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Interview with Dr. Paul Reiman

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Leading the way to higher ground

Dr. Paul Reiman is an orthopedic surgeon from Southern California who is working to solve some of healthcare's most challenging problems. Whether it's improving the concussion protocols in motor sports or changing the culture of call pay in his medical community, Dr. Reiman believes in the power of team collaboration.

Given his ability to work closely with other physicians, it's easy to understand why two different hospitals would tap him to be a part of their physician call committee process. It's also why MaxWorth recently asked him to join our team as a physician facilitator.

During our conversation, we discuss the value of physician input, the need for transparency, and the divisive nature of traditional call pay arrangements, which often prompts the search for an alternative approach.

Thanks for speaking with us today, Dr. Reiman. Why don't we start by having you tell us a little about call pay arrangements prior to your work on The Physicians' Call Committee™?

Well, it was really pretty ill designed from the standpoint on how the monetary amount was determined for each specialty. I worked in multiple hospital systems and it seemed like the physicians with the most political, capital, and negotiating power individually or within a group could go to the administration and somehow get higher call pay than someone who had just the same intensity and same call burden. So it was really pretty ill designed and it varied widely from system to system. Some systems seemed quite fair and others did not. And again it really came down to what I felt were the individuals or groups with a lot of political, capital, and negotiating power did better than those who might be outstanding physicians but did not necessarily have that negotiating power.

So what kind of impact would that environment have on your working relationships?

Well it absolutely lowered moral and caused a lot of grumbling from the standpoint that this guy or lady is sitting here having a cup of coffee while I'm working extremely hard and I know that they were getting paid significantly more for less work. This would lead to conflict within any field let alone medicine.

How were these arrangements communicated to the medical staff?

In my experience, they really were not. And that caused a lack of trust not only from physician to physician, but physician to administration. And again, this is not just one system, this is several systems that over the years in my career I've worked at.

Dr. Reiman, when did you first hear about The Physicians' Call Committee™ as an alternative approach?

I was involved with a large group of physicians in the creation of a brand new hospital from the ground up within our local community and we had brought in an administration [and were] trying to build the medical staff, build the facility, and determining what physicians should be involved, what services should the hospital have, and as well which physicians do we need to take call. These physicians by far and away would be physicians who were already established in the community and involved in the medical staffs of other facilities. The administration and several members of the MEC had investigated the MaxWorth call pay plan and were quite interested in developing a call committee. As I was involved with the hospital formation from day one, they asked me to be chairman of the call committee to investigate to see if it would work within our community and most importantly within our brand new hospital.

This was your fist experience with the process. Since then, another hospital has actually asked you to participate in their committee process as well.

Yes, another hospital system within our community has decided to also investigate this process and asked me to be on their physician call committee, not as chair, but as a member.

And that hospital was an established facility?

Yes, they've been established in town for many, many years.

When you were first asked to be a committee member, what was your initial reaction? Did you have concerns or expectations?

Well I was anxious but at the same time I was confident. I felt we could put together a fair plan. Given that at this initial hospital we had a blank slate and there was no record of anybody getting any money for the hospital paying for anybody to take ER call because there was no ER call. I knew I had - and the other committee members - had a lot to learn about the process but I was confident that we could work together. The members were a diverse group with eight specialties within the hospital but there was mutual respect and really nobody bringing an agenda to the committee to try to push through for one group, one specialty. Everybody advocated their own specialty, but at the same time they understood the other individual. So yes I was anxious. Any time you're chair of a committee that's going to affect a physician's lifestyle and finances, you know you're going to get scrutinized, but the whole process is designed and the biggest concern was making sure it was fair and decisions that were made by my colleagues not just myself and not just the administration.

Did the call committee process address your initial concerns?

Yes, because we felt we had the key specialties on the committee. We would rate each specialty in regards to their call burden. And not only their perceived call burden but as much as possible their real call burden. On their frequency, their intensity, the community need for the program as well as the cost of the program to the individual physician obviously some specialties will have much higher malpractice insurance than others. We learned as each physician was an advocate for their own specialty, we learned a lot about the other specialties and we were able to advocate our own. It was a little humbling for all of us because we all feel we are extremely important to any hospital system and we recognized that we were all quite important.

Call pay can be a contentious and dividing topic. What was it like working with other physician committee members on this issue?

It differed in the two hospital systems because one was new with a blank slate. The other had a wide variety of different levels of reimbursement [due to] the negotiating prowess and the political capital that some of these specialties had. With the new hospital, it really wasn't contentious and dividing. It was a very open and frank discussion, but at the same time an educational process for each of us. With the existing hospital, it was somewhat different because of what was already there and some of the conversation related to: Well this particular specialty doesn't seem to be as busy as what their existing call pay is and how can we reconcile that? And how is the existing medical staff going to respond to that? Not only the staff as a whole, but the medical executive committee as well.

