On-Call Emergency Care Issue Revives Debate

BY JENNIFER SILVERMAN
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WASHINGTON — On-call emergency care dominated the agenda at the inaugural meeting of the Department of Health and Human Services technical advisory group on the Emergency Medical Treatment and Labor Act.

EMTALA, enacted in 1986 to ensure public access to emergency services regardless of ability to pay, requires hospitals to maintain a list of physicians who are on call to the emergency department. Hospitals have the discretion to maintain these lists in a manner that "best meets the needs" of the hospital's patients.

The Medicare Modernization Act of 2003 required HHS to establish a technical advisory group to review EMTALA regulation.

While the obligation to provide the on-call list falls on the hospital, physicians assume new liability and other obligations once they agree to take on-call responsibilities, Charlotte Yeh, M.D., an emergency physician and advisory group member, said in an interview.

Hospitals cannot force physicians to be on call, although individual hospital policies may require on-call services as a condition for having privileges, she said. "Factor in issues such as reimbursement, and the physician is asking himself: Why should I do this? And that's how physicians get into the EMTALA debate."

Hospital groups who testified before the advisory group said their emergency care was suffering because of physicians' unwillingness to provide on-call services.

"It has become increasingly difficult for hospitals to manage their on-call rosters in a manner that best meets the needs of their patients because of their trouble filling on-call slots," said Jeff Micklos, vice president and general counsel for the Federation of American Hospitals.

"Also, there no longer is any certainty that an on-call physician will report for duty when called," he said. Physicians say that economic, medical practice, and lifestyle considerations affect their desire and ability to provide on-call coverage. As a result, they'll either refuse to be on call, or want to be paid ever-increasing fees, "which adds to EMTALA's practical effect as an unfunded mandate for hospitals," Mr. Micklos said.

Physician-owned specialty hospitals, already a volatile issue, have exacerbated the on-call issue, said Mary Beth Savary Taylor, who spoke on behalf of the American Hospital Association. "Physicians who own limited-service hospitals often refuse to participate in emergency on-call duty at community hospitals, leaving them struggling to maintain [emergency department] specialty coverage."

Hospitals are at a disadvantage, as they can be terminated from Medicare and Medicaid for any kind of noncompliance under EMTALA, whereas physicians are terminated only in cases where the violation is "gross, flagrant, and repeated," Ms. Taylor said. To provide hospitals with some type of due process, the Centers for Medicare and Medicaid Services should revise its regulations to establish an administrator-level appeals process—before a CMS regional office issues a finding of noncompliance and public notice of termination, she said.

Leslie Norwalk, CMS deputy administrator, told advisory group members that the agency could issue guidelines to hospitals on how they could protect themselves from lawsuits. "We'd like to help so courts will not punish [hospitals] for doing the right thing," she said.

Mr. Micklos asserted that the statute's obligations should apply equally to hospitals and physicians, noting that a hospital "can only can be as good as the physicians on its medical staff."

EMTALA states that on-call coverage is a joint decision between hospital administrators and physicians who provide on-call coverage, said Jason W. Nascone, M.D., who testified on behalf of the American Association of Orthopaedic Surgeons and the Orthopaedic Trauma Association.

"But it is unrealistic to expect physicians to work together with hospitals in developing and implementing on-call plans if physicians aren't included as equal partners with more authority, oversight and control, in the development and implementation of these plans," Dr. Nascone said.

Interpretive guidelines developed to clarify hospitals' EMTALA responsibilities should be amended to further encourage true partnership arrangements between hospitals and physicians, Dr. Nascone said.

Physician groups urged CMS to adopt an affirmative rule prohibiting hospitals from requiring physicians to provide 24-7 emergency call coverage.

"We support the rule that physicians are not required to be on call at all times, but we fear that this provision doesn't go far enough to protect on-call physicians from nevertheless being required by hospitals to provide continuous emergency on-call coverage," Alex B. Valadka, M.D., who spoke on behalf of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons, testified.

Physicians also had concerns about a provision requiring response time to be stated in "minutes." The advisory group should recommend modifications that such response times could be stated in a range of minutes, Dr. Valadka said. "Exceptions should be explicitly permitted in situations when the on-call physician cannot respond within the stated time frame because of circumstances beyond his or her control." ■

West Virginia Sees Malpractice Improvement After Reform

BY MARY ELLEN SCHNEIDER
Senior Writer

The malpractice environment may be starting to improve for emergency physicians in West Virginia 2 years after a comprehensive medical liability reform bill was enacted in the state.

"It's probably too early to see a huge improvement," said Frederick Blum, M.D., president-elect of the American College of Emergency Physicians. "But the signs are encouraging."

The first signs are coming from the insurance industry. Loss ratios for medical liability carriers have improved since the reform legislation was passed in 2003, according to a report from the state's insurance commissioner. The percentage of medical liability insurance premiums spent on claims and expenses in the state fell from 134.6% in 2002 to 128.5% in 2003. Ratios above 100% indicate that the insurer has an underwriting loss.

The 2003 law established a $250,000 cap on noneconomic damages and set an overall cap of $500,000 on economic and noneconomic damages for injuries sustained at trauma centers. The law also strengthened the qualifications required of an expert witness.

Within weeks of the passage of the law, physicians stopped talking about leaving the state, said Steven Summer, president of the West Virginia Hospital Association. "Retention changed almost overnight."

And the malpractice insurance market has become more predictable, he said. The next piece will be a reduction in premiums for physicians, he said.

There has been a slight uptick in the number of emergency physicians practicing in the state, according to the West Virginia Board of Medicine. In 2003, 178 physicians licensed in the state designated their specialty as emergency medicine. By the end of 2004, that figure had risen to 188 physicians.

But physicians aren't out of the woods yet, said Dr. Blum of West Virginia University, Morgantown.

The law is already under attack by plaintiffs' lawyers, who are trying to have the reform declared unconstitutional by the courts. But physicians got a boost last year when a state Supreme Court justice hostile to medical liability reform lost his bid for reelection. ■