REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-09)
Emergency Room Contracts and Hospital Privileges
(Resolution 806, I-08)
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2008 Interim Meeting, the House of Delegates referred Resolution 806, introduced by the Florida Delegation, which calls for the AMA to "develop guidelines for contractual arrangements between physicians and hospitals regarding emergency room call and reaffirm the rights of physicians not to sign such contracts and not take call if they choose; …monitor and oppose any legislation that mandates emergency room coverage as a requirement for medical staff privileges and state licensure; …and adopt as policy the position that hospital medical staff bylaws not contain any provision that mandates emergency room call as a condition of medical staff privileges." The Board of Trustees referred this item to the Council on Medical Service for a report back to the House at the 2009 Interim Meeting.

This report provides background on the challenges of mandated on-call coverage for physicians, summarizes relevant AMA policy and guidance on contractual arrangements between physicians and hospitals, reviews options for providing on-call coverage, discusses concerns related to Resolution 806 (I-08), and presents recommendations to encourage physicians and hospitals to work collaboratively to meet the emergency care needs of their communities.

The Council believes that previously established AMA principles for physician on-call coverage for emergency departments continue to be relevant. Council on Medical Service Report 3-I-99, "On-Call Physicians," and Board of Trustees Report 29-A-00, "On-Call Physicians Task Force," shared the conclusion that it is highly unlikely that one solution to the on-call coverage problem will universally apply to every situation and every market.

The goal of referred Resolution 806 (I-08) is to protect physicians from unreasonable demands to provide emergency services, which is a goal that should be balanced with the societal need for adequate coverage for emergency services. Onerous on-call schedules are not consistent with providing efficient and high quality care, and the AMA urges physicians or physician groups that believe they are being coerced into specific employment arrangements to contact the AMA/State Medical Society Litigation Center, their state medical association, and/or legal counsel. At the same time, the Council strongly believes that every health care facility and the medical staff should jointly share the responsibility to provide needed emergency and transfer services. Among its recommendations, the Council encourages physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring mandatory on-call requirements.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-09

Subject: Emergency Room Contracts and Hospital Privileges (Resolution 806, I-08)

Presented by: Barbara L. McAneny, MD, Chair

Referred to: Reference Committee J (William J. Holt, MD, Chair)

At the 2008 Interim Meeting, the House of Delegates referred Resolution 806, introduced by the Florida Delegation, which calls for the AMA to "develop guidelines for contractual arrangements between physicians and hospitals regarding emergency room call and reaffirm the rights of physicians not to sign such contracts and not take call if they choose; …monitor and oppose any legislation that mandates emergency room coverage as a requirement for medical staff privileges and state licensure; …and adopt as policy the position that hospital medical staff bylaws not contain any provision that mandates emergency room call as a condition of medical staff privileges." The Board of Trustees referred this item to the Council on Medical Service for a report back to the House at the 2009 Interim Meeting.

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BACKGROUND

Access to specialists across national emergency departments (EDs) has deteriorated. In 2005, 73% of EDs reported inadequate on-call coverage by specialist physicians, as compared to 66% in 2004 (American College of Emergency Physicians [ACEP], 2006). In the past 10 years, the number of patients accessing EDs has increased 30% (PriceWaterhouseCoopers [PwC] Consumer Access Survey, 2009).

Several factors have contributed to insufficient ED call coverage, including inadequate payment, a shortage of specialists, increasing demand for ED services, changing physician practice and lifestyle interests, legal concerns, and changes in regulatory rules. Hospitals once were the foundation for developing a private practice and provided physicians an incentive to provide on-call service. More recently, the increase in office-based procedures has led to a decreased dependence on hospital admitting privileges. Physicians sometimes receive little or no payment for being on-call, although the ED is a high-risk liability environment because of the seriousness of cases presenting and the lack of a pre-existing patient-physician relationships. In addition, many physicians desire more flexible work schedules so they can devote more time to their families. Finally, the Centers for Medicare and Medicaid Services (CMS) interpretation of the Emergency Medical Treatment and Labor Act (EMTALA) changed in 2003, resulting in many hospitals either

dropping call coverage requirements or adopting partial-call coverage requirements for many specialties.

