

AM Ortho Breakout II: Part 1
Donald Wiss, MD; Gary Zohman, MD
Strategies for Meeting the Standard of Care While on Call in the Age of
Subspecialized Orthopedic Group Practice

Orthopedics remains an emergency specialty and one of the cornerstones of every hospital emergency department. Yet the explosion of subspecialty expertise and training in joint replacement, spine, hand, sports, pediatrics, oncology, and fractures has produced a generation of orthopedic subspecialists.

As a surgeon's practice matures and becomes more focused on a particular subspecialty, the comfort level and desire to treat orthopedic emergencies wanes inversely. Willingness to participate in emergency on-call rosters is further eroded by the prospects of treating injured patients with whom there is no previous doctor-patient relationship, and from whom reimbursement is often not received.

This issue has come to a head over the past decade. Many subspecialists have stopped voluntarily taking emergency call. In order to close gaps in the call roster, hospital administrators sometimes responded by making emergency call a condition of hospital privileging, or by extending the number of years of call required after joining the staff.

These measures has led to the exodus of many specialists whose practices do not require hospital privileges, such as hand surgeons, and sports surgeons who work primarily out of ambulatory surgery centers. Many community hospital emergency orthopedic rosters have been decimated, and hospital to hospital transfers are commonplace.

Over this same period, the number of trauma-fellowship trained orthopedic surgeons has steadily risen. Trauma specialists have been recruited by to provide state-of-the-art fracture care to group patients. Fracture surgeons, like their subspecialist colleagues, may desire to focus their daytime practices on their areas of expertise: complex fractures, disorders of fracture healing, or post-traumatic deformities.

This has further removed fracture care from the comfort zone of the non-trauma orthopedic specialists in the group, and it has not increased their desire to cover emergency call. Young trauma-trained surgeons, in many communities, can be found

covering most of the emergency call, or providing “shadow call” for their non-trauma-trained colleagues.

The winds of change in medical practice are now blowing. In order to create a sustainable practice, many multi-specialty orthopedic groups have settled on the following model. Emergency night and weekend call coverage is shared by all group members. During the week, it is understood that absolute emergencies must be treated by the on call physician overnight, but many conditions may be temporized until the trauma surgeon is available.

Examples of some conditions that demand urgent treatment include: compartment syndromes requiring fasciotomy; contaminated open fractures requiring wound debridement and possible joint-spanning external fixation; infected flexor tendon sheaths in the hand requiring drainage; displaced pediatric supracondylar distal humerus fractures requiring reduction and stabilization; and knee dislocations that may require spanning external fixation.

Over the weekend, the list of conditions that ought to be treated by the on-call physician expands somewhat. In particular, the on-call skill set ought to include the stabilization of proximal femur fractures by cannulated screw fixation, hemiarthroplasty, sliding hip screw, or cephalomedullary nailing. Furthermore, if a complex or open articular fracture presents over the weekend, then it may be necessary to provide limb stability with an ankle or knee joint spanning external fixator until the soft tissue conditions will permit safe and definitive reconstruction by a fracture surgeon.

Clearly the competencies and skill set required by an on-call physician will depend a great deal on the spectrum of injuries typically seen in a given community. It will also depend on the available skills of physician colleagues to whom the on-call surgeon may triage these injuries after the call night is over.

The protocols established by a given group for what must be done overnight and on weekends by the on-call physician will take into account several factors. These factors must weight and balance the need to provide appropriate, immediate care for some injuries, while deliberately temporizing other injuries which would be more appropriately cared for by a colleague with a different set of skills.

