

## **Dealing with the stress of being “on call”**

*Take steps to reduce stress for better patient care and physician well-being*

**By Ronald A. Ripps, MD, and John-Henry Pfifferling, PhD**

Orthopaedic surgeons must contend with a number of major stressors in their practices. Among the most burdensome is the necessity of being “on call,” particularly in these days of decreasing reimbursements and increasing regulations, such as the Emergency Medical Treatment and Active Labor Act (EMTALA). On-call emergencies are one of the most disruptive elements in a physician’s day. No matter how carefully the doctor schedules the day and organizes time, emergency interruptions will create havoc. But there are steps you can take and procedures your practice can implement to help reduce the stress of being “on call” and improve both patient care and physician well-being.

### **Sources of on-call stress**

Before you can deal with on-call stressors, you first have to identify them. Although the disruption in your day is one source of stress, there are usually several contributing elements. These include the challenges of defining an emergency, dealing with patients whose conditions are outside your area of expertise and your comfort zone, allocating on-call duties among the physicians in a group practice and coping with reimbursement issues.

Every surgeon and every specialty has a different definition of “emergency,” so competition over the operating room (OR) schedule is often fierce. Conflicts over whose emergency takes priority regularly occur. To further complicate matters, although a group may have assigned one doctor to cover emergencies, patients may insist on seeing “their” doctor. Even overscheduled colleagues may insist on seeing “their” patients.

Because “call” is an add-on episode, it can create anxiety, fear and irritability. For example, how does a specialist in spine surgery handle foot, hand or knee problems when on call? When subspecialists are on call, their stress levels increase as they anticipate having to deal with skills and decision-making in areas where they are no longer competent or comfortable.

Orthopaedists who are part of a large practice with several subspecialists may have less recent fluency in general orthopaedics. Anticipatory anxiety (often unacknowledged), as well as stress during call and afterwards, amplifies this situation.

Emergency physicians also have varying levels of competency in different areas of appropriately referring for orthopaedic expertise. Orthopaedic surgeons may be concerned about the emergency physician’s use, referral and “inappropriate” (aggressive or perceived incompetent) practice in boundary areas of orthopaedics and emergency medicine. Emergency physicians differ in their propensity to call for help, as well as their ability to “hold the fort” until that help arrives.

Attending to emergencies not only exposes the surgeon to the risks of transmissible diseases, but also increases the risk and stress of medical liability litigation on two fronts. Having no prior relationship with these emergency cases immediately places the surgeon at higher risk for litigation and possible slips. In addition, the surgeon who spends the night managing an emergency puts his or her next day’s patients at risk because of post-call fatigue. Post-call emotional exhaustion is commonly reflected as irritability with staff, family and colleagues.

These additional risk, work and litigation concerns—without compensatory payments—are stressful. Inadequate sleep, increased fatigue, inadequate pay, and unavailability of resources all increase a surgeon’s aversion to on-call duty.

Many older surgeons who legitimately expected to “age-out” of this responsibility must continue to take call or pay a substantial penalty to opt out. Their expectations clash with current financial reality and colleagues’ desires. Conflict management is necessary to solve these dilemmas. Financial penalties alone provoke intragroup rivalry. As one older orthopaedist stated after paying dearly to relinquish call, “It was like taking a thorn out of my eye.”

### **Reducing on-call stress**

There are several ways to reduce the stress of being on call. Perhaps the most important is addressing on-call stress within your practice and developing a unified, fair response.

First, the group has to make a commitment to quality-of-life concerns aimed at reducing the stress and consequences of on-call responsibilities. This commitment requires acknowledgment of the costs of call, regular assessments and interventions. It also requires that everyone in the group agree upon a definition of what is an emergency.

Many groups develop “aging-out” policies, but then hire three or four people in the same age cohort. Thus, the cohort ages out simultaneously, defeating the purpose of the policy. Aging and the associated transitional stages in practice and personal life are predictable. Mature practices regularly revisit policies so that unusual and predictable conflicts can be resolved. If the issue is too difficult or sensitive to handle in an open meeting, bring in a facilitator (familiar with medical practice) to move the policy-making along smoothly.

