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EMTALA: requirements for on-call physicians

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Over the past several years, hospitals have found it increasingly difficult to secure specialists to treat patients in the emergency department (ED). Numerous studies and surveys have documented the limited availability of on-call specialists, and recent research has linked these shortages to adverse patient outcomes. [1] Two-thirds of ED directors in Level I and II trauma centers say that more than half of all patient transfers they receive occur as a result of lack of timely access to specialists at the transferring hospital. [2] A Sentinel Event Alert issued by the Joint Commission found that 21% of patient deaths or permanent injuries related to ED treatment delays were attributed to lack of availability of specialists. [3] The specialists who are the most difficult to secure include orthopedic surgeons, neurosurgeons, plastic surgeons, trauma surgeons, hand surgeons, ob-gyns, neurologists, ophthalmologists, and dermatologists. [1]

"'Crisis' may often be overused, but it properly describes the concern about the ability of patients to access the level of care needed to meet their needs. As the call panels of hospitals erode, the safety net goes with it." [4]

While there are many reasons for the on-call physician shortage, many observers believe that the current crisis has been exacerbated by the law that firmly established the "safety net" more than 20 years ago—EMTALA. Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986 in response to widespread reports that hospital EDs were transferring uninsured and indigent patients to public hospitals, a practice also known as dumping. "Since its passage in 1986, EMTALA has provided an unfunded safety net program for everyone using the nation's emergency departments. Demand for emergency care continues to grow by 5 million visits each year on average to more than 144 million in 2003, up from 90 million visits in 1993, while capacity continues to decrease, which is stretching resources to the breaking point." [2]

Though EMTALA primarily requires hospitals that receive federal funds to perform certain acts, the law also applies to physicians who are on-call for the ED. On-call physicians who fail or refuse to respond to the ED within a reasonable time after notification are subject to fines of up to $50,000 per violation.

This article will discuss the obligations of physicians who are on-call for the ED and how they can avoid violating federal law. This article is not intended to be a comprehensive discussion of EMTALA, but an abbreviated summary of physician obligations under the law. For detailed information on EMTALA and how it applies where you practice, please review your hospital's medical staff bylaws, rules and regulations, or policies and procedures.

EMTALA defined

EMTALA imposes two major requirements on hospitals that operate EDs and accept Medicare reim-

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bursement. First, if an individual comes to the ED and requests examination or treatment for a medical condition, the hospital must provide an appropriate medical screening examination to determine if an emergency medical condition exists. Second, if the individual is found to have an emergency medical condition, the hospital must stabilize the medical condition, within the capabilities of the hospital, or transfer the individual to another hospital. As a third requirement under EMTALA, hospitals with specialized capabilities (such as burn units or trauma centers) are obligated to accept patient transfers unless the acceptance would exceed the hospital's capability and capacity for providing care. [5]

Each of the following phrases has a specific meaning under the law.

An "appropriate medical screening examination" is an examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists." [5]

An "emergency medical condition" is "(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
(ii) serious impairment to bodily functions, or
(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child." [5]

Under EMTALA, "stabilize" means "medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or with respect to a pregnant woman, to delivery (including the placenta)." [5]

Neither the screening examination nor any necessary stabilizing treatment may be delayed to inquire into the patient's method of payment or insurance status. [5]

Transfers

EMTALA also governs patient transfers from one hospital to another. Once it is determined that the patient has an emergency medical condition, transfers are restricted unless:

- the individual (or a person acting on the individual's behalf) requests a transfer in writing after being informed of the hospital's obligations under EMTALA and the risks of the transfer;
- a physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from treatment at another facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child;
- if a physician is not present in the ED, a qualified medical person has signed the certification after consultation with a physician and the physician determines the benefits of the transfer outweigh the increased risks, and the physician subsequently counter-signs the certification. [5]

A transfer made under the above exceptions must also meet requirements for an appropriate transfer. These include:

- the transferring hospital provides treatment within its capacity to minimize the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;
- the receiving hospital has space and qualified personnel to treat the individual, and has agreed to accept transfer of the individual;
- the transferring hospital must send all pertinent medical records available at the time of transfer;
- the transfer is effected through qualified personnel and transport equipment; and
- the transferring hospital must also send the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. [5]

