# Hospitals' creative solutions ensure adequate ED coverage

"It's getting a little scary out there."

So says **Michael R. Callahan, Esq.,** a healthcare attorney at Katten Muchin Rosenman, LLP, in Chicago, who works frequently on hospital medical staff issues, in reference to the difficulties hospitals face trying to ensure the availability of specialists to provide emergency department (ED) coverage. Faced with a shortage of physicians willing to take call, hospitals are trying to find ways to enforce an obligation to take ED call without alienating the medical staff—mostly without success.

When hospitals make call coverage a condition of exercising certain privileges, they often find that physicians will voluntarily relinquish the privileges that carry an ED call obligation, Callahan says. Similarly, if the hospital requires active medical staff members to take call, some physicians may switch to courtesy or inactive staff membership status to avoid the obligation.

## Is taking call a duty?

Taking ED call has traditionally been an obligation of medical staff members and considered an integral part of the physician's duty to the hospital and to the community. In the past, many physicians had accepted the notion that in return for the use of the hospital facilities to provide medical services to their patients, the physicians would provide emergent care on some weekends and nights to patients who presented at the hospital's ED. Physicians used this obligation to their benefit to build a patient base among the population of emergent patients and garner referrals from colleagues.

However, as Callahan explains, many physicians have become fearful of the liability issues associated with treating emergent patients. Similarly, the health insurance market in the United States means that a disproportionate percentage of ED patients lack adequate health insurance, so treating them is a financial sacrifice for the physician. Finally, physicians' lifestyle expectations have changed—younger physicians are less willing to sacrifice personal time and family time to provide ED call coverage.

Despite these changes affecting the willingness of physicians to take ED call, most organizations' medical staff bylaws continue to require active members of the medical staff to adhere to their department's call schedule. Unfortunately, perhaps because historically the obligation to take ED call was assumed, many medical staff bylaws do not explicitly make medical staff membership contingent on a physician's willingness to participate in ED call, Callahan says. Although the realities of today's healthcare marketplace may force hospitals to provide some type of benefit to physicians who take ED call, Callahan advises hospitals to negotiate from a position of strength by ensuring that their medical staff bylaws

clearly require active members of the medical staff to participate in the call roster.

It is important to establish call coverage as a duty, Callahan says. "Some physicians are willing to take call because they want the revenue or are interested in expanding their practices. However, if the hospital ever excludes such physicians from the call roster—as it might if the hospital enters into a services agreement with a specialty group to provide call coverage—the excluded physician will have no legal argument to make if he or she has been relieved of a duty," he explains.

If the duty is not explicit, the excluded physician may attempt to argue that he or she has been denied the privilege of treating emergent patients and barred from benefiting from the revenue these patients generate. Although this is unlikely to be a winning argument in court, clearly establishing that ED call is a duty of medical staff membership may prevent the physician from making the argument in the first place and will drastically reduce the chances that a judge may find it persuasive, Callahan says.

## The role of EMTALA

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a federally mandated standard of practice for hospitals and physicians. It requires a hospital that participates in Medicare and treats emergent patients to assess the patient through a medical screening examination regardless of the patient's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with emergency medical conditions. EMTALA mandates that a hospital must transfer a patient if the hospital is unable to stabilize a patient, or if

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## Understanding EMTALA

Beyond credentialing and accreditation concerns, hospitals must ensure compliance with federal regulations. Congress, as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986. EMTALA is designed to prevent hospitals from refusing to treat patients or transferring them to charity hospitals or county hospitals due to patients' inability to pay for the care that they require.

According to a statement from the American College of Emergency Physicians, EMTALA has, in effect, designated emergency departments (ED) as America's healthcare safety net.

As part of the Medicare *Conditions of Participation,* CMS requires hospitals to provide consultative services to emergency patients when those services are routinely available in the hospital.

A hospital's ED on-call list must include every specialty for which physicians hold privileges in the hospital, unless too few physicians exist in a specialty to provide on-call coverage. CMS does not require a lone specialist to be on call at all times. In fact, there is no minimum number of physicians in a specialty that triggers the obligation to establish an on-call list for that specialty. The interpretation of whether or not the hospital is obligated to maintain an on-call list for a specialty is based on an assessment of whether the hospital has appropriately met the community need for that specialty. Specifically, the CMS *State Operations Manual* states that, "Each hospital has the discretion to maintain the on-call list in a manner to best meet the needs of its patients."

EMTALA does require hospitals to have a policy addressing how to care for emergency patients who need care when an appropriate specialist is unavailable. That policy could include a formal or informal transfer agreement with another facility.

EMTALA also requires that hospitals post in the ED a date-specific roster of physicians who take ED call. Once a physician agrees to have his or her name placed on the ED on-call roster, he or she is obligated to respond under EMTALA. However, legal obligation to respond is not triggered without such an agreement.

*Source:* Emergency Department On-Call Strategies: From Team Management to Compensation Plans, *published by HCPro, Inc., 2006.*

## ED coverage

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the patient requests a transfer. The burden of EMTALA compliance rests primarily with the hospital, as opposed to physicians, since it is usually the hospital that is fined or sanctioned for failure to comply.

Sanctions can include exclusion from the Medicare program if an emergent patient does not receive proper screening or stabilizing treatment. And if a hospital provides inpatient services that the patient requires, it must have appropriate staff available to arrange for, and provide, those services to the emergent patient, Callahan explains.

