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April 15, 2002

The Honorable Tommy G. Thompson, Secretary  
U. S. Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 615F  
Washington, DC 20201

RE: Emergency Medical Treatment and Labor Act (EMTALA)

Dear Secretary Thompson,

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), we would like to take this opportunity to thank you for creating your Advisory Committee on Regulatory Reform, and for directing the Committee to focus part of its efforts on the Emergency Medical Treatment and Labor Act (EMTALA). As you are aware, the requirements of EMTALA directly impact neurosurgeons and as such we are keenly interested in facilitating several changes and clarifications to the regulations implementing this law. There is one critical area, however, that we believe needs ***immediate*** resolution, so neurosurgeons, and the hospitals that they serve, can ensure that they are in compliance with the law. This involves questions related to EMTALA's on-call requirements.

### **Background**

EMTALA requires hospitals to maintain a list of physicians who are on call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition. Physicians who are on-call to the emergency department are also subject to the requirements of EMTALA. Current Center for Medicare and Medicaid Services' (CMS) interpretive guidelines<sup>1</sup> provide some clarification of the on-call rules, however, there are several

<sup>1</sup> Interpretive Guideline Tag Number A404 states, among other things, that:

- The purpose of the on-call list is to ensure that the emergency department is prospectively aware of which physicians, including specialists and sub-specialists, are available to provide treatment necessary to stabilize individuals with emergency medical conditions. If a hospital offers a service to the public, the service should be available through on-call coverage of the emergency department.
- The medical staff by-laws or policies and procedures must define the responsibility of on-call physicians to respond, examine and treat patients with emergency medical conditions.
- Physicians, including specialists and sub-specialists (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.

contradictions and gaps in these guidelines. Furthermore, recent information provided to us last week by Dr. Trent Haywood, CMS Region V Chief Medical Officer, who participated on an EMTALA discussion panel at the AANS Annual Meeting in Chicago, has caused a great deal of confusion and angst among our neurosurgical colleagues. The three primary issues of concern are (1) whether EMTALA requires neurosurgeons to serve on-call 24 hours per day, 7 days per week, 365 days per year, (2) whether EMTALA permits neurosurgeons to be on-call to more than one hospital emergency department at the same time (simultaneous call), and (3) whether EMTALA permits neurosurgeons to schedule elective surgery when they are on-call to the hospital emergency department. We will discuss each issue in turn.

### **24-7-365 Emergency Coverage**

Clearly, the interpretive guidelines state (and Dr. Haywood confirmed) that physicians are not required to be on-call at all times. Rather, it is the hospital's responsibility to have in place policies and procedures to be followed when a particular specialty is not available to the emergency department. Unfortunately, however, there are many hospitals around the country that are attempting to force neurosurgeons to provide on-call emergency coverage 24 hours per day, 7 days per week, 365 days per year through various different mechanisms. Some of these hospitals are simply trying to intimidate neurosurgeons to provide 24-7-365 call by telling them that EMTALA mandates that they do so. In these cases, the hospital administration has threatened to "turn in" neurosurgeons to the state and federal government agencies that oversee EMTALA if they do not agree to provide continuous emergency coverage. In other instances, the hospital medical staff bylaws or other rules and regulations require 24-7-365 call (and/or the hospital administration interprets them as so requiring), so neurosurgeons with privileges at such institutions have no choice but to comply with this hospital requirement to be in compliance with EMTALA. It is not always feasible for the neurosurgeons or others on the medical staff to modify the bylaws or hospital rules, so they are forced to either comply or resign from the medical staff.

According to the American Hospital Association, there are 5,810 registered hospitals in the United States. There are approximately 3,900 actively practicing neurosurgeons. Not all hospitals provide neurosurgical services, but neither do all neurosurgeons take call every day, with some arrangements having one neurosurgeon cover for up to 7 or more other neurosurgeons during night hours. Doing the math, it is obvious that there are not enough neurosurgeons to provide full on-call emergency coverage to all the hospitals in this country 24 hours per day, 7 days per week, 365 days per year. It is therefore unreasonable for hospitals to force individual neurosurgeons to provide continuous on-call coverage as part of their hospital privileges. HHS and CMS must provide physicians, especially those who are in short manpower supply, with some protection from such hospital tactics and stringent rules and policies regarding continuous on-call coverage.

