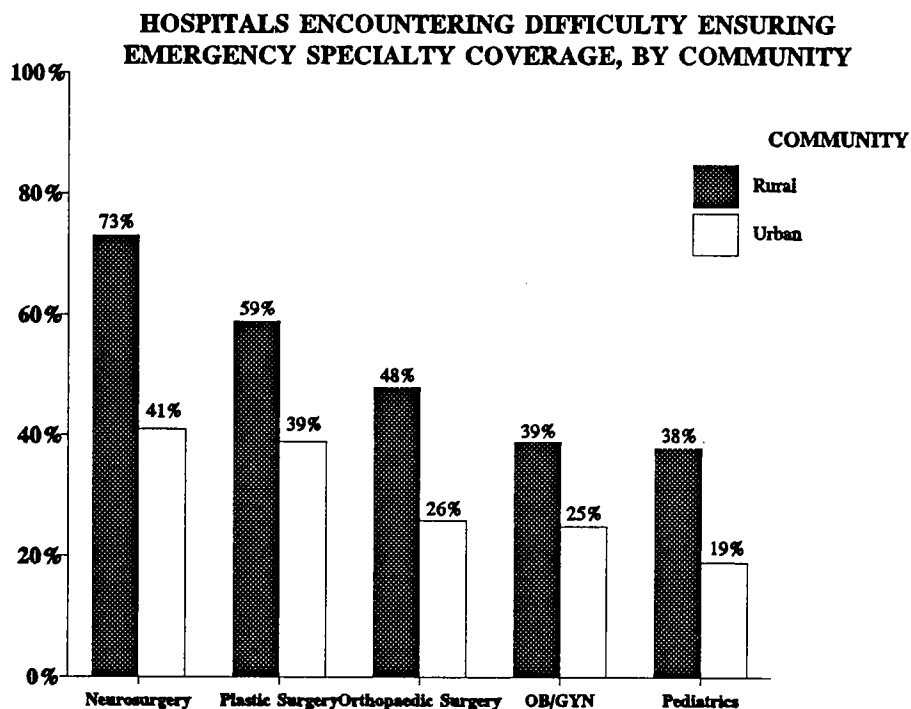
Rural hospitals are more likely than urban hospitals to have difficulty ensuring specialty coverage in their emergency departments (see figure 2). Of the rural hospitals we surveyed, 73 percent reported difficulty staffing neurosurgery; 59 percent staffing plastic surgery. Rural hospital administrators also report more trouble staffing orthopaedic surgery, obstetrics/gynecology (OB/GYN), and pediatrics than their urban counterparts.

Often the population base in rural areas is simply too small to support a variety of high-cost specialty physicians. Consequently, rural hospitals do not offer as broad a range of specialties as urban hospitals. Seventy-eight percent of rural hospitals do not offer neurosurgery in their emergency departments and 72 percent do not offer plastic surgery coverage.<sup>8</sup>

The problem facing rural areas reflects the national distribution of specialty physicians, who are located overwhelmingly in metropolitan areas. This concentration may be attributed in part to the fact that many specialty physicians are attracted to the major university and teaching hospitals in urban areas where more comprehensive services are offered.

Although fewer urban hospitals than rural hospitals encounter difficulty staffing emergency specialty services, they still must contend with the shortage of specialty physicians. Specialty physicians located in cities tend to provide coverage at more hospital emergency departments than do their rural counterparts. Thirty-six percent of urban hospital administrators versus 23 percent of rural administrators said that those specialty physicians who are available for emergency call cover too many hospitals.<sup>9</sup>

FIGURE 2



Source: OIG/OEI national mail survey of hospital administrators, May 1991. N=447

The types of emergency cases treated at urban hospitals tend to differ from those at rural hospitals and reflect the social problems of cities. One California neurosurgeon we spoke with said that many of the emergency patients he treats are victims of "the very high level of continuing high-intensity violence that occurs" in the city where his hospital is located. Inner-city emergency departments need specialty physicians to provide trauma care for penetrating injuries, such as gunshot or stab wounds associated with crime, drug wars, and gang violence.

*Thirty-six percent of hospital administrators report that ensuring specialty coverage in their emergency departments has become more difficult over the past two years.*

There appear to be no parameters on how many specialty physicians are needed in an area to ensure adequate emergency coverage. Neither the medical specialty societies nor the American Hospital Association (AHA) was able to provide us with a definition of medical specialty shortage areas. Nevertheless, a substantial but growing minority of hospitals in both urban and rural areas report increasing difficulty in furnishing emergency specialty coverage. We were told repeatedly by emergency department directors and hospital administrators that staffing their on-call panels has become steadily more challenging.

Two recent studies document these growing difficulties on the State and county levels. In a Massachusetts study, more than 90 percent of hospitals reported specialty coverage problems in the 6 months prior to the survey.<sup>10</sup> A Los Angeles County study provides a disturbing example of the adversity that can befall a local emergency care system that faces a shortage of specialists. With a population of almost 9 million, Los Angeles County contains only 120 practicing neurosurgeons. The on-call problem is said to be so widespread there that a majority of hospitals have at least considered closing their emergency departments,<sup>11</sup> and as of August 1991, 21 of the county's 89 hospitals had closed their doors to neurosurgical emergencies. As ambulances have been diverted to hospitals that continue to accept neurosurgical cases, the pressures on these hospitals to provide coverage have become acute, leading to threats that they will have to limit their emergency coverage or close their doors to neurosurgical care.<sup>12</sup>

Hospitals' inability to ensure emergency specialty coverage can have serious consequences for the public's access to these services.<sup>13</sup> The situation can result in the downgrading or closure of emergency departments, diversion of ambulances to other facilities, or treatment of serious trauma cases by physicians without the appropriate training.

#### **HOSPITALS ARE LIKELY TO CONTINUE TO EXPERIENCE DIFFICULTY OBTAINING SPECIALTY COVERAGE IN THEIR EMERGENCY DEPARTMENTS.**

*Sixty-six percent of specialty physicians responding to our survey fear increased malpractice liability as a result of covering hospital emergency departments.*

A widespread perception among specialty physicians is that emergency patients--many of whom are indigent--are more likely to sue than are other patients. An orthopaedic surgeon from California told us that emergency department coverage "is pure public service--tough patients who sue." According to a plastic surgeon "the problem [of emergency specialty coverage] will get worse as long as anyone can sue a physician for an adverse result. The emergency room patients carry the greatest risk here."

Emergency care involves treating patients with whom physicians have not established a relationship. Physicians believe that these patients run high risks of adverse outcomes because many have not received adequate health care prior to their appearance in the emergency department. One hospital administrator illustrated this problem by describing the situation he faces with obstetricians in his hospital. He explained that the obstetricians are reluctant to provide emergency coverage because they may be called in to deliver babies for women who have received no prenatal care. These obstetricians worry that they will be sued if these women experience complications or poor outcomes.

Specialty physicians also fear that participation in emergency care will increase the cost and decrease the availability of malpractice insurance. They are concerned that insurance companies will be reluctant to underwrite policies for physicians who participate in emergency care. We learned about a case in California in which a physician-owned insurance company threatened to withhold coverage for physicians who served in emergency departments. Under pressure from the medical community and the State attorney general, this company eventually withdrew its threat. But contrary to physicians' perceptions, a representative from a large association of insurance companies told us that physician participation in emergency service affects neither the price nor the availability of malpractice insurance.

Empirical studies on the incidence of malpractice claims call into question the accuracy of the perception that indigent patients are more likely to sue. A 1989 study published in the *Journal of the American Medical Association* shows no difference in the frequency of malpractice claims filed by indigent patients compared to privately insured patients.<sup>14</sup> A study by the American College of Obstetricians and Gynecologists (ACOG) concluded that Medicaid patients are no more likely than other patients to be litigants in malpractice suits arising from obstetrical care.<sup>15</sup> In Maryland, researchers found that "the proportion of claims filed by persons enrolled in Medicaid before and/or during the alleged malpractice incident was lower than the proportion of state residents enrolled in Medicaid."<sup>16</sup> However, none of these studies is specific to suits arising solely from the emergency department.

*Forty-four percent of specialty physicians responding to our survey believe that reimbursement for emergency services is inadequate.*

Economically, emergency department coverage has little appeal for specialty physicians. Specialty physicians say that low reimbursement rates for Medicaid patients and the possibility of no payment from uninsured patients deter them from providing emergency care. The American College of Emergency Physicians found that an average of 31 percent of emergency physicians' charges go uncollected. Many reported uncompensated care levels as high as 50 or 60 percent of gross patient charges.<sup>17</sup>

Specialty physicians' frustrations over low income from emergency services are compounded by the disruption in their private practices caused by being summoned to the emergency department. Specialty physicians contend that a call to the emergency department in the middle of the night may force them to cancel their scheduled appointments for the next day, thus resulting in a loss of income from their regular practices.

While specialty physicians' concerns about low payment should not be ignored, since they could affect the availability of emergency care, these concerns should be put in context. Obviously, a large uncompensated care clientele would be a burden on these physicians. At the same time, however, the medical specialties surveyed for this study include some of the most highly paid physicians. A recent survey of physician

compensation reported a median income of \$338,692 for neurosurgeons, \$274,255 for orthopaedic surgeons, and \$197,745 for obstetricians/gynecologists.<sup>18</sup>

*Forty-seven percent of specialty physicians responding to our survey consider the Federal patient transfer law to be a serious drawback to participating in emergency care.*

The Federal patient transfer law (referred to as COBRA, because it was enacted in the Consolidated Omnibus Budget Reconciliation Act of 1985) has heightened specialty physicians' anxiety about providing emergency department coverage. This law is designed to guarantee patients medical treatment for emergency conditions regardless of their ability to pay. Yet, many physicians resent it as an intrusion into their clinical decisions. The law adds to specialty physicians' concerns about reimbursement and liability in the emergency department. COBRA does not require specialty physicians to serve on-call panels. But if a physician agrees to be on-call for emergency duty and fails or refuses to appear at the hospital within a reasonable period of time after notification, the physician may be subject to penalties under the law, depending on the facts and circumstances of the refusal or failure to appear.