What are the primary objectives of the call committee?

It's to really align the medical staff to the call pay. It's to make sure that the needs of the emergency department are fulfilled, that there are no blanks in a call pattern, particularly for the critical specialties. Two examples would be if a hospital has stemi program that there are significant invasive cardiologists to cover that. Another example would be a trauma system whether it be the general surgeons or the orthopedic surgeons or the neurosurgeons within in the trauma, that those needs are fulfilled. The medical staff has to feel that it's fair and that the process has been fair. And I think that's the major thing. Again, we've talked about political capital, and negotiating prowess, and I think that comes in to people feeling that an administration would favor one specialty verses another as opposed to your colleagues helping to determine what your burden is. And the physicians are involved. And it's transparent. It has to be presented to the medical staff. For the administration, it gives them a much better way to budget. They know what their costs are going to be and that it's transparent. Using the business term of stakeholders, the stakeholders are the physicians, the emergency department, the administration, and most importantly the community, that the community has a properly staffed and equipped hospital.

How long does it typically take for the committee to reach its final recommendation?

The initial set up is four meetings, two meetings one week and several weeks later, a second set of meetings. It helps confirm what has gone on and where the rating system is, but also to allow the committee members to reflect on some of the ratings that they gave each of the specialties and to not necessarily talk to their colleagues, because we try to keep the meeting confidential, otherwise you're going to have multiple members of the medical staff wanting their two cents in the process, to be on the committee. The meetings that I've attended at both facilities usually were two hours long and again two consecutive nights one week, anywhere from two to four weeks break and then two more consecutive nights. With our new hospital, the discussions proceeded quite readily and quite timely, some disputes but they were resolved pretty easily and it was a unanimous decision in the end. And we haven't changed it a whole lot over the last six years, so we thought that our initial process worked well. With the existing hospital that we're still in process on, it's been a little harder because of the existing history and some of the disparity on what is being paid now. Right now it is not a unanimous decision and things are still in a little flux. I believe the initial meetings went well, but some political capital has been brought into the process and I think that has caused some concern and may make some of the decisions for the administration a little tougher.

And what about the medical staff? How were the committee's recommendations received by them?

At our new hospital, they were accepted quite read-

ily. We made sure that we knew what the regional standard was for call pay plans. So we tried to, not necessarily mimic but we tried to make sure that we were within a reasonable fair market value for each specialty. And really did not get any push back from any individual hospital and certainly not any large group. My presentation to the MEC went as smooth as any presentation I've had and there were several questions, but beyond that there wasn't any discord. For our second hospital system, we're really still in the process and have not presented it yet to the MEC or the medical staff. We have had a quite extensive discussion on what (during the committee meeting) how we feel there might be push back from both the staff as a whole and individual specialties that may have to be adjusted or may surprisingly get more pay that they had in the past, but also at the same time the potential push back on the transparency issue once other physicians have seen what their colleagues are being reimbursed. Again that was the discussion within the committee, but we haven't presented it to either the MEC or the staff to know whether they will be pushing back or whether they won't.

So the medical staff was able to hear about the process and how the recommendations were made at the conclusion of the committee's work?

Yes. And I feel that's very important. That's part of the process, too, that the medical staff knows that these tiers and assignments to the different levels were made by their colleagues and not an administration. Every hospital has times where there's excellent administration/physician relationships and sometimes it's contentious, but if their colleagues are making their decisions and it's transparent in those decisions then I think it is accepted on a much wider basis and it's a little tough for the physicians to argue with it.

So, Dr. Reiman, based upon your experience, over the past five years as a committee chair person and a committee member, do you feel the process addresses initial concerns of trust, fairness, and transparency as they relate to call pay?

Yes I do. And I feel very strongly on that. The physicians are really quite happy with it over all. We do reimburse quite a few specialties, including some unique ones, but that fulfill a strong need within the hospital and do have a strong call burden. The hardest thing that we've had to do, not only at our new hospital but at the existing hospital, is to make sure we're basing decisions based on good data. And that's the hardest thing I've seen in my experiences. I think the data that we used and are using is good relative data. Whether it's absolute data is a little more difficult to determine but I think the relative burden of each of the specialties we've been able to have some good relative data on what that is.

Where do you think the medical staff would be today if you had followed the traditional approach for paying for call at your hospital?

At our new hospital, I think it would have continued the culture that was already in the community and one of the reasons the large group of physicians were building a new hospital was to get away from that culture. I think it would have caused significant division within the medical staff. For some of the services that we were bringing in and recruiting outside physicians to be able to increase our services at that hospital and I think those were unknown physicians to other people in the community and I think they felt they were getting favors, getting overpaid, caused a great division. But I think we've succeeded in creating a whole different culture than had been in the community and a much closer working relationship. [There's] not much grumbling in the medical staff lounge, "I had a bad call night and I'm not getting paid enough for it." Everybody's working hard, but I think they're working together as a team. And it's very good call.