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- Each hospital has the discretion to maintain the on-call list in a manner to best meet the needs of its patients.
  - Physicians are not required to be on call in their specialty or subspecialty for emergencies whenever they are visiting their own patients in a hospital.
  - If a staff physician is on-call to provide emergency services or to consult with an emergency room physician in the area of his or her expertise, that physician would be considered to be available at the hospital.
  - If a physician demonstrates a pattern of not arriving at the hospital while on-call, but directs the patient to be transferred to another hospital where that physician can treat the patient, this may be a violation.

### **Simultaneous Call**

As you may be aware, it is customary for neurosurgeons to have hospital privileges at multiple institutions because, as stated above, there are more hospitals than neurosurgeons. This practice allows our citizens to have the broadest access to critical neurosurgical services. It is also typical that as a condition of their privileges neurosurgeons are required to provide on-call emergency services. As a practical matter, this means that most neurosurgeons are on call at the same time to more than one hospital. Indeed, it is not uncommon for one neurosurgeon to simultaneously provide emergency coverage for 4 or more hospitals.

Until we heard from Dr. Haywood last week, neurosurgeons were under the impression that EMTALA permitted simultaneous call. Although there is no specific guideline directly on this point, we can find nothing in the law, regulations or interpretive guidelines specifically prohibiting such practice. Take the following scenario, for example: Dr. Neurosurgeon is on call to Hospital A and Hospital B at the same time. There are no other neurosurgeons in the community available to provide back-up emergency call coverage. Hospital A calls Dr. Neurosurgeon to evaluate and treat a neurosurgical emergency, and the patient ends up requiring emergency surgery. While he is in surgery, Dr. Neurosurgeon is called by Hospital B to treat an emergency there as well. He is obviously not available since he is currently treating emergency number one. Our reading of the guidelines would render his unavailability as “beyond his control,” and hence no EMTALA violation.

We specifically outlined this scenario for Dr. Haywood, who informed us that he sought clarification directly from CMS headquarters' staff and was told that EMTALA **prohibits** simultaneous call. He suggested that this policy is justified because Dr. Neurosurgeon placed himself in a position of possibly not being able to respond to Hospital B, and since there was no back-up plan for coverage and Hospital B held itself out to the public to have neurosurgical emergency coverage, Dr. Neurosurgeon's failure to respond would not be beyond his control and he would therefore be in violation of EMTALA. When pressed further, Dr. Haywood suggested that if neurosurgeons are going to provide simultaneous call, that the neurosurgeon and all the hospitals involved must have a coordinated back-up plan in advance to ensure neurosurgical coverage if they are going to hold themselves out to the public to be available to provide emergency neurosurgical services.

There are several problems with this policy. First, as with the 24-7-365 issue, neurosurgeons are in short manpower supply relative to the number of hospitals, so it is not always possible to have back-up neurosurgical coverage. Second, it is not necessarily feasible for multiple hospitals to get together and devise a global neurosurgical emergency system, particularly where there is no official regional trauma/EMS system in place. Indeed, antitrust laws may actually prohibit competing hospitals from dividing the market for emergency neurosurgical services unless such negotiations are conducted under the auspices of a government agency. Third, and most important, if neurosurgeons are not permitted to take call at more than one hospital at a time, access to emergency neurosurgical services is going to be severely restricted and patients will likely find themselves having to travel greater distances to find available neurosurgeons. We are already hearing that neurosurgeons who have privileges at multiple institutions are now rethinking this and restricting their practices to one hospital because they fear EMTALA prosecution. Not only will this limit patient access to emergency neurosurgical services, but it will affect patient access to elective neurosurgical services as well. Clearly, EMTALA was enacted to improve and expand access to emergency medical services, and prohibiting simultaneous call runs counter to this goal.