Fifty-nine percent of the specialty physicians responding to our survey reported that they provide emergency department coverage at two or more hospitals. Reflecting a concern expressed by some of these specialists, one neurosurgeon stated, "There are legitimate times when we are tied up in surgery and not available . . . [but] the Federal patient transfer law does not address such a problem." Although a few specialty physicians suggested that ambiguities in the Federal patient transfer law might lead them to limit their participation in emergency care, to date no case has been prosecuted against a physician who failed to appear at one emergency department while caring for patients at another. We were unable to find any data documenting how many physicians actually have withdrawn from emergency service due to COBRA requirements.



## **CURRENT HOSPITAL STRATEGIES TO ENSURE EMERGENCY SPECIALTY COVERAGE APPEAR TO BE INADEQUATE SOLUTIONS TO THE PROBLEM.**

*Seventy-six percent of hospitals require that members of their medical staff provide emergency services. These requirements, however, do not alleviate their difficulty ensuring emergency specialty coverage.*

Medical staff bylaws traditionally have required that physicians with admitting privileges participate in their hospital's emergency department on-call panel. But hospitals that require on-call coverage report that they encounter difficulty in staffing their on-call panels to the same degree as hospitals without this requirement. One hospital administrator we interviewed noted that when his hospital faced difficulty ensuring emergency coverage, medical staff added mandatory on-call panel participation for physicians, but the addition of the bylaw requirement failed to remedy the problem.

Enforcing bylaws governing emergency service participation rests with the hospital's medical staff. Administrators contend that they have little leverage to ensure that physicians meet these requirements because physicians want administrators to exercise as little control as possible over medical staff decisions. Moreover, many physicians resent the principle behind mandatory on-call panel participation. In fact, ten percent of hospitals responding to our survey reported that their medical staffs have made efforts to remove the on-call requirement from the bylaws.

Despite resistance to emergency service from medical staffs, most hospital administrators manage to put together on-call panels. Administrators work with their medical staff and chiefs of services to persuade them to participate in emergency department coverage. However, some administrators have resorted to other strategies in an attempt to ensure emergency department coverage.

*Twenty-six percent of hospitals report that they offer incentives for specialty physicians to participate in emergency care, but the effectiveness of these incentives is unclear.*

Hospitals offer two types of incentives to make emergency department coverage more appealing: those with direct financial implications and those that are primarily administrative in nature. Although about one-quarter of hospitals offer some type of incentive, no single approach dominates.

Ten percent of hospitals encourage specialty physicians to provide emergency care by offering them direct compensation for being on the on-call list. The costs of such payments can be substantial. One administrator we interviewed from a community hospital pays neurosurgeons a "nuisance fee" of \$1,000 per night merely for carrying a beeper to respond to potential emergency calls. Specialty physicians who actually come to the emergency department to provide care receive payment for patient services plus the basic on-call payment from the hospital.

Four percent of hospitals guarantee physicians a minimum reimbursement rate for services rendered in the emergency department. This approach is an attempt to address physicians' concerns about inadequate payment for emergency services. Another administrator we spoke with estimates that his hospital spends \$500,000 per year for such guarantees. These funds come directly out of the hospital's bottom line and are not recognized as part of its charity care contribution.

Six percent of hospitals report that they address specialty physicians' concerns about malpractice coverage by paying malpractice premiums for coverage in the emergency department. In these cases, the hospital adds specialty physicians to its professional liability policy.

Administrative strategies are designed to address other concerns that physicians have raised. In response to specialty physicians' concerns about stress and the disruptive nature of emergency service, about ten percent of hospitals limit the frequency of on-call service. While this practice has the immediate benefit of decreasing the burden on individual physicians, it does not ensure that a hospital will be able to provide emergency specialty coverage on a daily basis. Seven percent of hospitals have attempted to reduce the administrative burden of emergency care by offering direct hospital billing of emergency patients for specialty physicians. This practice provides administrative support by including the physician's services on the hospital bill.

The effectiveness of these incentives remains unclear. Forty-eight percent of hospitals offering incentives report growing difficulties in providing specialty coverage over the past two years, compared to 30 percent of those that do not offer special incentives. On the other hand, it may be that the difficulties these hospitals face drove them to offer incentives in the first place.

## KEY AREAS FOR ACTION

---

The issues addressed in this report raise some fundamental questions about the nature of our health care system. To some degree, these difficulties reflect broader problems of cost and access that have been well-documented elsewhere. Certainly, any meaningful reform of the nation's health care system could provide some relief for the difficulties described in this report.

We believe, however, that continuing to wait for meaningful national reform will only aggravate the existing problems. We recognize that the issues are perplexing and difficult to resolve. Nevertheless, the gravity of the situation challenges all parties involved in the delivery of health care services to develop solutions.

The challenges facing our nation's emergency care system can only be resolved through the joint efforts of physicians, hospital administrators and boards, consumers and advocacy groups, health insurers, and government officials at the Federal, State, and local levels. Toward that end, we urge these groups to take action in the areas addressed below.

### **DEFINE THE ESSENTIAL ELEMENTS OF AN EFFECTIVE COMMUNITY-WIDE EMERGENCY CARE SYSTEM.**

Before the problem of emergency specialty coverage can be resolved, parameters must be established to define what constitutes an adequate number of specialty physicians available for emergency care. As noted in this report there are no common criteria by which to measure whether a region or community has adequate emergency specialty services to meet its needs.

Simply increasing the number of specialty physicians does not appear to be an appropriate solution. In fact, in the past two decades the trend among physicians has been to select specialty careers over primary care.<sup>19</sup> The problem of emergency specialty coverage appears to be one of resource allocation rather than scarce resources. The key issue is how to assure that specialty physicians are available for serious emergency cases in which their special skills are required.

The next step is determining where our emergency system falls short. Some States, through their emergency medical services offices, have begun to gather and maintain information on the availability of specialty services in their hospitals. This type of data base enables them to identify gaps in service and to direct ambulances carrying patients in need of specialty care to hospitals where those services are available. It also provides baseline information about how best to organize a regional or community emergency care system.

## **DETERMINE HOW HOSPITALS CAN BEST COLLABORATE TO PROVIDE EMERGENCY SPECIALTY COVERAGE.**

Individual hospitals cannot solve the problem of emergency specialty coverage alone. Even hospitals that offer incentives to physicians to provide emergency services report difficulty ensuring adequate coverage of their emergency departments. Hospitals need to devise strategies that address the imbalance between the demand for emergency specialty coverage and the supply of physicians who are willing to provide these services. Joint efforts among area hospitals could provide some relief for this complicated problem. Examples of such efforts include sharing lists of physicians who are available for emergency department coverage and coordinating on-call schedules with other area hospitals.

Recognizing the need for collaboration among hospitals in order to promote access to trauma and emergency care, Congress authorized the Trauma Care Systems Planning and Development Act of 1990 (P.L. 101-590). Five million dollars has been appropriated for FY 1992 to help States develop, implement, and improve regional trauma care systems through a competitive grant program. This legislation provides the opportunity for States to begin to address regional concerns about the availability of specialty physicians, facilities, and transportation for emergency care.

## **DETERMINE PHYSICIANS' RESPONSIBILITY FOR PROVIDING EMERGENCY SPECIALTY CARE.**

Most hospitals have bylaws that require physicians to provide emergency care, yet they still report difficulty ensuring specialty coverage. Generally, medical staffs are responsible for enforcing this requirement, leaving hospital administrators with little leverage other than persuasion to assure compliance. Hospital administrators and medical staffs need to reach consensus on how much discretion physicians should have in deciding to provide emergency service.

We urge hospital administrators to work with their medical staffs to develop systems for ensuring specialty coverage in their emergency departments. Such systems should clearly outline specialty physicians' obligations to provide emergency specialty coverage.

## **ADDRESS PHYSICIAN PERCEPTIONS ABOUT MALPRACTICE RISKS ASSOCIATED WITH EMERGENCY CARE.**

There are no data that indicate a higher risk of malpractice in the emergency department, yet specialty physicians believe that they increase their chances of being

sued by providing emergency care. Steps that might address their concerns include the following:

(1) Research to determine the incidence of malpractice claims arising from emergency care could fill an informational void, helping to clarify whether this perception is correct. Hospitals could then offer educational programs to their specialty physicians about the actual incidence of malpractice.

(2) Hospitals can work with insurance companies to institute effective risk management strategies. Such actions could help to allay specialty physicians' concerns about emergency care, and enhance hospitals' ability to attract specialty physicians. Examples of such approaches include a single master insurance policy covering both the hospital and affiliated physicians, and the creation of multi-hospital risk pools.

# COMMENTS ON THE DRAFT REPORT

We received written comments on the draft report from the Office of General Counsel (OGC), the Public Health Service (PHS), and the Health Care Financing Administration (HCFA), and verbal comments from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) within the Department of Health and Human Services. We also received written comments from Public Citizen Health Research Group (PCHRG), the American Hospital Association (AHA), the American College of Emergency Physicians (ACEP), the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Orthopaedic Surgeons (AAOS), and the Joint Council of State Neurosurgical Societies (JCSNS), and verbal comments from the American Medical Association (AMA).

We respond here to the major themes contained in the comments. We first provide a summary of the comments, and then provide our response in italics. We include the complete text of the written comments in Appendix B.<sup>20</sup>

## Federal Patient Transfer Law

The HCFA and the OGC believe that the report could aid in dispelling misconceptions about this law by clarifying the language that appeared in the draft text. Comments from several of the other organizations suggested that such a clarification would be beneficial.

*We have clarified our description of the Federal Patient Transfer Law in response to these comments. We specify that an on-call physician who refuses or fails to appear at a hospital may be subject to penalties, depending on the facts and circumstances of the refusal or failure to appear. We also indicate that Medicare-participating hospitals must provide for their ordinarily available services to be available for emergency patients.*

## Local Collaboration

Most of the organizations directly supported our call to develop collaborative approaches for resolving problems associated with specialty coverage in hospital emergency departments. Several of these organizations asked us to define more precisely how hospitals, physicians, and other groups could work together to ensure specialty coverage. For example, they requested that we specify how often physicians should take call, discuss how hospital by-laws can be enforced, assess the practicality of sharing on-call lists, determine how to foster urban-rural collaboration, define the appropriate distribution of specialty physicians, and address the capacity of different hospitals to provide sophisticated specialty services.

