COMPREHENSIVE

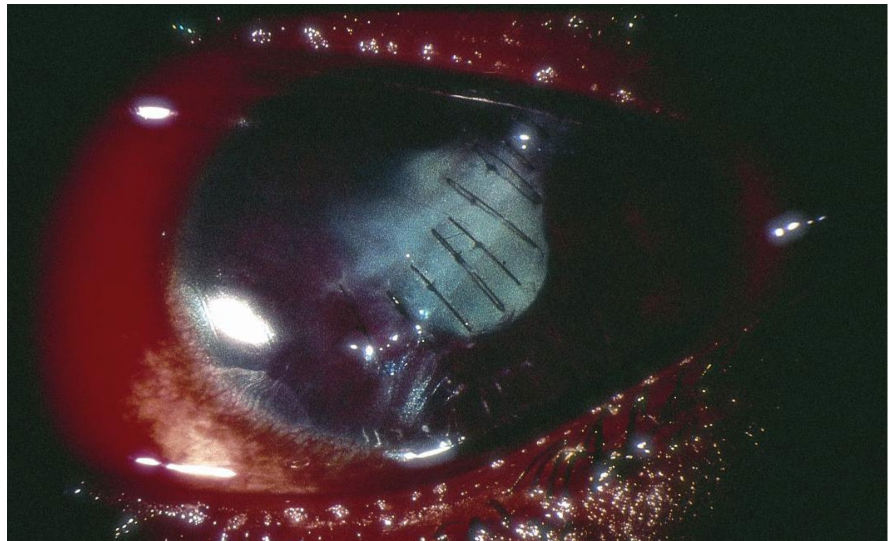
CLINICAL UPDATE

Why I Take Call: Weighing Rewards and Responsibilities

Years ago, ophthalmologists in private practice were expected to take call; often it was a requisite for hospital privileges. Now, with the rise of ambulatory surgery centers (ASCs), many ophthalmologists are no longer required to obtain those privileges, and, for this reason in combination with others, hospitals continue to experience challenges in obtaining on-call coverage by specialist providers.[1]

It is a trend with serious implications, since eye emergencies such as open globe injuries, traumatic hyphema, and endophthalmitis can lead to permanent loss of vision, said Fasika Woreta, MD, MPH, at Wilmer Eye Institute in Baltimore and president of the American Society of Ophthalmic Trauma. With fewer experienced ophthalmologists to examine, consult, and perform surgery on emergency department (ED) patients, there is an increased chance of misdiagnosis and poor outcomes.[2]

Several ophthalmologists who are bucking the trend take a look at the reasons for the shortage and share insights into how and why they take call.



TRAUMA. *Complete cortical opacification after a penetrating injury.*

A Critical Shortage

The growth of ASCs during the past few decades is just one factor in the decline of ophthalmologists covering call for eye emergencies. Among other factors are the following:

Less emphasis on taking call in the community. Some say one important issue is that call in the community is not emphasized. "If residents see that ophthalmologists in the community don't want to take call and send their patients to academic medical centers, then they're not going to want to take call themselves when they graduate. We need to set the example for our residents," said Dr. Woreta.

Residency is the ideal time to promote the importance of taking call, said Jill Foster, MD, at the Eye Center of Columbus and affiliated with The Ohio State University. She noted that it's important to create a culture of taking call when ophthalmologists are starting out because they aren't likely to go back and do it after they are established.

Burnout during training. Rikki Enzor, MD, PhD, at Great Lakes Eye Care in St. Joseph, Michigan, has a contrasting view. "I wonder whether the burden of taking call during training may lead to burnout and a reluctance to take call when young ophthalmologists are seeking their first jobs. If residents or fellows feel overworked and unsupported in caring for patients with complex eye issues during training, they may learn that call is something to avoid." She expressed gratitude for residency mentors who provided an excellent example of taking responsibility for call patients, alongside their trainees.

Disconnection from hospital community and fewer incentives. With fewer ophthalmologists taking call, the sense of community with local hospi-

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tals has waned, said Dr. Foster. In past decades, covering call strengthened ties between doctors and hospitals, and hospitals would provide benefits to ophthalmologists who took call, such as CME courses and facilitating research projects, but these benefits are no longer offered, she said.

