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The Surgicalist: A New Concept in On-Call Care

ROLE OF THE SURGICALIST

You working that 12-hour shift in an Emergency Department no one is coming to see that unfounded acute abdomen or may be you have a 7 a.m. OR case and the ER is calling you at 1 a.m., are surgicalists are the new answer. I am your host Dr. Shira Johnson and joining us today to discuss the role of the surgicalist rhymes with hospitalist is Dr. John McConnell, who has his PhD from Stanford University, but he is also an associate professor of emergency medicine at Oregon Health & Science University. He has been working on a committee formed by the Institute of Medicine to solve the on-call crises in Palm Beach County.

DR. SHIRA JOHNSON:

Dr. McConnell, welcome to ReachMD.

DR. JOHN MCCONNELL:

Hi, thanks for having me, it is nice to be here.

DR. SHIRA JOHNSON:

So, what is your role in the department of emergency medicine?. How did you get involved in all this?

DR. JOHN MCCONNELL:

Well, I took a typical academic route and I got my PhD in a economics program at Stanford and then was looking for academic jobs and had been in the <_____> before and saw the department advertising for something that was probably more like and epidemiologist, but I talked my way into it and turned out to be a lot of interesting issues around economics and emergency medicine, so it has been a good fit.

DR. SHIRA JOHNSON:

How widespread is this problem with obtaining subspecialty coverage?

DR. JOHN MCCONNELL:

It is pretty widespread. You know, we had good survey data from 2005 and 2006 that said about 40% to 50% of hospitals were paying stipends, and this is a sort of intensive study in Oregon and had some national survey data of all hospitals. It may be 40% to 50% of the hospitals were paying stipends, which is one indicator of hospitals having difficulty with the specialists. There is more recent study that located about 11 committees across the US and looked at how many of them were employing specialists. They found that of 11 committees they looked that 8 of them were employing specialists. So, it is fairly widespread and seems to be increasing over time.

DR. SHIRA JOHNSON:

Now, can I ask you when you say they are paying stipends, this is a small or medium size hospital and they are paying, for instance ENT or anybody who won't take call regularly or we are gearing it towards the surgical role?

DR. JOHN MCCONNELL:

The median stipend that we found in 2005 was about $1000 per night. These were being paid to also to specialties, the most common specialties were orthopedics, neurosurgery, and general surgery, but we found it for ENT for hand surgeons for other subspecialties, less common. I guess for psychiatric services, less common for primary care, but to lot going on with surgical specialties and related specialties.

DR. SHIRA JOHNSON:

What types of hospitals are hardest hit, years ago I was moonlighting in a very small hospital and they could not get coverage for plastics, for trauma, for anything, but is it also affect medium-sized hospital?

DR. JOHN MCCONNELL:

Really it is affecting all the hospitals and instead of the main differences is just sort of how they can respond, and what is happening with big hospitals is that they are generally spending more. They are opting to continue coverage, but to pay a lot in terms of stipends or in terms of employing specialists. The smaller hospitals they often are just going without call, then the medium hospitals are sort of faced with dilemma between do I pay stipends, do I try to employ specialist, do I drop 24 x 7 coverage and you know one hospital here in Oregon, they had a very difficult decision that they were weighing and they may still be weighing, which was do we continue to pay between half a million and million dollars a year to maintain coverage for certain specialists or do we drop our accreditation from a level 2 to level 3 trauma center.

DR. SHIRA JOHNSON:

Now, why had this has been allowed to happen, it is not new?

DR. JOHN MCCONNELL:

No. It is not new and you know I think there is a couple of thinks and so some of what it has been a change in the voluntary medical staff model and kind of old days taken emergency call was in an accepted responsibility of medical staff. It was not always something that people look forward to either. There is a lot things that made this unattractive to late night call, not getting paid by somebody without insurance. There are lots of concerns about loss rates with high-risk emergency patients and those things were always there, but I think there is a few things that have changed the dynamic very recently. One of those instead of the way that physicians practice and there is a lot of opportunities now to have a successful surgical practice that is not related to the hospital. So you could practice in a day surgery or ambulatory surgery center have a successful practice and not have to deal with big hospital and with emergency department patients, and so there is ability to take the practice outside the hospital and so that you are not behold into the hospital. The second is a change in the entire interpretation in 2003 and <_____> is the federal law that mandates that all hospitals except patients regardless of their ability to pay and stabilize them before discharging them, and the Center for Medicare & Medicaid Services (CMS), who oversees medicare and **4:35** <_____> they have made some changes in hospital coverage and these are complicated and I think the intention was good, but in the end what they said was very clear that would be up to each hospital to adopt its own reasonable coverage standards and there would be no minimum requirement for frequency of call coverage to things like that and after the publication of these regulations lot of hospitals added special call coverage for formulas instead of the kind of open things up, so there is a lot more push for changes in how hospitals cover their emergency call.