*We intentionally do not define the elements of a collaborative system for emergency coverage. We believe that these systems will be developed most appropriately at the community and State levels, rather than through a mandate of the Federal government.*

*The issues these organizations raise need to be addressed to resolve emergency department specialty coverage problems. Many of these issues also require that hospitals and their medical staffs actively cooperate in examining and enforcing the bylaws that govern the provision of all services, including requirements for on-call coverage.*

*Within the Department, we believe that opportunities exist within PHS to place concerns about further definition of the scope and nature of this problem on the health policy research agenda. As the operating division within the Department responsible for implementing the Trauma Care Systems Planning and Development Act, and for funding research through the Agency for Health Care Policy and Research, PHS is in a unique position to encourage examination of these issues. The demonstrations described by HCFA also appear to offer models that might be replicated elsewhere to address emergency service delivery. We encourage the dissemination of results from demonstrations and research that explore emergency department specialty coverage as an important way to clarify these issues.*

### Financing Emergency Care

The organizations representing the specialty physicians emphasized the importance of financing issues in problems of emergency care. They cite financial disincentives for performing certain procedures and examinations, the structure of reimbursement for different types of medical services and specialties, and the high uncompensated care burden in emergency departments.

*The points that these groups raise further verify our discussion about the financial drawbacks of emergency department coverage for many specialty physicians. As we also note, meaningful reform of the nation's health care system could provide some relief from these problems. Resolving the debate over fundamental financial reform in the nation's health care system exceeds the scope of this inspection.*

### Malpractice

The PHS, ACOG, and JCSNS criticized our discussion of malpractice issues. They question whether further research into the incidence of malpractice will yield useful information for resolving physicians' concerns about increased exposure to malpractice claims arising from emergency care. The ACOG and JCSNS encouraged further exploration of alternatives, such as State initiatives to provide physicians some protection from liability in emergency obstetric care and to free trauma surgeons from malpractice risk if the trauma service meets certain standards.

*We raise the issue of malpractice in this report as a leading concern cited by the physicians we surveyed. We do not claim to have solutions to concerns raised about malpractice liability; rather, we encourage development of data to fill an informational void about malpractice risk in emergency departments. We certainly encourage analysis and dissemination of information on options for addressing these concerns, including the success of State programs that provide protection from liability for emergency care.*

## Methodological Issues

The OGC and the PHS raised questions about our selection of the four specialties included in the physician survey. The PHS questioned the power of our findings because of a 57 percent response rate on the survey of specialty physicians. The PHS also questioned our presentation of data on pediatrics in Figures 1 and 2, since this specialty was not included in our survey of physicians.

*We selected the four specialties examined in this report on the basis of earlier research that showed that hospitals encounter particular difficulty attracting physicians in these specialties for emergency coverage. We have expanded the methodological appendix to clarify this point.*

*The response rate for the survey of hospital administrators was 75 percent. Those responses form the basis for two of the three major findings, and five of the eight subfindings. We believe that the data from the survey of specialty physicians are sufficient to use as we report them. The comments we received from the medical specialty associations--about malpractice risks, financing emergency care, and the Federal Patient Transfer Law--further support our identification of these as primary problems that specialty physicians perceive with emergency department coverage.*

*The data presented in Figures 1 and 2 are derived from the survey of hospital administrators, as the subtext in these figures indicates. The percentage of hospitals reporting that they encounter difficulty ensuring emergency coverage for pediatrics was sufficiently high that we thought it important to report data on this specialty.*

## Other Issues for Research and Examination

Several of the organizations that responded to the draft report identified a number of research topics that would further elucidate emergency specialty coverage issues. These topics include collecting data on model programs, identifying factors that might distinguish different hospitals' ability to attract specialty physicians, assessing the extent to which coverage difficulties result from geographic shortage areas versus inability or unwillingness of physicians to be on call, and describing the role of the emergency department in meeting primary care needs.

*We believe that these questions deserve further research and analysis. However, they exceed the scope of this report, and we do not address them here. We encourage other organizations to explore these issues as they undertake further research in this area.*



# APPENDIX A

---

## METHODOLOGY

### *Hospital Sample Selection and National Survey*

We conducted a mail survey of a national sample of hospital administrators on issues related to emergency department care. The sample universe consisted of all acute short-term hospitals with an emergency department listed in the Health Care Financing Administration Provider of Service file. The sample was selected using stratified simple random sampling with six strata:

- Small rural hospitals (fewer than 100 beds)
- Small urban hospitals
- Medium rural hospitals (100-299 beds)
- Medium urban hospitals
- Large rural hospitals (300 or more beds)
- Large urban hospitals

We defined six strata for California and six strata for the remaining States, for a total of 12 strata. We sampled hospitals at a higher rate in California than in the remaining States because this inspection began as part of an examination of State laws prohibiting hospital employment of physicians, which have particular applicability in California.

Originally, we selected 637 hospitals for the survey, but due to mergers and closures, the sample size was decreased to 598. We distributed surveys on May 10, 1991, to these 598 hospitals, with a followup mailing to nonrespondents on May 31. We received responses from 447 hospitals, a response rate of 74.7 percent, forming the data base for this study. A sample size of 447 provides estimates within  $\pm 5$  percent of the true value at the 95 percent confidence level.

### *Specialty Physician Sample Selection and Survey*

We also surveyed a random national sample of neurosurgeons, plastic surgeons, orthopaedic surgeons, and obstetricians/gynecologists. We surveyed physicians in these four specialties because they had been highlighted in two major reports<sup>21</sup> on emergency rooms as posing particular difficulties for emergency department coverage.

We selected the sample of physicians using a stratified two-stage random sample. Two strata were created. The first contained the three Medicare Part B carriers covering the States of California and Texas, so these carriers were selected with a probability of one. As part of our companion study, *State Prohibitions on Hospital Employment of Physicians* (OEI-01-91-00770), we wanted to gather data on the views of specialty physicians from those two States. The second strata contained all other carriers administering the Medicare Part B program.

For each carrier, an unduplicated count of the number of provider numbers (EINs) found in each of the four specialty groups was produced from the Part B Medicare Annual Data (BMAD) system one percent sample file. Using the total number of EINs, across all specialties, we determined the size of the carriers in the second strata as the proportion each carrier represented of the total number. We then chose six carriers, with replacement, with probability proportional to size. Overall, the sampled carriers contain approximately 25 percent of the neurological surgeons, obstetricians/gynecologists, orthopaedic surgeons, and plastic surgeons contained in the BMAD one percent sample. To achieve a sample size of 200 for each of the four specialty, a sampling fraction was determined for each specialty group and applied within each carrier. The actual size of the selected sample was 853, because of rounding and variation in the number of specialties across each carrier. Names and addresses for 837 of these physicians were obtained from the carriers.

On June 21, 1991, we mailed the surveys to this random sample of specialty physicians, with a followup mailing to nonrespondents on July 5. We received usable responses from 493 specialty physicians. Thirty-seven surveys (4.4 percent) were returned to us because the physicians had retired, died, or moved. Sixteen responses were eliminated from the analysis because the physicians indicated that they practice in specialties other than the four we chose to survey. This yielded a data base of 477 specialty physicians, an effective response rate of 57 percent--132 orthopaedic surgeons, 118 plastic surgeons, 119 neurosurgeons, and 108 obstetricians/gynecologists.

### *Interviews*

Our interviews included telephone and in-person discussions with hospital administrators from California and Massachusetts, States in which major studies of emergency department issues had recently been conducted. (These studies are cited in appendix C.) We also conducted telephone interviews with officials from state hospital associations in Arizona, California, Colorado, Georgia, Illinois, Iowa, Kansas, Massachusetts, Mississippi, Montana, Ohio, Texas, and Washington, and regional hospital councils in California. We also interviewed State medical society officials in California, Iowa, Massachusetts, and Texas, and physicians from California, Texas, Florida, and Massachusetts. These interviews were expansions of research on our companion study, *State Prohibitions on Hospital Employment of Physicians*.

We also interviewed representatives of the following national organizations: American Medical Association, American Hospital Association, American College of Obstetricians and Gynecologists, American College of Emergency Physicians, American Society of Orthopaedic Surgeons, American Society of Plastic and Reconstructive Surgeons, and American Association of Neurological Surgeons.

### *Review of Literature and Legislation*

We reviewed journal articles, studies conducted by professional associations, and recent legislation on trauma and emergency care services.

# APPENDIX B

---

## DETAILED COMMENTS ON THE DRAFT REPORT

In this appendix we present the full comments of all parties that responded in writing to the draft report. The comments offer a wide range of views and pertinent information bearing on the issues presented in our report. We urge the reader to review them carefully. In order, the comments presented in this appendix are from the following:

	Page
The Office of General Counsel .....	B-2
The Health Care Financing Administration .....	B-4
The Public Health Service .....	B-9
The Public Citizen Health Research Group .....	B-12
The American Hospital Association .....	B-15
The American College of Emergency Physicians .....	B-18
The American College of Obstetricians and Gynecologists .....	B-20
The American Academy of Orthopaedic Surgeons .....	B-23
The Joint Council of State Neurosurgical Societies .....	B-27



NOTE TO RICHARD KUSSEROW

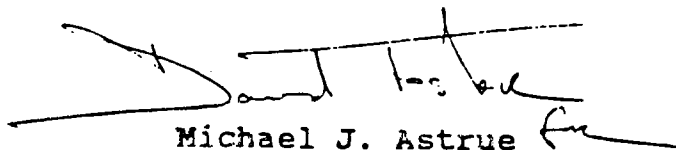
Re: OIG Draft Report: "Specialty Coverage in Hospital  
Emergency Departments" OEI-01-91-00771

Both editorial and substantive comments are noted in the body of the attached report. The following sets forth just the substantive comments.

1. The report never defines the term "specialty coverage" except by implication. By sending the survey to orthopedic surgeons, neurosurgeons, plastic surgeons, and obstetricians/gynecologist, there is an implication that these are the types of physicians who provide "specialty coverage."
2. In the Executive Summary and on page one there is a description of who is protected by the statute. The report presently reads that the statute requires treatment of persons with emergency medical conditions, including women in labor. However, not all women in labor are protected by the statute, only those women who are having contractions and there is inadequate time to effect safe transfer prior to delivery or the transfer may pose a threat to the health and safety of the mother or the unborn child. Therefore, we suggest the sentence be amended to read: "Under the Federal patient transfer law Medicare-participating hospitals must meet a number of specific requirements regarding treatment of persons with emergency medical condition, including certain women in labor."
3. On page four, the report states that specialty physicians are located overwhelmingly in metropolitan areas because many specialty physicians are attracted to the major university and teaching hospitals in urban areas. Is there support for this statement?
4. On page eight, there is a statement that an on-call physician who refuses or fails to appear at the hospital is subject to penalties under the law. This statement should be modified to state that the physician may be subject to penalties under the law, as it depends on the facts and circumstances of the refusal or failure to appear.

