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OMIC DIGEST

ER Call: Another Layer of EMTALA Liability

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Fans of the hit television series, *ER*, are familiar with this scenario: a patient is rushed to the ER in need of life-saving treatment but the specialist on call, be it an OB/GYN or CT surgeon, fails to answer the ER's page. Drs. Weaver, Carter, and Company are then charged with cracking chests, doing stat sections, and taking other heroic measures to stabilize the patient—all in one entertaining hour, including commercials.

Even Hollywood knows that transferring an unstable patient is against the law. That federal mandate, the Emergency Medical Treatment and Active Labor Act (EMTALA), is part of the Comprehensive Omnibus Budget Reconciliation Act (COBRA) passed by Congress in 1986. This well-intentioned piece of legislation was enacted to discourage hospitals from turning away patients based on their ability to pay. Widening legal interpretation of EMTALA provisions has created a host of accountability and risk management issues for physicians who provide emergency room coverage.

Under EMTALA, any patient who presents to a hospital ER must be afforded an "appropriate medical screening examination to determine the presence of any emergency medical condition." EMTALA defines emergency medical condition as one in which "the absence of immediate medical attention would…result in placing the person's health in serious jeopardy, cause serious impairment to bodily functions or cause serious dysfunction to any bodily organ or part."[1] An appropriate medical screening examination need satisfy only two elements to be compliant with EMTALA standards: (1) it should be reasonably expected to identify an emergency medical condition; and (2) it need be directed only at the signs and symptoms described by the patient or identified by the physician—NOT signs and symptoms the physician is not made aware of or might otherwise overlook.[2]

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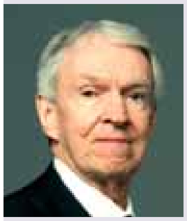
MESSAGE FROM THE CHAIRMAN



One of the measures of a company's success is the strength and continuity of its leadership. OMIC is the only insurance carrier governed by a Board of Directors and Committees composed entirely of ophthalmologists who understand both the practice of ophthalmology and the challenges of modern day medicine. At the end of this year, we say goodbye to two long-time OMIC supporters who will complete their final terms as directors: Bruce E. Spivey, MD, and B. Thomas Hutchinson, MD. These two distinguished leaders in ophthalmology have helped OMIC attain its high level of achievement and recognition in the health care and insurance industries.

No one was more instrumental in bringing to fruition the visionary plan that became OMIC than Bruce Spivey. As executive vice president of the American Academy of Ophthalmology in 1987, Dr. Spivey put the Academy's resources behind the creation of a freestanding independent professional liability insurance carrier

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If the ER physician determines that an emergency medical condition exists (or cannot be ruled out), he or she may refer the patient to the appropriate physician on call for evaluation and management. The on-call physician is not only obligated to answer a page in a "timely fashion" (the definition of which is usually buried in one's medical staff bylaws) but to evaluate the patient in the ER if requested to do so by the ER physician. The on-call physician must never try to talk the ER doctor out of a request to evaluate the patient. It may sound like the most routine, unequivocal case of conjunctivitis to you over the phone at one o'clock in the morning, but if the ER doctor asks you to come in, you must do so. (By the way, in the real world, those on-call OB/GYN and CT surgeons who failed to respond to their pagers in the *ER* episode would be subject to EMTALA fines of up to $50,000 each.)

Appropriate Patient Transfers

So you leave your daughter's piano recital to see a patient in the ER. You diagnose an open globe with vitreous presenting at the wound—a qualifying emergency medical condition. But the hospital's vitrector is being repaired and there is no surgical eye team available. What should you do? If the hospital's facilities or ancillary staff are inadequate to treat a patient with an emergency medical condition, a transfer must be effected.

Since EMTALA was enacted to prevent indiscriminate transfer of patients to other facilities, one would expect strict guidelines on what constitutes an acceptable transfer. Federal law defines an appropriate transfer as one in which: (1) the patient has been treated within the capacity of the transferring hospital, thereby minimizing the risks of transfer; (2) a hospital with the space and personnel to care for the patient has been identified and has agreed to the transfer; (3) all records are sent, including informed consent, the transferring doctor's certification that transfer is in the best interest of the patient, and, if applicable, the name and address of any on-call physician who refused or failed to evaluate the patient; and (4) qualified personnel, equipment, and transportation are utilized to effect the transfer.

Under most state laws, hospitals that are legally obligated to provide emergency care are also obligated to accept a patient transferred from another facility. Not as widely recognized, however, is an EMTALA provision affectionately known as the "snitch rule." This whistleblower statute obligates the receiving hospital to report any inappropriate transfers to federal authorities. Failure to report such an infraction may invoke the same penalties for the receiving hospital (fines of up to $50,000 and exclusion from Medicare) as are levied on the hospital that initiated the transfer.

While this covers the primary areas of EMTALA's impact on ER call physicians, there are many gray areas not addressed by its statutes (see **Frequently Asked Questions About ER Call** and this issue's **Risk Management Hotline**, which elaborates on follow-up duties). As legal interpretations and provisions vary from state to state and hospital to hospital, OMIC recommends that ophthalmologists seek the counsel of their hospital medical staff office or our risk management department for further guidance.