DR. SHIRA JOHNSON:

So, that mean it is up to their discretion some days they may have ENT coverage and some days they may not.

DR. JOHN MCCONNELL:

Yes.

DR. SHIRA JOHNSON:

So, it is all about reimbursement, and now it is really about life style too, correct?

DR. JOHN MCCONNELL:

Well, ya. I think really it is and I think, you know, specially for some of these hospitals in the smaller areas what they have got, they have got may be two specialists, you know two general surgeons, or two obstetricians, or something like that. They do not have a great way of getting those physicians to take call every other night that is what we take if only had 2 specialists in your area. In those conversations, they sort of revolves around while if I could pay you more and lot of times answer is no that just do not want to take call every night and it is not a matter of $1000 a night stipend or 2000 or 3000, just they do not want to do it. There has also been pretty good research on this and there is a sort of a decided change between the kind of the order cohort of physicians in the younger cohort physicians. The young cohort coming in and saying, you know, I want to have a real life and I want to have a family life and that means I do not want to be working 24 hours a day, 7 days a week and so, there is some significant kind of lifestyle issues around whether or not your going to be working all the time and always taking call.

DR. SHIRA JOHNSON:

So, if you are just tuning in, you are listening to The Channel for Medical Professionals. I am your host Dr. Shira Johnson and joining me to discuss the role of the surgicalist is Dr. John McConnell.

So, tell me Dr. McConnell how does the surgicalists model operate?

DR. JOHN MCCONNELL:

Well. This is totally like the hospitalist models and surgicalists are essentially surgeons that are employed by the hospital and since that of collecting their reimbursement on the basis of what services they charged to the patient and how they provided and how they collected. The hospital takes care that and pays the surgicalists salary and the surgicalist works on salary basis and the hospital collects all the physicians' charges there. So, the issues around call should resolve this part of this physician's responsibility and salary negotiations.

DR. SHIRA JOHNSON:

So, he does not collect any fees from the patient directly. He does get his employment from the hospital?

DR. JOHN MCCONNELL:

Yes.

DR. SHIRA JOHNSON:

And the hospital, do they pickup his malpractice also?

DR. JOHN MCCONNELL:

In some cases they do. I do not know sort of how wise that is, but I think that is a sort of a common arrangement.

DR. SHIRA JOHNSON:

Is this reimbursement done sufficient for most physicians who are surgeons? They are satisfied with arrangement and the hospital satisfied also, right?

DR. JOHN MCCONNELL:

Ya, I think that there some selection that these are sort of physicians, who are interested in doing that kind of work and I think some of them feel like it freeze them up from some of the difficulties though it has not being associated with the hospital and having to manage some of the billing issues and allows them just to practice, whereas other physicians may not like that arrangement and may not want to

deal with the emergency patients since they are less likely to select into that model.

DR. SHIRA JOHNSON:

So, let me see if I understand the practical side of this just say they are on-duty, but paid by the hospital or call to the ED, they go down, they examine an acute abdomen for example, decided it is an OP, they take him to the OR and then what happened. They do the followup?

DR. JOHN MCCONNELL:

They may do some followup. I think there are attempts to sort of a coordinate with primary care physicians so that the patient is discharged and that sort of the hospitalist models just sort of try to offer the followup. This is a good question. I do not know exactly how much of that is happening. How much the coordination of cares happening with this. I think sort of a big paradigm shift is just there is new found interest in employing the surgicalists as supposed just having them be part of medical staff.

DR. SHIRA JOHNSON:

Seems like everybody wins. The patient get seen right away. The physician has certain frame of hours, but he is reimbursed for services and may perhaps the surgery gets done more promptly and that is what he is there for. Is there a downsides to this at all?