AMA POLICY AND GUIDANCE

Council on Medical Service Report 3-I-99, "On-Call Physicians," addressed mandatory call coverage. In its report, the Council noted that bylaws mandating call coverage appear to work best when there is an adequate number of physicians to share the mandated call, the mandate is reasonable, managed care plans are diligently paying for services provided, and there are not large numbers of uninsured patients. The Council also noted that a mandated approach can fail if physicians simply leave the medical staff or give up their active staff privileges in favor of courtesy privileges, which do not require being on-call. In lieu of opposing mandatory call coverage, the Council developed the following guidance on emergency room contracts and hospital privileging:

> Our AMA: (1) advocates that physician on-call coverage for emergency departments be guided by the following principles: (a) The hospital and physicians should jointly share the responsibility for the provision of care of emergency department patients. (b) Every hospital that provides emergency services should maintain policies to ensure appropriate on-call coverage of the emergency department by medical staff specialists that are available for consultation and treatment of patients. (c) The organization and function of on-call services should be determined through hospital policy and medical staff by-laws, and include methods for monitoring and assuring appropriate on-call performance. (d) Hospital medical staff by-laws and emergency department policies regarding on-call physicians' responsibilities must be consistent with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements. (e) Medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage. (f) Hospitals with specialized emergency care capabilities need to have a means to ensure medical staff responsibility for patient transfer acceptance and care. (g) Hospitals that lack the staff to provide on-call coverage for a particular specialty should have a plan that specifies how such care will be obtained. (h) The decision to operate or close an emergency department should be made jointly by the hospital and medical staff; (2) supports the enforcement of existing laws and regulations that require physicians under contract with health plans to be adequately compensated for emergency services provided to the health plans' enrollees; and (3) supports the enactment of legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans' enrollees or be subject to significant fines similar to the civil monetary penalties that can be imposed on hospitals and physicians for violation of EMTALA. (Policy H-130.948, AMA Policy Database)

Board of Trustees Report 29-A-00, "On-Call Physicians Task Force," examined several potential coverage options for medical staff on-call requirements including mandatory on-call coverage through medical staff bylaws, mandatory on-call coverage through managed care contracts, voluntary on-call coverage, and regional on-call coverage. The report shared the conclusion of CMS Council Report 3-I-99 that it is highly unlikely that one solution to the on-call coverage problem will universally apply to every situation and every market. The Council and the Board expressed the concern that advocating for specific national policies or solutions may be detrimental to local communities and regions of the country that have developed workable on-call physician coverage arrangements.

Council on Medical Service Report 8-A-05 addressed methods for offsetting the costs of providing uncompensated emergency care and advocated redirecting funds currently spent to offset the cost of providing coverage for the otherwise uninsured toward the purchase of health insurance

coverage (AMA Policy H-160.923). In addition to these reports, the AMA has established a number of policies related to on-call emergency services and physicians (H-130.970, H-225.957, H-225.997, and H-130.978). In particular, Policy H-130.978[3] supports the fair distribution of call-responsibilities and the adequate compensation for physicians providing on-call services. Policies H-310.999[F], H-160.927, and H-383.997[2] provide extensive guidance for physicians regarding hospital contracting. The Council notes in particular that Policy H-310.999[F] acknowledges that onerous on-call schedules are not consistent with efficient delivery of care, and advocates that the hospital should commit itself to fair scheduling of duty time for all members of the house staff, including the provision of adequate off-duty hours. Policies H-160.927 and H-383.997[2] urge physicians who believe hospitals are negotiating contracts without appropriate input, and who feel coerced into signing contracts, to contact the AMA/State Medical Society Litigation Center, their state medical association, and/or legal counsel.

Policy D-130.971 supports expanding the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care.