1. 42 C.F.R. §489.24(b)
2. Reynolds v. Maine General Health 1st Cir, 2000 218F.3d78.

Frequently Asked Questions About ER Call

Q: Do I have to take call at my local hospital if most of my cases are handled in an ASC?

A: It depends. Federal laws do not mandate taking calls, but whether you volunteer, take call as a requirement of medical staff bylaws, or independently contract your services to an ER, once you enter into a formal agreement to provide emergency coverage, you must comply with EMTALA regulations. Some ophthalmologists need hospital privileges as a condition of being a provider in a managed care contract and end up with call coverage as a result of those privileges.

Q: My hospital's ER is poorly equipped to evaluate and manage eye emergencies. Do I have to come in if I know the patient will be transferred anyway?

A: Yes. You are still obligated to stabilize the patient within the available capabilities of the hospital's staff and facilities. Once the risks of transfer have been minimized and if you determine that the benefits of transfer outweigh the risks on an unstable patient, you must effect a transfer. Later, you may want to discuss with your department chair or the ER department the need for adequate equipment to properly evaluate and manage common eye emergencies.

Q: I'm on call during a busy clinic day and get called to see a patient in the ER. Wouldn't it be easier to have the patient come to my office for an evaluation?

A: Yes, but only easier for you. The ER doctor is asking you to come

in to see the patient and, instead, you are proposing that the patient come to your office solely for your convenience. If the patient deteriorates enroute, you will effectively have authorized, by phone, an inappropriate transfer under EMTALA laws. If, however, the ER doctor determines that no emergency medical condition exists, then the patient can be safely discharged from the ER to follow up in your office.

Q: I am an oculoplastics specialist. Do I have to come in for a retinal detachment?

A: Yes. Staff bylaws may spell out the scope of your clinical privileges and expertise, but if you take call, it is assumed that you are capable of evaluating ocular problems even if you're not qualified to treat them. Again, your job as an on-call doctor is to stabilize the patient and arrange appropriate consultation as needed. Some hospitals arrange call schedules so that various subspecialists provide back-up coverage. If a patient must be transferred to another facility, document that the benefits of a transfer outweigh the risks.

Q: The ER doctor calls and tells me a patient has conjunctivitis and, while I don’t need to come in, the ER doctor wants the patient to follow up in my office. The patient presents the next day with a corneal ulcer, not conjunctivitis. Am I in violation of EMTALA laws?

A: No. If you were not asked to come in, the ER doctor is effectively saying that he or she has ruled out (albeit incorrectly) an emergency medical condition based on a screening examination. Case law generally holds that a hospital and its ER physicians are not in violation of EMTALA for failing to treat an emergency medical condition if the facts demonstrate the hospital had no knowledge of the condition despite an appropriate screening examination. The ER doctor still may be liable for failure to diagnose and delay in treatment under regular malpractice laws, however, and such situations may expose the ophthalmologist to malpractice claims. Thus, it is critical to properly document and retain a record of your discussion with the ER doctor.

Q: If I am called in to treat a patient emergently, do I have to provide follow-up care?

A: The emergency transfer laws do not address the issue of follow-up care to patients who have been treated and stabilized in the ER and then discharged. However, a common law duty to the patient may arise since, arguably, a doctor-patient relationship is established by your treatment of the patient in the ER, giving rise to the expectation by that patient that you will provide follow-up care. You should consult your medical staff bylaws, as some specifically address this issue. Some bylaws establish a duty and require the on-call physician to see the patient in follow up and throughout the course of the illness that brought the patient to the ER.

Q: A patient is evaluated and treated in the ER while I'm on call but no one notifies me. The ER doctor discharges the patient to follow up with me the next day. Am I required to see this patient?

A: Not from an EMTALA standpoint. While there would be no EMTALA violation since the patient was presumably stabilized and discharged by the ER, your medical staff bylaws may require you to see the patient. When in doubt, you should accept a patient who presents to your office if the patient was treated in the ER while you were on call. Work with your hospital to establish a protocol for follow-up care.

Q: The ER doctor calls me one night and based on his or her description, I decide to wait to see the patient in my office the next morning. Is this an EMTALA violation?

A: It depends. If the ER doctor asks you to see the patient, you must do so when called, not the next morning. If the ER doctor feels the patient is stabilized and can wait until the next morning and the patient's condition deteriorates because of the delay, the primary malpractice liability rests with the ER doctor. (EMTALA does not apply in this case because the patient was discharged in stable condition.) If the ER doctor cannot rule out an emergency medical condition, you as the on-call specialist cannot do so over the phone, as an appropriate medical screening exam has not technically been performed. As always, it is critical to document your discussion with the ER doctor.

Q: It's bad enough that I can be fined by the federal government for EMTALA violations. Can I be sued by the patient too?

A: The federal government may fine both hospitals and individual physicians for EMTALA violations. Additionally, a patient may sue a hospital for EMTALA infractions. A patient may NOT sue a physician for breaking EMTALA laws. However, any doctor or hospital providing emergency room care is subject to civil claims of negligence and medical malpractice.