EMTALA also spells out obligations for the acceptance of transfer patients. Hospitals with specialized capabilities (such as burn units, shock-trauma units, neonatal intensive care units) "shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual." [5]

Hospitals may legitimately refuse a patient transfer only if the hospital is clearly unable to provide the necessary care, such as if there are no ICU beds. [6]

"EMTALA duties are discharged when the patient is admitted, a screening examination has been provided with a determination that an emergency medical condition does not exist, when the emergency medical condition is stabilized, or when an appropriate transfer is made." [7]

Maintenance of on-call lists

For years, EMTALA requirements regarding on-call physicians have caused confusion and contention among hospitals and physicians. Many physicians have come to view EMTALA as a "mandate to provide around-the-clock coverage to the ED." [8] However, it should be noted that EMTALA does not directly mandate that physicians take call. EMTALA places this burden on hospitals, as each hospital is required to maintain a list of physicians who are on call. "Physicians accept on-call responsibility according to medical staff bylaws and department rules and regulations. The provision of on-call physicians is the responsibility of the hospital—not of the emergency physicians." [9]

In 2003, the Centers for Medicare and Medicaid Services (CMS) issued clarifications of EMTALA related to on-call coverage. [10] The clarifications stated that:

• "Each hospital has the discretion to maintain the on-call list in a manner to best meet the needs of its patients."

• "Physicians, including specialists and subspecialists (e.g., neurologists) are not required to be on-call at all times. The hospital must have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control."

• "CMS does not require that a hospital's medical staff provide coverage 24 hours/day 365 days/year. If there comes a particular time that a hospital does not have on-call coverage for a particular specialty, that hospital lacks capacity to treat patients needing that specialty service and it is therefore appropriate to transfer the patient because the medical benefits of transfer outweigh the risks."

• "A determination about whether a hospital is in compliance with these regulations must be based on the facts in each individual case. CMS will consider all relevant factors, including the number of physicians on staff, other demands on these physicians, the frequency with which the hospital's patients typically require services of on-call physicians, and the provisions the hospital has made for situations in which a physician in the specialty is not available or the on-call physician is unable to respond." [10]

The clarifications also stated that physicians can schedule elective surgery while they are on call and that physicians can be on call simultaneously at more than one hospital in the community. "The hospital must have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control. The policies and procedures a hospital adopts to meet its EMTALA obligation are at the hospital's discretion, so long as they meet the needs of the patients who present for emergency care." [10]

While affording hospitals flexibility in maintaining their on-call lists, CMS also stated their intention to enforce the on-call mandate. "We will continue to investigate such situations in response to complaints and will take appropriate action if the level of on-call coverage is unacceptably low." [11]

Physician obligations under EMTALA

Response

Physicians who are listed on a hospital's on-call list have specific duties under EMTALA. These physicians must respond to the ED when requested to help determine if a patient has an emergency medical condition or to help stabilize a patient with an emergency medical condition unless circumstances beyond the physician's control prevent a response. Physicians who do not respond have violated EMTALA and may be subject to sanctions. [5, 9, 12]

"When an on-call physician's obligations are triggered is determined by the emergency physician. The law also requires the on-call physician to respond within a 'reasonable period of time.' Again, the emergency physician decides what is reasonable." [9]

Arranging and certifying transfers

Physicians responsible for transferring the patient must discuss the case with the receiving hospital's authorized representative and obtain agreement to accept the patient. Transferring physicians must also "certify" that the medical benefits of the transfer outweigh the risks to the patient. The physician must actually weigh the risks and benefits and some hospitals require the physician to describe those risks and benefits on the transfer certificate. [5, 9, 12]

"A physician responsible for the examination, treatment, or transfer of patients must not sign a certification for transfer that the physician knows or should know is not for an appropriate transfer or misrepresent the patient's condition or other information (including a hospital's EMTALA obligations) in general. A physician who executes a certificate authorizing transfer certifying that the risks of transfer are outweighed by the benefits without actually engaging in any meaningful analysis of the risks and benefits of treatment versus transfer may find himself or herself subject to the statutorily authorized penalties." [7]

Accepting transfers

"When on call, a physician is acting as the hospital's agent and must accept appropriate transfers whenever the hospital is required to accept them regardless of the effect on the physician's private practice. Out of state, out of county, no insurance, wrong managed care plan, closer to another hospital, not my patient, busy in the office, big day of elective surgery tomorrow—these and all other nonmedical reasons are absolutely no excuse to refuse a patient in transfer." [6]

Additionally, on-call physicians, who may be on-call at another hospital simultaneously, must not request that a patient be transferred to another hospital for the physician's convenience. [6]

Common questions regarding EMTALA obligations

I disagree with the emergency physician and I do not think that I need to see the patient. Do I still have to go to the ED?

