

## The Ophthalmologist's Role in Emergency Care: On-Call and Follow-up Duties Under EMTALA

### Purpose of risk management recommendations

OMIC regularly analyzes its claims experience to determine loss prevention measures that our insured ophthalmologists can take to reduce the likelihood of professional liability lawsuits. OMIC policyholders are not required to implement risk management recommendations. Rather, physicians should use their professional judgment in determining the applicability of a given recommendation to their particular patients and practice situation. These loss prevention documents may refer to clinical care guidelines such as the American Academy of Ophthalmology's *Preferred Practice Patterns*, peer-reviewed articles, or to federal or state laws and regulations. However, our risk management recommendations do not constitute the standard of care nor do they provide legal advice. Consult an attorney if legal advice is desired or needed. Information contained here is not intended to be a modification of the terms and conditions of the OMIC professional and limited office premises liability insurance policy. Please refer to the OMIC policy for these terms and conditions.

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"The Ophthalmologist's Role in Emergency Care" focuses on on-call and follow-up duties. It is designed as a companion piece for "EMTALA: An Overview for Ophthalmologists," which provides information on the basic obligations hospitals and physicians have under EMTALA<sup>1</sup> (available online in the "Risk Management Recommendations" section at [www.omic.com](http://www.omic.com)). The EMTALA regulations contain many defined terms. Ophthalmologists should be careful to distinguish between their usual understanding of these terms (e.g., *emergency medical condition*) and the legal definition given in the EMTALA regulations. Words with special legal meaning are placed in *italics* and explained as necessary. For ease of use, this discussion is organized in a question and answer format and contains legal information from attorneys with special expertise in this arena. At times, the legal situation is not clear. In those instances, ophthalmologists should exercise their medical judgment and prioritize patient safety.

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<sup>1</sup> Published in draft form in 1988, the interim final regulations were filed in 1994. The statute was amended in 2000, but some of those changes were repealed in the 2003 amendments. The Center for Medicare and Medicaid Services (CMS) published Interpretive Guidelines in 1996, which were revised in 1998 and 2004, as well as Special Advisory Bulletins. The EMTALA statute is found in the United States Code Title 42 Section 1395dd, and the regulations are in the Code of Federal Regulations Title 42 Sections 413.65(g), 482.12, 489.20, and 489.24. The Interpretive Guidelines are in the *Medicare State Operations Manual*, and available at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap\\_v\\_emerg.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_v_emerg.pdf).

While this document analyzes a physician’s responsibilities under EMTALA, there may also be state laws or regulations governing emergency room care and on-call responsibilities, as well as duties imposed by hospital medical staff by-laws or HMO contracts. Ophthalmologists should verify their understanding of these other laws and regulations.

## **1. WHAT TYPE OF ON-CALL COVERAGE DOES EMTALA MANDATE?**

### **Do I have to serve on call?**

No. You are not required to serve on call under EMTALA, but the hospital where you have privileges may have on-call responsibilities which it can only meet through its medical staff. It may, therefore, require call as a condition of obtaining privileges, since, under EMTALA, a hospital with a dedicated ED must “maintain a list of physicians who are on call to come to the hospital to provide treatment necessary to stabilize an individual with an emergency medical condition” (M. Steven Lipton, *A Guide to Patient Anti-Dumping Laws*, California Hospital Association, 2004, page 111; page numbers in parentheses refer to this publication).

### **Do I have to serve a certain number of days per month?**

Not under EMTALA. However, the hospital and its medical staff must decide how to meet the hospital’s on-call responsibilities and may set such rules. The regulations stipulate that the on-call list must meet the needs of emergency patients in accordance with the resources available to the hospital, including the availability of on-call physicians (111). CMS does not require every medical and surgical specialty on the medical staff to have a call schedule or to be on call at all times (112). There are no set requirements on how frequently physicians must be on call. Coverage may be full- or part-time (112-113).

## 2. WHEN IS A PHYSICIAN CONSIDERED TO BE ON CALL TO THE ED?

### **Am I on call?**

Have you agreed to serve on-call to this hospital?

- YES.
  - Are you on the on-call roster for today?
    - If YES, you are on call.
      - A physician is considered to be on call when she is listed on the on-call roster of the ED for a particular day (115). Once a physician has agreed to serve on call to the hospital, she must abide by the EMTALA laws and regulations. If called by the ED physician, the physician must respond within a reasonable amount of time. The time should be stated in the hospital policies (116). See the next section for your duties.
    - If NO, you are not on call.
      - When one is not on-call (i.e., when a physician's name does not appear on the list for a particular day), that doctor has no legal duty under EMTALA to accept consultations or referrals from the ED.
- NO.
  - You are not on call.
    - If you have not agreed to serve on-call to that hospital, you have no duties under EMTALA, and therefore, you have no obligation to answer calls from the hospital ED.

