Transcript Details
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Solutions to EMTALA and the On-Call Crises

Its 3 a.m., no one wants to come in and see your acute surgical patient in the emergency room. Your ED is in crisis and as AJN put it in 1992, it's a window with a view. You are listening to ReachMD 160, The Channel For Medical Professionals. Welcome to The Clinician's Roundtable. I am Dr. Shira Johnson, your host, and with me today is Dr. Scott Rudkin, Associate Clinical Professor of Emergency Medicine at University of California, Irvine School of Medicine. Dr. Rudkin has a study recently published in American Journal of Emergency Medicine on the worsening of ED on-call coverage in California. He has been an invited speaker at many medical conferences on emergency room overcrowding and the economic and medical impact that affect all of us in practice. We are discussing this shortage of on-call coverage for the emergency room and the crisis that represent.

DR. SHIRA JOHNSON:

Welcome Dr. Rudkin.

DR. SCOTT RUDKIN:

Thanks for having me here.

DR. SHIRA JOHNSON:

Why is there an emergency room on-call shortage in California at all?

DR. SCOTT RUDKIN:

Well I think it's a fundamental issue of economics. You've got a busy practice yourself and talk about an on-call specialist. They've a busy practice for seeing their patients and as part of their messed up bye-laws, they've agreed to take ED calls. The only problem is EMTALA, it is un-funded visit, it says that in the ED one must care for all patients who hit our door regardless of their ability to pay. They've got a busy practice, they are on-call. They have got a whole set of patients for the next day, 12 midnight and your patient comes in, unfunded, uninsured, much more likely to sue them actually, all these facts make it very difficult for them to come in. They come in, they don't get paid, they actually may care for the patient, because if you factor the malpractice premium it actually costs them to care for the patient and then they have to go hopefully catch a few hours of sleep and see a whole set of patients the next day. It really is an issue of economics where these docs I think are trying to do a good job, they do it out of their ethics, but at some point, I don't fault them, they don't want to come in.

DR. SHIRA JOHNSON:

But its not new, I mean may be the amount of patients that sue has gone up in the last 10 or 15 years, but the situation where you are tired and you are on-call and you come in, that isn't a new situation correct?

DR. SCOTT RUDKIN:

Correct, I don't think it is, but I think what has happened is we could absorb small peaks and valleys, but now with an increase in patients of roughly 90 million to 110 million, we have seen a big increase in patients, the number of uninsured has gone up. Really it is an issue where I think that they could kind of make ends meet as reimbursements have gone down in healthcare. Every new patient counts. I think it's a matter of both local economics and it is also paying for these patients before the doctor out of their goodwill could take up these patients, but now it becomes a simple matter of economics. They want to put food on the table for their family.

DR. SHIRA JOHNSON:

Is it also in anyway part of a lifestyle change on the part of physicians that may be idea of being up 24 on-call all the time maybe 1 or 2 generations ago was expected if you are a doctor and now, I want to sleep at night, I have to be in the OR at 7, I deserve a better lifestyle.

DR. SCOTT RUDKIN:

I think there is probably some truth to that statement, but most of the docs that I know that are on-call, they have still the same work ethic. I mean we joke about it a lot that now with the resident work hours cuts, yeah now we have an 80-hour work week. The thing is that most of the docs who are on cart now, we all trained before work hours came into place. These guys are not afraid to be up all night and go work. Is it safe for the patient, I don't know, but I don't think it is a work hours or a worth ethic issue right now. It may become an issue as the next generation of docs comes online, but right now I would say no.

DR. SHIRA JOHNSON:

What's some of the possible solutions that you've explored at your facility or in California?

DR. SCOTT RUDKIN:

Well California and also Oregon too. A lot of them, they have tried to do is stipends, see hey we will pay you a stipend to be on-call. These can range anywhere from nothing all the way up to around $3000 for some fields like neurosurgery. It worked for the short-term, what they found is that actually up in Oregon, they did a study, it was 05 and 06. Where they looked at this to see if the issue had gotten worse. What they found was that the number of stipends had gone up, but yet the call crises had gotten worse. They found that at least 1 specialty for half the hospitals they couldn't get and they are forced to actually transfer out at least half the patients who had request for specialty needs. All these factors combine make it much more difficult to care for the patient. Stipends worked for the short term. You can try to offer deals where in Orange county California, we actually have a fund, it is a state fund, we have tobacco tax settlement funds to help pay for those folks who have no insurance. There are ways you can get them from the state and federal level, but unless you can tap on this issue more globally, its not going to end.

DR. SHIRA JOHNSON:

So you are private insured patient, you go to your local community hospital, it has got a reputation, you lacerated a tendon perhaps in your forearm. There is no hand surgeon on-call and with the changes in EMTALA as I understand it, they don't have to have a hand surgeon on-call, so you are transferred out, correct?