Disagreements may sometimes occur about the patient's condition or the need for the on-call physician to come to the hospital. In these situations, CMS states "We also believe any disagreement between the two [emergency physician and the on-call physician] regarding the need for an on-call physician to come to the hospital and examine the individual 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." [13]

"Disputes sometimes arise as to the need to appear and can be avoided, to some extent, through the use of protocols developed and approved by the medical staff. However, on-call physicians should note the absolute nature of the statute's language in regard to sanctions when a physician at the hospital requests the on-call physician's appearance." [7]

Can I ask the emergency physician to send the patient to my office rather than going to the ED?

CMS interpretive guidelines for EMTALA state that it is not acceptable to refer emergency cases to physicians' offices for examination and treatment. "Any time an emergency physician needs an on-call specialist to help determine if an individual has an EMC or to help

stabilize an EMC, the physician must do so in the emergency department or the hospital." [6]

There are exceptions to the rule. A patient can be transferred to a physician's office if the physicians' office has specialized equipment and capability that the transferring hospital does not have. "For example, ophthalmologists routinely have better equipment in their offices that is necessary for examining a patient to determine if an EMC is present. Movement to the office in such a case becomes a medically indicated transfer to a higher level of care than the hospital can provide." As such, the EMTALA rules governing the transfer of patients apply. [6]

It is important to note that the CMS rule about treatment in the ED only applies to patients who have emergency medical conditions and are unstable. "It is standard practice in most hospitals for the emergency physician to splint a displaced fracture and send the patient to the on-call orthopedic surgeon's office for reduction and further treatment. . . If the emergency physician 'stabilizes' the fracture, EMTALA no longer applies. Thus, it is reasonable to send patients to the orthopedist's office for further treatment as long as they are legally stable at the time of discharge from the emergency department. Whether the patient is stable to go to the orthopedist's office depends solely on the judgment of the examining emergency physician." [6]

Does EMTALA require that I accept a patient in my office who was referred to me by the ED for follow-up care even though I was NOT called into the ED to examine or treat the patient.

Once a patient no longer has an emergency medical condition or is stable when discharged from the ED, EMTALA no longer applies. Therefore, in this situation, EMTALA does not extend to the on-call physician's office. [7]

Follow up outside the hospital is not an EMTALA issue, but is instead a hospital bylaw or protocol issue. Most often, hospitals define the responsibilities of on-call physicians with regard to follow-up care of patients seen in the ED. "The failure to provide follow-up care may be a violation of the terms of hospital privileges and the hospital may take adverse action against the physician. So there is risk to the physician in regard to staff privileges and general medical liability for refusing to treat a person referred by emergency room physicians, but those risks are not a result of EMTALA obligations." [7]

Physicians can determine their specific responsibilities for providing follow up care by reviewing the medical staff bylaws and medical staff rules and regulations for the hospitals where they maintain privileges.

After I treat the patient in the ED, what are my obligations?

Once the patient's condition is stabilized or the patient is transferred, the on-call physician's EMTALA obligation ends. [6] However, the physician may still have obligations to provide follow-up care or risk allegations of patient abandonment. "In general, the physician must see the patient for follow up until he or she is stabilized from the event. For example, an orthopedic surgeon who is on-call in the ED and sees a patient with a broken leg must care for the patient through that acute episode. In this example, the orthopedic surgeon is only obligated to treat the patient for the broken leg and generally would not have to treat the patient for any unrelated condition. Again, physicians are encouraged to review the terms of their medical staff bylaws and medical staff rules and regulations to determine their specific responsibilities for follow up." [14]

I am on-call for the ED and the physician called me to come and treat a patient who has been dismissed from my practice. Do I have to treat the patient?