### **I am not on call, but I received a call anyway from the ED physician. What should I do?**

Inform the ED physician "I do not take call at your hospital/I am not on call today. Please call the ophthalmologist on-call for today."

## 3. WHAT MUST A HOSPITAL DO IF NO ON CALL PHYSICIAN IS AVAILABLE?

### **When I inform the ED physician that I am not on-call, he says that there is no ophthalmologist available to his hospital. Does that mean I have to help?**

No, but you are free to do so if you want. If you do not have privileges at the hospital, however, you will be limited to providing telephone consultations. You are liable for any negligence in your telephone evaluation or treatment recommendations. Carefully screen the patient's history and complaints, and document the information received and given, as well as your diagnosis, treatment recommendations, and follow-up plan. Keep a copy of the documentation in an "ER Advice" folder for ten years.

As for the hospital, it must have written policies and procedures for handling emergency patients when a particular specialty is not available (113) or "the on-call specialist cannot respond due to circumstances beyond his or her control (such as attending other emergency

patients)” (114). In other words, each hospital is required to have a back-up plan, which usually involves transferring the patient to a hospital with the capability and capacity to accept the patient. If you are not on call and do not want to offer your services, inform the ED physician “I appreciate your situation, but am not on-call at your hospital. If you have no on-call ophthalmologist, follow your hospital’s back-up plan. This may mean that you have to transfer the patient to another facility.” See below for a discussion of what to do if you are not available while on call.

#### 4. DUTIES WHILE ON-CALL

##### **I terminated a patient from my practice. Do I have to treat this patient if asked to do so by the ED physician?**

Yes. You cannot refuse to treat a patient when serving on-call. “Physicians who serve on call must provide emergency services without regard to a person’s race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, economic status or ability to pay, except where age, sex, pre-existing medical condition or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient” (111).

In the case of a patient whom you have terminated from your practice, inform the patient that your care is limited to providing care in the Emergency Room. Inform the ED physician of the situation so that alternative outpatient follow-up care can be found. Document both disclosures.

##### **The ED physician insisted that I come to the hospital to treat a patient who I felt could be safely treated by the ED, discharged, and sent to me for outpatient follow-up. Who gets to decide?**

The on-site treating physician has the primary responsibility for making patient-care decisions (47). If there is a disagreement between the treating physician in the ED and the on-call physician about the need to come to the hospital, the Center for Medicare and Medicaid (CMS) has indicated that the dispute “must be resolved by deferring to the medical judgment of the emergency physician or other practitioner who has personally examined the individual and is currently treating the individual” (116). Therefore, if asked to come to the ED, you should do so.

##### **One of the hospitals where I am on call doesn’t have the ophthalmic equipment necessary to treat certain conditions. Can I ask the ER physician to send the patient to my private office instead?**

Only if the ED physician has determined that the patient is *stable for discharge*. As defined in the CMS Interpretive Guidelines (IG), “an individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an in-patient, provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions” (80; see section on follow-up care, below).

If the ED physician has determined that the patient is *stable for discharge*, EMTALA no longer applies, so you may see the patient in your office. If the patient has an *emergency medical condition* but is not *stable for discharge*, you must treat the patient in the hospital within the capability and capacity of the facility (48).

If the patient needs treatment that cannot be provided at that facility, you will need to transfer the patient to a hospital that can provide it. There are four components to an *appropriate transfer*: 1) the transferring hospital provides medical treatment within its capacity to minimize the risks to the individual's health; 2) the receiving hospital has available space, qualified personnel, and has agreed to accept the patient and provide treatment; 3) the transferring hospital sends medical records, including treatment records, written informed consent, and the name and address of any on-call physician who refused or failed to appear within a reasonable time to provide necessary stabilizing treatment, and 4) the transfer is effected using proper personnel and equipment, and necessary and medically appropriate life-support measures (82-83).

**The ophthalmologists at a local hospital refuse to take call, and patients from that ER are routinely transferred to the hospital where I am on call. Do I have to treat these patients?**

Yes, if it is medically appropriate to do so. This occurs when the hospital has the duty to accept an emergency transfer (i.e., if it has the capability and capacity), you are on call, AND contacted about the patient (*California Physician's Legal Manual*, 14:53; hereafter, referred to as CPLH).

## 5. CLARIFICATION OF LIMITS OF ON-CALL DUTIES

**What kind of care may I provide to my own patients while I am on call?**

A physician may visit her own patients in the hospital without being considered to be on call (117). She may also maintain office hours and perform other professional duties. Unless the hospital is considered a critical access hospital, the doctor may also perform elective surgery while on call, as long as she and the hospital have a back-up plan.