Page 2 - Richard P. Kusserow

If you have any questions, please contact Leslie Shaw at  
(202) 619-1306.



Michael J. Astrue  
General Counsel

Attachment



JUL 21 1992

Memorandum

Date *William Toby, Jr.*  
From Acting Administrator

Subject Office of Inspector General (OIG) Draft Report: "Specialty Coverage in Hospital Emergency Departments," OEI-01-91-00771

To Inspector General  
Office of the Secretary

We have reviewed the subject draft report in which the OIG examines hospitals' capacity to provide specialty coverage in their emergency departments. This report grew out of a study requested by Congress on the impact on emergency care of State laws prohibiting hospital employment of physicians.

Earlier research for the Congressionally-mandated study showed that these laws are just one of many factors limiting some hospitals' ability to provide emergency specialty services. OIG decided to expand this study to determine what other factors were affecting hospitals' ability to provide these services.

In this expanded study, OIG found that two-thirds of the hospitals surveyed currently encounter difficulty ensuring coverage for at least one specialty service offered in their emergency departments, and that these difficulties are likely to continue. OIG believes current hospital strategies to ensure emergency specialty coverage, such as requiring medical staff members to provide emergency services and offering incentives for physicians to participate in emergency care, have not effectively addressed these problems.

OIG has targeted key areas for action in attempting to address the challenges facing our nation's emergency care system, including: (1) defining the essential elements of an effective community-wide emergency care system, (2) determining how hospitals can best collaborate to provide emergency specialty coverage, (3) determining physicians' responsibility for providing emergency specialty care, and (4) addressing physician perceptions about malpractice risks associated with emergency care. OIG acknowledges that accomplishing these objectives will demand the joint efforts of physicians, hospital administrators and boards, consumers and advocacy groups, health insurers, and government officials at the Federal, State and local levels. Consequently, the report contains no recommendations for the Health Care Financing Administration (HCFA) or any other discrete party.

Page 2

HCFA has some concerns about issues raised in this study. Specifically, we believe that this report may further promote misconceptions prevalent among physicians about Federal patient transfer law. The report fails to clarify that the law uses the established scope of services offered by individual hospitals as the basis for determining whether sanctions should be applied, and that physicians fulfilling their established responsibilities, including the delivery of emergency services, are unlikely to be sanctioned. We have additional information for OIG on Congressionally-mandated studies we are conducting that may be pertinent to this audit. Our further specific comments are attached for your consideration.

Thank you for the opportunity to review and comment on this draft report.

Attachment



Comments of the Health Care Financing Administration (HCFA)  
on Office of Inspector General (OIG) Draft Report: "Specialty  
Coverage in Hospital Emergency Departments,"  
OEI-01-91-00771

General Comments

Misconceptions About Federal Patient Transfer Law. Nearly half of the physicians surveyed for this report said the Federal patient transfer law is a serious drawback to participating in emergency care (page 8). Letters and phone calls addressed to HCFA from health providers have also demonstrated that misconceptions about this law have contributed to a reluctance among specialty physicians to provide emergency services. In particular, we believe there is a widespread misperception that this law, codified as section 1867 of the Social Security Act, includes specific requirements for physicians on a hospital on-call panel.

Section 1867 merely requires that Medicare-participating hospitals' policies provide for their ordinarily available services to be available for emergency patients. It does not provide specific direction on what these services must be, or how on-call panels must be designed. Since the imposition of sanctions under this law depends on evaluation of each hospital's established roster of services, it is highly unlikely physicians would be immediately subject to repercussions. Many physician concerns arising from the law relative to participation on on-call panels are not justified, such as beliefs that failure to be immediately available for an emergency at one hospital when providing emergency care at another location will result in automatic application of sanctions.

To aid in dispelling such misconceptions about this law, we suggest that OIG clarify this report to reflect the extent of the law's requirements for hospitals with varying scopes of service. Our efforts to undo such misconceptions are also continuing. HCFA plans to issue regulations or guidelines which will serve to interpret section 1867. We believe the release of such materials will help alleviate confusion among physicians, hospitals, and the community at large.

Malpractice Liability. We agree with OIG that there is widespread interest in the topic of malpractice liability faced by emergency room physicians by specialty and payer (pages 6-7). Previous studies have shown that physicians' perceptions of possible malpractice liability from Medicaid patients have been inaccurate. However, no research has examined differences in liability across specialties in an emergency room setting.

The only data we are aware of that could be used for this research is the National Practitioner Data Bank maintained by the Bureau of Health Professionals in the Health Resources and Services Administration (HRSA). This database contains national data from 1990 to the present. We believe HRSA would be the logical sponsor of further research on this topic.

Ongoing Research. HCFA has several ongoing demonstrations and programs that address various problems in hospital emergency departments. Although these demonstrations and programs do not specifically address the issue of physician specialty coverage in emergency departments, they do have an indirect impact worthy of note when considering this topic.

- In January 1991, HCFA funded the first year of a 3-year emergency room triage demonstration at Highland General Hospital in Oakland, California. The explosive demand for the services of Highland's emergency department had severely strained the resources of the hospital. The demonstration was mandated by section 6217 of the Omnibus Reconciliation Act of 1989 (OBRA 89), which provided up to \$500,000 funding per year. Most of the funds have been used for the hiring of mid-level practitioners to treat patients needing only minimal services. This frees up physicians to treat more seriously ill patients. In addition, patient advocates were hired to ease stress among patients and practitioners in this crisis-laden environment by helping with scheduling and by answering non medical questions.
- The Essential Access Community Hospital program, mandated by OBRA 89, and the Montana Medical Assistance Facility Demonstration, mandated by the Social Security Act Amendments of 1983, take unique approaches to the provision of emergency services in rural areas. Both programs established limited-service hospitals and provide for emergency department staffing in these facilities by mid-level practitioners. In addition, these programs encourage the establishment of networks of facilities that together provide the full range of medical services. Patients who require services that are not available at the limited-service facilities can be quickly transferred to better equipped full-service hospitals where the range of highly specialized physicians referred to in this audit may be found.

Technical Comments

Page 8, Second Paragraph. In keeping with our comments on the Federal patient transfer law, we suggest the following statement be revised to acknowledge that meting out penalties is dependent upon the circumstances of an individual case and upon existing hospital policies:

But if a physician agrees to be on call for emergency duty and fails or refuses to appear at the hospital within a reasonable period of time after notification, the physician is subject to penalties under the law.



## Memorandum

Date • 11/14/92

From Deputy Assistant Secretary for Health Management Operations

Subject OIG Draft Report "Specialty Coverage in Hospital Emergency Departments," OEI-01-91-00770

To Deputy Inspector General for Evaluation and Inspections, OS

We have reviewed the subject audit report. Although the OIG draft inspection report has no recommendations, we have the following comments on it.

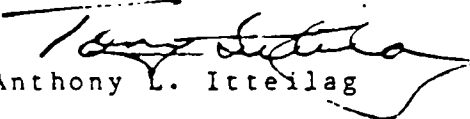
- o While this report provides some evidence that there are significant problems related to specialty coverage in emergency departments, it also highlights a need for further definition of the exact nature and scope of the problem and investigation of possible solutions.
- o The OIG conclusions are based on mail surveys and interviews with various professionals, i.e., hospital administrators and physicians, and their perceptions of the problem and its causes. Although such surveys document that providers have heightened concerns about providing emergency department coverage, they do not describe scientifically the nature and extent of the problem. We believe that the description of the survey methodology, which included the selection of four subspecialties, should be expanded. The 57.8 percent response rate may cast some doubts on the survey's findings.
- o As indicated above, primary attention was focused on four subspecialties: orthopedic surgeons, neurosurgeons, plastic surgeons, and obstetricians/gynecologists. The OIG report does not provide any evidence that pediatricians were surveyed as a group. However, pediatricians are included on two statistical tables (FIGURE 1 and FIGURE 2) on the OIG findings. Psychiatrists are not mentioned at all. The particular needs of children and the whole range of psychiatric emergencies warrant increased attention.
- o The report also does not address the differences related to the profit and nonprofit status of the hospitals that would have an effect on results. The OIG statement that

hospital emergency departments provide the public's only access to around-the-clock care, 365 days per year, is not quite accurate. Many community-based primary care physicians, group practices and managed care organizations provide 24-hour service. We believe it would be more accurate to state that there are certain services requiring specific resources that can be obtained only in emergency rooms.

The matters addressed in the "KEY AREAS FOR ACTION" section of the OIG report are broad and non-specific. Our comments are as follows:

- o The report notes that "to some degree, these difficulties [re: specialty coverage in hospital emergency departments] reflect broader problems of cost and access . . .", yet, to a large extent the focus is limited to emergency service. A broader focus on systems of health services delivery could suggest strategies for addressing the problems. For instance, one illustration cites obstetrician reluctance to provide emergency coverage that could involve delivering babies for women who have not received prenatal care. We believe a system which seeks to expand such care would clearly address this factor. The President's health care reform proposals embody such a system.
- o "DEFINE THE ESSENTIAL ELEMENTS ON AN EFFECTIVE COMMUNITY-WIDE EMERGENCY CARE SYSTEM." Before defining "common criteria by which to measure whether a region or community has adequate emergency specialty services to meet its needs," it would seem prudent to first determine where the shortages actually exist, geographically, by specialty, and rural versus urban. Then a comparison could be made to determine whether or where State laws and physician training programs had an effect.
- o "ADDRESS PHYSICIAN PERCEPTIONS ABOUT MALPRACTICE RISKS ASSOCIATED WITH EMERGENCY CARE." We also believe that better data collection would facilitate determining whether the perceptions about malpractice risks are realistic. There are aspects of the emergency situation that might be relevant to this issue such as relative lack of established physician-patient relationships and disproportionately high usage by patients with vulnerable health status. Research to determine actual risk may affect malpractice risk perceptions should it show higher risk in emergency situations.

