We Get Letters

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This newsletter is written in response to numerous questions the Loss Prevention Department has received from policyholders about on-call coverage.

Pager failure: EMTALA violation?

Q: Recently while on-call, I noted that my pager had not alerted me all evening, so I called my answering service. Much to my surprise, I discovered that an emergency physician had called several times. For the first time in many years of on-call coverage of the ED, my pager had failed me. I called the ED and was thoroughly chewed out by the physician on duty, who said that I could be sanctioned heavily by something called EMTALA. What is EMTALA and how could I be sanctioned for inaccessibility when I was totally unaware of my pager's demise? I have a long record of on-call reliability, demonstrated by my call to the answering service when I noticed my pager's silence that very evening.

A: A failure to respond while on-call to an emergency department is a violation of EMTALA, the federal Emergency Medical Treatment and Active Labor Act, and carries a penalty of up to $50,000. However, fines are reserved for those instances in which the failure to respond was "negligent," "gross and flagrant," and/or "repeated," none of which apply to the circumstance you describe. It is likely that the diatribe to which the emergency physician subjected you was that of an over-stressed colleague who impulsively misdirected his frustrations on you.

EMTALA was implemented to prevent "patient dumping" or the unsafe transfer of individuals who present to a hospital for emergency care and whose condition is medically unstable. EMTALA's original intent was to protect uninsured patients who are unable to pay for their care, but it applies

to all patients regardless of insurance or ability to pay. The law requires hospitals to ensure that individuals are medically screened and treated without inquiry into their ability to pay, and are either stabilized or transferred only when stable enough to be transferred safely.

Hospitals are also required by EMTALA to provide emergency on-call coverage and may do so by implementing one of a variety of solutions and policies; physicians who provide on-call coverage usually do so by virtue of their agreements with those hospitals. Federal law does not dictate how facilities will maintain on-call panels, but medical staff protocols are usually specific and include physicians' on-call obligations, how disputes will be resolved, and how violations will be handled.

ED sends patients to my office: EMTALA mandate?

Q: When I see patients in the ED as an on-call consultant, I inform them that my treatment will be limited to the problem with which they present; occasionally, this includes follow-up care in my office. However, the hospital recently informed me that under EMTALA, I am also obligated to see individuals who come to the ED during my on-call hours, but whom I do not see in the ED; in those cases, the emergency physician and I determine that the patient does not require my immediate care.

The hospital said that the ED staff can tell these patients to present at my office for follow-up to their emergency care within the next 24-48 hours, because I was on-call when they were seen. I am not taking new patients, I do not take Medicare or Medicaid patients in my private practice, and I don't want to see every person who requires follow-up care for his/her ED treatment. Am I obligated to see these patients after they were treated in the ED simply because I was on-call at the time they were seen?

A: According to the Center for Medicare and Medicaid (CMS) Interpretive Guidelines of the EMTALA rules, when the ED telephones an on-call consultant and the patient's condition requires the consultant's presence, the on-call physician must come to the hospital to examine and treat the patient in the emergency department. An ED physician cannot arbitrarily send emergency patients to a consultant's office to be seen there either during the consultant's on-call hours or the following day simply because the patient was seen in the ED while the consultant was on-call. EMTALA does not require on-call physicians to see patients referred to their offices from the emergency department. On-call physicians would be required to see ED patients in their offices only if they agreed to do so in a separate agreement with the hospital or a managed care entity. (See Question on page 4.)

Avoiding certain patients: Can I?

Q: Our group occasionally withdraws from a patient's care and we agree not to readmit that patient to our practice. We all rotate on the emergency department's on-call roster, however, and occasionally we are called to treat one of the former patients we no longer wish to see. Also, sometimes we are called to see one of our competitors' patients in their absence, when we'd rather avoid a co-treating relationship with those physicians. How can we avoid those patients? If we can't avoid them, how do we prevent reestablishing doctor-patient relationships and their return to our practice? Must we provide their follow-up care, too?

