**Concorso Pubblico per n. 1 posto a tempo indeterminato disciplina Medicina d'Emergenza-Urgenza o Medicina Interna o Chirurgia Generale**

# Domande inglese

**1.** Compensation models in Emergency Medicine (EM) are varied and complex. They have often been developed over a long period of time to meet the needs of healthcare institutions, contracting or employed physicians, communities, and the marketplace. Some are also designed, at least in part, to serve the interests of for-profit corporations and their shareholders.

**2.** Patient needs are often not explicitly considered in physician compensation agreements, which can lead to perverse incentives that are not in patients' best interests. Economic models based on health insurance contracts, fixed payments, or bundling possibly could lead to the withholding of necessary diagnostic studies and treatments or attempts to shift services to other locations or providers at later times.

**3.** Compensation models designed to control utilization may also discourage both referrals by other providers to the emergency department (ED) and admission decisions in ways that compromise patient care. In contrast, strict fee-for-service compensation models, including models based on relative value units (RVUs), may encourage inappropriate testing, procedures, or admissions.

**4.** Following a brief description of some compensation models used in EM, this article reviews basic goals of health care systems, individual physicians' goals and desires, and fundamental bioethical principles, noting how these goals and principles bear on physician compensation arrangements.

**5.** The article does not endorse a single model of compensation for emergency physicians (EPs). Rather, it examines ethical issues surrounding physician compensation that may affect patients, physicians, the medical profession, hospital owners, and the health care system.

**6.** EP compensation is commonly based on both clinical and non-clinical factors. Both types of factors can reflect valuable contributions to the health care enterprise that deserve compensation. Clinical factors include efficiency (e.g., number of patients seen or RVUs per hour), patient outcomes (e.g., pay-for-performance measures), and patient satisfaction [e.g., Press-Ganey or National Research Corporation (NRC) scores].

**7.** Other clinical metrics are rates of patients left without being seen (LWBS), elopements, unexpected 72-hour returns, and appropriate or inappropriate utilization of testing (e.g., laboratory

studies, CT scans, and ECGs) and procedures. Non-clinical factors include seniority in the group, hospital and departmental administrative roles, group or departmental citizenship, service to the public or the profession, scholarly achievement, biomedical research, and resident and medical student teaching, supervision, and evaluation.

**8.** Compensation for various types of employment has evolved, from models in which most if not all employee pay was based on an hourly wage rate and the number of hours worked, to more recent emphasis on compensation based on productivity, that is, the quantity and quality of one's work product.

**9.** In addition to productivity, incentives and bonuses are key components in compensation. Productivity is an economic measure of output per unit of input. Inputs include labor (hours worked) and contributed capital, and output is typically measured in revenues and other measures of production such as publishing or teaching. An incentive is something of value that motivates a party to do more of what the employer or contractor desires.

**10.** In EM it is very difficult to use RVUs or patients per hour since the quantity, complexity, and treatment needs of patients can be very different depending on the day of the week, the particular shift, the insurance coverage, and the psychosocial needs of patients, with many of these differences due to random variation. Morally, the duty of a physician to any patient should not vary with these factors.