- o We suggest that the OIG include in the "key areas" section the need for better data, and more "targeted" health services research to give health administrators and policy makers more conclusive information upon which to make policy decisions.
- o Other key areas for action might include training of personnel, transportation, consumer information and education, legislative and administrative actions, financial arrangements, and system development efforts beyond collaboration concerning specialty coverage.

  
Anthony L. Itteilag





# Public Citizen



Buyers Up • Congress Watch • Critical Mass • Health Research Group • Litigation Group  
Ralph Nader, Founder

June 12, 1992

Richard P. Kusserow  
Inspector General  
Department of Health and Human Services  
Washington, DC 20201

BY FAX: (202) 619-0160 (Attention: Emilie Baebel)

Dear Dick:

Enclosed are our comments on your draft report "Specialty Coverage in Hospital Emergency Departments," as requested in your letter of April 29, 1992. We apologize for the delay in getting back to you, but we learned from your staff that the deadline for comments had been extended by a few weeks.

On the whole, this is an excellent report on a topic critical to ensuring access to emergency services by people with all types of emergency medical needs. We are extremely interested in this and other emergency service issues flowing from our work on enforcement of the federal "patient dumping" law. In connection with this work, we have spoken to a number of professionals working in emergency medical systems about the factors affecting access to such care. One of the problems most often cited by this group is the lack of specialty coverage in emergency rooms. Thus, we were particularly pleased to learn that you were working on this issue.

We urge you to use this report as a springboard for focusing widespread attention on this and other problems impeding access to emergency care. If we can be of assistance in that effort, please do not hesitate to contact us.

Sincerely,

Sidney M. Wolfe, MD  
Director

Joan Stieber  
Staff Attorney

PUBLIC CITIZEN HEALTH RESEARCH GROUP

cc: Russell W. Hereford, Project Leader, Boston Region

enclosure

COMMENTS ON THE INSPECTOR GENERAL'S DRAFT REPORT ON  
"SPECIALTY COVERAGE IN HOSPITAL EMERGENCY DEPARTMENTS"

Submitted by Joan Stieber, JD, MSW, on behalf of Public Citizen Health Research Group, June 12, 1992.

On the whole, this is an excellent report on an important topic. We have just a few suggestions on additional points that we would like to see addressed. While some of these questions may be beyond the scope of the current project, we suggest they be considered as topics for further study.

(1) Specialty services offered in emergency rooms: The draft report looks at ensuring specialty coverage in hospitals that offer particular specialty services in their emergency rooms. However, it does not address the question of how it is determined what services are offered in the emergency room.

The Florida legislature is currently considering a hospital licensure bill that includes a provision on this topic, which may be instructive to review as sample legislation. It basically requires hospitals that bill for particular services to make the same services available on an emergency basis, either directly or through contract with another facility. Thus, hospitals would be obligated to provide the same services to emergency patients as are available elsewhere in the hospital. While not all specialists need be available every day, hospitals would have to ensure access to specialty services within a regional system. For further information on this bill, contact its legislative sponsors: Florida Representative Elaine Bloom, staff: Mike Hansen or Lucy Bloom (House Health Care Committee) at (904) 488-7384; and Florida Senator Jeanie Malchon, staff: John Wilson or Wanda Carter (Senate Health and Rehabilitative Services Committee) at (904) 487-5824.

(2) Collaboration between urban and rural areas: The draft report notes that the specialty coverage problem is exacerbated for hospitals in rural areas. In discussing the need for regional collaboration (on page 12), it may be helpful to stress the need for such agreements between urban centers and their adjacent rural areas. Perhaps a few good models of urban-rural collaboration could be described.

(3) Concentrations in particular hospitals: Another regional planning issue is distribution of coverage within a regional area. Are specialty doctors concentrated in particular hospitals that may be viewed as more desirable than others? Apart from doctors' attraction to urban university and teaching hospitals (which is mentioned), what can be learned about factors that distinguish one hospital from another in the ability to attract specialty physicians?

(4) Consequences to patients: We would particularly like to learn more about the consequences this problem has for patients. The draft report touches on this on page 6, noting the "downgrading or closure of emergency departments, diversion of ambulances to other facilities, or treatment of serious trauma cases by physicians without the proper training." It would be valuable to take this analysis a step further by examining what happens to patients in each of these situations in terms of trauma, cost, and clinical outcomes.

(5) Lack of specialty coverage as basis for patient transfers: The draft report notes that the federal patient transfer law has contributed to specialty physicians' reluctance to work in emergency rooms. But there is also a question as to the relationship between this problem and the incidence of "patient dumping". The federal law only requires hospitals to screen emergency patients "within the capability of the hospital's emergency department," and to provide stabilizing treatment "within the staff and facilities available at the hospital." 42 U.S.C. § 1395dd(a) and (b) (emphasis added). We are very interested in the question of how often a lack of specialty coverage is used as the basis for a "legitimate" transfer under this law.

(6) Direct employment of physicians as strategy to alleviate problem: You note that this report is an offshoot of your earlier study examining the effect of state laws that prohibit hospitals from employing physicians. That study found that such prohibitions make it harder to staff emergency services in general and specialty emergency services in particular, although these laws were not viewed as a major factor contributing to the specialty coverage problem. Even in states that permit direct employment of physicians, most hospitals rely on on-call contract staff for emergency specialty coverage.

However, it seems like the relationship between these issues has some implications for addressing the specialty coverage problem. Why don't more hospitals choose to directly hire specialty physicians to ensure emergency coverage? Given the absence of legal prohibitions in most states, should hospitals be encouraged to reconsider this option as one strategy in addressing this problem? Alternatively, as part of regional collaborative efforts, could several hospitals jointly hire such physicians who could alternate shifts between different hospitals or be on-call to more than one of them?





Capitol Place, Building #3  
50 F Street, N.W.  
Suite 1100  
Washington, D.C. 20001  
Telephone 202.638-1100  
FAX NO. 202.626-2343

June 15, 1992

Richard P. Kusserow  
Inspector General  
Department of Health and Human Services  
330 Independence Avenue, S.W.  
Washington, DC 20201

Dear Mr. Kusserow:

We appreciate the opportunity to preview and comment on the Office of the Inspector General's (OIG) draft report on "Specialty Coverage in Hospital Emergency Departments." The American Hospital Association (AHA) represents over 5000 hospitals nationwide and is committed to assisting hospitals in providing quality care to residents of their communities.

Many hospital communities continue to struggle with how to effectively assure adequate physician specialty coverage in emergency departments, a critical issue with important implications for patients' access. We applaud the OIG for devoting resources to help address it.

The draft OIG report indicates over two-thirds of hospitals nationwide report difficulty in ensuring physician coverage for at least one specialty service they offer in their emergency department, and suggests even more difficulty for hospitals in the future. Two strategies available to individual hospitals to provide specialty coverage -- i.e., requiring the members of their medical staff to be on call and offering physicians financial and administrative incentives to participate -- appear to be inadequate, according to the draft OIG report. To the extent that individual hospital strategies to assure physician coverage are found inadequate, community-wide remedies may well be in order.

We would like to commend the OIG for its accurate characterization of the issue of specialty coverage as a community responsibility. As the draft report points out, problems in specialty coverage can only be resolved through joint efforts of physicians, hospital administrators and boards, consumers, and government officials at the Federal,

Richard P. Kusserow  
June 15, 1992 - page 2

State, and local levels. Individual hospitals cannot solve the problem alone; all parties must work together to develop effective systems for assuring specialty coverage.

To the extent that time permits, we suggest a slight expansion of the report in the following four areas to enhance its contribution to resolving this critical issue.

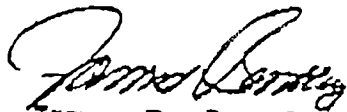
1. Given that federal statutes designed to ensure all Americans access to emergency services are directly relevant to the current debate, a more detailed discussion of federal statutory provisions relating to specialty coverage would provide critical context to the issues raised in the final report.
2. To the extent that the OIG's survey of hospital administrators revealed any suggestions to enlist physician participation, their dissemination in the final report would contribute to and inform hospital practices. AHA would be pleased to work with the OIG in communicating models to hospitals and their communities, and to discuss potential demonstration programs testing community-wide strategies to ensure access to specialty care.
3. Geographic areas with a limited supply of specialty physicians face added difficulty in maintaining coverage for emergency departments. Clarifying the extent to which coverage difficulties result from geographic shortage areas versus what appears to be the inability or unwillingness of specialty physicians to be on call, would be useful to the design of appropriate area-specific solutions.
4. A summary of the OIG's November 1991 report on "State Prohibitions on Hospital Employment of Physicians" would complement the information provided in the draft report currently under review. The November report reviewed state laws that might be interpreted as limiting hospital's employment of physicians and evaluated the resulting impact on hospitals' capacity to provide specialty coverage in emergency departments.

If you have questions or comments, please contact Peggy McNamara, Division of Ambulatory Care (312/280-5921), Tom Granatir, Division of Health Policy (312/280-6183), John Steiner, Office of General Counsel (312/280-6510), or Pat Surdyk, Division of Medical Affairs (312/280-6116).

Richard P. Kusserow  
June 15, 1992 - page 3

Thank you again for inviting the American Hospital Association to share its perspective on the important issue of specialty coverage in emergency departments.

Sincerely,



James D. Bentley, Ph.D.  
Senior Vice President for Policy







# American College of Emergency Physicians

WASHINGTON OFFICE  
900 17th Street, N.W., Suite 1250  
Washington, D.C. 20005  
(202) 728-0610 FAX # (202) 728-0617

June 2, 1992

Richard P. Kusserow  
Inspector General  
Department of Health and Human Services  
Washington, D.C. 20201

Dear Mr. Kusserow:

Thank you for requesting the comments of the American College of Emergency Physicians (ACEP) on the draft report, "Specialty Coverage in Hospital Emergency Departments". The College is pleased that the Inspector General is concerned about the problems that hospitals have in ensuring adequate specialty coverage in their emergency departments.

In general, ACEP agrees with the findings of the draft report, and the key areas identified for action. However, we are submitting the following comments and recommendations for your consideration.