DR. JOHN MCCONNELL:

There may be. I may not think generally the people are happy with this and seems to be a model that is spreading. I think you know I am not sure if there is an immediate downside. I guess the concern that I have is a sort of whether or not it is the long-term solution, and so what is happening out there what has been described by policy researches that there sort of separation and kind of a two-way separation between hospitals and physicians and one separation is a sort of ambulatory surgery versus hospital care and the other is a sort of emergency types of care versus elective surgery, so there is some overlap are related there, but for example you know orthopedics used to be. If you are an orthopedists that most of your work intensive work wold be in the hospital, but now there is a lot of very good business that can happen in the ambulatory surgery arena and so you can work 9 to 5 have a good para mix. You know, patients love you, your family loves you, because you are around, reimbursement is good. You can sort of capture any ancillary charges associated with the surgical center if your are part of owner not just the physicians changes and that is a pretty compelling, strong, attractive model, and so the issue is whether the hospital can compete with that and still maintain the cost. The hospitals get more complex patients and uninsured patients and so you know the issue of emergency call that can be entirely solved through the surgicalist's model when may become increasingly more attractive for some physicians to practice outside the hospital. I think that is still has to be resolved somewhat.

DR. SHIRA JOHNSON:

Now, you mentioned something to me when we talk before the show as well the acute care surgeon. Can you tell us something about that model?

DR. JOHN MCCONNELL:

Ya. This is a model that has been proposed that is in similarly just kind of the inpatient version of the emergency physician, so emergency medicine your listeners probably know is a relatively young speciality that is a sort of grew out of, you know, there used to be a model work physician kind of showed at the Emergency Department and have specialty training, but learned to take care of emergency patients while the other interests was in internal medicine or primary care or something like that. What is happening was the on the inpatient side is that there is a sort of realization that a lot of the emergency patients that come in that need to be cared for, you know, they often sort of get send to one specialist, may be somebody with knee problems has to go to an orthopedists, somebody with trauma problem has to go to trauma surgeon, somebody with, you know, infection or wound goes to a general surgery, and so there is a lot of different specialist, who are covering this sort of a broad range of emergency issues, but one of those emergency issues might be handled better by one specialist, who was trained to take care of those inpatient issues and so they would not be quite as specialized as orthopedists to do some of the, you know, a knee replacement, but they could take care some of the emergency knee issues that an orthopedists would normally be on call.

DR. SHIRA JOHNSON:

Ya. If I was gonna go to the OR for a specific orthopedic related emergency may be even that in the middle of the night, I think I want an orthopedic. I am not so sure are OP. I probably trust a general surgeon is probably little mixed previews on this now?

DR. JOHN MCCONNELL:

Ya, I think there are. Some of these economists I do not have great history of all the divisions between the specialist, but I think there has been some pushback by some of the specialists, saying well.

DR. SHIRA JOHNSON:

That's my ability.

DR. JOHN MCCONNELL:

Ya, that is my ability and so they are not so sure that they like this, but you can certainly see whether they are going in why it has been proposed at least for consideration.

DR. SHIRA JOHNSON:

I saw one and I was looking this up and was similar in the middle of Tennessee and has had minimal trauma, so that must be part of the appeal for these guys right ?

DR. JOHN MCCONNELL:

May be part of the appeal. I think in some ways it dependent on the hospitals. You know, how much trauma there is. I think the trauma question is sort of related to this acute care surgeon model and part of what is happened here is that trauma care has gotten really good at managing patients without having to operate on them and so part of the issues that that she got the patient to have a blunt trauma to their abdomen and may be they need to be observed by a trauma surgeon, but may be there only need to have surgery, and so can you

take the general surgeon because of the need to go and do an intensive trauma surgery procedure, but needs to go to wash them in the same way that the trauma surgeon did. Is there some way to recognize the overlap their and train up the general surgeons, so that they can do the observation as the trauma surgeon might have developed.

DR. SHIRA JOHNSON:

I would like to tank my gust Dr. John McConnell for joining us to discuss the surgicalists and new concept in delivering on-call care. You have been listening to the Clinician's Roundtable. For complete program guide and Podcasts visit www.reachmd.com. and thank you as always for listening.