DR. SCOTT RUDKIN:

That is correct and what's the sad thing is that don't forget that when you transfer a patient, you cannot mention insurance status. The part of EMTALA states that, the first part is that you must care for all patients that come to you, stabilize their condition. If you deem them to unstable which means you don't have capacity to care for that patient. You must transfer them out. As you transfer them out, you also cannot ask about insurance info. So what happens is that, if you have gold card insurance and you are in a hospital that is underfunded, the recipient or the person that is on-call is going to just assume that you have another unfunded patient to send their way and they are going to give you some answer of, I don't have the capacity, I am in OR, I can't care for this patient. It is very difficult to care for these folks. I mean I have had cases where trying to have a hand guy come in can take 12 hours plus and again I work at a level 1 trauma center.

DR. SHIRA JOHNSON:

So many of our listeners maybe primary care docs, family medicine specialists. If they are listening, why should this be a concern to them also. Why isn't it just the ER's problem?

DR. SCOTT RUDKIN:

This is a system's issue again, see yourself personally when you come into the hospital, obviously you want to get care. If you have your MI, your stroke, if the ED can't care, it is going to affect you personally, but really if you think about the hospital where you practice at or work at, it is a systems issue. Half the admits come to the ED, if hospitals really want to tackle this problem, they need to really realize the systems issue. As you can move your patients in faster, get upstairs faster, it is better care for all and really this is a systems issue.

DR. SHIRA JOHNSON:

So tell us about your study, how has this been measured?

DR. SCOTT RUDKIN:

What we did was both in 2000 and 2006 we looked at all of California, ACEP, the American College of Emergency Physician docs in California. It was a survey study. We got a 70% response rate from all the EDs. What we found is that in California from 2000 to 2006, we've seen an increase in the number of hospital reports difficulty in getting on-call coverage, hospital reports using more stipends. They are trying to basically band-aid a problem that is really more global and more large than just a state level issue. Until we can fix the underlying issue of EMTALA and the unfunded medic at the federal level, this issue is going to keep on happening.

DR. SHIRA JOHNSON:

For those of you just tuning in, you are listing to ReachMD 160, The Channel For Medical Professionals. I am Dr. Shira Johnson and I am speaking with Dr. Scott Rudkin and we are discussing the emergency room on-call crises and how it affects all of us.

You mentioned this a little bit before, but what is the other side of the coin, the story of the ENT, perhaps who has a small, but thriving practice. He gets referrals in the daytime from the surgeons and the PCPs, and he doesn't want to take emergency room calls, should he be forced to?

DR. SCOTT RUDKIN:

That one's difficult, from a personal standpoint, I think the answer is actually no. You've got a doc who really just wants to make his practice happen. We are asking this physician to come in on their own time, provide essentially free care, it may actually cost him when you think about the malpractice premiums. They are being asked to provide care without being compensated. I think until we can fix the fundamental issue of the funding problem where patients come in, they are unfunded, and we expect physicians to break up the next day, really impact their lifestyle and alter their ability to provide food for the family. This issue will continue.

DR. SHIRA JOHNSON:

Is it stipend, way of dealing with this problem, is it working. I am seeing more and more of those ads in the back of medical journals all the time.

DR. SCOTT RUDKIN:

Stipends we thought were going to be the big panacea for this issue. You know, we opt for the stipend, you will take coverage and stuff, but really Oregon did the best research on this topic. They offered stipends. Stipends worked for the short term. The problem is stipends kept going up and up and up and at the same time period, they found that actually it became more and more difficult to find coverage and the transfer rate actually went up. So although stipends sounded like a great idea, I don't think they work.

DR. SHIRA JOHNSON:

What's happening with the hospital by-laws requiring staff physicians to take emergency room calls. Are those regulations getting looser because of EMTALA in 2003 or are they getting tighter because of the on-call crisis.

DR. SCOTT RUDKIN:

Definitely much looser for 2 factors. One is EMTALA in 2003, they tried to clarify the role that we all had hoped would make this easier to apply, but what they really did was they softened the regulations for consultants to come in. It was as simple as that. They weakened the law. More importantly though, staff by-laws had a good phase for a long time. If you want to be on a hospital staff, wanted to have OR privileges, you had to agree to take call and help out and they all shared the burden equally. Problem is that now surgicenters have opened up and specialty harder to come by. They are really commanding what they want to do. They say, listen if you make me be on call, I can go over to this local surgicenter that is not hospital based and never be on-call, so back off.

DR. SHIRA JOHNSON:

Is there any legal consequences or any precedence for this if somebody refuses to come in and say its an emergency room, some of the smaller ones, they will actually have an on-call ward in their emergency room and its 3 in the morning and they are called, and the person doesn't respond and they don't come in. Can there be legal consequences?