Policy H-130.970[2] supports the principle that all physicians and health care facilities have an ethical and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay, and an AMA ethical opinion states that physicians may not refuse to care for patients when operating under a contractual arrangement that requires them to treat (Opinion 10.015).

Finally, the AMA "EMTALA Quick Reference Guide for On-Call Physicians" provides a summary of what is expected of on-call physicians. The guide is available on the AMA Web site, www.ama-assn.org/ama1/pub/upload/mm/21/emtalarefguide.doc.

MANDATED EMERGENCY ROOM CALL

EMTALA is the federal law enacted by Congress in 1986 to assure that patients who come to hospitals for treatment of an emergency condition are not turned away or transferred to another facility based on their inability to pay. In 2003, the CMS published new rules for the interpretation of EMTALA (Federal Register, 2003), which clarified that it would be up to each hospital to adopt its own reasonable coverage standards, and that there would be no minimum requirement for frequency of on-call coverage based on the number of specialists a hospital had on staff. In addition, physicians under EMTALA are permitted to be on-call at more than one hospital at the same time and may limit the amounts of call time they are willing to take. The more recent interpretation acknowledged the need to balance hospital and physician legal duties with the realities of crowded EDs, but does not address the serious EMTALA-created burden for hospitals to secure specialist care.

OPTIONS FOR PROVIDING ON-CALL COVERAGE

In 2005, the American College of Emergency Physicians (ACEP) published a paper entitled "Availability of On-Call Specialists," which identified best practices to successfully implement mandatory on-call policies and regulations for hospital staff credentialing. The ACEP best practices include:

- On-call requirements must be included in hospital bylaws and procedures;
- Hospital administration must be responsive to physician concerns regarding on-call policies and bylaws;
- Physicians must be allowed to participate in strategic and operational decisions regarding on-call requirements;
- Requirements for physician on-call policies and bylaws must be consistently implemented;
- Regular communication of hospital performance should be reported to physicians; and
- An on-call physician quality assurance program should be implemented to assess compliance with mandatory on-call coverage.

As noted in Council Report 3-I-99, hospitals are pursuing a variety of strategies to secure specialist emergency on-call coverage, including employing hospitalists or specialists, contracting for on-call services, paying stipends to physicians, and taking legislative or regulatory actions. Other solutions include improving the physician work environment, providing payment for each uninsured patient a physician treated while on-call, providing payment for physician liability insurance premiums, promoting regionalization, and expanding the use of technology (e.g. telemedicine).

Employing Hospitalists or Specialists and Contracting for On-Call Services

Some hospitals secure ED on-call coverage via contracts with physician groups that take responsibility for ensuring emergency coverage. Alternatively, hospitals may use a direct employment model with specialist physicians or hospitalists hired to treat patients full-time, thereby replacing local physicians. This model may not alleviate on-call problems with certain subspecialties. Smaller hospitals may have difficulty financing the specialist or contract model.

Physician Stipends

Some hospitals pay stipends or provide other compensation, which recognizes the opportunity costs of serving on an on-call basis and compensates physicians for being available and ready for service. In 2002, the California Medical Association (CMA) adopted the position that hospitals should pay on-call physicians regardless of whether they are called to the ED. The trend to compensate physicians for call service appears to be gaining momentum, with 36% of ED directors reporting that their hospitals paid stipends to specialists for taking coverage in 2005, compared with only 8% in 2004 (ACEP, 2006).

Although specialists demand higher payments to take call, hospitals are wary of overpayments, which might trigger allegations of violations of the federal anti-kickback statue if the arrangement is used to generate referrals for services that are reimbursed by a federal health care program.

Legislative or Regulatory Actions

In 2004, a coalition including the California Healthcare Association, the CMA, and the American College of Emergency Physicians of California, sponsored a ballot initiative that would have raised approximately $500 million a year for emergency services by boosting the state surcharge on long-distance phone calls. Although the initiative was unsuccessful, the proposed legislation provides an example of how physician organizations can promote legislative solutions to adequately staff and equitably compensate all physicians covering the ED.