Interference with private practice. Some ophthalmologists with established practices are disinclined to take call, knowing that they will have to interrupt their workday at the office and reschedule patients or perform consults after a busy clinic, said Dr. Foster. "You're giving up your practice time, and your overhead at your office is still accruing when you're running into the hospital. That's a real negative."

Covering call can lead to a chaotic workday, said Eugenia White, MD, at Colorado Eye Institute in Colorado Springs: "If you get a patient with an open globe injury when you're in the middle of clinic, that can be really hard. I think that's why doctors don't want to cover call because you're setting yourself up for anything that might happen."

Hesitancy in handling trauma. In addition, some ophthalmologists may not be confident in their skills in trauma surgery if the last time they repaired an open globe injury was during residency, said Dr. Woreta. "As ophthalmologists, we should all keep current with CME in ophthalmic trauma. Every ophthalmologist should be comfortable with taking call and realize it's an obligation that we have both to our patients and the profession."

Inadequate tools. However, she added, those ophthalmologists who do take call may find that the hospital does not have the proper tools to handle trauma cases. "Some hospitals may not even have an operating microscope. So, even if ophthalmologists want to take an urgent case, often they have to transfer the patient to the nearest academic center," Dr. Woreta said.

How to Handle the Hospitals

Fair pay. Ophthalmologists have a duty to serve their communities, said Dr. Woreta, and taking call is part of that; however, the ophthalmologist's time is valuable and hospitals should acknowledge that. "Zero compensation is not acceptable and demonstrates a lack of priority for our field." Although ophthalmologists can submit consultation charges when they see patients in the ED or hospital, adequate compensation for taking calls in the middle of the night or on the weekends is needed, she said.

Dr. White, who started practice in 2022, said that being paid adequately for call was a factor in choosing which hospitals to work with. Some offered her what she felt was insufficient remuneration for call at a high-volume ED. In contrast, her current schedule has her taking call concurrently at two hospitals during a 24-hour period, doubling her call income.

Equitable reimbursement is important, said Dr. Foster. Being paid for call makes a difference: "When there's a monetary reward, that's a little bonus at the end of the day because it's not money where you normally would be paying practice overhead before it comes to you."

Not only does pay for call vary widely between hospitals and regions, but there is often a disparity between the money offered and the amount of work expected. Dr. White said she saw these differences firsthand during her interview process prior to settling in Colorado Springs.

Dr. Foster noted, "Different hospitals have different reward systems and for some of them, you think, 'This is definitely not worth it.'"

Learning to negotiate. Ophthalmologists need to ask for appropriate remuneration from hospitals, and they should keep in mind factors such as the period of time spent away from their practice and the potential cost to the practice if the doctor is taking call during office hours, said Dr. Foster. "The hospitals have to recognize this sacrifice if they want working ophthalmologists to come in and take call," she said. "When you're trying to negotiate that with the hospitals, you're talking to an administrator who may or may not understand the value of what you're providing, and I think that's a real frustration."

Ethics Perspective

The Ethics Committee recently heard from a patient who had been treated by a retina specialist in a midsize Midwestern city. The evening after receiving an intravitreal injection, the patient called the practice's emergency number and described pain, fever, redness, and loss of vision. The answering service indicated the retina practice provided no after-hours care, and local hospitals were not equipped for ophthalmic emergencies. Consequently, the patient was directed to the nearest tertiary care center, which was 30 miles away. That may not seem far, but for a monocular senior at nighttime, it might as well have been 300 miles away. The patient arranged transportation and ended up spending four days in the area of the tertiary care center. Fortunately, she received excellent care for the infection and has regained sight in the eye. But at what cost? This situation could have been avoided if the retina specialist had some form of after-hours care for patients.

Ophthalmologists should provide after-hours care for their established patients or arrange for care by others. To routinely direct their own patients to a distant ER for after-hours care is likely not in the patient's best interest and does not foster a meaningful physician-patient relationship. This practice can also significantly impact vulnerable populations.

Local hospitals also have a certain level of responsibility in this situation. There should be support for providing appropriate ophthalmic equipment and fair compensation for on-call services. Hiring ophthalmic hospitalists (hospital-based ophthalmologists) or locum tenens to fill in on-call coverage gaps are potential ways for hospitals to develop creative and sustainable models for after-hours care in the community. *—Academy Ethics Committee*

And negotiations can be complicated. In a 2014 statement, the Academy points out that, from a legal standpoint, structuring compensation for on-call coverage can be complex, and it recommends engaging an experienced legal advisor to avoid compliance issues.[3]

Building a Call Community

Although many physicians view taking call as part of their obligation and responsibility, there are other intangible benefits to doing so, including the personal satisfaction of helping others, and the chance to bolster professional relationships.