The risk of violating EMTALA increases if a hospital has insufficient emergency coverage, says **Kathryn Burnett**, an attorney at Tulsa, OK–based Conner & Winters, LLP, because providing the screening assessment and stabilizing treatment to certain patients may require specialist care. "Hospitals that cannot arrange for appropriate coverage may be unable to provide the level of treatment that EMTALA requires," she explains. Burnett also says if the hospital has made coverage arrangements, and the covering physician does not attend an emergent patient who requires the physician's services, the physician is also subject to fines and exclusion. Although rare, CMS has sanctioned individual physicians for failing to meet their obligation to take call.

### Compensating physicians for call coverage

"Many hospitals that have trouble finding physicians to cover ED call conclude that they must compensate physicians for making themselves available to cover emergent patients on nights and weekends," says Burnett. Once the hospital has decided that it will pay physicians for taking call, it must determine which variation of a number of compensation models will best meet its needs.

Burnett says that among her clients, many hospitals are choosing to enter into personal service agreements with specialists to provide ED call coverage. She says this is becoming more common among physicians on the hospital medical staff. Often, physicians will request that the hospital enter into a separate agreement that sets forth the physician's agreement to take call and arranges appropriate compensation.

**Jodi Knox**, an attorney at Winston-Salem, NC–based Womble Carlyle Sandridge and Rice, has clients who are taking a somewhat different approach. They are trying to establish a minimum call obligation in which each medical staff member must be available for emergency call. Any physician willing to take additional days of call will receive compensation.

Implementing this system will require each department to establish its minimum call threshold, depending on the number of specialists available in that department. Knox says deciding what the minimum call obligation threshold should be is proving difficult.

Knox also represents hospitals that do not compensate for call, but do reimburse physicians for seeing emergent, indigent patients, as long as the physician agrees to do the following:

- Provide a minimum amount of uncompensated emergency care each month
- Complete medical records and the CMS 1500 form
- Not bill the patient
- In some cases, provide medically appropriate follow-up care

In return, the hospital will reimburse the physician for services rendered in accordance with EMTALA, if the patient is indigent according to its charity care criteria. Reimbursement is provided at the Medicaid rate. In this way, the hospital is compensating the physician for providing treatment that would have been paid by the patient's insurer if the patient had insurance.

### Communicate and cooperate

Burnett says even when hospitals pay physicians to take call, there is sometimes a discrepancy between the two parties' expectations.

She says hospitals and physicians should discuss their expectations candidly prior to entering into a coverage agreement.

For example, if the hospital believes that the physician should remain on the premises while on call, or should come to the hospital whenever he or she is called, the negotiation and agreement should make that expectation clear.

Similarly, if the physician expects that the coverage agreement requires only that he or she remain available by telephone, within a reasonable distance of the hospital, and unimpaired, the physician should also make that expectation explicit.

Finally, Burnett notes the importance of communication between the hospital administration and the medical staff leadership. She says sometimes the hospital executives and the medical executive committee will each be working in isolation to produce a plan to solve the hospital's emergency coverage dilemma. In such cases, the two resulting plans are often different, and an opportunity to reach a workable and fair resolution may be lost.

"A cooperative effort between hospital administrators, medical staff leaders, and specialists with coverage challenges is critical to ensure that the hospital meets its patient care obligations," Burnett says. ■

## Legal precedent and ED call

The struggle to secure emergency department (ED) coverage originates from many sources: rising ED patient volume, issues surrounding managed care, increasing liability, shortages of various specialists, physician practice and lifestyle changes, and legal and regulatory issues that hospitals and physicians face.

### Legal mandates

When discussing ED coverage, many healthcare practitioners and industry experts point to growing legal concerns as one of the biggest obstacles hindering physician participation in on-call panels. Unfortunately, these legal concerns are not unfounded.

**Precedent:** A young athlete breaks his leg during a high school football game. He is brought to the local hospital ED, where a general practitioner who is serving his turn in staffing the department evaluates the fracture and casts the leg. The patient is admitted and, during his hospital stay, complains of leg pain. The general practitioner, who has not treated a fracture in over three years, does not request a consultation. Two weeks later, the patient is transferred to another facility, where his leg is amputated due to the onset of gangrene.

You probably recognize this case as *Darling v. Charleston Community Memorial Hospital,* 1965.

This landmark case acknowledged a hospital's independent duty to patients, particularly in the areas of selection and performance of independent medical staff members. The case also set an important precedent regarding hospital liability for treatment provided in the ED.

**Precedent:** In *Joiner v. Mitchell County Hospital Authority, et al.,* 1971, a patient seen in the ED for chest pain was sent home, where he died less than two hours later.

The patient's family sought to impose liability on the hospital for negligence in permitting the treating physician to serve on its medical staff. The Georgia Supreme Court rejected the hospital's contention that it was not liable because it delegated its authority to screen medical staff applicants to existing medical staff members.

The court found that the medical staff had acted as an agent for the hospital in screening applicants. The court viewed the hospital's failure to appropriately screen the treating physician as an independent act of negligence.

Clearly, hospitals have an obligation to their patients to carefully select competent practitioners and monitor both the quality and the timeliness of the care they provide. This obligation extends to granting only privileges in which the provider has demonstrated competency.

Nowhere is this need more evident than for services offered within a facility's ED.

*Source:* Emergency Department On-Call Strategies: From Team Management to Compensation Plans, *published by HCPro, Inc., 2006.*

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