What advice would you give a new prospective committee member who may be considering participating in the process?

Number one, that it is a transparent, fair process. That physicians will have strong input not only in their own specialty, but other specialties as well. It's really not anybody trying to trick you or manipulate any physician to take less pay. The physicians are always worried about time, money, and work load and this helps, from a call burden work load, to make sure it's fair across the board. There's really not a hidden agenda in this. It's a process, a well designed process, to make things fair. [There are] Just as many advantages to physicians as there are to administration. You get to work closely with administration and they get to hear a group of physicians of multiple specialties telling them about what their call burden is and I think it increases the level of understanding for the administration and for your fellow physicians that they understand my specialty better, I understand theirs better. I would

tell them that it's win/win. You will be involved. It's not an overly burdensome assignment to be on the committee but you can make a large impact.

What about hospital administration, what advice would you give them concerning implementing the Physician's Call Committee?

Well, I think in setting up the call committee, I think you have to make sure that several things are absolutely included. I think an administrator needs to be part of the committee as an ex officio member, not necessarily a voting, but to be able to add input into the physicians' decision making, but also to learn about how your physicians think. You'll increase your knowledge about how your emergency department runs and what their call burden is. I think it certainly helps them to standardize their budget. It may not save them any money, but they will know what the budget is. They will not have physicians knocking on their door on a monthly basis saying, "I had a bad night last night and I need more money." So it allows them to manage and budget better. I think it increases their administration/physician interaction and communication and it put things above board for everybody. As far as who you appoint to the committee, I do feel it should be an independent player. It doesn't necessarily have to be from a major group but I think it needs to be someone that physicians feel is a-political and not necessarily going to take the majority group and favor them. You must involve key specialties within in your committee and that is entirely dependent on your community. I think the administration has to go in with a budgetary idea, but as they listen to the physicians be willing to modify that and take that back to their board saying x dollars is not going to work because that doesn't keep us competitive within the region and we probably need x plus y dollars to make this fly. And then finally they need to identify special programs that might be outside the call duty that either the physicians are getting the fees for reads or whatever but also may not need to be within this tiered system. An example of that might be the radiology, anesthesia, pathology specialties, potentially cardiology, stemi and/or trauma maybe outside this plan. They have to go in with some flexibility, not only on budget; they have to go in with an open mind. They're going to learn as much as the physicians and I think that'll make it a win/win situation.

Some programs elect to include a voluntary physician benefit known as a non-qualified deferred compensation program or we call it a physicians' advantage plan. How has that program been a value to you and your medical staff?

Again at our existing hospital, we're still in the process, but we've had this program for actually close to seven, six years now and the physicians initially were wary of it, and the more they learned about it and the more they participated in it, the happier they got. It does work as an investment mechanism. It's widely used in other fields outside of medicine for executive compensation and it allows one to defer income if you so desire. It's not limited on how much you can put in unlike 401ks and other retirement vehicles. It does have its rules. Some physicians are happy with the rules, some are not, but it doesn't necessarily lock up the money forever for them or until they turn 65 or 70 and it allows variability for a life event. It does become taxable if you take the moneys out. At our existing hospital, it was a required part of the plan. We had very little push back. We did modify it somewhat to allow young physicians to better be recruited and allow them to take some of their money out initially which would help an individual young physician with initial student loans, practice start up costs. It would allow a group to help finance that new physician. Some physicians if it's voluntary would not have done the program because they would use the money for students loans, overhead, other personal expenses, but overall our physicians over a six-year time period have been extremely happy with it.

In what ways does it benefit the hospital?

It is more paper work for the hospital from that standpoint. The trust is designed for the long term, not short term. Long term the hospital does have a way to recoup some of their moneys beyond my analysis, I'll leave that to the people with more financial savvy than I have, but it does allow the hospital to recoup some of that. For physicians, particularly those who have become financially stable, it can certainly be a recruitment tool to say that we have this in addition to what most other hospitals don't, that we have a way for you to invest your money tax free until you take it out above and beyond any retirement vehicles that you've got.

Personally, Dr. Reiman, what has that benefit meant to you?

It's worked very well for me. I'm what you call a mature physician now that I'm over age 60. Within the plan it does give those physicians much more flexibility as far as leaving the money in, taking the money out, taking it out yearly, or to continue to invest. I did use it for a life event earlier where I needed some of my own orthopedic surgery done and I was off and I used it to supplement my disability insurance income during that time. And that was beneficial for me as well.

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