Physician alert: the legal risks associated with ‘on-call’ duties in the USA

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ABSTRACT
On-call physicians encounter a diverse aggregate of interfaces with sundry persons concerning patient care that may surface potential legal peril. The duties and obligations of an on-call physician, who must act as a fiduciary to all patients, create a myriad of circumstances where there is a risk of falling prey to legal ambiguities. Understanding the doctor–patient relationship, the obligations of physicians under the Emergency Medical Treatment and Labor Act, the meaning of medical informed consent and the elements of negligence will help physicians avoid the legal risk associated with the various encounters of being on call. After introducing the legal concepts, we will explore the interactions that may put physicians at legal risk and outline how to mitigate that risk. Being on call is time consuming and arduous. While on call, physicians have a duty to act morally and ethically in the best interest of the patients.

INTRODUCTION
On-call physicians would be prudent to understand how to meet their duties and obligations when they interact with other physicians, nurse practitioners, physician assistants, nurses, the answering service and patients. Furthermore, physicians must understand that interpreting medical data, making a diagnosis, advising a course of treatment and recommending follow-up surveillance and treatment while serving as the on-call physician must be carefully and comprehensively documented. Additionally, physicians must understand the importance of documenting all phone and personal conversations, the rationale for medical decisions and the rationale for prescribed follow-up.

Fundamental to understanding and meeting their duties and obligations physicians on call must understand the doctor–patient relationship, the Emergency Medical Treatment and Labor Act (EMTALA), medical informed consent and the fundamental elements of negligence. These duties and obligations are the ethical and moral duties physicians have to their patients in the USA.

This article will outline the numerous duties and obligations physicians confront when on call. We discuss the potential legal vulnerabilities that may put the physician at risk of allegations of negligence, and possibly result in liability. Understanding the doctor–patient relationship, EMTALA, medical informed consent, negligence and the nuisances of the assorted interactions and duties physicians face with various people will limit the potential for liability.

The Doctor–Patient Relationship
The doctor–patient relationship is a fiduciary relationship, in which mutual trust and confidence are essential. The physician acting as a fiduciary to the patient must act in the best interest of the patient. Physicians are held to a standard of medical care defined by the accepted national standards of practice. Some of the obligations of a physician’s responsibility of due care include: the obligation to fully inform the patient of his or her condition, to continue to provide medical care once the physician–patient relationship has been established, to refer the patient to a specialist, if necessary, and to obtain the patient’s informed consent to the medical treatment or operation. Informed consent evolves from a shared decision-making process between the physician and the patient. Confidentiality laws protect the physician–patient relationship and the patient’s consent must be obtained before medical records may be released.

Generally, an affirmative act on the part of the physician must exist before a legal duty arises. Once the physician–patient relationship has been established, it continues until it is ended by the consent of the parties or revoked by the dismissal of the physician or until the physician’s services are no longer needed. Without proper notice of withdrawal, affording the patient ample opportunity to seek alternative care, the physician’s termination of services to the patient could be held to be abandonment, subjecting the physician to the charge of negligence and liability to the patient for any damages proximately caused by such negligence.

Succinctly stated, the physician–patient relationship can be defined as ‘a consensual relationship in which the patient knowingly seeks the physician’s assistance and in which the physician knowingly accepts the person as a patient’.1 That fundamental relationship is the buttress of good medical care as it reflects a shared decision-making process between the physician and the patient.

Emergency Medical Treatment and Labor Act
EMTALA was enacted to prevent hospitals from refusing to treat patients or prevent transfer of patients just because they could not pay for their care. EMTALA requires Medicare-participating hospitals with an emergency department (ED) to provide a screening examination to determine whether a patient has an emergency condition. An emergency medical condition is an illness that necessitates immediate medical attention to prevent serious jeopardy to the patient’s immediate and long-term health. The clinical condition is such that
there is not adequate time to transfer a patient without posing a threat to the health or safety of that patient. Under EMTALA, the on-call physician must appear in person to evaluate and stabilise the patient if summoned by the ED physician requesting consultation. Failure to come, or directing transfer without an evaluation, may be in violation of EMTALA and subject the hospital and physician to a fine.

There are no further EMTALA obligations or duties once a patient is admitted, stabilised or transferred to another hospital. When a transfer is deemed appropriate, a physician must endorse that the benefits of transfer outweighs the risks. A patient is stabilised when it is unlikely that his or her condition will deteriorate as a result of during transfer. The physician is forced to use expert medical judgement when making decisions regarding stabilisation. This is an area of legal risk. There is not an expectation of ongoing medical care, but the hospital is expected to provide patients with the information they need to obtain appropriate follow-up care to prevent a relapse or deterioration of their medical condition. Failure to provide that information would fall below the standard of care and violate EMTALA.