**Question 11. Can I serve on call to more than one hospital?**

Yes. The physician may provide simultaneous coverage at more than one hospital, provided that each hospital has written policies and procedures to address when the on-call physician is not available. Examples of these procedures include having back-up call or making an appropriate transfer in accordance with EMTALA standards (118). If you are treating a patient in one ED, be sure to notify the other hospitals when you are unavailable, and again when you are free to take calls. Document these notifications.

## 6. POST-DISCHARGE CARE

### **Under EMTALA, who is responsible for follow-up care?**

EMTALA stipulates that the hospital must provide the patient with “a plan for appropriate follow-up care as part of the discharge instructions” (80). The Interpretive Guidelines clarify that the hospital is “‘expected within reason’ to assist or provide discharged patients with the necessary information to secure follow-up care in order to prevent relapse or deterioration of the medical condition” (80). The plan should include resources that are geographically and financially accessible to the patient. If the patient is “not aligned with a local physician or the hospital does not arrange follow-up care, the hospital should consider giving the patient instructions to return to the hospital for follow-up services if the patient is unable to find a physician or a provider” (80).

### **If I am on call to the ED, does EMTALA require me to provide post-discharge care?**

Your responsibility as a physician for post-discharge care is not discussed in the EMTALA statutes or interpretive guidelines (CPLH 14:53). To complicate the situation further, the hospital’s EMTALA obligations end when a physician or qualified medical person decides that there is no emergency medical condition (although the underlying medical condition may persist), or that the emergency medical condition still exists but the patient is appropriately transferred or admitted to the hospital for further stabilizing treatment (CPLH 14:53).

EMTALA, therefore, does not mandate who must provide the post-discharge services, nor stipulate that the hospital must ensure that follow-up care is obtained. Thus it is not clear under EMTALA whether or not physicians have a duty to provide post-discharge care for emergency patients. Moreover, once the ED physician has determined that the patient either has no “emergency medical condition” or is “stable for discharge,” the hospital has no further obligation, and EMTALA no longer applies to the physician or the hospital. Remember, however, that once you have cared for the patient either in person or over the phone, some plaintiff attorneys will argue that a physician-patient relationship has been established and you may have liability exposure (see below).

### **Does serving as an on-call physician create a physician-patient relationship that would require me to provide post-discharge care and expose me to professional liability?**

It might. The legal theory of professional negligence is based upon the duties that arise from the physician-patient relationship. When it comes to serving on-call to the ED, it is not always clear if a physician-patient relationship has been established that would impose an ongoing duty to the patient, as the on-call physician’s involvement may include personally examining and treating the patient, speaking only to the ED physician, having his or her name appear on the discharge instructions, being the on-call physician for that day, or simply being part of an on-call panel. Moreover, even if a physician-patient relationship was established, the relationship may be limited to providing stabilizing treatment in the ED rather than obliging the physician to provide ongoing care (CPLH 14: 54).

Patients may reasonably assume, however, that if you provide emergency care and tell the patient of the need for ophthalmic follow-up care, you will provide it. The same is true if the ED tells a patient for whom you provided a telephone consult to follow up with you, or if your name appears on the discharge instructions. As noted above, EMTALA does not address the role of the on-call physician in follow-up care. You will be judged, therefore, on the standard of care as interpreted by the laws governing medical malpractice and patient abandonment in your state.

If you do not intend to provide post-discharge care, you need to take certain steps. Be sure to inform the ED physician and hospital that you will not provide the follow-up care, so that they can identify alternative sources of care and thus fulfill the hospital's EMTALA duty. Provide the *stabilizing* treatment in the ED, and document the care and follow-up recommendations. Inform the patient, while still in the ED, that your care is limited to providing *stabilizing* treatment, and that the ED will provide the patient with the name of an available ophthalmologist. Document the discussion. OMIC policyholders who need help determining their relationship and duties are encouraged to call our Risk Management Department.

**One of my patients was seen in the ER. Do I have a duty to provide post-discharge care?**

Yes. If you have a preexisting physician-patient relationship with the individual, you should assume that you are responsible for outpatient follow-up care whether or not you were on call. Obtain the ED record so that you know what care was provided.

**A patient I have never seen before was discharged from the ED. I was not on call the day he was seen. Do I have to provide follow-up care?**

No. As noted above, the hospital and ED physician are obligated under EMTALA to attempt to find available care for the patient. Be sure to check your medical staff by-laws and contracts with HMOs, however, to be sure they do not impose a follow-up duty.

