Doctor's Other Office, an Alternative to the Emergency Room

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Doctors' Other Office (DOO), a group of ten family physicians, offers after-hours and weekend health care to non-critical patients who might otherwise go to a hospital Emergency Room, even though their medical problems do not require expensive, elaborate facilities of the Emergency Room. Advantages to patients include less expense than the ER, care that is appropriate to their needs, and comprehensive, continuous care through dealing with physicians who will follow through with referral to a regular physician, often the patient's own family physician. DOO physician members enjoy a rational division of after-hours and weekend coverage among colleagues that permits more free time, yet assures that patients receive good quality, continuous care. The methods of operation are discussed, including personnel schedules, consultants, hospital coverage, and finances. The DOO income just meets office expenses; however, life insurance and other fringe benefits that physician members receive through the corporation aid in making this organization more financially attractive.

In a previous paper[1] one of the authors challenged family physicians to organize 24-hour coverage systems to provide more appropriate alternatives to the hospital Emergency Room. The other two authors are members of an organization called "Doctors' Other Office," (DOO), a group of ten (sometimes eleven) solo family physicians who formed a corporation six years ago near Sacramento, California, in order to provide after-hours coverage that is appropriate, continuous, and much less expensive than the Emergency Room.

The primary purpose of DOO is to provide continuous care to the member physicians' regular patients for non-critical medical emergencies after hours, that is, situations that need immediate attention but that do not require the expensive, elaborate facilities offered by a hospital Emergency Room. In practice, patients who are treated include some who cannot and do not wish to contact their regular doctor after hours; many, such as transients and newcomers, who have no regular doctor; those who find doctors' regular office hours inconvenient or impossible; and some who simply do not wish to wait for an appointment during regular hours. In other words, DOO treats mostly the types of patients who make up that large group of inappropriate users of many hospital Emergency Rooms. Cost to the patient is about one half what the same treatment would cost in an Emergency Room because there is no charge for the Emergency *Room.*

During regular working hours, each member physician maintains his own private office, yet he has the advantage of a formally organized coverage system with a large enough group of other physicians that his patients always have a place to go, regardless of the hour.

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Methods

Operation

One of the family physicians rents his office to the corporation for these off hours. A doctor is present every weekday evening from 7 to 11 PM and weekends and holidays from 10 AM to 11 PM. A receptionist assists the doctor on duty during these hours by taking phone calls, registering patients, taking temperatures, "chaperoning" gynecological examinations, and preparing examination rooms. She also maintains financial records, completes insurance forms, and types medical reports. On weekends and holidays, when patient loads tend to be heavier, a nurse is present from 10 AM to 6 PM. The history, physical examination, and treatment program are recorded by the doctor on duty and a copy is sent to the patient's own doctor.

After 11 PM calls are infrequent, so an answering service refers them to the home phone of the physician on call that evening. Most of these late calls can be handled over the telephone. Those that cannot be so easily resolved are usually of a truly emergent nature and require ER facilities or hospitilization, so the doctor either refers the patient to the community hospital Emergency Room or goes himself to meet the patient there.

Personnel Schedules

Schedules of auxilary personnel are set. The office manager at DOO works as the evening receptionist each weekday. Her hours are from 3 to 11 PM. On Saturdays, Sundays, and holidays a different receptionist works from 8 AM to 4 PM, followed by another receptionist from 4 to 11 PM. Time spent by the receptionists before DOO hours is used to catch up on correspondence and records. One registered nurse is employed to cover the weekend and holiday daytime hours.

Among the doctors, schedules are worked out so that each spends an average of two weekday nights and one Saturday or Sunday per month. Holidays are chosen by lot, and arrangements for vacation time and other planned absences are worked out for fairness and convenience. Doctors who leave their own offices early in

the day or who are absent refer patients who call that day to the DOO doctor who is to be on duty that evening. Thus, a DOO physician may see patients of the other doctors in his own office that day. Another backup feature is that if any one of the physician members is too busy to see all his regular patients he can refer the overload, usually one to five patients with urgent problems, to the DOO that evening.

Consultants and Hospital Coverage

Each member doctor provides the DOO with a list of the consultants he uses. Then, if a patient of another doctor must be hospitalized, the DOO physician on duty can make the arrangements, call in orders, and have the attending doctor notified in the morning of his patient's admission. If an Emergency Room doctor calls after admitting the patient of one of the DOO physicians, the DOO doctor on duty again makes the arrangements. The DOO doctor is not responsible for non-DOO doctor patients after 11 PM.

For Saturdays, Sundays, and holidays, the ten DOO doctors are split into subgroups of four, three, and three. The member in the subgroup who is on duty at DOO also makes hospital rounds for each of the other doctors in his group for that weekend. He sees and is responsible for the care of all of the hospital patients belonging to these three or four doctors, both new and old hospitalizations. New hospitalizations occur through the DOO doctors or the ER doctor, but continuing care is then the responsibility of the weekend on-call doctor.

Patient Referral Sources

Patients are referred to the DOO from many sources. The primary source is the answering services of the physicians who are members of the DOO. Some non-member physicians also sign out to the DOO. The telephone book lists the DOO and its hours both in the standard white listings and in the yellow classified advertisements under "Physicians." Of course, patients refer other patients. Rarely, the hospital ER refers its overload of non-emergent patients and the DOO refers its after-hours overload to the ER. Most patients call before appearing in the office. Return visits to the DOO for follow-up are discouraged; instead patients are urged to see a doctor during regular hours whenever possible.

