



REPORTED CASES OF SPECIALISTS refusing to respond to requests to examine patients at hospital EDs impelled ACEP, the American Hospital Association and the American Society for Healthcare Risk Management to issue a "quality advisory" reminding members that failure to have an effective on-call physician arrangement violates EMTALA. The advisory also notes a number of states have laws similar to EMTALA that must also be followed strictly. **At a minimum,** hospitals must maintain a list of physi-

cians, including specialists, who are on call to treat patients in the ED. They are responsible for ensuring that on-call physicians respond within a reasonable time, and must have policies and procedures to handle situations when a particular specialist is not available or an on-call doctor cannot respond because of situations beyond his control. Also, staff bylaws or procedures must define the responsibility of on-call physicians to respond and treat patients with emergency medical conditions.

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A Letter from the Chair of the Board

Is There A Doctor in the House?

Dear Colleague:

When you assume the role of an "on-call" physician, you also assume certain legal duties and responsibilities that have been established in the law. This issue of the newsletter presents the law, and provides a thoughtful discussion for understanding your role in the on-call process and to aid in reducing your liability risk.

*D. Ted Lewers, M.D.
Chair of the Board*

Case Summary: A physician (Dr. A) agreed to take calls for a primary "on-call" doctor (Dr. B) while this doctor was out for the evening. Subsequently, a 69 year-old female arrived at the local emergency room at 7:00 p.m. complaining of abdominal pain and vomiting. She was seen by the emergency physician who believed the patient needed to be admitted and contacted the on-call physician for that evening (Dr. A). The on-call physician agreed to take on the patient and she was admitted at 10:00 p.m. with a diagnosis of cardiac and respiratory failure. The on-call physician was called 30 minutes later and advised that the patient was getting worse and that tests had been ordered. The E.R. physician was told to call the primary on-call physician (Dr. B) who had now returned home. The primary on-call physician was notified at 12 midnight and ordered a consult. The patient was never seen by the consulting physician. On the floor, the emergency physician ordered pain medications. The primary on-call physician (Dr. B) arrived at 6:00 a.m. the next morning. The patient died shortly after her arrival. Suit was filed against all physicians, including the consultant, for failure on the part of all to appropriately treat this patient and a failure of the on-call physician to examine the patient.

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The case raises a number of questions regarding on-call coverage by physicians starting with one of the most important:

- **What obligation does a physician have who agrees to serve on-call?**

Once a physician accepts on-call responsibilities, the physician must comply with federal and state emergency transfer laws and may be liable for any failure to do so. Unfortunately, Federal law is not very specific regarding on-call responsibilities. However, it does require that hospitals maintain a list of physicians who are on-call for emergency department consultation to provide treatment necessary to stabilize an individual with an emergency medical condition (42 U.S.C. § 1867(d)(2)(B)(C)). On-call physicians who are not present in the hospital at the time an emergency consultation request is made must respond by telephone within a reasonable period of time (usually ten to fifteen minutes). The on-call physician must then come to the hospital to care for the unstabilized patient within a "reasonable" time frame, which must be established in the hospital's by-laws or rules and regulations. Emergency department staff are required to record the time at which the initial call seeking on-call physician emergency consultation was made and the time at which the on-call physician responded by telephone as well as the time he or she arrived at the hospital to care for the patient. If the on-call physician fails to respond in a timely manner, (i.e., outside the time frames established within the hospital's by-laws), he or she may be cited by HCFA (Health Care Financing Act) and subject to termination from the Medicare and Medicaid programs and subject to a substantial fine.

If the on-call physician fails to respond or refuses to come into the hospital within the time-frame established in the hospital's by-laws under the stabilization requirement under the Act, the emergency physician is permitted to transfer the unstable patient to an appropriate accepting facility for stabilizing care. Under these circumstances, the emergency physician initiating the transfer is not subject to a HCFA citation. However, the transferring physician is required by law to identify on the transfer form the name of the on-call physician who failed to care for the patient. In addition, the receiving hospital must report the transfer to HCFA who will investigate the circumstances of the improper transfer. HCFA may then cite *both the transferring hospital and the on-call physician*, who failed to respond to the emergency request for consultation, (but HCFA may not cite the transferring emergency physician). HCFA's investigation will seek to identify a pattern of on-call physician refusals to stabilize the hospital's emergency patients. If a pattern of such refusals is substantiated, the penalties are quite substantial and include fines of up to \$50,000.00 against



the hospital and the on-call physician(s) for each violation (\$25,000 for hospitals under 100 beds) in addition to suspension from the Medicare program.