EMTALA applies in this situation and the on-call physician must treat the patient in the ED. [14] "When this happens, we recommend that the physician send a follow-up letter to the patient saying that though the patient was treated in an emergency situation, the physician-patient relationship remains terminated," says Jane Holeman, vice president of risk management for TMLT.

I am the only neurologist in town. Am I required to be on call all the time?

According to the EMTALA clarifications released in 2003, physicians are not required to provide 24-hour ED coverage. "Each hospital has the discretion to maintain the on-call list in a manner to best meet the needs of its patients. Physicians, including specialists and subspecialists (e.g., neurologists) are not required to be on-call at all times. The hospital must have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control. If there comes a particular time that a hospital does not have on-call coverage for a particular specialty, that hospital lacks capacity to treat patients needing that specialty service and it is therefore appropriate to transfer the patient because the medical benefits of transfer outweigh the risks." [10]

Penalties

The CMS and the Office of Inspector General (OIG) jointly enforce EMTALA. "Each agency performs a distinct function: CMS has the power to terminate the Medicare participation of a noncompliant hospital or physician, while the OIG's punitive 'stick' is its authority to assess civil monetary penalties." [15]

A hospital that fails to meet the obligations under EMTALA is subject to a civil monetary penalty of up to $50,000 per violation (or not more than $25,000 if the hospital has less than 100 beds) and may have its Medicare provider agreement terminated. [5]

Physicians who violate EMTALA are also subject to a civil monetary penalty of up to $50,000 for each violation and may be excluded from participating in Medicare or Medicaid programs for repeated violations or violations that are "gross" and "flagrant." [5] Recall that physicians including both the ED and the on-call physicians can violate EMTALA by:

- failing or refusing to respond within a reasonable period of time to the ED when called to provide a medical screening examination or stabilize the patient;
- signing a transfer certification stating that the medical benefits of the transfer outweigh the risks if the physician knew or should have known that the benefits did not outweigh the risks; or

EMTALA case study

The following case study describes the application of EMTALA to a clinical situation. The events in this case took place in late 1986, and this was the first case in which a physician was fined for violating EMTALA. [17]

Presentation

A pregnant woman arrived in the emergency department (ED) at Hospital A at 4 p.m. She was at or near term with her sixth child. She was experiencing one-minute, moderate contractions every three minutes and her membranes had ruptured. Two obstetrical nurses examined the patient and found she was in labor and had high blood pressure. The patient had received no prenatal care, did not have a physician, and did not have health insurance.

Physician action

The obstetrical nurse called Ob-gyn A, who was on-call to treat unassigned obstetrics patients. When Ob-gyn A was told of the patient's history and condition, he told the nurse that he "didn't want to take care of this lady." He asked the nurse to prepare the patient for transfer to Hospital B, which was 170 miles away. Ob-gyn A said he would call back in five to 10 minutes.

The obstetrical nurses told the nursing supervisor and hospital administrator of their belief that it would be unsafe to transfer the patient. When Ob-gyn A called back, the nurse told him that according to hospital regulations and federal law, Ob-gyn A would have to examine the patient and arrange for Hospital B to receive her before she could be legally transferred. The nurse also asked for permission to start magnesium sulfate. Ob-gyn A told the nurse to begin administering the medication only if the patient could be transported by ambulance.

Ob-gyn A arrived at 4:50 p.m. and examined the patient. The examination revealed that the patient had ruptured membranes, was dilated 3 cm, and the fetus was "smaller than usual."

Her blood pressure was 210/130 mm Hg and the physician was concerned the patient had been hypertensive throughout her pregnancy. He arranged for the patient's transfer to Hospital B, which was better equipped to handle any complications that might occur as a result of the mother's hypertension. The nurse was ordered to begin magnesium sulfate and have the patient transferred by ambulance.

At 5 p.m., the nurse showed Ob-gyn A the hospital's EMTALA guidelines, but he refused to read them. He told the nurse that the patient represented more risk than he was willing to accept from a malpractice standpoint. The nurse explained that the patient could not be transferred unless Ob-gyn A signed a hospital form titled "Physician's Certificate Authorizing Transfer." Ob-gyn A signed the form, but did not complete the certificate. He told the nurse that until the hospital "pays my malpractice insurance, I will pick and choose those patients that I want to treat."

