

WHITE PAPER

THE HIDDEN COST OF CALL: MEASURING PHYSICIAN BURDEN IN MODERN HEALTHCARE



Executive Summary

Healthcare organizations are facing growing pressure to maintain physician coverage while navigating increasing provider shortages, physician burnout, rising operational complexity, and heightened regulatory scrutiny. As hospitals and health systems continue to rely on specialty call coverage to support emergency care, trauma services, and patient access, many organizations are realizing that traditional approaches to managing physician call arrangements are no longer sustainable.

Historically, physician call coverage was often treated as a flat administrative obligation — compensated through standard stipends with limited visibility into actual workload intensity. Today, however, the realities of modern healthcare delivery have fundamentally changed.

High-burden specialties frequently experience:

- repeated overnight interruptions,
- emergency procedures,
- restrictive response-time requirements,
- uncompensated care,
- significant lifestyle disruption.

At the same time, regulators and healthcare valuation experts increasingly expect organizations to justify physician compensation arrangements using objective operational data and defensible fair market value (FMV) methodologies

This evolving environment has transformed “burden of call” from a subjective concept into a measurable operational, financial, compliance, and workforce issue.

Healthcare organizations can no longer afford to rely on fragmented spreadsheets, anecdotal workload assumptions, or disconnected tracking methods to evaluate physician burden. Instead, leaders are shifting toward data-driven burden validation models built on centralized workflows, operational analytics, timestamped activity tracking, and audit-ready reporting.



Our Focus Areas

- What is “Burden of Call”?
- Why Healthcare Organizations Are Paying Attention
- The Operational Problem
- How Burden is Measured
- Specialty-Specific Burden Differences
- The Shift Toward Data-Driven Burden Validation
- The Future of Burden-of-Call Management
- Conclusion

What is the Burden of Call?

In healthcare compensation and valuation analysis, the “burden of call” refers to the intensity, restrictiveness, and workload associated with physician on-call responsibilities.

The concept gained prominence in the 1990s and early 2000s as hospitals began formalizing emergency department call coverage arrangements in response to EMTALA obligations, growing physician shortages, and heightened scrutiny of compensation arrangements.

Initially, many hospitals compensated physicians using standardized flat-rate call stipends. Over time, however, healthcare organizations and valuation firms recognized that not all call responsibilities carry the same operational burden.

Some physicians experienced infrequent interruptions and limited overnight activity, while others faced constant pages and severe sleep disruption from repeated callbacks and emergency surgeries.

As a result, the burden of call evolved into a measurable workload concept used to assess the true operational demands associated with physician coverage responsibilities.

Modern burden-of-call analysis commonly considers factors such as frequency of call assignments, in-person hospital returns, procedural intensity, uncompensated care, response-time requirements, sleep disruption, geographic restrictions, and physician scarcity.

Today, burden-of-call measurement plays an increasingly important role in physician compensation, fair market value analysis, workforce sustainability, provider retention, and operational planning.

According to a report from [Physician Side Gigs](#), an online community of more than 195,000 physicians:

75%
of physicians reported that
call is mandatory.

60%
of those who responded
reported call being a source of
burden.





Why Healthcare Organizations Are Paying Attention

The growing focus on physician call burden is being driven by several converging industry pressures.

EMTALA and Coverage Expectations

Hospitals are required to maintain adequate emergency coverage to support patient access and regulatory obligations. As specialty shortages increase nationwide, maintaining consistent call coverage has become significantly more difficult — particularly in high-acuity specialties such as neurosurgery, trauma surgery, OB/GYN, and interventional cardiology.

Healthcare organizations are now competing not only for physicians, but also for physician availability.

Physician Burnout and Workforce Sustainability

The human impact of call burden has become impossible to ignore. High-burden call schedules often involve repeated overnight interruptions, little post-call recovery, restrictive response requirements, and chronic sleep disruption. For many physicians, call burden directly impacts work-life balance, long-term career sustainability, and overall job satisfaction.

Organizations increasingly recognize that unmanaged call burden contributes to burnout, recruitment challenges, provider turnover, and early retirement. As healthcare systems face growing workforce shortages, provider sustainability has become both an operational and strategic priority.



Increased FMV and Audit Scrutiny

Increased FMV and Audit Scrutiny
Regulators and valuation firms are placing greater emphasis on defensible physician compensation methodologies.

Healthcare organizations are increasingly expected to justify why one specialty receives higher call compensation, why burden differs between facilities, and how payment arrangements align with actual workload intensity. Traditional flat-rate compensation models often fail to account for callback frequency, procedural complexity, acuity, and operational disruption.