Legal and financial fairness must be taken into consideration when looking at call reduction or call premiums. As overall reimbursement decreases, more groups negotiate more significant penalties for those off call. What are the other options? Productivity formulas only maintain a semblance of fairness as overhead inflation continues. Those senior members who built the practice are often the ones who feel most penalized because they must make large payments to reduce their call responsibilities. They suffer geometric penalties as they age, as reimbursement decreases and as surgery risks increase and expectations rise.

Develop an agreed-upon policy well in advance and revisit the policy regularly. Even when someone is off call, they are still liable for other’s actions (an “associate overhead”). Consider using external facilitators to help develop these policies.

### **Reducing interruptions**

On a practical note, the group needs to explore ways to soften that strident emergency interruption. This might require hiring a physician’s assistant to be a first responder, or hooking up the hospital’s X-ray system to your office computer so that you can see the patient’s radiographs before leaving for the emergency room. All-digital practices do reduce some of these problems.

In some busy practices, each doctor may have one week devoted exclusively to handling emergencies and in-patient affairs, leaving all other aspects of the practice to the rest of the group. Patients, family members and practice members must all understand why the practice is a group practice and not separate practices.

Regular debriefings with emergency department physicians can prevent “inappropriate” call and enhance their skill sets. Such meetings also reduce conflict between colleagues. Facilitated problem-resolution sessions can include: surgery/anesthesia, emergency/surgery and surgery/administration. These groups may have different attitudes toward litigation risk, so ease of calling orthopedic surgeons reduces one group’s stress while provoking surgical load and resultant stress. Reconciling these differences is tricky because professional images are on the line—prepare carefully for these discussions.

### **Special situations**

The problems faced by rural and limited specialty groups are entirely different issues. These groups need to consider how vacations, sabbaticals, or locum tenens help can be arranged and funded. They must also ask how the productivity of the group might be affected by having one physician handle hospital emergency call. One option would be to have the physician be second call to a triage surgical physician’s assistant. Both local patient or community expectations and legal demands affect these decisions. Unfortunately, these kinds of pressures may reduce specialty care in rural areas.

Where call is especially difficult, the surgical community needs to work quickly to develop stress assistance programs. Cross-coverage between groups, for instance, only works if patients continue to be well cared for and satisfied. Particularly busy shifts (like holidays and weekends) may require joint call.

Transfer patterns have to be worked out for subspecialty coverage so an undue burden of risk is not placed on the on-call doctor. Other groups have tried variations of the following ideas:

- Focusing on better patient education to promote appropriate use of emergency facilities and reduce inappropriate call
- Regular in-service meetings with an emergency department representative
- Feedback notes to referral sources, including comments on ambiguous or troublesome areas
- Meeting agenda categories related to “onerousness” of call
- Planning sick call into the schedule
- Encouraging administrators to shadow surgeons so they develop a better understanding of the stress
- In all cases, it is imperative that there be unanimity among members of the orthopaedic (and surgical) community on the call issue. When dealing with a large entity, like a hospital (or health care system), divisiveness will prevent resolution. But when a united front exists, cooperative agreements are more likely.

The emergence of the “hospitalist” is an example of how primary care physicians learned to cope with the call issue. Will there be a day when we see surgical hospitalist teams? Who will pay these people and how will they share continuity of care with the primary surgeon?

Shared call among different groups in a community may be a step in that direction. Can lessons be learned from hospitalist burnout so surgeons are less likely to suffer?

Ronald A. Ripps, MD is president of the Connecticut Orthopaedic Society. He can be reached at: [ronripps@worldnet.att.net](mailto:ronripps@worldnet.att.net) John-Henry Pfifferling, PhD, is director of the Center for Professional Well-Being and can be reached at [cpwb@mindspring.com](mailto:cpwb@mindspring.com) or (919) 489-9167.