

# From my perspective

In the June issue of the *Bulletin*, I wrote about the imminent physician workforce shortage and its impact on emergency care. Since then, several surgeons have shared with me some rather disturbing information about how this looming crisis is affecting them.

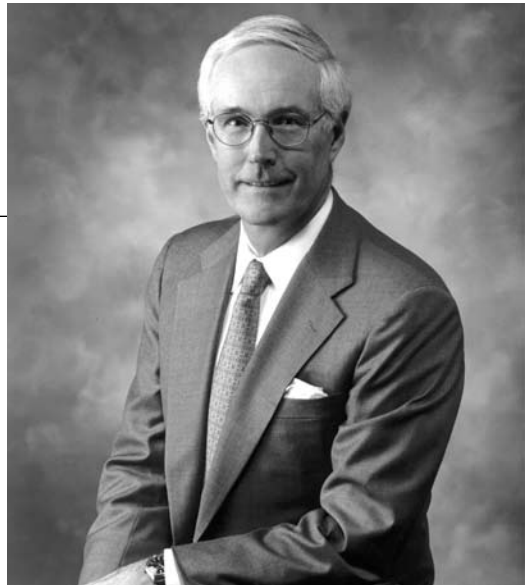
Based on their stories, it is apparent that unrealistic time commitments, astronomical medical liability premiums, and decreased reimbursement are deterring some individuals from upholding one of surgery's noblest traditions: willingly being on call for emergency cases. This trend could have potentially devastating consequences both for our most critically ill and injured patients, as well as for those surgeons who are trying to do the right thing by covering the emergency room (ER) and, on occasion, providing charitable care.

## *Causes and effects*

One surgeon who has written to me about this situation is in private general surgery practice with his son, and they are on staff at a suburban Atlanta, GA, hospital that has a large trauma service. The younger surgeon is on a required 24-hour rotation of nine general surgeons who cover the ER. During that rotation, it is not unusual for him to complete multiple procedures and a range of consultations. Needless to say, by the following morning, he and his ER colleagues are cognitively and physically spent and in no condition to see patients the following day, let alone operate.

Similarly, when I was in Wyoming recently, a surgeon told me that he had been up for two nights straight taking ER call in a critical access hospital and had no backup for his upcoming elective procedures. Although we all know a rush of adrenalin generally kicks in when we need to operate, we aren't necessarily able to function at anywhere near full capacity physically or mentally. The consequences of operating in this state could be quite negative.

It is ironic that we have set limitations on the number of hours residents can be available to work in the hospital out of concern about their ability to function without proper rest, yet we expect practicing surgeons to work two days in a row with little concern for how well they will be able to perform following their ER rotation.



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After all, people's stamina and powers of recuperation are higher when they are younger, not as they age.

Furthermore, we need to consider what sort of message overstressed attending surgeons are sending to medical students and residents who are concerned about whether they will have time to pursue their personal interests and lifestyle goals. Many young surgeons learn of these time-consuming and exhausting ER rotations during their interviews to get on staff at institutions. Because these surgeons are now coming out of an environment in which as residents they are expected to commit a set amount of time to

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being on call, they have a hard time accepting that they will need to be on call for extended periods. Ultimately, many of them decide to seek out privileges at facilities that receive fewer trauma patients.

Surgeons who take ER call find that their frustration is compounded by the fact that they are more vulnerable to liability claims. They are serving more seriously injured and ill patients, many of whom have other health problems that have been inadequately treated, diagnosed, or documented in the past. Although many hospitals pay a portion of a surgeon's liability premium associated with ER care, this sort of assistance does not extend to surgeons' ever-increasing liability premiums for the provision of elective care. In order to pay those expenses, surgeons need to perform more elective operations. The "catch-22" here is obvious.

In addition, given the Medicare payment cuts that have occurred in recent years, many surgeons believe that they absolutely cannot afford to lose time they would spend providing care to their regular, nonemergency patients.

Sadly, many general surgeons who take ER call are unable to count on their peers for support. In some instances, hospitals and general surgeons have asked specialists to become more available for ER cases. However, many of these specialists see cases that are beyond their scope of expertise and have to call upon general surgeons for assistance.

### *Solutions are needed*

The number of surgeons who are willing to devote their time to these endeavors is dwindling. As a professional organization, the College needs to determine how we can encourage surgeons of all specialties and all ages to accept responsibility for providing ER coverage. What incentives can this organization offer? Could hospitals and payors provide some sort of stimuli?

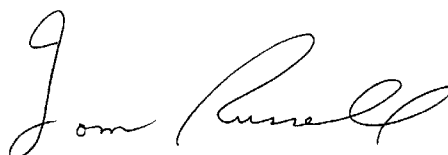
One much-discussed solution of late is the development of a new category of health care professional known as the "surgical hospitalist" or "acute care surgeon." These individuals would be trained specifically in the provision of the broad range of services associated with in-hospital emergency care and would be employed by facilities that need a regular staff

of surgeons to handle a stream of urgent care patients. Placement of these individuals on institutions' staffs would ease the need for surgeons to provide extended on-call trauma and critical care.

Other individuals believe that hospitals should offer stipends to surgeons and other physicians who take ER call. Some institutions already pay physicians for each night they are on call.

Another alternative would be to develop highly trained emergency medical service teams, who could offer more advanced on-the-spot care. As a result, patients who receive more thorough care at the scene of injury or illness would require less intense treatment when they arrive at the hospital.

I am certain that many other solutions are conceivable, and it is imperative that we seek them out. It would be a great tragedy if surgeons were to abandon their tradition of serving their hospitals, communities, and patients by volunteering for ER call. Needless to say, the College continues to welcome any suggestions you have regarding how we can help to avert this potential crisis.



*Thomas R. Russell, MD, FACS*

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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at [fmp@facs.org](mailto:fmp@facs.org).