MEDICAL INFORMED CONSENT
Medical informed consent is essential to the physician’s ability to diagnose and treat patients as well as the patient’s right to accept or reject clinical evaluation, treatment or both. Medical informed consent should be an exchange of ideas that buttresses the patient–physician relationship. The consent process should be the foundation of the fiduciary relationship between a patient and a physician. Physicians must recognise that informed medical choice is an educational process and has the potential to affect the patient–physician alliance to their mutual benefit. Physicians must give patients equality in the covenant by educating them to make informed choices. When physicians and patients take medical informed consent seriously, the patient–physician relationship becomes a true partnership with shared decision-making authority and responsibility for outcomes. Physicians need to understand informed medical consent from an ethical foundation, as codified by statutory law in many states, and from a generalised common-law perspective requiring medical practice consistent with the standard of care. It is fundamental to the patient–physician relationship that each partner understands and accepts the degree of autonomy the patient desires in the decision-making process.

Ethically and legally, all physicians have a mandatory obligation to understand the medical informed consent process. Understanding this process allows for the exchange of ideas in medical practice that will yield informed decisions and will lead to the best outcomes on the basis of shared information. Further, informed consent limits the potential for negligence cases brought for lack of informed consent.

NEGLIGENCE
Negligence requires that four elements be established for liability of the physician-defendant: a duty of the physician to meet a particular standard of care, the physician’s failure to perform that duty, a causal connection (proximate cause) between the physician’s failure and the patient’s injury, and an injury for which monetary compensation is adequate relief. An allegation of negligence can only be asserted if there is a doctor–patient relationship.

On-call physicians who fail to respond when called may also be subject to adverse action under any on-call services agreement. Such agreements generally require compliance with EMTALA and/or other applicable laws, and may have specific requirements for responding to calls. The on-call physician may be liable to the hospital for resulting damages the hospital may incur, including but not limited to the cost of responding to EMTALA investigations, EMTALA penalties and suits by individuals. Failure to meet these obligations puts the physician at risk for allegations of negligence.

ON-CALL ACTIVITIES THAT POSITION PHYSICIANS AT RISK FOR LIABILITY
Legal risks associated with your answering service
The telephone answering service may be an asset or liability for physicians. The telephone answering service is a necessary component of medical practice. The answering service is the nexus between the patient, physician, nurse practitioner, physician assistant and nurse, and the on-call physician. The potential liability is when a physician does not respond in a timely and appropriate manner to a patient’s medical emergency.

An example will highlight this malpractice risk. You are busy rounding on the medical wards with incoming pages from nurses and attending to patients who are ill. A patient’s daughter calls your answering service asking to speak to the physician on call because her father is experiencing left-sided numbness, blurred vision and confusion. The daughter had called yesterday with similar concerns and an emergency room (ER) visit occurred with no diagnosis identified. You contact the patient 3 hours later and the patient has had a stroke; tissue plasminogen activator is not administered within the 3-hour window, paralysis ensues and you are sued for malpractice and abandonment. You are now faced with defending yourself in the timeliness and appropriateness of your response and the advice you gave the patient.

You also may be placed in the position of defending the standard of care of your answering service. A patient calls with a headache and says it is not an emergency, but later is diagnosed with a ruptured cerebral aneurysm. You will have to show that the failure of the answering service to call you was reasonable given the clinical scenario. The answering service is regarded as an agent of the physician. Therefore, under agency law, the physician is responsible for the selection, training and monitoring of the answering service. Ultimately, the physician is responsible. A pattern of chaotic message forwarding may include untimely calling, absence of dating and timing the calls, calling the wrong physician, transposing a number or misinterpreting a message. A plaintiff’s attorney may allege negligence for a physician not correcting this pattern of chaotic messaging.

Make sure the answering service knows who is on call and how to contact that person. Make available to the answering service complete information for on-call schedules and for hospital and medical practice arrangements for coverage. If you are the physician on call, you should provide all your contact information including your cell phone number, text-messaging information, email address, home phone, beeper number and alternative person you designate in case you cannot be reached. The message is loud and clear—make sure you are available.

The answering service should first ask the patient if the call is for an emergency. If the answer is yes—have the patient call 911. The answering service must be a human being who has good communication skills and empathy for a patient in distress. It is imperative that operators for the answering service understand they never diagnose maladies or prescribe treatments. They should have the autonomy to tell patients to call 911, or go to the ER, if the physician cannot get back to the patient in a reasonable amount of time.
Malpractice risks associated with your answering service

Patient satisfaction is critical to your practice and the answering service creates a large impression on patients after hours. The operators must respond in a timely manner, have good communication skills, empathy, patience and follow through. How can you protect yourself? Scrutinise your answering service—call as a patient and check the efficacy, efficiency and accuracy of your operators. If you are not satisfied, make changes immediately. You have a legal duty to reach patients in a timely fashion. The standard of care is physicians in a similar circumstance would have reached the patient in a similar time frame and would have given similar advice.

Answering service cases often are argued from a claim of proximate cause which is defined as a causal connection between the alleged departure from the standard of care and the patient’s damages. The question that will be posed is: ‘Did the failure to respond to the patient in a timely manner and/or give reasonable advice within the patient’s clinical context cause the patient’s injuries?’ Alternatively, ‘Would the progress of the disease have been the same regardless of the alleged malfeasance of the physician or his answering service?’

In the event of a lawsuit, your documentation of your meeting the standard of care in terms of timeliness is critical. All communications between the answering service and patients must be carefully documented in the medical record. Additionally, all communication between a physician and other physicians and patients should be carefully documented with date and time.