A: A physician is obligated by EMTALA regulations to see patients while on-call to the ED, including patients from whom the physician has withdrawn care, patients the physician knows and does not like, patients whose regular physicians are competitors, and patients you know are not likely to pay their bills. You may, however, inform patients seen for emergencies that you will see them for resolution of the emergency only and that they will need to seek follow-up care with another physician (assuming you have no other contractual obligation, such as a contract with a managed care entity). You may wish to prepare a brief written statement to that effect for patients you will see while on-call to the ED but will not follow after their emergency condition is stabilized. (Feel free to send a draft of such a statement to the Loss Prevention Department for review.)

Specialist's duty under EMTALA

The following questions required the expert advice of a defense attorney. We thank Tom Donnelly, of Donnelly & Nelson, Walnut Creek, California, for succinct and thoughtful responses.

Q: ***I am an orthopedist who doesn't "do hands," and haven't for many years. Must I answer the ED's call for hand cases that are outside my area of expertise? I don't want to hurt anyone.**

***I am an ophthalmologist who has been in practice for 20 years and has never treated minors. Recently the hospital where I have privileges changed its policies and I have been told that when I serve on the on-call panel, I will be obligated to see minors. This does not feel safe to me, because I am not comfortable providing emergency care to minors for the first time since my residency. Can the hospital force me to do this?**

***I am a neurologist who, while on-call, is often asked to consult on cases that are clearly neurosurgical in nature. When I protest, and say that a neurosurgeon will have to be called anyway and that they might as well start there rather than call us both to the ED, I am told that if I don't come in, I will be in violation of EMTALA. Is this true?**

A: EMTALA and the CMS Interpretive Guidelines require hospitals, through medical staff bylaws or policies and procedures, to define the responsibility of on-call physicians to respond, examine and treat patients with emergency medical conditions. The concerns expressed by the orthopedist who may be called in to see hand injuries in the emergency department or the ophthalmologist now required to see minors are legitimate. EMTALA does not require a physician to provide medical care outside his or her own specialty or which may ultimately harm the patient. Nor does EMTALA require a physician to commit malpractice in attempting to comply with the law. The purpose of the on-call list is to insure that the ED is prospectively aware of which physicians, including specialists and sub-specialists, are available to provide treatment necessary to stabilize individuals with emergency medical conditions. If a patient is found to have an emergency medical condition, the hospital must provide either further medical examination and treatment as required to stabilize the medical condition within the capabilities of the staff and facilities available at the hospital; or transfer of the individual to another medical facility in accordance with EMTALA provisions.

CMS has developed a non-exclusive list of orthopedic conditions considered to be emergency medical conditions and subject to EMTALA:

Life or limb-threatening injury;
Extensive bone and soft tissue injury;
Vascular and/or nerve injury with open or closed wound;
Dislocated joint;
Infected/septic joint;
Tendon injury

The questions from the orthopedist and the ophthalmologist raise the issue of whether these two specialists are actually within the areas of their expertise in dealing with hand injuries or ophthalmologic injuries to minors. Neither should arbitrarily refuse to come in if called by an ED physician to at least evaluate the patient. If the patient's problem exceeds one's capabilities, it is usually good practice to check and see if another specialist capable of evaluating and treating such patients is available to come in. If it is determined that a patient has an emergency medical condition which the orthopedist, ophthalmologist or other physician does not feel capable of stabilizing or treating, a transfer to a facility with such expertise can be arranged pursuant to EMTALA guidelines. It is not a violation of EMTALA for an on-call physician to request an emergency physician to transfer a patient to another facility as long as there are legitimate medical reasons to do so; the transferring facility does not have back-up coverage available in the same specialty; the emergency physician concurs that the transfer is appropriate under the circumstances; and the transfer is carried out in accordance with EMTALA standards. In the meantime, it would be worthwhile checking to see if the medical staff bylaws or policies and

procedures address these concerns.