Patients who have been stabilized do not trigger the on-call physician provisions of the Act and on-call physicians are not required under the Act to respond to calls to treat stabilized patients. Although hospitals must provide an on-call panel of physicians available to respond to emergency calls for patient stabilization, there may be occasions when no on-call physician will be listed for a particular specialty. For example, a smaller hospital with only one neurosurgeon or only one plastic surgeon would not be required to place that one neurosurgeon or that one plastic surgeon on call 365 days out of the year. The hospital's by-laws must formally recognize such limitations in the capacity of its medical staff to provide on-call coverage and the on-call panel supplied to its emergency department for a given day must reflect what coverage is and is not available for that day.

It is vital that physicians who serve on-call whether voluntarily, as a condition of medical staff privileges, by contract or through any other mechanism, be acutely aware of their obligations and respond when called. It must be emphasized that even physicians who voluntarily serve on-call must fulfill their agreement.

It is also essential that physicians who serve on-call take steps to reduce their liability risk. For example, it may be advisable to institute a date and time specific roster of on-call coverage, such that there can be no questions as to which staff members are on-call and when. Because federal law requires hospitals to maintain a list of physicians who are on-call and to report those who do not respond when called, informal or ad hoc arrangements may not be appropriate. Hospitals and medical staffs unable to provide this coverage may be found to reduce their scope of services or eliminate their emergency departments altogether.

- **What if I don't get the page or I am busy with another patient?**

Keep in mind that under federal law, an on-call physician will be liable for fines of up to \$50,000 per offense if the failure to respond was "negligent." If the violation is also "gross and flagrant" or "repeated," the physician is also subject to exclusion from the Medicare and Medical Assistance program (42 USC §1395dd(d)(1)). No exception to the duty to respond are expressly recognized under the law. Moreover, because of the potential for abuse, the authorities are likely to take a dim view of cases in which the physician fails to respond because of reasons allegedly out of his or her control

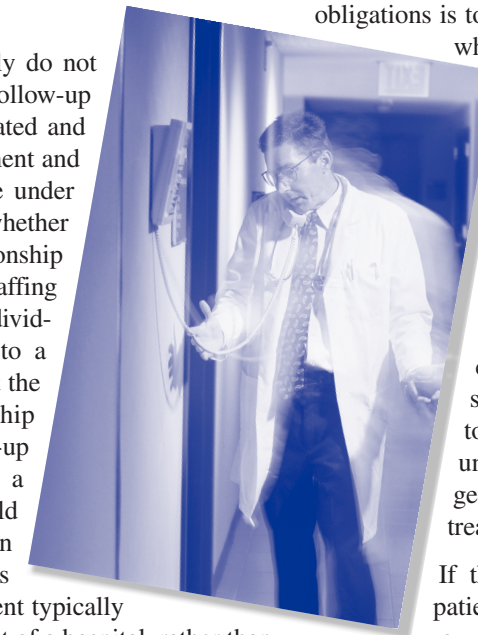
— such as a beeper malfunction or being caught in traffic. Where such problems occur, physicians would be wise to contact the emergency department as soon as possible, explain the problem, and document efforts made to respond and comply with on-call duties.

It is unclear how the law will apply with respect to availability of an on-call physician who, when called, is already treating another patient. If one of the physicians or patients develops an emergency condition during the physician's on-call shift, the physician has a duty to treat the patient or risk a charge of patient abandonment. Additionally, more than one patient from the same specialty may present to the emergency department in need of services. A telephone consultation may be adequate to stabilize the patient. However, sometimes telephone consent may not be possible or may not be sufficient.

Although there are strong agreements that physicians should not face liability for failure to respond because they were treating another patient, the law does not provide an express exception for this situation. Therefore, medical staff should, whenever practical, adopt policies and procedures designed to provide back-up on-call coverage. Physicians should also consider their on-call responsibilities when scheduling other patient care activities.

- **Who provides follow-up in an on-call situation? (Or, whose patient is it anyway?)**

The emergency transfer laws simply do not address the issue of provision of follow-up care to patients who have been treated and stabilized in the emergency department and then discharged. The primary issue under common law, therefore, will be whether the patient has established a relationship with the hospital, the physicians staffing the emergency department, or an individual on-call physician, giving rise to a patient's reasonable expectation that the party with whom the relationship is established will provide follow-up care. For those patients who have a regular physician, the patient should be returned to their regular physician for follow-up care and for referrals for specialty care. Because the patient typically presents to an emergency department of a hospital, rather than requesting the services of any given physician, it may be argued that the patient has established a relationship with the hospital, rather than with an individual physician. Under these circumstances, a court may find that the hospital owes a continuing duty to provide the patient with any follow-up care necessary for treatment of the condition which presented the emergency. Under such an analysis, the patient would return to the emergency department for any follow-up care. This would be true as well if the court were to find that the patient had established a relationship with physicians who were part of the emergency medical group staffing the emergency department.