### **Elective Surgery when On-Call**

Typically, neurosurgeons continue to perform elective surgery when on-call to the emergency department. As with the simultaneous call issue, from time-to-time, neurosurgeons may not be able

to respond to an emergency if they are performing elective surgery. When we reviewed the interpretive guidelines for clarification on this issue, they seem to contradict themselves. On the one hand the guidelines state, "Physicians are not required to be on call in their specialty or subspecialty for emergencies whenever they are visiting their own patients in a hospital." On the other hand, the guidelines go on to indicate, "If a staff physician is on-call to provide emergency services or to consult with an emergency room physician in the area of his or her expertise, that physician would be considered to be available at the hospital." This is highly confusing and so we asked Dr. Haywood to clarify this issue. According to him, unlike the simultaneous call issue, EMTALA does not prohibit scheduling elective surgery when the surgeon is also on call. He went on to say, however, that if the on-call surgeon is in elective surgery and therefore cannot respond to an emergency he could be in violation of EMTALA. This seems a bit schizophrenic to us. Of course, if there is a back-up plan in place, and another neurosurgeon is able to respond to the emergency, then there will not likely be an EMTALA problem. In manpower shortage areas like neurosurgery, however, this is not always possible.

This is a very big problem, since neurosurgeons are often on-call for a week or more at a time. If, as a practical matter, they are not permitted to schedule elective surgery when they are on-call it will seriously limit their ability to provide timely care to their regular patients. It will also have a serious detrimental effect on their ability to generate income to maintain their practices. With decreases in Medicare and other reimbursement and significant increases in professional liability insurance premiums and other practice expenses, neurosurgeons can ill afford to eliminate elective surgery for weeks at a time when they are on-call to the emergency department.

### **Suggested Remedies and Recommendations**

At this time, the only apparent remedy available to physicians is to protect themselves through the medical staff bylaws and/or hospital policymaking processes. Since the EMTALA requirements are essentially placed on the hospitals and not the physicians themselves, if hospitals have plans in place to address the above issues then this can protect both the physician and hospital from EMTALA violations. However, there are numerous reasons why relying on hospital processes to protect physicians from EMTALA problems are not always possible. For example, if the neurosurgeon is unable to obtain the consensus of the medical staff to implement bylaws that provide the necessary protections, he or she will continue to face potential EMTALA violations. In addition, in some institutions, the hospital administration or board has the final say in any bylaws changes. Therefore even if the medical staff adopts provisions to protect on-call physicians, the administration may refuse to implement such changes. The AANS and CNS therefore believe that the federal government must provide added protections for on-call physicians. To this end, we recommend, among other things, that HHS and CMS:

- Create EMTALA "safe harbors" that recognize some exceptions to strict EMTALA compliance. Safe harbors could be created that would:
  - Permit simultaneous call, particularly for those manpower shortage specialties like neurosurgery.
  - Permit the transfer of patients to the hospital where the on-call physician is physically located when, in the judgment of the treating physician, transfer would ensure the fastest or most effective treatment.
  - Permit physicians to schedule and perform elective surgery when they are on-call, especially for manpower shortage specialties like neurosurgery.
- Adopt an affirmative rule prohibiting hospitals from requiring physicians to provide 24-7-365 emergency coverage.

- Establish an EMTALA Technical Advisory Group, which could provide expertise and assist HHS and CMS in developing rationale changes to the EMTALA rules and interpretive guidelines.

### **Concluding Thoughts**

EMTALA was meant to enhance access to emergency medical treatment. We fear, however, that if the current interpretations of the on-call requirements stand, this laudable goal will not be achieved and patients will find themselves without access to many specialty services, especially neurosurgery.

Mr. Secretary, the AANS and CNS want to again thank you for making EMTALA reform one of your high priorities. We do believe that progress is being made and that HHS and CMS staff are clearly more willing to revisit the intent and purpose of EMTALA and take the necessary steps to ensure that the rules more closely align with this purpose. We therefore urge you to do whatever you can to facilitate a quick solution to address the problems on-call physicians face in complying with EMTALA. Given the steep financial penalties for violating this law, it is imperative that these be resolved immediately so patients continue to have access to critical emergency neurosurgical services.

Thank you very much for considering our problems and recommendations. We look forward to continuing to work with you and your staff on this and other important health care issues. In the meantime, if you have any additional questions or need further information, please contact Katie O. Orrico, Director of the AANS/CNS Washington Office at 202-628-2072.

Sincerely,

/s/

/s/

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President  
American Association of Neurological Surgeons

Stephen Papadopoulos, MD  
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cc: Thomas A. Scully  
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