The question from the neurologist presents a different dilemma. Any on-call physician who refuses to accept a patient or refuses or fails to come to the hospital to consult or evaluate the patient when obligated to do so is in violation of EMTALA. The fact that the neurologist feels his or her presence is either redundant or unnecessary does not alter one's obligation to respond. EMTALA regulations require documentation in the patient chart of the name and address of any on-call physician who refuses to consult or examine a patient when called to do so. Therefore, even if a specialist feels his or her attendance is not necessary, that physician should normally respond to the emergency department when called to do so. The problem should be discussed with the chief of the ED to see if the inefficient practice of calling both neurologists and neurosurgeons can be modified or ended.

Obligation to treat patients referred from the ED

Q: I recently heard a rumor that to be re-credentialed at one of the hospitals where I have privileges, I will have to agree to see any and all patients who are referred to my office by the emergency department. I am aware that this cannot be required by EMTALA. Can the hospital enforce this by any other means?

A: You are correct that EMTALA does not require a physician to agree to see patients referred out of the ED. The question is whether or not the hospital can condition re-credentialing on such an agreement. One wonders why the hospital would want to do that or what advantage it perceives by making such an agreement part of re-credentialing. It may be that the hospital somehow perceives it will ultimately derive financial benefit by having some of these patients hospitalized if they need additional hospital care or perhaps its emergency department will become more popular if the hospital can represent to the public that staff physicians will accept all referrals out of the ED. To this end, the re-credentialing requirement could be viewed as "economic credentialing" which is currently a controversial issue. The AMA position is that medical staff credentialing processes should be related only to physician competency and the quality of patient care.

At the same time, hospitals have wide latitude in determining on what basis physicians will be allowed hospital privileges. Many hospitals are using staff privileges as a tool in realizing hospital goals, both from a patient care and business perspective. In a recent case, the South Dakota Supreme Court upheld a hospital's decision to deny staff privileges to an orthopedic surgeon who joined an orthopedic group which had built its own surgery center and was therefore in economic competition with the hospital itself. If re-credentialing at your hospital is really going to be conditioned upon an agreement to see any and all patients referred from the ED, you are essentially being forced to undertake care of patients you might not

otherwise treat. I suspect your physician colleagues would be as upset about such a requirement as you are but the hospital can attempt to place conditions on the granting of staff privileges. Your initial recourse should be to determine if the rumor is correct and marshal your colleagues to try to prevent such a requirement. In the meantime, carefully review any medical staff bylaws addressing credentialing or privileges. If denied renewal of privileges, there may be administrative recourse. Ultimately, legal action is possible, but such a course is expensive and time consuming.

MIEC's recommendations related to emergency department on-call coverage:

- If you are not already familiar with EMTALA and related state laws, contact your local medical association or specialty society for more detailed information about how it pertains to you.
- Know what you agreed to do when you obtained hospital privileges. If you are not familiar with current hospital by-laws, regulations, rules, and policies you agreed to uphold when you obtained privileges, refresh your memory in the context of on-call obligations, EMTALA requirements, and recent policy changes.
- Office-based physicians who are on-call for the ED and emergency physicians in the ED should establish comfortable relationships, working agreements, and effective communication with one another. On-call physicians should ensure that the ED physicians and relevant staff know the primary and secondary means by which to contact you.
- If you are called to see a patient in the ED, and you discover the patient is someone you have dismissed from your practice and do not want as a patient, inform the patient of the limitations of your relationship. You may wish to give the patient a brief written notice stating that the doctor-patient relationship is limited to resolution of the patient's emergent condition, and document that you gave the patient the notice: alternatively, you may orally inform the patient of the limitation and document that discussion in the ED/hospital chart. You may also return the patient to his or her physician, if the patient routinely sees a physician who is qualified and willing to manage the patient's follow-up care and the patient wishes to return to that physician.
- ED physicians should know which office-based physicians are accepting new patients, including new Medicare and/or Medicaid patients. When ED physicians refer patients to a physician who is accepting new patients for ED follow-up care, the ED staff should send the physician a copy of the main chart form, appropriate test results, aftercare instructions and other information that will facilitate follow-up care. If the documentation arrives, but the patient doesn't, the physician can return the information to the ED, where a decision will be made about subsequent action to be taken, if any.

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