Under the Federal Tort Claims Act (FTCA), liability insurance is provided to protect volunteers of free health clinics. An ACEP On-Call Task Force report suggests potentially advocating for national or state legislation that could include protections to emergency and on-call specialty physicians similar to those found in the FTCA (ACEP, 2008).

Improving the Physician Work Environment

Some hospitals studied offer practice management support by working with orthopaedic surgeons to develop more "surgeon-friendly" operating room schedules in return for ED call. Another hospital puts payments for physicians' time spent providing coverage into a tax-deferred life insurance investment account that is vested after five years (Center for Studying Health System Change [HSC], 2007).

Providing Payment to Physicians for Each Uninsured Patient

Increasingly, in addition to stipends, some hospitals pay for each uninsured patient physicians treat while on-call. Some of the hospitals studied reported paying physicians at least at Medicare rates for patients with no coverage. One hospital guarantees at least Medicare rates plus 20% for treating uninsured patients (HSC, 2007).

The primary challenge of paying for each uninsured patient is the expense. With particularly large numbers of uninsured individuals in certain regions of the country, the costs of paying for each uninsured patient could easily become unmanageable for some hospitals.

Paying Physician Liability Insurance Premiums

Physicians may be reluctant to take call because of the rising cost of liability insurance, and because the ED is a high-risk environment with respect to liability. To mitigate these concerns, the on-call physicians could receive affordable liability insurance from the hospital in return for serving on-call. Also, shielding physicians from frivolous lawsuits may encourage more physicians to remain on-call.

Promoting Regionalization

Improving regional cooperative coverage and creating a state-based transfer call center are two policy options that are often offered as solutions to ED staffing problems. A recent article discussed potential options for regionalization, in which individual hospitals would not need to maintain on-call coverage for all specialties. Instead, a group of physicians or hospitals would be designated to provide coverage for the entire region. Such arrangements aim to provide a more efficient allocation of resources and reduce the burden of taking call for physicians and hospitals (*Annals of Emergency Medicine*, 2008).

Regulations promulgated as a result of the 2003 EMTALA changes clarify that physicians can be on-call at more than one hospital, if all hospitals are aware of the call schedules and are able to screen and stabilize emergency patients. Yet there are several challenges to regionalizing call schedules. As described in a 2008 *South Florida Sun-Sentinel* report, physicians and hospital executives created a plan for Palm Beach County's 13 hospitals to voluntarily join a regional system. An online call schedule was envisioned where hospitals would pay to maintain a full complement of surgeons. Nevertheless, the plan subsequently failed to obtain sufficient specialist care.

Expanding the Use of Technology

A recent PriceWaterhouseCooper's study found that nearly half of respondents surveyed said they went to the ED for a reason other than an emergency in the past year. The study also found that consumers are willing to participate in a variety of alternative ways to access care (PriceWaterhouseCooper, 2009). Consultative telemedicine services may provide an innovative solution to problems with ED on-call coverage.

RESOLUTION 806 (I-08)

Resolution 806 (I-08) seeks AMA support for the physician's right to autonomous decision-making regarding mandatory on-call coverage. The Council recognizes the frustrations caused by an on-call system that fails to adequately compensate physicians for the services they provide while on-call, the time they spend away from their practices and families, and for the related legal costs they encounter. However, the Council notes that long-standing AMA policy and ethical guidance state that physicians have the fundamental responsibility to treat patients in need of care.

The Council continues to strongly support Policy H-130.948, which established principles for physician and hospital contractual arrangements, regarding on-call coverage. In particular, the Council believes Policy H-130.948 addresses the concerns of the first resolve of Resolution 806 (I-08), which asks the AMA to develop guidelines for contractual arrangements between physicians and hospitals regarding emergency room call. Furthermore, the availability of on-call physicians continues to be highly influenced by market forces, with different specialties encountering different obstacles in different regions of the country. The Council recognizes that there are a variety of possible solutions, and believes that no single overall approach is best for all regions and hospitals.