With respect to whether the patient has established a relationship with any given on-call physician, the basic question is whether a general physician-patient relationship has been established or whether that relationship is limited to the stabilization of the patient. If a general physician-patient relationship has been established, the physician has a duty not to "abandon" the patient — that is, the physician has an ongoing responsibility to the patient to provide for necessary medical care until the relationship is terminated.

The courts are likely to view this situation from the standpoint of a reasonable patient. This means that the courts will look for evidence of what the patient might reasonably expect under the circumstances (i.e., whether the patient felt a physician-patient relationship had been established). Factors likely to be considered include whether the patient was transferred to another health facility, the communications between the patient, the physician, and other health facility personnel, the nature of the treatment, and the availability of alternative sources of follow-up care. Medical staffs are encouraged to work with their hospitals, county facilities and other sources of follow-up care to establish reasonable policies regarding this issue, that take into account all important factors and seek to ensure that communications to patients by physicians and hospital representatives are consistent.

The safest course for physicians who are unsure of their obligations is to (a) provide treatment, (b) inform the patient, while still in the emergency department or hospital, that the physician's care is limited to providing stabilizing treatment, and then (c) follow-up with a letter confirming that the relationship terminated when the patient left the hospital, and that the patient will need to find another source of care. It is also advisable for the medical staff and hospital to develop a standard list of sources of care which may be distributed to patients. In some communities, the local hospitals, medical staffs and medical societies have cooperated to fund and staff an outpatient clinic where unaligned patients who have received emergency department care may go for follow-up treatment.

If the emergency department's call relates to a patient of a physician you are covering for, then you would have a duty to respond by virtue of your agreement to cover for the other physician. In such a situation, you would also be subject to all the state and federal transfer laws.

The above provides a general understanding of how to handle "on-call" situations. However, there is uncertainty in the law. Physicians serving in on-call situations would be well advised to seek advice from legal counsel if they are uncertain as to their legal duties under particular circumstances.



CME Test Questions

Instructions for CME Participation

CME Accreditation Statement--MEDICAL MUTUAL Liability Insurance Society, which is affiliated with Professionals Advocate, is accredited by the Medical and Chirurgical Faculty of Maryland to sponsor continuing medical education programs for physicians. MEDICAL MUTUAL designates this educational activity for a maximum of one hour in Category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

Instructions--to receive credit, please follow these instructions:

1. Read the articles contained in the newsletter and then answer the test questions.
2. Mail or fax your completed answers for grading to the address or fax number provided below:
Med•Lantic Management Services, Inc.
P.O. Box 64100
Baltimore, MD 21298-9134
FAX (410) 785-2631

Upon completion, a certificate for the credit will be mailed to you. Please allow three weeks to receive your certificate.

3. Answer the evaluation questions to help improve future CME activities.

1. HCFA regulations do not apply to current hospital on-call situations.
A. True B. False
2. Hospitals and medical staff unable to provide on-call coverage may have to reduce their services.
A. True B. False
3. Hospitals need to provide on-call services for every specialty when required.
A. True B. False
4. Federal law expressly addresses all aspects of on-call care for patients.
A. True B. False
5. If you do not know what to do about an on-call situation your best recourse is to do nothing.
A. True B. False
6. Hospital by-laws may determine the timeframe within which an on-call physician must respond.
A. True B. False
7. When you provide treatment to a patient as an on-call physician, the doctor-patient relationship has been established.
A. True B. False
8. Hospitals are required by law to maintain a list of physicians serving in an on-call capacity.
A. True B. False
9. The doctor, not the hospital, will be cited by HCFA for refusing to respond to an on-call request.
A. True B. False
10. The on-call physician determines what constitutes a reasonable time to respond to a request to see a patient.
A. True B. False



CME Evaluation Form

Statement of Educational Purpose

"Doctors RX" is a newsletter sent bi-annually to the insured physicians of MEDICAL MUTUAL/Professionals Advocate. Its mission and educational purpose is to identify current health care related risk management issues and provide physicians with educational information that will enable them to reduce their malpractice liability risk.

Readers of the newsletter should be able to obtain the following educational objectives:

- 1) gain information on topics of particular importance to them as physicians,
- 2) assess the newsletter's value to them as practicing physicians, and
- 3) assess how this information may influence their own practices.

	Strongly Agree	Strongly Disagree
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Part I. Educational Value:

5 4 3 2 1

I learned something new that was important.

I verified some important information.

I plan to seek more information on this topic.

This information is likely to have an impact on my practice.

Part 2. Commitment to Change: What change(s) (if any) do you plan to make in your practice as a result of reading this newsletter?

Part 3. Statement of Completion: I attest to having completed the CME activity.

Signature: _____ Date: _____

Part 4. Identifying Information: Please PRINT legibly or type the following:

Name: _____ Telephone Number: _____

Address: _____