ACEP believes the report could be improved by including additional background information on several topics. First, we are concerned that the draft report fails to adequately describe the role of emergency physicians. Emergency physicians not only provide a broad range of clinical services to patients, but also manage the care of patients from the time they become ill or injured in the field through their care in the emergency department. They coordinate the patients' admission to hospitals, and manage their referrals to other specialists. The College would be pleased to provide the Inspector General with additional information on the role of the emergency physician.

We are also concerned that the report does not adequately explain the need for specialty coverage in the emergency department and its relation to the care provided by emergency physicians. The report could be improved by providing additional information on the federal patient transfer law, particularly the penalties for non-compliance with the requirements that hospitals maintain a list of on-call physicians.

Furthermore, although the report appropriately focuses on the shortage of certain sub-specialties that pose particular difficulties, such as neurosurgery and plastic surgery, the College believes that some discussion of the availability of primary care coverage would also be useful. One way to do this would be to include family practice and internal medicine data in the bar graphs (figures 1 and 2). This data should be supplemented with supporting text describing the emergency department's role as a "safety net" for those without access to other sources of care.

The College also wishes to highlight several other areas of significance: screening examinations, uncompensated care, coordination of care, and medical liability reform.

First, the report mentions federal requirements that hospitals provide medical screening examinations to all persons presenting to the emergency department. Emergency physicians are responsible for providing these screening exams, and additional treatment, if necessary. However, no payment to either the physician or hospital was mandated by law. Often the physician and the hospital are not reimbursed for the screening exam, even when patients have health insurance.

ACEP's ethical principles state that all patients seeking care in the emergency department should receive treatment, regardless of their ability to pay. However, we believe that failure to appropriately reimburse health care providers for screening examinations, when public or private insurance coverage is available, only worsens the financial difficulties that emergency departments across the nation are facing.

Second, ACEP believes that the growing number of uninsured Americans and the increasing burden of uncompensated care in emergency departments is exacerbating the problem of obtaining specialty coverage. The report states that the types of cases seen in urban emergency departments tend to differ from those at rural hospitals and reflect the social problems of cities. The College would like to add that many of the cases related to the "urban" problems of crime, drug wars, and gang violence ultimately result in expensive, uncompensated care. This growing burden of uncompensated care has already forced many trauma centers to close, as has been documented by recent General Accounting Office reports.


Third, the report states that hospitals need to collaborate to provide emergency specialty coverage. The report cites the Trauma Care Systems Planning and Development Act as a program that will lead to this type of collaboration. ACEP supported this legislation and is actively working for additional funding so that the goals of the program can be achieved. However, the trauma program established by that Act cannot, alone, accomplish the level of collaboration called for in the report.

Fourth, the College concurs with the finding that specialists perceive themselves to be at increased risk for malpractice liability in the emergency department. ACEP believes that this perception must be addressed as part of an overall reform of the liability system.

Last, ACEP strongly agrees with your recommendation that hospitals enforce their bylaws that require specialty physicians to provide emergency care. Hospitals and physicians must work together to continue to provide emergency coverage.

If you have any questions or wish to have our assistance in expanding upon any of these comments, please do not hesitate to contact Roslyne Welner of our Washington Office at (202) 728-0610.

Sincerely,

  
Colin C. Rorrie, Jr., Ph.D.  
Executive Director

The  
American  
College of  
Obstetricians and  
Gynecologists

May 29, 1992

Richard P. Kusserow  
Inspector General  
Department of Health & Human Services  
330 Independence Avenue, SW, Room 5246  
Washington, DC 20201

Dear Inspector General Kusserow:

The American College of Obstetricians and Gynecologists (ACOG), an organization representing more than 31,000 physicians specializing in women's health care, appreciates the opportunity to comment on your draft report "Specialty Coverage in Hospital Emergency Departments." Emergency departments are a key part of our health care delivery system and assuring adequate specialty coverage is critical. We believe this report will encourage further review of the problem and could stimulate appropriate actions.

Many factors make it difficult to assure adequate specialty coverage and accordingly, multifaceted solutions are needed. In our view, financing of emergency services is a major problem, however, the report glosses over financing by stating that physicians make a lot of money. Incomes of physicians is not the issue. If the reimbursement for emergency services doesn't compensate a physician adequately for his or her time, as compared to other services, physicians may make an economic decision not to provide emergency services. Furthermore, for many emergency rooms a large portion of care is totally uncompensated. A problem for rural hospitals is the lack of adequate numbers of specialty physicians in the community. Thus, rural hospitals experience greater difficulty obtaining specialty coverage. The report would be improved if these two factors were examined in greater detail and recommendations were made for dealing with the problem in these areas.

Turning to the specific recommendations for action, we do not have major problems with what is included, but we believe they should be strengthened.

*Determining how hospitals can best collaborate to provide emergency specialty coverage would be useful. It would be more useful if the report indicated who should do this and how it should be done. We believe perinatal regionalization and transport for obstetric services should be described as part of this recommendation.*

*We also question the practicalities of sharing on-call lists. Do these physicians become credentialed at both hospitals? Another problem is how often physicians would be required to be on-call. Obstetrician-gynecologists have frequent interruptions in their practices due to deliveries, and increasing the on-call burden raises serious problems. In addition, they often practice in more than one hospital, which can become a logistics difficulty.*

*Although we agree with the need to determine physicians' responsibilities for providing emergency care, we must express caution about requiring on-call services. We have great concerns about the number of obstetrician-gynecologists who are giving up obstetrics. They do so for many reasons. Adding "to avoid providing on-call obstetric services" to the list will not help to assure adequate specialty coverage. A better approach is for hospital and medical staff to work together to develop a way of assuring adequate coverage. A solution designed to meet the local needs based on the available staff resources is preferred. In some cases, the issue may be money; in other cases, malpractice. We even heard of one case where a new staff lounge was part of the solution. We shouldn't underestimate the value of local negotiations.*

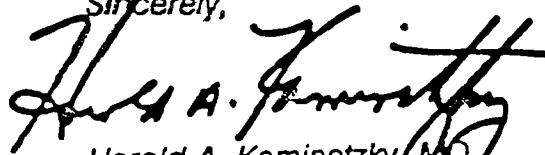
*The recommendation on malpractice is particularly weak. Although more study is recommended, the assumption appears to be that it is a "perception" problem, not a real one. The only study cited is one that deals with the indigent, not emergency care. A number of states have addressed the liability problem in emergency obstetric care by providing the physician some protection from liability. This option should be explored in the report. Also, the report might recommend that hospitals consider providing the liability coverage for physicians providing emergency care services. If, as the report states, it is a "perception" problem, such coverage should prove to be inexpensive.*

*The reference to an ACOG study on page 7 needs to be clarified. The study looked at suits resulting from in-hospital births and compared obstetric suit rates for privately insured patients with those for women whose care was paid by Medicaid. The scope of the study was much more limited than the report suggests. Also, there is no such entity as the "Northern California Chapter of ACOG." The reference should be to ACOG District IX.*

Inspector General Robert P. Kusserow  
May 29, 1992  
Page 3

Again, thank you for giving us the opportunity to comment on the draft report. If you would like any additional information, please don't hesitate to contact us.

Sincerely,

A handwritten signature in black ink, appearing to read "Harold A. Kaminetzky". The signature is fluid and cursive, with a large initial "H" and "K".

Harold A. Kaminetzky, MD  
Director - Practice Activities

HAK:B:dr





# American Academy of Orthopaedic Surgeons

222 South Prospect Avenue, Park Ridge, Illinois 60068-4058

Phone 708/823-7186 • 800/346-AAOS • Fax 708/823-8125

June 22, 1992

Richard P. Kusserow  
Inspector General  
Department of Health and Human Services  
330 Independence Ave., SW  
Washington, DC 20201

Dear Mr. Kusserow:

Thank you very much for sending us a copy of the draft report, "Specialty Coverage in Hospital Emergency Departments."

The ability of hospitals to provide sufficient specialty coverage in their emergency departments is of critical importance. We at the Academy, therefore, applaud and appreciate the efforts of your office to examine this issue.

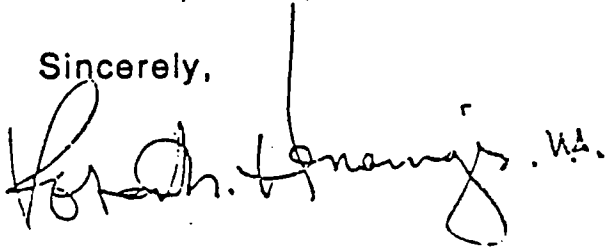
We support the report's conclusions regarding the need to define the essential elements of an effective, community wide emergency system and the need to determine how hospitals can best collaborate to provide emergency specialty coverage.

In addition, the Academy believes steps must be taken to eliminate the financial disincentives now faced by physicians and other health care professionals who provide trauma care. These steps include providing equitable payment for surgeons performing multiple independent procedures under the same anesthetic. They also include creating payment differentials for services delivered during nights, weekends, holidays and other "after hours", which is when most trauma care occurs.

I am enclosing a copy of the Academy's position statement, "Improving America's Trauma Care System," which emphasizes our commitment to work collaboratively to raise the quality and accessibility of trauma care in this country.

Thank you again for the draft report, and we look forward to seeing the completed project.

Sincerely,

A handwritten signature in cursive script, appearing to read "Robert N. Hensinger, MD". The signature is written in dark ink and is positioned below the word "Sincerely,".

Robert N. Hensinger, MD  
President

- cc: Lawrence B. Bone, MD
- cc: Robert A. Winkvist, MD
- cc: Richard F. Kyle, MD
- cc: Bruce D. Browner, MD
- cc: Robert A. Worsing, Jr., MD
- cc: Peter G. Trafton, MD
- cc: Colin C. Rorrie, Jr., Ph.D.





American Academy of Orthopaedic Surgeons

# A Position Statement”

222 South Prospect Avenue • Park Ridge, IL 60068-4058  
708/823-7186  
800/346-2267

Contact: AMn Nagelberg

## Improving America's Trauma Care System

The National Academy of Sciences has declared injury the nation's leading public health problem. It is the leading cause of death among people under age 45 and the fourth leading cause of death for all ages, with more than 140,000 fatalities annually. It is also the most expensive health problem, with an estimated 4 million years of productive work lost each year through death and disability. In 1988 alone, \$180 billion in direct and indirect costs were incurred as a result of injury.

