

**PREDICTING COMMUNITY
EMERGENCY MEDICINE NEEDS AND
EMERGENCY PHYSICIAN
COMPENSATION MODELING; TWO
SIDES OF THE SAME COIN?**

To the editor: Dubinsky's broad overview of emergency physician (EP) "workload" models¹ has important implications to population health outcomes and national physician resource planning. It seems that this is a complex issue and that there is "no perfect single existing model." I wonder, however, whether this article adequately differentiates between 1) matching emergency medicine capacity with patient/population needs and 2) modeling workload for the purposes of fair compensation. Practically, they may be two sides of the same coin, but conflating these two perspectives risks creating conflicting priorities. As Einstein has said, "Formulating the problem is more essential than the solutions."

If matching capacity is the problem, then we will solve this with a public health lens. We know that prolonged emergency department wait times are associated with mortality in a dose-response relationship that suggests causality.² And we know that inadequate EP coverage prolongs wait times in a nonlinear relationship similar to the oxygen-dissociation curve^{3,4} (when it starts to fall apart, it really falls apart). In this context,

problem solving is patient outcome centred and forward looking (predicting patient/community needs). This process, then, is evidence based and policy driven. Ideally, the Canadian Association of Emergency Physicians could use its national perspective and patient advocacy role to endorse a "best practice" methodology (which may look very similar to the author's hybrid model).

If modeling workload for compensation is the problem, then the hours of coverage issue gets bundled with the hourly rate issue, and we will "solve" this issue through negotiations. Although this makes intuitive sense to funding bodies transitioning from a fee-for-service framework, this can lead to some unintended consequences. In this context, the approach becomes remuneration focused and backward looking (measuring physician work). Physician negotiators (with less fiscal/system accountability) are incented to inflate workload metrics, and government negotiators (with less patient care accountability) are incented to consider the coverage issue as just another leverage point for give and take. Also, any increase in funding that may occur (in relation to increased volume/acuity/complexity) gets framed as a raise in physician's salaries (rather than as a need to recruit more full-time equivalents to improve patient access).

Situating discourse and decision making in the realm of health care policy (rather than in the potentially adversarial and opaque process of physician services negotiations) brings more evidence, transparency, public accountability, patient centredness, and fiscal responsibility to dialectically working toward creating a safe and sustainable emergency health care system.

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