Patient loads vary considerably. An evening load may be from three to 18 patients, while a Saturday or Sunday load may be 14 to 40 patients.

Finances

Financial arrangements are kept as simple as possible; if possible, the patient pays for the visit before leaving. This keeps down overhead and noncollectable bills. Welfare patients' bills must be sent to the appropriate state or federal agency, however, and insurance companies must often be billed so they will reimburse patients. Each night, the receptionist sends out that evening's billings and doctors' reports of diagnoses and treatments. Patients are charged a set fee ($18) for their visit, which is commensurate with the community hospital Emergency Room doctor's fee; however, this amounts to less than one half of what the patient would have paid at the hospital for the same service because there is no $20 to $25 charge for the use of the room.

An accountant audits the books once a month and sends a statement to each physician member. All bills are paid monthly, and remaining revenue is then divided equally among the ten doctors.

Results

An analysis of the numbers and kinds of patients seen at DOO demonstrates its utility. During an average month (March 1976), 514 patients were seen. Of these, 57.6 percent (296) were regular patients of physicians who are members of DOO; 21.4 percent (110) were regular patients of non-member physicians; 17.5 percent (90) were patients who did not have a regular physician but referred themselves through a friend or the telephone book; and 3.5 percent (18) were miscellaneous. These figures tend to change in the summer when greater numbers of patients are from non-member physician sources, due to the increase in people passing through on vacations.

Patients can also be analyzed as to source of payment. Of 3,753 patients seen in the first nine months of 1975, 83.7 percent (3,147) were private patients who paid personally or through medical insurance, 15.4 percent (577) were welfare recipients, and 0.9 percent (34) were covered by Workmen's Compensation Insurance through their jobs.

Proximity plays a predictable role in determining where patients choose to go. The closer the patient lives to the DOO, the more likely he or she is to visit it, if indeed the problem is an after-hours one that does not require Emergency Room facilities. If a hospital is considerably closer to the patient's residence than the DOO, however, the patient is more apt to stop at the Emergency Room, even for non-emergency cases, and even in spite of the higher cost.

Financially, DOO pays for itself; income from patients just covers the expenses incurred. Physician members gain certain fringe benefits, however, that are available to them through the corporation, for example, a group life insurance plan. Table 1 shows actual operating expenses and income for 1975.

Discussion

Benefits provided the patient are that after-hours service is available from his own doctor or a closely associated colleague, a record of services performed is promptly transmitted to his own doctor and consequently becomes part of his permanent medical record, and, last but not least, the charge is about one half that of an ER fee for a similar problem. DOO also has been able to accept "no-doctor" patients and patients of other doctors during the duty hours, again providing needed services at less cost than hospital Emergency Rooms. On the other hand, the $18 DOO fee is higher than the average $12 to $14 fee the members charge for a regular-hours visit.

Unfortunately, many insurance companies recognize after-hours ER care for payment but not after-hours

Table 1. Statement of Annual Income and Expenses for 1975 for the Doctors' Other Office Medical Group, Inc.*

Income from patients	$ 86,421
Expenses:	
Salaries and wages:	
Doctors	29,355
Nurses	21,129
Office Supplies and expenses	2,180
Miscellaneous	90
Telephone	1,353
Legal and accounting	2,060
Utilities	132
Medical supplies	7,297
Janitor	710
Rent	4,800
Life insurance	11,494
Depreciation	41
Amortization of organization expenses	188
Payroll taxes	4,631
Other taxes and licenses	273
Promotion	682
	$ 86,415
Net Income	$ 6

*This is an unofficial, unaudited financial statement.

care at a physician's office. Thus, many patients find that their insurance will pay the entire ER fee and none of the DOO fee, even though it costs twice as much at the Emergency Room. One would expect this to change when medical insurance companies become aware of the availability and low cost of DOO facilities.

Benefits for the doctor are obvious: no telephone disturbances during off hours, no driving back and forth to the office or hospital to see patients after hours, only two weeknights and one weekend day worked every month, and, most important, satisfaction that his patients are well cared for in his absence.

The DOO does have limitations. The existence of the office has not been well-promoted, even to the DOO doctors' regular patients. The result is that many of the DOO doctors' patients still end up in the ER for their after-hours care through lack of awareness of the DOO's existence. Greater patient loads could easily be achieved if each doctor notified all his patients about DOO. The DOO also lacks somewhat the more intimate colleageal relationship of a regular group practice because the doctors are never in the office at the same time.

To date the DOO has not utilized mid-level practitioners such as family nurse practitioners or physician's assistants. More active promotion of the office's services would probably result in sufficient increase in patient load to support a physician/mid-level practitioner team for DOO coverage.

Conclusion

The DOO is a viable alternative to the expensive, inappropriate, and overutilized ER for the care of most non-emergent patient needs after-hours and on weekends. Because the DOO is located in the area served by the physician members, and because of the effective patient record reporting system, care has continuity and prevents the fragmentation caused by the ER "one-shot" care of episodic illnesses. The DOO presents an efficient method of handling patients at odd hours so that care is truly available and accessible without costing the physician his sanity and his sleep. The record system provides rapid information to the patient's family physician, and an efficient, predetermined system of referral and hospitalization has been worked out by each physician for his own patients. Charges are approximately one half those for similar services in the Emergency Room.

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Reference

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