Despite these and other catastrophic effects, the nation's commitment to treating injury continues to wane. A lack of centralized planning, coupled with insufficient financing, has rendered our trauma care system wholly inadequate for a nation which prides itself on high quality health care.

*The American Academy of Orthopaedic Surgeons believes our trauma care must be elevated to a level which ensures that each injured person has the greatest possible chance of survival and recovery.*

To accomplish this, the Academy endorses efforts to establish statewide and regional trauma care systems consisting of strategically located trauma centers designed according to widely accepted national guidelines. Overwhelming evidence indicates that these systems would save more lives and prevent more disabilities than today's haphazard distribution of state and local trauma centers, many of which are overly concentrated in large urban areas. Statewide and regional trauma care systems would assure that more injured patients have access to quality trauma care and would reduce the number of patients brought to hospitals which lack the resources to deal with injury.

*The American Academy of Orthopaedic Surgeons believes that the financial losses incurred by health care entities providing uncompensated trauma care must be eliminated.*

According to conservative estimates, hospitals provided approximately \$1 billion in uncompensated trauma care in 1988, representing 12 percent of all uncompensated care provided that year. Many hospitals are being forced to either withdraw from their area trauma care system or close altogether due to the financial difficulties of providing uncompensated trauma care.

Therefore, any concerted effort to improve our trauma care system must address the issue of health care for the uninsured. To this end, the Academy reiterates that

it is prepared to join with other medical organizations, civic groups, business and government to examine all options and to create a forum in which this issue can be addressed.

July 1990



JOINT COUNCIL OF STATE NEUROSURGICAL SOCIETIES  
of the  
AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS  
and the  
CONGRESS OF NEUROLOGICAL SURGEONS



May 12, 1992

*Chairman*  
Donald Sheffel, MD  
31 North 35th Avenue  
Golfwood, FL 33021  
(305) 965-1490

*Recording Secretary*  
Kelvin L. Cheatham, MD  
300 N. Brent Street  
Suite 202  
Ventura, CA 93003  
(805) 643-2179

*Corresponding Secretary*  
E. Schwetschenau, MD  
Montgomery Road

Wickliffe, OH 45242  
(513) 791-6400

*Treasurer*  
William L. Pritchard, MD  
309 Medical Drive  
Suite 101  
Payetteville, NC 28304  
(919) 484-0014

*Regional Chairmen*  
Herbert S. Oestreich, MD  
(N.E. Region)  
David A. Herz, MD  
(N.W. Region)  
August W. Geise, MD  
(S.E. Region)  
Robert H. Saxton, MD  
(S.W. Region)

Richard P. Kusserow  
Inspector General  
Dept. of Health and Human Services  
Washington, D.C. 20201

Dear Inspector General Kusserow:

We thank you for forwarding the draft copy of Specialty Coverage in Hospital Emergency Departments to the American Association of Neurological Surgeons for comment.

It is our opinion that the committee preparing the paper has identified almost all of the root-causes of the difficulties in providing neurotrauma care in the United States. Their response is that of a governmental body looking at the financial, political, social, and legal parameters of this problem. The response of the practicing neurosurgeon is of necessity tempered by the demands that society makes on his physical and economic resources. The high incidence of neurotrauma associated with trauma in general, the limited number of neurosurgeons as compared to other surgical specialists who are involved in trauma, the occurrence of injuries at inopportune times whether this be late at night or in the midst of a demanding elective neurosurgical schedule, make many neurosurgeons unwilling to commit to a mandated responsibility for trauma care. This is especially so as they become more senior in their discipline.

Yet, there are compatible solutions to these problems both from the standpoint of the public and the neurosurgeon. Their interests coincide in developing trauma systems that make it easier for the neurosurgeon to participate while still delivering state-of-the-art care.

In addressing the elements of the Office of Inspector General's report the individual items excerpted from it will be in bold print and the comments will follow.

**Define the essential elements of an effective community-wide emergency care system.**

The problem appears to be one of resource allocation rather than scarce resources. Simply increasing the supply is not a solution.

49% of hospitals that offer neurosurgery in their emergency departments encounter difficulty ensuring coverage.

72% of rural hospitals cite a shortage of specialty physicians.

36% of urban hospital administrators said that specialty physicians cover too many hospitals.

Inner city hospitals need specialty physicians to provide trauma care for penetrating injuries such as gunshot or stab wounds associated with crime, drug wars, and gang violence.

With a population of a million, Los Angeles County contains only 120 practicing neurosurgeons. Twenty-one of the county's 89 hospitals had closed their doors to neurosurgical emergencies.

Not every hospital that offers emergency care or has a neurosurgical department should necessarily offer neurotrauma care. There have been major developments in the care of neurotrauma victims prominent among these being CT and MRI scanning as well as sophisticated intensive care units. Despite these advances, we find trauma victims deposited at hospitals with very minimal neurosurgical capabilities. Historically, the neurosurgeon has been under pressure from both hospital administrators and medical staff members to cover these emergency rooms.

Rural hospitals are correctly noted in the report to have too small a service area to support high cost specialties. What is needed is stable, reliable, referral patterns to neurosurgeons and other specialists. We have to better plan to send the problem, of which there are many, to the neurosurgeon rather than sending the neurosurgeon, of whom there are few, to the problem. Dr. James Bean who practices in Lexington, Kentucky

with a referral practice encompassing a large rural setting makes the following point. "The neurosurgeon is, in effect, providing coverage for more hospitals than could ever require his physical presence. His principal practice may be at one or two hospitals, he may attend occasionally at one or more additional area hospitals and he may serve as a referral resource for numerous hospitals remote from his primary location. A referral area with 30 to 40 referring hospitals would not be unusual for a large group of neurosurgeons. Considering this the concept of either rural or urban hospitals all expecting onsite neurosurgical ER coverage as an ideal aim is ill advised."

Citing the fact that Los Angeles County has "only" 120 neurosurgeons for less than 9 million people seems to imply that this is an insufficient number. Indeed, France with an effective medical system, has only 250 neurosurgeons for the entire country. Increasing the number of neurosurgeons will only increase the surgeons competing for elective cases, increase those cases done for marginal indications, and certainly would not be cost effective.

Trauma is only one aspect of the neurosurgeons role in medicine. To be effective in trauma care the neurosurgeon must maintain his skills in all areas of the neurosurgical discipline.

Dr. John Kusske who is as familiar with the problems of neurosurgical coverage in Los Angeles as anyone in our country makes the following comment. " At least in the case of Los Angeles County many of the hospitals that indicated difficulty obtaining neurosurgical coverage were not in fact institutions that most neurosurgeons were comfortable with in terms of providing emergency neurosurgical care."

The question of treating the product of the "knife and gun clubs" in inner cities is a daunting project. Obviously, prevention is more important than treatment. As long as our inner city conditions continue as they are now it may be that it will be necessary to identify these "war zones" and provide special help to those inner city hospitals involved. Perhaps financial incentives to hospitals could be made part of the programs now being pushed by Jack Kemp, Secretary of HUD, for the redevelopment of our inner cities.

Finally, it is not only the attitude of neurosurgeons and other specialty physicians but that of hospital administrators and their Boards. There is an increasing demand from every segment of society to reduce the cost of medical care. In order to remain viable institutions, hospitals are going to be

faced with increasingly perplexing choices as to what role they should play in the delivery of medical care. Thus, among other things, hospitals will be careful not to drive away those patients and physicians who maintain the institution's viability by overburdening the hospital surgical suite and intensive care units with trauma patients to the exclusion of more elective cases.

In conclusion to this portion of the report we would answer:

There has to be a limitation on the number of hospitals that accept neurotrauma victims. Many hospitals do not have the neurosurgical expertise nor are they willing to devote the economic resources such as sophisticated ICUs, 24 hour operating room crews, 24 hour availability of CT scanning, etc. to deliver the best of trauma care that our public deserves. Thus, we must begin to identify those hospitals which have the capability and are willing to undertake the commitment to trauma care and fuse them into a politically homogenous and integrated trauma system. In this respect, we should encourage hospitals where neurosurgeons congregate to become part of an organized system of trauma care.

Forty-four percent of specialty physicians responding to our survey believe that reimbursement for emergency services is inadequate.

Many reported uncompensated care levels as high as 50 or 60 percent of gross patient charges.

The facts are there has to be some provision for uncompensated care both for hospitals and specialty physicians. Without such a realistic approach to the problem no trauma system is going to endure very long. The data regarding medium incomes for different surgical specialties is misleading. Neurosurgeons that provide the bulk of ER coverage are likely to be in the lower income categories. In Los Angeles County 1/3 of the patients seen in emergency rooms have no funding and another 1/3 are funded by Medi-Cal or Medicare. These third party payors do not approach the cost of providing emergency care for hospital or physician.

Further, it seems all too likely that Medicare payment reform and the expected transfer of the RBRVS scale to private payor schedules will soon reduce the neurosurgeons income significantly making the reimbursement issue even more important.

Lacking health care reform the issue of reimbursement and other factors delineated in the report has to be dealt with in the current pluralistic, mixed public-private, multiple payor, autonomous institutional health care system. This provides a major disincentive to participation in emergency room work. Given that the surgeon is paid several times more to perform elective surgery than to treat seriously injured trauma patients in the middle of the night it seems self evident why neurosurgeons are not fighting to be placed on emergency room call schedules.

The payment system requires modification to reward those willing to take on this difficult burden.

Current hospital strategies to ensure emergency specialty coverage appear to be inadequate solutions to the problem.

Seventy-six percent of hospitals require that members of their medical staff provide emergency services. These requirements, however, do not alleviate their difficulty ensuring emergency specialty coverage.

Twenty-six percent of hospitals report that they offer incentives for specialty physicians to participate in emergency care, but the effectiveness of these incentives is unclear.

Failure to enforce medical staff bylaws is not a staff members failure but is an administrative failing involving the organized medical staff, the administration and the hospital board. The insurance of hospital bylaw enforcement comes from the JCAHO survey as an extra institutional oversight. If this aspect of hospital function were included in routine survey and hospital accreditation were dependent upon it, enforcement would be much more carefully observed.

Hospital availability and privileges determines much more of a specialists livelihood and success than any other incentive. These complex, procedure-oriented specialties require a work place in which to perform. Financial or administrative incentives may assist in compensating the surgeon for uncompensated and inconvenient care. These have nowhere near the power of adequate medical staff bylaw enforcement. However, the hospital does not always enforce its bylaws fearing the practitioner will resign and relocate, causing severe financial loss to the hospital.