If you do not want to provide post-discharge care to patients seen when you are not on call, inform the Medical Director of the ED and the Chief of Medicine/Surgery of the hospital orally and in writing. Once you have clearly indicated that you are not available, they should not refer patients to you. Contact the ED and Chief of Staff in writing each time you are referred such a patient.

**If I accept patients for post-discharge care, and they don't make or show up for their appointment, do I have any follow-up duties?**

You and the patient both face risks in this situation if the patient does not receive the appropriate care. Your name may very well appear in the ER record and on the discharge instructions. A plaintiff attorney will likely argue that you have a duty to follow up on this patient; the defense attorney may respond that there was no relationship and that the patient was noncompliant.

Consider these actions to help decrease your liability exposure and promote patient safety:

- To avoid the problem of having all patients seen for eye conditions in the ED referred to you, help write policies indicating that only patients needing follow-up care are referred to you.
- Ask in writing that the ED fax you the ED record of all patients referred to you for post-ED follow-up. It is essential that you be given the patient's name, address, and phone number.
- Notify your staff of the type of appointment that should be scheduled, so that your office can follow-up in the event of a no-show.
- Follow-up on missed appointments. Ask you staff to notify you of no-shows. Have them place one call to the patient. If they cannot reach the patient, send a [No-show letter](#).

**The ED referred a patient to me for post-discharge care. When she presented to my office, my staff learned that she has an insurance plan that we do not accept. When they offered to help her make a payment plan, the patient left without being seen. Can I ask patients to pay for post-discharge care? If they won't pay, do I have to see them?**

Your office staff may follow normal protocol with new patients referred for outpatient care, including those referred by the ED. In most practices, this protocol includes determining insurance coverage and informing the patient of charges and financial responsibilities. Patients who have no coverage should be told that you are available to care for them. Many practices allow patients to make payment plans. Offering such help can refute allegations of abandonment.

Patients have the right to refuse treatment, whether for financial or other reasons. Patients who leave without being seen or who decline fee-based services when making the appointment should be reminded of the need for proper follow-up. See the sample [Refusal of care letter](#).

**Need confidential risk management assistance?**

OMIC-insured ophthalmologists, optometrists, and practices are invited to contact OMIC's Risk Management Department at (800) 562-6642, option 4, or at [riskmanagement@omic.com](mailto:riskmanagement@omic.com).



This sample letter is provided as a guideline only **and should be modified according to the situation. Be sure to place a copy of the letter in your "On-call" File.** If you do not give this to the patient personally, and the patient's condition warrants a certified letter, send it both certified and through the regular mail. Place the letter and the signed return receipt in the On-call File. Copy the Emergency Department physician.

**SAMPLE LETTER: NO-SHOW**

(On Physician's Letterhead)

**CERTIFIED MAIL-RETURN RECEIPT REQUESTED**

(Date)

Dear (Patient):

As you know, Dr. (name) of (name) Hospital's Emergency Department referred you to me. I am an ophthalmologist (eye physician and surgeon). The physician in the Emergency Department diagnosed you with an eye condition. This condition could get worse without care. You could lose vision or go blind.

Please make an appointment right away with an ophthalmologist. You may contact your insurance company for ophthalmologists in our area who accept your insurance. Or you could call my office to reschedule an appointment.

Sincerely,

(Physician's Signature & Name)

cc: (name of ED physician)

This sample letter is provided as a guideline only **and should be modified according to the situation. Be sure to place a copy of the letter in your "On-call" File.** If you do not give this to the patient personally, and the patient's condition warrants a certified letter, send it both certified and through the regular mail. Place the letter and the signed return receipt in the On-call File. Copy the Emergency Department physician.

### **SAMPLE LETTER: REFUSAL OF CARE**

(On Physician's Letterhead)

#### **CERTIFIED MAIL-RETURN RECEIPT REQUESTED**

(Date)

Dear (Patient):

As you know, Dr. (name) of (name) Hospital's Emergency Department referred you to me for post-discharge care. When you called/came to my office, we learned that we do not accept your insurance/that you have no insurance. My staff informed you that I am available to care for you and offered to help you make a payment plan but you left without being seen/were not willing to do so.

Continued care is essential to the health of your eyes. The physician in the Emergency Department diagnosed you with an eye condition which may worsen without proper care. Permanent damage may occur, resulting in visual loss or blindness. Kindly realize this letter is not meant to alarm you, but to encourage you to take proper care of your eye condition.

Please contact your insurance company or the Emergency Department for the names of other ophthalmologists in our area who accept your insurance and are available for care.

Sincerely,

(Physician's Signature & Name)

cc: (name of ED physician)