Rural physicians practising emergency medicine: paying the piper

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Introduction

When an emergency department (ED) physician at a rural hospital attends a patient with an acute myocardial infarction, that physician also plays the part of the technician who obtains an ECG tracing, the second nurse (who sets up the intravenous thrombolytics), the respiratory therapist who draws the gases (if the test is even available), and the internist who would have been the admitting physician. We can consider ourselves lucky that in *most* Canadian hospitals the ED physician is no longer expected to take and develop the patient's chest x-ray, unlike rural Australia!

How do you compensate a doctor for this work, when that doctor could earn just as much doing a well patient exam and checking Johnny for an earache in the office? Answering this question is difficult, because it involves assigning worth to the doctor's work and defining the rural context that determines the work.

Rural context and "on call"

A functional definition of "rural" ED is an ED that lacks sufficient volume to justify having 24-hour in-house physician coverage. This lack of in-house staffing is the feature that spawned several controversial ED funding arrangements in Canada.

Rural doctors are on call (a lot!) and must be "called in" for emergencies. This provides contextual meaning to the "deferrable" triage category. It means deferring late night patients until the next morning — declining income to preserve functional ability in the event that a real emergency arrives. "Call has value" is a rallying cry of rural doctors' associations the world over. From a funding point of view, it says that making oneself available to the community is worth something, even if the doctor is not called.

In 1989, the Australian Rural Doctors Association was born over "call has value." The government of the day, concerned by runaway utilization of walk-in clinics, had planned to severely reduce after-hours fees. Rural doctors, who depended on this payment to cover hospital callbacks, were outraged and walked out *en masse*. The government was unable to replace them. Subsequently, a separate fee schedule was instituted for rural doctors in New South Wales, with generous provisions for callback and adjustment for inflation.

First Canadian solutions

Canada's problem reached a head in 1994. Because of a rural doctor shortage, unmet physician needs for a balanced lifestyle, and relatively poor remuneration, many rural Ontario hospitals began "topping up" doctors' ED earnings. Some hospitals engaged outside agencies to provide ED coverage. Difficulty staffing rural EDs led the government to appoint a fact-finder, Graham Scott, QC, to identify causes and solutions to the problem.[1]

Among other things, Scott found that "medical school and residency training programs are not providing the necessary pool to avoid a rural crisis." He found no simple solutions, but his 1995 report included several recommendations aimed at making rural doctors' lifestyle sufficiently attractive to entice physicians. Perhaps not surprisingly, Scott's only widely implemented recommendation is the one he is now famous for: replacing fee-for-service (FFS) with ses-

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sional payments of $70/hr to cover weeknights and weekends. The rationale was that, during these unsociable hours when FFS income is not sufficient incentive, sessional payment would compensate physicians for being "on call."

As a rural doctor who does his share of ED work, it would be ingenuous of me to claim that this was not welcome. But the plan was fundamentally flawed: without increasing physician supply, it could not improve rural working conditions. By putting the entire emphasis on "on call" and none on work volume, the "Scott sessionals" gave more benefit to physicians who worked in the smallest EDs. Consequently, these EDs became the easiest to staff, and many small hospitals were able to attract regular weekend help from city doctors.

But the sessional fee was controversial in larger EDs.[2] Many felt it was unfair to have some physicians work while others slept (as it was characterized) for the same money. Critics pointed out that the sessional fees were not sufficient to induce urban physicians to relocate to a rural setting. The problem became antagonism between a sense of the value of the work (equal pay for equal work), versus the value of physicians making themselves available in the context of the most vulnerable ED. This debate generated different solutions in other parts of Canada.[3]

Many variations in rural "on call" payments have emerged, sometimes linked to volume. Nova Scotia pays in-hospital ED sessional fees beginning at $53/hr for EDs treating less than 13,000 patients per year. Busier EDs get stipends peaking at about $75/hr. Quebec blended FFS payments with sessional rates. Between 8 pm and midnight, physicians may bill straight FFS or $140 plus 50% of FFS billings. Between midnight and 0800, they may bill $402 plus 75% of FFS billings. Rural Saskatchewan pays a bonus of $10/hr plus FFS on weeknights and $25/hr plus FFS on weekends. In 1998 in British Columbia, the "Dobbin" report yielded $20/hr plus FFS for "on call" in designated Northern Isolation Allowance (NIA) hospitals. The same year, Alberta offered $17/hr plus FFS for physicians on call at rural EDs.

Second round

If these incentives had been enough, the story would have ended. However, since 1994 the net annual attrition rate for rural doctors in Canada has averaged 4%![3] Even in urban Canada the rise in physician numbers has barely kept pace with population increases. Many urban settings are, for the first time, experiencing the same difficulties rural Canada is so familiar with. To further stress the situation, new Ontario licensing requirements made resident physicians ineligible for "moonlighting," thus eliminating another source of physician supply for rural EDs.

Inevitably, Ontario has seen a second round of "top up" wars, and this time the ante is higher. Market forces, as opposed to social policy, have led many small hospitals to guarantee $100/hr for ED shifts (and more for busy shifts), just to keep the ED open.

In December 1999, to stop hospital bidding wars, the Ontario provincial Minister of Health offered small hospitals (<10,000 visits) contracts paying $100/hr in lieu of FFS, with a proviso that the hospital add no more. Payments increase in incremental fashion to $150/hr in larger hospitals (>30,000 visits). Unlike the Scott payments, the plan has been structured to address market reality rather than as a policy to distribute physicians evenly throughout Ontario**.**

Will increased remuneration bring physicians into rural EDs? Probably, for a while. Predictably, in Wallaceburg, Ont., two physicians closed their offices to work exclusively in the ED. In Grimsby, Ont., the physicians who previously covered the intensive care unit (ICU) moved to the ED, leaving the ICU short-staffed. Other health services will be lost, but the ED will remain open, and higher pay for ED work will stop the top-up wars. The fundamental problem of having the right number of physicians in the right places doing the right work is yet to be solved. While governments delay increasing medical school enrolment and educational reform, the working conditions in rural EDs continue to worsen.

References

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