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 physicians, 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.

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.

Continued on next page.
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 is required by 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. Hospitals may 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. Although physicians who are 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 staffs must also be required to record the time at which the initial call seeking on-call physician evaluation, 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 required 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 to the physician 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 refusal 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 physicians who are on-call 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 media 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 are strictly 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. This may ensure that the on-call physician receives a copy of the patient’s chart and are aware of the circumstances of the patient’s injury. In some hospitals, on-call physicians 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.

The on-call physician’s legal duties are limited to the following:

- **Who provides follow-up in an on-call situation?**

  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 room. A physician who is on-call, who is treating another patient, the law does not provide an 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?)**

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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 Medicaid Assistance program (42 U.S.C. 1395kk(k)(1)). So excepted 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.
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:
   MedLantic 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.

Part 1. Educational Value:

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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: ____________________________