Ob-gyn A went to care for another unassigned patient and the nurses arranged for the transfer. The patient's blood pressure was 173/105 mm Hg at 5:30 p.m.; 178/103 mm Hg at 5:45 p.m.; 186/107 at 6 p.m.; and 190/110 mm Hg at 6:50 p.m. At 6:50 p.m., the patient was wheeled to the ambulance. Ob-gyn A did not re-examine her before she was taken to the ambulance and he did not order any medication or life support equipment for the patient during transfer. An obstetrical nurse and two emergency medical technicians accompanied the patient.

Approximately 40 miles into the 170-mile trip to Hospital B, the nurse delivered the baby in the ambulance. She directed the driver to a nearby hospital to obtain pitocin. While at that hospital, the delivering nurse called Ob-gyn A, who ordered her to continue to Hospital B despite the birth. In accordance with the patient's wishes, the ambulance returned her to Hospital A where Ob-gyn A refused to treat her. He ordered that the patient be discharged if she was stable and not bleeding excessively. Another ob-gyn examined and admitted the patient. Three days later, the patient and her baby were discharged in good health.

Legal implications

As a result of the events in this case, HHS determined that Ob-gyn A violated EMTALA by ordering a woman with hypertension and in active labor with ruptured membranes transferred from the ED of one hospital to the ED of another hospital 170 miles away. The physician was assessed a penalty of $25,000. Ob-Gyn A appealed the decision, claiming that the patient received all the care that she was due under EMTALA because he stabilized her hypertension sufficiently for transfer and she was not in active labor when she left the hospital in the ambulance.

An administrative law judge (ALJ) upheld the fine but reduced it to $20,000. The HHS appeals board affirmed the ALJ and the United States Court of Appeals for the Fifth Circuit affirmed the HHS appeals board decision.

Based on a review of the expert testimony heard by the ALJ and the appeals board, the court found that the record showed "substantive, if not conclusive evidence" that the patient's hypertension was an "emergency medical condition" as defined by EMTALA. Therefore, the patient required stabilization before transfer. The court found that the evidence supported the determination that Ob-gyn A did not provide stabilizing treatment and violated EMTALA.

The court also focused on Ob-gyn A's decision to authorize the transfer. Accordingly, there were two reasons why the transfer was inappropriate. First, Ob-gyn A did not weigh the risks and benefits of the transfer, making the decision to transfer inappropriate. "Every reasonable adult, let alone physician, understands that labor evolves to delivery, that high blood pressure is dangerous, and that the desirability of transferring a patient with these conditions could well change over a two-hour period. [The physician's] indifference to [the patient's] condition for the two hours after he conducted his single examination demonstrates not that he unreasonably weighed the medical risks and benefits of transfer, but that he never made such a judgment." [17]

The second reason the transfer was considered inappropriate was because the accompanying personnel were only fully qualified to deliver the baby in the absence of complications. The nurses and EMTs were not qualified to perform a cesarean delivery or treat other complications from the patient's hypertension that could have developed. Additionally, Ob-gyn A did not order a fetal heart monitor or other specialized neonatal equipment for the ambulance. [17]

• misrepresenting a patient's condition or other information, including a hospital's obligations under EMTALA. [5,7]

Under EMTALA, if a patient is transferred because an on-call physician failed to respond, the hospital must send the name and address of that on-call physician to the receiving hospital. [5] "Failure to provide this information is itself a violation of EMTALA by both the hospital and the transferring emergency physician." [7] In cases where an on-call physician fails to respond to the ED when called, OIG typically fines both the hospital and the physician. [7]

"The standard for imposing monetary penalties is ordinary negligence. There does not have to be improper motive, and the patient does not have to have suffered harm." [9]

In addition to fines from the federal government, "any person who is harmed as a direct result of a hospital violation of EMTALA may sue the hospital for damages available under the state's personal injury and malpractice laws. Only hospitals, not physicians, can be sued for damages under EMTALA, and hospitals are directly liable, not vicariously liable, for its physicians' actions." [9]

"Physicians must recognize that violating EMTALA may lead to a number of other investigations or potential sanctions against them by state peer review organizations, state licensure boards, state health care programs, or the local Medicare intermediary. These may threaten a physician's ability to practice medicine or to bill government health care programs in that state." [6]

The case study on page 5 describes a situation in which an on-call physician was fined for violating EMTALA.