The responsibility is institutional and the mechanism for responding to that responsibility is already established.

Forty-seven percent of these specialty physicians consider the Federal (COBRA) patient transfer law to be a serious drawback to participating in emergency care.

"There are legitimate times when we are tied up in surgery and not available.....(but) the Federal patient transfer law does not address such a problem."

As indicated above COBRA requirements are viewed with fear by many specialty physicians. This, especially, relates to the spectre of a new body of liability law now being created under federal sanction. The mere occasional use of a facility for neurosurgical procedures, or the presence of a neurosurgeon on that staff, does not qualify that institution for optimal neurosurgical complex medical care. The Federal patient transfer law has the effect of restricting transfers for legitimate reasons as well as for the occasional illegitimate reason. The question arises as to whether COBRA cause more interference with orderly and efficient planning of emergency care than it prevents "patient dumping".

Federal regulations need to be clearly written so that they re-assure on call physicians. Neurosurgeons need to know that if they are willing to be "on call" that they will not suffer adversely from either Federal sanctions or increased civil liability suits engendered by COBRA. Failing this, the Federal transfer laws may result in limiting public access to specialty physicians rather than enhancing it.

Sixty-six percent of specialty physicians responding to our survey fear increased malpractice liability as a result of covering hospital emergency departments.

Research to determine the incidence of malpractice claims arising from emergency care could fill an informational void.

Hospitals can work with insurance companies to institute effective risk management strategies.

Examples of such approaches include a single master insurance policy covering both the hospital and affiliated physicians.

The prospect of increased exposure to medical malpractice claims, whether a real or perceived danger, has to have both a short term and long run solution before those who deal with trauma are going to be willing to give a wholehearted



commitment to further and more intensive involvement. There is an inescapable psychological burden placed on the neurosurgeon who must awaken at 3:00 A.M. after a long surgical day to treat what may be a difficult and desperate case realizing at the same time that due to the severity of the injuries and the frequent youth of the patient a major claim for negligence can develop.

Further research into emergency room malpractice incidence or risk management strategies is not going to encourage surgeons to enthusiastically assume a further role in neurotrauma care.

It is probably an unacceptable financial burden for a hospital to take on the insurance risk for all of its staff members involved in emergency care. The pricing of malpractice insurance for hospitals and physicians depends on their being more than one "deep pocket".

There has to be further incentive for involvement with trauma by the Federal Government limiting or doing away with the malpractice exposure in specialty trauma care.

Finally, one wonders if there would be any problem in staffing emergency rooms if the following scenario existed:

In return for a hospital maintaining a trauma service based on the "American College of Surgeons Hospital and Pre-Hospital Resources for Optimal Care of the Injured Patient" that institution and its trauma surgeons would be legally freed of malpractice risk and that there be some rational level of compensation for the neurosurgeons involved in delivering care. A continuation of these benefits would depend on the institution meeting site review and demonstrating a commitment to excellence in trauma care.

#### Conclusions:

Our conclusions, very simply stated, are similar to yours though we probably approach the solutions from a somewhat different vantage point:

I. Development of trauma systems based at hospitals with adequate facilities and neurosurgical manpower.

II. Compensation for uncompensated care to both hospitals and neurosurgeons.

III. Statutory relief of malpractice exposure for specialty physicians involved in emergency care.

IV. Promulgating clear COBRA regulations that do not put the neurosurgeon in a "catch 22" situation.

V. Hold hospital boards, administrators, and medical staffs responsible for adequate bylaw enforcement.

VI. Increasing the absolute number of neurosurgeons only compounds the problem. Better allocation of the resources available is the solution.

VII. Reasonable ways exist to draw the practicing neurosurgeon into the "on call" system.

VIII. There has as yet been no overall commitment or allocation of sufficient resources by either the Federal or State Governments to improve neurotrauma care. A commitment from public agencies is going to have to compliment a commitment from hospitals and surgeons if we are going to solve the problem of trauma care delivery.

If such methods are rationally explored so that it becomes less burdensome for the neurosurgeon to deliver state-of-the-art trauma care it is very likely that American neurosurgery will respond to such developments.

Certainly, we in neurosurgery realize that there is a less than optimal delivery system for trauma care. That the great advances in technology which have occurred in the last few decades are not being applied equally across our country. That there is a great variance in trauma care depending not only on residence location or insurance status but simply as to which hospital facility the trauma victim is transported. Whether one is among the wealthiest or poorest of our citizenry it is the commitment, facilities, and expertise of the hospital to which he is brought that may determine his survival.

Organized neurosurgery has been looking at this problem of neurotrauma care for a number of years. It has several resources which can be made available to the Federal Government in considering the aforementioned problems. We have a Section on Neurotrauma and Critical Care which houses a separate committee dedicated to the organization of trauma systems on a local, regional, and national basis. We would be most happy to make these consultants available to any State or Federal agency to improve the level of neurotrauma care in the United States.

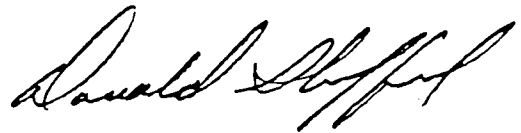
These comments on "Specialty Coverage in Hospital Emergency Departments" were coordinated by Donald Sheffel, M.D., Florida, Chairman, Joint Council of State Neurosurgical Societies in conjunction with:

James Bean, M.D., Kentucky, Chairman Medial Practices Committee

John Kusske, M.D., California, Chairman Committee for the Organization of Neurotrauma Care

R. K. Narayan, M.D., Texas, Chairman Section on Neurotrauma and Critical Care

Lawrence Pitts, M.D., California, Former Chairman Section on Neurotrauma and Critical Care



Donald Sheffel, M.D.

DS:mt



## APPENDIX C

---

### ENDNOTES

1. Robert S. Stern, Joel S. Weissman, and Arnold M. Epstein, "The Emergency Department as a Pathway to Admission for Poor and High Cost Patients," *Journal of the American Medical Association*, 266, no. 16 (October 23/30, 1991), p. 2238.
2. David W. Baker et al., "Patients Who Leave a Public Hospital Emergency Department Without Being Seen by a Physician," *Journal of the American Medical Association*, 266, no. 8 (August 28, 1991) p. 1085.
3. Hospital Association of Southern California, Los Angeles County Medical Association, County of Los Angeles Department of Health Services, *Study of Medical Specialist Emergency On-Call Practices of Hospitals in Los Angeles County*, December 1990.
4. U.S. Department of Health and Human Services, Office of Inspector General, *Use of Emergency Rooms by Medicaid Recipients*, OEI-06-90-00180, March 1992.
5. 42 U.S.C. sections 1395cc and 1395dd.
6. U.S. Department of Health and Human Services, Office of Inspector General, *State Prohibitions on Hospital Employment of Physicians*, OEI-01-91-00770, November 1991.
7. American Medical Association, *Physician Characteristics and Distribution in the U.S.*, 1990.
8. In this report we focus on the staffing difficulty encountered by hospitals that offer specialty services. In addition, a substantial number of hospitals *do not provide* certain specialty services at all. Based on our survey, 78 percent of rural hospitals and 21 percent of urban hospitals do not offer neurosurgery services; 72 percent of rural hospitals and 12 percent of urban hospitals do not provide plastic surgery services; 35 percent of rural hospitals and 8 percent of urban hospitals do not offer pediatrics; 35 percent of rural hospitals and 5 percent of urban hospitals do not offer ob/gyn services; and 36 percent of rural hospitals and 2 percent of urban hospitals do not offer orthopaedic surgery.
9. Providing specialty coverage at multiple hospital emergency departments is a common practice among physicians. The number of hospitals that is considered too many for emergency department coverage is highly subjective and depends on how busy the emergency department is and whether other attending staff are available. In our survey of physicians in four specialties, we found that of those who provide emergency care, 32 percent are on-call at 2 hospitals, 15 percent at 3 hospitals, and 12 percent at 4 or more hospitals.

10. *The State of Hospital Emergency Departments in Massachusetts*, Massachusetts Medical Society and Massachusetts Chapter, American College of Emergency Physicians, in cooperation with Massachusetts Hospital Association, January 8, 1991, p. 61.
11. *Study of Medical Specialist Emergency On-Call Practices of Hospitals in Los Angeles County, op. cit.*
12. The Trauma Care Systems Planning and Development Act of 1990 (P.L. 101-590) is a Federal initiative designed to promote public access to trauma and emergency care. In 1991, Congress appropriated 5 million dollars to help States to develop, implement, and improve regional trauma care systems through a competitive grant program. This legislation does not specifically address hospitals' capacity to provide emergency specialty coverage, but is aimed at the larger issues dealing with cooperative arrangements among hospitals to deliver comprehensive regional emergency services.
13. U.S. General Accounting Office, *Trauma Care: Lifesaving System Threatened by Unreimbursed Costs and Other Factors*, Report No. GAO/HRD-91-57, May 1991, p. 36.
14. M. McNulty, "Are Poor Patients Likely to Sue for Malpractice?" *Journal of the American Medical Association*, 262, no. 10 (September 8, 1989), p. 1391.
15. American College of Obstetricians and Gynecologists, *Hospital Survey on Obstetric Claim Frequency by Patient Payor Category*, February 1988.
16. Mary G. Musman et al., "Medical Malpractice Claims Filed by Medicaid and Non-Medicaid Recipients in Maryland," *Journal of the American Medical Association*, 265, no. 22 (June 12, 1991), p. 2992.
17. American College of Emergency Physicians, "Access to Emergency Medical Care: Emergency Physicians and Uncompensated Care," *Annals of Emergency Medicine*, 16 (November 11, 1987), p. 1302.
18. Laurie Anderson, "What's Up, Doc? Primary Care Salary," *Healthweek*, December 1991.
19. Roger A. Rosenblatt, "Specialists or Generalists: On Whom Should We Base the American Health Care System," *Journal of the American Medical Association*, 267, no. 12 (March 25, 1992), p. 1665.
20. The text of the comments from ASPE and the AMA are not included since they were conveyed verbally.
21. *Study of Medical Specialist Emergency On-Call Practices of Hospitals in Los Angeles County, op. cit.*; *The State of Hospital Emergency Departments in Massachusetts, op. cit.*