The right thing to do. Dr. Foster is of the generation that was required to take call, and she continues to do it for many reasons. "There's a certain benevolent part of you that says some of these people wouldn't get care if you weren't here, so it's not ideal that it's 3:00 in the morning, but somebody should take care of this. It makes me feel good to do something that I know will make a difference."

Dr. White added, "There was a great sense of pride for me of moving to this particular area [Colorado]—it was something I'd always dreamed of—and finally being here and being able to serve in the emergency room here."

Sharing the responsibility. In her St. Joseph, Michigan, practice, Dr. Enzor said ophthalmologists share the commitment of taking call for the local hospital system, and what's more, they do it for free. She pointed out that taking call is even more important in a rural setting like southwest Michigan because there are no large academic hospitals or trauma centers nearby.

Dr. Foster noted that taking call is made easier by being in a group practice. "I'm very fortunate because I've got three partners. It would be really hard if I were in solo practice."

Relationships and loyalty. One reason that Dr. Foster takes call is because of her long-standing friendships with physicians and staff at nearby Nationwide Children's Hospital and Ohio-Health Grant Medical Center, a Level 1 trauma center. She takes call 24/7 for the children's hospital, a commitment she made because of her early training at Children's Hospital of Philadelphia. "It's a labor of love," she said.

For Dr. White, covering call is a way to get to know other doctors in the Colorado Springs community, and obtaining referrals from them has been vital to building her fledgling practice. In the hospitals, she said, "I'm meeting with referring doctors and building a reputation that way, which is very helpful to me, being new in town."

The bigger picture. Another concern, said Dr. Foster, is that if ophthalmologists don't cover call, hospitals may move to provide care with nonphysician providers in the ED. "If doctors refuse to take call at hospitals, the hospitals will have to find someone else who can, and I think that's a problem," said Dr. Foster. A study last year comparing use of nurse practitioners (NPs) to physicians in Veterans Health Administration EDs found that use of NPs increased costs and patient length of stay, at the same time leading to less favorable patient outcomes.[4]

Other Solutions

The promise of telemedicine. Dr. Woreta believes some of the burden of call can be lightened through telemedicine, which has been explored more in depth since the advent of the pandemic. Ophthalmologists can work with onsite ED providers to take a history and examine ED patients remotely.[5] This model can be helpful in triaging and diagnosing those urgent cases that can be seen in clinic the next day versus true emergencies, she said.

Urgent add-ons. Improving access to same-day appointments available in the clinic schedule can be another way to accommodate these patients so that they do not have to be sent to the ED. This is a strategy being employed at Wilmer Eye Institute, Dr. Woreta said, and it has been successful in reducing length of visit and cost, and improving patient satisfaction.

Dr. Enzor is also advocating for urgent care slots on her schedule to accommodate patients with high eye pressures and other pressing needs. "It's really difficult, in a more resource-limited or rural setting, to provide urgent surgical care," she said. "I am advocating for a team approach in which we make accommodations for anticipated needs."

Looking to the Future

It's important to keep talking about the ethics (see sidebar) and responsibilities involved in covering call, said Dr. Woreta. With fewer and fewer ophthalmologists willing to take call, this is leading to a crisis of ED coverage. Encouraging ophthalmologists to consider their commitment to their communities—and to serving patients in the best way they can—is always a conversation worth having, she said. "We all need to share the burden of call and not delegate it only to residents or academic medical centers."

1 O'Malley AS et al. *Center for Studying Health System Change.* 2007;115:1-7.
2 Nari J et al. *Can J Ophthalmol.* 2017;52(3):283-286.
3 American Academy of Ophthalmology, February 2014. aao.org/education/clinical-statement/oncall-compensation-ophthalmologists.
4 Chan DC, Chen Y. The Productivity of Professions: Evidence From the Emergency Department, www.nber.org/papers/w30608.
5 De Arrigunaga S et al. *Semin Ophthalmol.* 2022;37(1):83-90.

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