Risk management considerations

The following risk management considerations may help on-call physicians minimize the risk of violating federal EMTALA rules.

Respond timely when contacted by the ED. Remember that the on-call physician's EMTALA duty is triggered by the emergency physician. "Frequently telephone consultation is sufficient to resolve an emergency physician's concerns. The on-call physician must appear only when actually requested to appear." [6]

Make sure your pager or cell phone works. There may be some areas of the hospital where your cell phone cannot receive calls. Be aware of these areas and make alternate arrangements so you can be contacted when working in these areas.

The ED physician has the "final word" on what is considered an emergency medical condition, if a patient is stable, and which specialist needs to see the patient. [6] "Deferring to the judgment of the ED physician who has actually seen and examined the patient is a prudent risk management technique," says Holeman.

Make sure you understand who is doing what. If after speaking with the ED physician and the two of you jointly decide on a plan of action for the patient, be clear about who will carry out the plan. Will the ED physician order the MRI and then call you with the results or should you call back to get them? If the ED physician agreed to observe the patient in the ED, make sure he or she understands when and under what conditions to contact you if the patient's clinical situation changes. Is the ED physician going to have the on-call internal medicine physician admit the patient or do you need to admit the patient? Be clear and explicit.

Document the discussions with the ED physician. Lack of documentation can make it difficult to determine what was said during conversations between ED and on-call physicians. Discrepancies can occur and to avoid them it is recommended that on-call physicians document these conversations.

Know the "excuses that don't work" that could subject you to an EMTALA fine and civil liability. These excuses include: "My practice is full. I'm not taking new patients." "I don't accept Medicaid." or "I don't participate in that patient's PPO." "I don't take patients from outside of the county or from out of state." "I don't accept illegal immigrants." [6]

Be familiar with your hospital's medical staff bylaws and the conditions of your hospital privileges. These may spell out your obligations to provide follow-up care to patients seen in the hospital's ED.

If you ask to see a patient in your office instead of going to the ED and the ED physician agrees with this plan, treat the patient as agreed. There have been situations in which a specialist agreed to treat a stabilized ED patient in the office, but then refused to treat the patient for economic reasons when he or she came for care. Though EMTALA may not apply in this situation because the patient is stable, from a risk management standpoint, this is not a good practice. "By agreeing to see the patient and then refusing when the patient arrives, the physician may open the door to allegations of patient abandonment or medical liability in the event of a bad outcome," says Holeman.

Conclusion

Though it has been in place for more than 20 years, EMTALA and the many obligations it creates continue to cause confusion. The 2003 clarifications were designed to alleviate some of this confusion, but . . . "the impact of the EMTALA amendment on the supply of and access to on-call specialists is not clear. Many believe that access to on-call specialists has worsened as a result. But others argue that the amendment has been beneficial. Had CMS not loosened on-call requirements, they argue, more specialists might have refused to take call in the ED altogether." [17]

A number of different strategies to alleviate the on-call crisis have been proposed. These include mandatory on-call requirements for hospital staff credentialing and privileges, compensating physicians for taking call, professional liability relief for care provided under EMTALA, and universal reimbursement for EMTALA-mandated care. [4]

In 2005, CMS convened a technical advisory group to study EMTALA. "The advisory group focused on incremental modifications to EMTALA, but also

envisioned a fundamental rethinking of EMTALA that would support development of regionalized emergency systems. A new EMTALA would continue to protect patients from discrimination in treatment, while enabling and encouraging communities to test innovations in emergency care design." [18] In a 2006 report, the Institute of Medicine also recommended regionalizing on-call services. [19]

The current shortage of on-call specialists is a serious and complicated issue and a simple solution is not likely to be forthcoming. "The on-call issue is very complex, highly politically and economically charged, and EMTALA is only one issue driving the diminishing provision of on-call services by our nation's physician specialists. The uncompensated care burden, malpractice liability issues, difficulties in obtaining payment from managed care entities, and lifestyle issues are probably much more compelling reasons physicians avoid emergency department on-call services." [20]

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