Legal risks associated with physician-to-physician and/or physician-to-non-physician clinicians calls

Physician-to-physician

When a physician receives a call from an ER physician, urgent-care physician or hospitalist physician, he/she must answer promptly, listen carefully and communicate harmoniously. It is important to succinctly reiterate what you have heard so it is abundantly clear that your understanding of the clinical discussion resonates with the calling physician. If the calling physician desires a consultation, the on-call physician should respond promptly to evaluate the patient and make recommendations on an integration and synthesis of a comprehensive history, physical examination, laboratory and imaging data. If the requesting physician is calling for advice, without an in-person consultation, their must be a clear understanding of the patient’s clinical condition and then comprehensive documentation of recommendations and the rationale for the decision-making and recommendations. The on-call physician making recommendations without a personal history and physical examination is always at risk for liability if medical advice is rendered. It is always better to see the patient and make recommendations based on an in-depth history and physical examination. There should be comprehensive documentation of all discussions with date and time noted.

Physician-to-non-physician clinicians calls

When a physician receives a call from a non-physician clinician (nurse practitioners, physicians assistants), he/she must answer promptly, listen carefully and communicate harmoniously. It is important to succinctly reiterate what you have heard so that it is abundantly clear that your understanding of the clinical discussion resonates with the calling non-physician clinician. It is safest in these situations to always personally evaluate the patient before making recommendations. The rationale for this recommendation is that in the event of an adverse outcome, the physician will be considered the respondent superior. The common-law doctrine of respondent superior was established in the 17th century to define the legal liability of an employer for the actions of an employee. The doctrine was adopted in the USA and has been a fixture of agency law. The non-clinician physician is considered an agent of the physician. The physician is considered the principal and is responsible for the agent’s actions. Physicians would be prudent to always fully participate in the medical evaluation, medical care and decision-making of a patient to prevent the potential for alleged negligence and possibly liability. Again, all communication and decision-making must be carefully and comprehensively documented. There are no short cuts to high-quality care.

Physician response to nurse calls

The on-call physician must remember that nurses are the critical piece to great patient care. They spend enormous time talking to the patient and examining the patient. Therefore, nurses develop an intimate and detailed knowledge of the patient’s symptoms, concerns, fears and hopes. This in-depth relationship between the nurse and the patient demands a physician’s recognition and respect. Excellent physicians understand they can gain great insight into the patient’s clinical condition if they communicate well with the nursing staff.

When nurses request to speak to the on-call physician, there should be a prompt response and a large ear. Physician listening skills are essential. The changing nature of a patient’s condition is most apparent to the nurse who is providing minute-by-minute care. Listen carefully to the nurse’s assessment and communicate with careful thought and compassion. It is important to succinctly reiterate what you have heard so that it is abundantly clear that your understanding of the clinical discussion resonates with the nurse. If there is concern about a changing medical status, it is prudent to go evaluate the patient immediately and comprehensively. If the call does not deem an immediate evaluation, but there is communication of critical medical information, it is prudent for the physician to carefully document the conversation and decision-making. Nurses will make or break a physician. If they feel you are not listening and lack compassion, they will stop communicating with you and again through agency law you are responsible.

THE ON-CALL PHYSICIAN AND THE NOVEL LEGAL RISKS OF TELEMEDICINE

The telecommunication era has introduced us to telemedicine. Physicians on call are often forced to respond to patient calls from rural areas. Physicians who practice telemedicine have to consider state laws, payment issues and licensing regulations, but another important consideration is medical liability. As the practice of telemedicine is exponentially growing so are the legal risks associated with virtual care.

Telemedicine can fuel a wide spectrum of legal issues, including malpractice, product liability claims, data exposure and credentialing risks. A central problem to telemedicine is that a uniform standard of care does not exist. Does the standard of care for services provided in person apply to the virtual care model? How do we determine whether informed consent occurred with virtual medicine? How does credentialing occur when the academic medical centre doctor provides medical care for the patient in a rural hospital? These novel legal concerns should be considered before participating in telemedicine. Remember, you are a provider for the health system until there is a lawsuit—then you are the physician.
CONCLUSION
Understanding the meaning and nature of the doctor–patient relationship, EMTALA law, medical informed consent and negligence will help the on-call physician cope with the myriad of situations and circumstances that occur when being on call and being summoned by the answering service, the ER, physicians, non-physician clinicians and nurses in the USA. Succinctly stated, to reduce legal risk, be prompt, listen intently, reiterate for clarity, go in promptly when the situation dictates, perform a comprehensive assessment and document in granular detail your conversations, examinations and decision-making. Being on call is a rigorous, time-consuming job that requires complete attention to detail.

Contributors ZRP, NJP and TEP all contributed equally to the planning, research, discussions, article content, review and editing of the article.

Competing interests None declared.

Patient consent Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

REFERENCES
3 OIG vs. St. Anthony Hospital, DAB Docket No. C-98-460, Decision CR620, October 5, 1999. The judge’s ruling was upheld by the HHS’s Appeals Board and the 10th Circuit Court of Appeals.