DR. SCOTT RUDKIN:

There are legal consequences, unfortunately its kind of a sledgehammer approach. There is no kind of way to kind of slowly talk to them, counsel them. If you are found guilty of an EMTALA violation which is you refuse to come in and they deem that the case has

merit, you can be fined yourself $50,000 and your malpractice premium coverage won't cover this and the hospital itself can also be fined $50,000. But to really allege an EMTALA violation is a big deal, its not the right move. Again we have had a couple of cases, we were so aggrieved we've actually gone down this pathway, but it takes months to investigate, the amount of resource it takes and time and manpower is huge and really the show that at that point in time that you had capacity. The big deal to it is, now in the 2003 regs is the topic of capacity which states that it is the receiving doctor's perception of whether he or she has capacity, meaning whether they can care for the patient in ICU bed and they are done. If none of those pieces are open, they can say I don't have capacity to care for the patient and they can get away with it that way.

DR. SHIRA JOHNSON:

So for a given hospital, and I am thinking of the smaller community hospitals or middle size, there is a guy in the ER who sees the patient and stabilizes him, so he is living up to the letter of EMTALA. The subspecialist doesn't return his calls, doesn't come in or doesn't come in timely, I think that is when the hospital is actually hit with the EMTALA violation, correct?

DR. SCOTT RUDKIN:

Yes, it can be. At that point though, the unfortunate sad thing is that for the local ED doc, we have got this term that we call dial-in for docs. What you do is you sit there and just call local hospitals and I have had people transferred from as far away as 600 to 700 miles away because EMTALA is clear. There are no state or local boundaries. If you are within the US, you can actually have a patient referred to you. I have had patients again from other states, again I am in California. I can think of multiple states that the patients have been sent to me from. The laws are clear. If they call, you must take them, but that also shows there are lots of hospitals in between saying oops sorry we have no capacity, sorry.

DR. SHIRA JOHNSON:

Are they obligated to call the hospitals in between. They just hit the biggest county hospital. I am thinking of a small hospital transferring to a county, bypassing the middle-size hospital who don't want to take on the financial burden and legal risk.

DR. SCOTT RUDKIN:

If I was working in the local small hospital and was trying to transfer, I work at a level 1 trauma center, a tertiary care center where we receive these patients. I don't fault these guys at all, the local hospitals, the small ones, they call the hospital next door and they are refused 10 times out of 10, they get that next case from there, they are probably just going to say, why call unless call a big hospital. What that does, is that kind of shifts the burden away from the local hospitals up to the big county and/or academic centers. So really what's happened is that the county and academic centers are being forced to share this burden and I think it is unfair.

DR. SHIRA JOHNSON:

I have interviewed physicians before on one particular on-call dilemma, that they were solving with the surgicalist, kind of a version of the hospitalist. It wasn't just a financial picture but it also brought up the lifestyle changes and it sounded like the surgicalist was working. Because you take a surgeon, someone who loves to be in the OR and it's a rough lifestyle. Most of us know until they retire, they may do 70-hour weeks and they offer them this job. May be when they are younger and starting out or maybe they are older, they come in, they take their stipend and I heard that was working at least for that specialty.

DR. SCOTT RUDKIN:

At our hospital, David Hall Reviews the chair of general surgery here. He is a trauma surgeon. He actually has been pushing this for years and actually works well with the ER doctor in the country. He has looked at this issue carefully, he has pushed this actually when he came onboard here several years ago, he actually makes his trauma guys take in-house call, it used to be similar to take home call. No when they are on-call at night, they are working, they are taking care of your ab, they are taking care of your gallbladder issues. Their problem is I think it really only works for more general things. You need you subspecialty call, your ENT, ortho. It doesn't make enough sense to really have them be an in-house call because there is not enough cases, but then again it goes back to same issues. So I think that there is some merit to have folks that are functioning like emergency physicians where you are on-call or you are basically taking in-hospital call, but it will only help for a small subset of patients.

DR. SHIRA JOHNSON:

Now with all the work and research you have done, you have certainly identified many problems, but if you look into your crystal ball, what would the future hold?

DR. SCOTT RUDKIN:

Well actually I am going to take the sideline and roll fast. In our 2006 trial, we actually found that one specialty got better in terms of call coverage, that was general surgery, I think that was a direct impact because now we have a surgicalist. So actually adds credence to the idea that for certain fields having in-house docs makes sense. Crystal ball of the future, lets fastforward, I think the federal mandate may change. I think that the public has stated this is enough, that this is not a poor issue, a racial issue, this is about everyone. No matter what your finding is, this is going to impact you. You need your care at 2 in the morning, you need to have your care. I think that people know this and I am very hopeful that from both the state and federal level that we will finally tackle this issue. This is not a local issue.

DR. SHIRA JOHNSON:

Dr. Rudkin it was great talking to you.

DR. SCOTT RUDKIN:

Thank you very much.

We give our thanks to Dr. Scott Rudkin who has been our guest today. We have been discussing the emergency room on-call crises, how it affects all of us who practice medicine. I am Dr. Shira Johnson. You've been listening to The Clinician's Roundtable from ReachMD 160, The Channel For Medical Professionals. Please visit our web site at ReachMD.com which features our entire library through on-demand podcasts and thank you for listening.