Medical Staff Briefing

ED call and other issues to address in bylaws

Editor's note: The following is an excerpt from the question and answer portion of the webinar "Writing Medical Staff Bylaws: How to Avoid Compliance Gaps and Implement Best Practices." For more information about this webinar, click here.

Q: Can you provide more clarification of the duty to take call that does not trigger hearing rights?

Callahan: Taking ED call is a duty, not a privilege. The bylaws should reflect that fact. Therefore, you can remove someone from their call "duty" without triggering hearing rights. That being said, no one should be removed without some legitimate justification.

Q: Can you clarify that ED call can be provided by an exclusive group for pay compared to the Office of Inspector General (OIG) advisory opinion about offering call for payment to all available medical staff members?

Callahan: We actually obtained the first OIG advisory on the methodology of the payment that was identified in that advisory. Although the hospital in that advisory made the program available to everyone on the medical staff there is no legal requirement to do it. Most hospitals that provide pay for ED call do so selectively.

Typically, if it is offered at all, it is because there is a dearth of coverage such that you can't provide 24/7 coverage. Not that you are required to, but if you are not requiring 24/7, then you have to make other arrangements, such as being prepared to transfer or share call with other hospitals in the community.

There are fair and legal ways of paying for ED call. Now again, there is no obligation that you have to do it for all physicians on your medical staff. Believe me, hospitals aren't looking to pay for coverage. As mentioned in the previous answer, it is a duty that should be included in the bylaws. It typically is covered under medical staff membership.

Q: Do medical staff bylaws apply differently to employed physicians?

Callahan: It depends. As a general rule, no, they have to be appointed and reappointed in the same way. Where there are typically differences is in the area of hearing rights. In most, but not all, employment agreements, a physician whose employment is terminated often times will waive hearing rights. That is a concept that is typically applied, for example, in the area of exclusive contracts and now most employment contracts. Bylaws should also have a provision that references the right to waive hearing rights and/or language that states that if the bylaws and the contract conflict with each other, then the contract prevails.

The good news for physicians is if there is no hearing, or no "professional review action," the decision to terminate is not reportable to the Data Bank. In fact, the Data Bank on its website more or less took that position in response to a question. I was just at a conference with the American Health Lawyers Association where we had a representative from the Data Bank repeat that position.

Other than this distinction, the bylaws should apply the same for all independent and employed physicians.

Q: How often should we review our bylaws without spending too much time or resources on the process?

Callahan: I believe accreditation standards talk about every couple of years. The more you try and track required or recommended amendments during that interim period, the less work it will be at the end. Also, because policies, procedures and the laws are constantly changing you should be periodically updating your bylaws. If you keep up with it, it becomes less cumbersome.

Believe me, it is not a lot of fun reviewing and amending bylaws. It does get to be a tortuous process because it goes to the bylaws committee, the MEC, then on to the medical staff, and finally to the board. The process is the process. But keep in mind, the bylaws are the most important governing document that the medical staff has.

[For best practices on reviewing and updating bylaws, click here.]

Q: Should we specify in our bylaws that only active staff members will take call?

Callahan: EMTALA requires that hospitals provide ED services in all areas and services for which they provide patient services. If you provide neurosurgery, you have to have neurosurgeons on call. You have to match up your call schedule with the services that you provide.

How you do that, and whether you have the right numbers to provide call so it is not so burdensome on any individual, will depend on how many physicians you have.

If you can meet the coverage requirement with just your active staff and people are not going to complain they are taking call too often because you have enough physicians at the active staff level to make it fair and equitable and not burdensome, that is great. But if you can't and since most hospitals want to provide 24/7 ED coverage, you either pay for ED call or dip down into associate staff and maybe courtesy staff.

You have to have adequate numbers—what it takes to get there is going to vary from hospital to hospital. Where you have coverage gaps, if payment is not an option, you then have to make other arrangements. You can't say, "Sorry, we only provide psych services on Mondays, Wednesdays, and Fridays. If you show up on Tuesday, you are out of luck." Even though the ambulance companies should know that you don't have coverage on Tuesday, if they show up, then you have to have an advance arrangement with Academic Center X that if someone shows up on a Tuesday, you are going to screen, stabilize, and transfer if stabilized to Academic Center X. Setting up a shared schedule with other hospitals in the community is another option.