As a result, healthcare organizations are moving toward more data-driven burden validation approaches designed to support FMV defensibility and audit readiness.



Compensation Fairness and Provider Retention

Physicians are increasingly aware of workload disparities across specialties, facilities, and organizations.

Without objective burden measurement, organizations risk inconsistent compensation practices, provider dissatisfaction, and erosion of trust between physicians and leadership. Transparency and fairness in burden assessment are becoming essential components of provider engagement and retention strategies.



The Operational Problem

Despite the growing importance of burden-of-call analysis, many healthcare organizations continue to rely on fragmented operational processes and disconnected tracking methods.

Common challenges include spreadsheets maintained across departments, undocumented callbacks, inconsistent physician activity tracking, manual reporting processes, limited operational visibility, and disconnected scheduling workflows.

In many organizations, there is no centralized system for tracking callback frequency, overnight disruptions, procedural intensity, response-time compliance, or workload trends across specialties and facilities.

As a result, healthcare leaders often lack the operational data necessary to justify compensation arrangements, support FMV analyses, benchmark burden accurately, identify staffing gaps, or evaluate provider sustainability.

Disconnected operational workflows also create inconsistencies between facilities, physician groups, compensation committees, and administrative teams.

Without reliable, centralized data, organizations are left relying on anecdotal feedback and manually assembled reports to evaluate one of the most critical components of physician operations.

This operational gap creates risk across compliance, compensation governance, provider retention, and workforce planning.

Increasingly, healthcare organizations are recognizing that burden-of-call management is not simply a compensation issue — it is a visibility issue.

How Burden is Measured

While there is no single universal burden-of-call formula, several widely accepted methodologies are commonly used by hospitals and healthcare valuation firms.

Callback Rates

Callback frequency is often considered one of the strongest indicators of physician burden because it reflects actual disruption rather than passive availability. High callback rates typically correlate with sleep disruption, emergency procedural activity, geographic restrictions, and increased burnout risk.

Many organizations classify burden levels based on average callbacks per shift, ranging from minimal to moderate, heavy, or severe burden. This methodology helps organizations differentiate between low-activity call coverage and truly disruptive overnight responsibilities.

Call Frequency

Call frequency evaluates how often physicians are assigned call responsibilities within a given period.

Examples may include call days per month, weekend coverage frequency, or consecutive call schedules. Although important, frequency alone rarely captures the full operational intensity associated with physician call burden.

Weighted Scoring Models

Many healthcare organizations utilize activity-based burden scoring systems that assign weighted values to different physician activities.

Examples may include phone consults, emergency department consults, inpatient admissions, emergency procedures, and in-person callbacks. Higher-acuity activities receive greater weighted scores to better reflect actual workload intensity.

These models help compensation committees and valuation analysts create more standardized approaches to burden evaluation.



Composite Call Burden Index (CBI)

More advanced methodologies combine multiple operational variables into a single composite burden score.

These models may incorporate call frequency, procedural intensity, callback disruption, weekend burden, response-time restrictions, and in-house call requirements.

Composite scoring models provide a more comprehensive view of physician burden across specialties and facilities.

Restrictiveness Models

Some healthcare organizations evaluate burden based on lifestyle restriction rather than activity volume alone.

These models assess variables such as response-time requirements, geographic limitations, consecutive call days, overnight interruptions, and availability expectations.

For many physicians, the inability to leave a service area or disconnect from work responsibilities contributes significantly to the perceived burden of call coverage.

SPECIALTY-SPECIFIC BURDEN DIFFERENCES



Not all specialties experience physician call burden equally. National benchmark data consistently demonstrates significant variation across specialties in phone-call volume, in-person callbacks, procedural intensity, and overnight disruption.

➤ NEUROSURGERY

Neurosurgery consistently ranks among the highest-burden specialties due to emergent surgical procedures, trauma activations, transfer coordination, and severe overnight disruption.

These physicians often face some of the most restrictive and demanding call expectations in healthcare.

➤ TRAUMA SURGERY

Trauma surgery frequently involves in-house overnight coverage, emergency OR procedures, rapid response expectations, and little opportunity for uninterrupted rest.

Many organizations classify trauma surgery as one of the highest overall burden specialties.

➤ OB/GYN

OB/GYN physicians commonly experience labor and delivery disruptions, emergent C-sections, repeated nighttime callbacks, and unpredictable overnight activity.

The specialty often ranks among the highest for callback frequency and sleep disruption.