The first resolve of Resolution 806 (I-08) also asks the AMA to reaffirm the rights of physicians "not to sign such contracts and not take call if they choose," which may conflict with existing AMA policies emphasizing that physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients and advocating that hospitals and physicians jointly share the responsibility for the provision of care of emergency departments (H-130.970[2]). Regardless, the Council believes that coercive contracts should not be used in lieu of appropriate communication between hospital staff and physicians, and that physicians who believe they are being coerced into specific employment arrangements should contact the AMA/State Medical Society Litigation Center, their state medical association, and/or legal counsel, consistent with Policy H-160.927.

The second resolve of Resolution 806 (I-08) asks that our AMA monitor and oppose any legislation that mandates emergency room coverage as a requirement for medical staff privileges and state licensure. Because hospitals are governed by state laws externally and hospital bylaws internally, the Council believes this activity has merit, but only if the state medical association also opposes the legislation. The Council does not see the merit in universally opposing mandated call coverage, which may work for the medical staffs in some communities and is supported by some state medical associations.

The third resolve of Resolution 806 (I-08) asks that our AMA adopt as policy the position that hospital medical staff bylaws not contain any provision that mandates ED call as a condition of medical staff privileges. The goal of Resolution 806 (I-08) is to protect physicians from unreasonable demands to provide emergency services, which is a goal that should be balanced with the societal need for adequate coverage for emergency services. To the extent that a medical staff

supports a provision mandating call coverage as the best solution for its community, an AMA policy opposing such a provision could be considered insensitive and intrusive.

DISCUSSION

Emergency services are vital to all communities and a lack of adequate on-call physicians is an increasingly serious concern in some regions of the country, exacerbated by EMTALA requirements. Onerous on-call schedules are inconsistent with providing high quality and efficient care. It is unlikely that one solution to the on-call coverage problem will apply to every situation in every market.

For that reason, the Council strongly believes that every health care facility and the medical staff should work together in their communities to develop solutions to adequately staff and equitably compensate all physicians providing on-call coverage in the ED. In particular, the Council supports innovative approaches to providing emergency care coverage. Regardless of the method (e.g., physician stipends, contracting for on-call services, improving the physician work environment), the Council believes that solutions based on adequate compensation and appropriate incentives are preferable to mandatory requirements.

Resolution 806 (I-08) recommended that the AMA adopt policy that hospital medical staff bylaws not contain any provision that mandates emergency room call as a condition of medical staff privileges. The Council concurs with the intent of this recommendation, but only if the state medical association also opposes the legislation. State medical associations are in a much better position to understand local needs and resources.

The Council supports reaffirmation of Policy H-130.948, which established principles to assist physicians and hospitals in addressing emergency call. In particular, the policy states that the organization and function of on-call services should be determined through hospital policy and medical staff bylaws, and include methods for monitoring and assuring appropriate on-call performance and that medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage.

The Council also supports reaffirmation of Policy H-160.927, which recognizes that individual physicians may feel coerced by hospitals to sign contracts. The policy urges those physicians and urges those who believe hospitals are negotiating contracts inappropriately, and who feel coerced into signing contracts, to contact the AMA/State Medical Society Litigation Center, their state medical association, and/or legal counsel.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 806 (I-08), and that the remainder of this report be filed:

1. That our American Medical Association strongly encourage physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage. (New HOD Policy)

2. That our AMA monitor and oppose any state legislative or regulatory efforts mandating emergency room on-call coverage as a requirement for medical staff privileges and state licensure that are not supported by the state medical association. (Directive to Take Action)

3. That our AMA reaffirm Policy H-130.948, which contains a series of principles to assist physicians and hospitals in addressing emergency room call coverage requirements. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-160.927, which urges individual physicians or physician groups that believe they are being coerced into specific employment arrangements to contact the AMA/State Medical Society Litigation Center, their state medical association, and/or legal counsel. (Reaffirm HOD Policy)

Fiscal Note: Staff cost estimated to be less than $2,000 to implement.

References for this report are available from the AMA Division of Socioeconomic Policy Development.