➤ CARDIOLOGY / INTERVENTIONAL CARDIOLOGY

Cardiology burden is often driven by STEMI call, cath lab activations, short response windows, and transfer coordination.

High-acuity cardiac emergencies significantly increase operational burden intensity.

SPECIALTY-SPECIFIC BURDEN DIFFERENCES



➤ OB/GYN

Orthopedic burden varies significantly depending on trauma designation and emergency coverage expectations.

Trauma-focused orthopedic programs often involve nighttime fractures, surgical emergencies, and substantial procedural burden.

These specialty differences reinforce why healthcare organizations can no longer rely on simplistic flat-rate compensation structures when evaluating physician call arrangements.

➤ GASTROENTEROLOGY

Although historically viewed as lower burden than surgical specialties, gastroenterology burden can increase substantially in organizations managing GI bleed coverage, tertiary referrals, and advanced procedural requirements.



The Shift Toward Data-Driven Burden Validation

Healthcare organizations are increasingly moving away from anecdotal burden assessments and toward data-driven operational validation models. Modern FMV analysis now places greater emphasis on actual workload logs, EMR timestamps, callback data, procedural frequency, transfer activity, and documented disruption metrics.

This shift reflects growing industry expectations surrounding transparency, defensibility, and operational accountability. Healthcare organizations are increasingly expected to demonstrate why compensation varies between specialties, how burden is quantified, and how physician workload aligns with compensation methodologies.

As a result, operational visibility has become critical. Organizations are investing in centralized workflows, integrated reporting, timestamped activity tracking, audit trails, analytics platforms, and enterprise-wide visibility tools.

These capabilities help healthcare leaders improve compensation governance, support FMV defensibility, identify operational inefficiencies, benchmark burden consistently, and better support provider wellbeing. Most importantly, centralized operational data enables organizations to move beyond assumptions and toward measurable, defensible burden analysis.



The Future of Burden-of-Call Management

The future of physician call management will likely become increasingly data-driven, predictive, and operationally integrated.

Emerging trends include AI-driven workload analytics, predictive staffing models, automated burden scoring, workforce sustainability planning, and compliance automation.

Healthcare organizations are beginning to recognize that burden-of-call management extends beyond compensation administration. It is becoming a strategic component of provider retention, operational planning, physician well-being, and enterprise risk management.

Organizations that invest in operational visibility and centralized burden management today will be better positioned to support sustainable physician coverage, improve workforce planning, reduce administrative burden, strengthen compliance defensibility, and create more equitable compensation models.

As healthcare complexity continues to increase, the ability to measure and manage physician burden effectively will become a competitive operational advantage.

Conclusion

The hidden cost of physician call coverage extends far beyond traditional stipend arrangements.

The burden of call impacts provider burnout, workforce sustainability, compensation governance, compliance defensibility, and operational performance across the healthcare enterprise.

Healthcare organizations can no longer rely on anecdotal call burden assessments or fragmented operational tracking methods to manage one of the most complex areas of physician operations.

Operational visibility is becoming essential for compliance, compensation fairness, provider retention, and sustainable workforce planning.

As the healthcare industry continues shifting toward data-driven decision-making, organizations that invest in centralized burden measurement, reporting, and operational transparency will be better equipped to support both physicians and long-term organizational success.

The future of burden-of-call management will belong to organizations capable of transforming operational complexity into measurable insight, creating a stronger foundation for provider sustainability, compensation defensibility, and patient care continuity.

References

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About the Author

**Kelly Witter,
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Kelly Witter has over 25 years of healthcare experience, including two decades in senior leadership roles. Renowned for her strategic vision and operational acumen, Kelly has successfully led initiatives to standardize clinical operations, evaluate provider compensation models, streamline onboarding processes, and build high-performing physician teams. In past roles, her leadership was instrumental in establishing a formal Physician Leadership Council, advancing organizational alignment and physician engagement across networks.

Recognized as a subject matter expert in oncology, palliative care, hospice, women's health, pediatrics, hospital medicine, and provider network development, Kelly brings this expertise to engagements. In addition to her consulting work, she serves as a university faculty member, teaching nursing and health science programs and mentoring the next generation of healthcare professionals.



ABOUT DYNAFIOS

Founded in 2004, Steve Elliott and Tina Brinton understood the complexities through their own experiences within the healthcare field. They knew busy schedules and physician burnout were all too common and saw providers facing additional challenges with compensation management.

Our solutions add transparency and flexibility to reduce the burden on physicians. We work closely with clients to streamline patient care and workflows– enhancing compliance, efficiency, and performance. Since our launch, we have grown our partnership with over 550 healthcare facilities across 40 states.

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