

AMERICAN ASSOCIATION OF
NEUROLOGICAL SURGEONS

THOMAS A. MARSHALL, *Executive Director*
5550 Meadowbrook Drive
Rolling Meadows, IL 60008
Phone: 888-566-AANS
Fax: 847-378-0600
info@aans.org

President

ROBERT A. RATCHESON, MD
Case Western Reserve University
Cleveland, Ohio



American
Association of
Neurological
Surgeons



CONGRESS OF
NEUROLOGICAL SURGEONS

LAURIE BEHNCKE, *Executive Director*
10 North Martingale Road, Suite 190
Schaumburg, IL 60173
Phone: 877-517-1CNS
FAX: 847-240-0804
info@1CNS.org

President

NELSON M. OYESIKU MD, PHD
Emory University
Atlanta, Georgia

Comments
of the
American Association of Neurological Surgeons
and the
Congress of Neurological Surgeons
to the
EMTALA Technical Advisory Group

Presented by

Alex B. Valadka, MD

Wednesday, March 30, 2005
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 305 A
200 Independence Avenue, SW
Washington, DC 20201

Staff Contact

Katie O. Orrico, Director
AANS/CNS Washington Office
725 15th Street, NW, Suite 800
Washington, DC 20005
Phone: 202-628-2072
Fax: 202-628-5264
E-mail: korrigo@neurosurgery.org

WASHINGTON OFFICE
KATIE O. ORRICO, *Director*

725 Fifteenth Street, NW, Suite 800
Phone: 202-628-2072 Fax: 202-628-5264

Washington, DC 20005
E-mail: korrigo@neurosurgery.org

Summary of AANS and CNS Comments and Recommendations

- We support the rule that on-call coverage is a decision made by hospital administrators and the physicians who provide on-call coverage for the hospital, and that each hospital has the discretion to maintain the on-call list in a manner that best meet the needs of the hospital's patients in accordance with the resources available to the hospital, including the availability of on-call physicians. However, the "best meet the needs" requirement is a vague standard, which may invite a whole new body of litigation aimed at defining this requirement. The TAG may therefore wish to provide further guidance on the "best meet the needs" requirement.
- We support the rule that physicians are not required to be on call at all times, but we fear that this provision does not go far enough to protect on-call physicians from nevertheless being required by hospitals to provide continuous emergency on-call coverage. Therefore the TAG should consider recommending that CMS adopt an affirmative rule *prohibiting* hospitals from requiring physicians to provide 24-7-365 emergency call coverage.
- We support the provision that there is no pre-determined ratio for identifying how many days a hospital must provide on-call coverage based on the number of physicians on staff for that particular specialty.
- We support the provision that all relevant factors will be considered in determining EMTALA compliance, including the number of physicians on staff and other demands on these physicians, and commend CMS for acknowledging that "We are aware that practice demands in treating other patients, conferences, vacations, days off, and other similar factors must be considered in determining the availability of staff."
- We support the provision that on-call physicians must go to the emergency department if called and that the decision as to whether the on-call physician must physically assess the patient in the emergency department is the decision of the treating emergency physician.
- We support the rule that patients cannot be transferred to the physician's office for emergency medical treatment, subject to the exceptions stated in the Interpretive Guidelines.
- We generally support the provision that repeatedly directing patients to be transferred to another hospital where the physician can treat the individual may be an EMTALA violation. The TAG should be aware, however, that there are many circumstances when it is clearly in the patient's best interest to be transferred to the hospital where the on-call physician is located since such transfers may actually prevent delays in treating emergency medical conditions.
- We have serious concerns about the provision requiring response time to be stated in "minutes" in the hospital policies. We therefore urge the TAG to recommend some modifications to this provision, to wit: (1) response time can be stated in a *range* of minutes (e.g., between 30-60 minutes), and (2) exceptions should be explicitly permitted in situations when the on-call physician cannot respond within the stated time frame because of circumstances beyond his or her control.
- We have serious concerns that the "selective" call provision of the Interpretive Guidelines as currently written is unclear and subject to multiple interpretations. We believe that the

Interpretive Guidelines should be amended to distinguish between two situations: (1) physicians who are on a hospital's call list and who selectively respond to emergency room calls when on-call; and (2) physicians who, for legitimate reasons, do not accept call at a particular hospital, but who do respond to calls relating to patients with whom they or their colleagues have an established physician-patient relationship. The first situation is clearly one in which an EMTALA violation could be incurred. The latter situation, however, does not violate EMTALA.

- We support the provision that states physicians are not considered on-call just because they are visiting their own patients if they are otherwise not on the on-call roster.
- While we support the provision that hospitals must have back-up plans when the on-call physician is not available, the rules only explicitly mention two options: back-up call schedules and transfer agreements. The TAG should identify other options that will satisfy the back-up plan requirement, including explicitly recognizing that diversion status is an acceptable back-up plan. The TAG should also expand the list of examples for what constitutes "circumstances beyond the physician's control".
- We support the rule allowing physicians to perform elective surgery while on call; however we oppose the provision that permits hospitals to have their own internal policies prohibiting elective surgery by on-call physicians. We therefore urge the TAG to consider recommending that CMS revise the Interpretive Guidelines to *prohibit* hospitals from implementing policies that prevent physicians from performing elective surgery while on-call.
- We support the rule allowing physicians to be on-call simultaneously at more than one hospital.
- We support the rule that EMTALA does not apply to hospital inpatients and believe that adequate safeguards are in place to protect patients from premature discharge or inappropriate inpatient transfers.
- We support the provision that recipient hospitals only have to accept a patient if the patient requires the specialized capabilities of the hospital and the hospital has the capacity to treat the individual. Notwithstanding this rule, however, anecdotal evidence suggests that many academic medical centers and other level 1 or level 2 trauma centers are experiencing a significant increase in transfers of neurosurgical emergency cases from community hospitals, and the TAG should continue to monitor this issue to ensure that patients who are transferred do indeed require the specialized capabilities of these recipient hospitals.

The American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing organized neurosurgery in the United States, appreciate the opportunity to provide the EMTALA Technical Advisory Group (TAG) with neurosurgery's views on the recently revised EMTALA regulations and Interpretive Guidelines. Complying with EMTALA has been one of the most critical and vexing issues facing practicing neurosurgeons, and we want to commend the Centers for Medicare and Medicaid Services (CMS) for making significant changes to the EMTALA regulations, which have provided much needed clarification and guidance on what is required under the law. By removing much of the uncertainty and providing additional flexibility for hospitals and on-call physicians, these changes should have a beneficial effect on patient access to neurosurgical emergency care.

For the most part, the AANS and CNS support the changes included in the revised regulations and guidelines. We do, however, have a number of comments and suggestions that we wish to bring to the TAG's attention. Most of these issues involve the requirements for on-call physicians, although we will provide comments on several additional aspects of the regulation and guidelines. For organizational purposes, our comments will generally follow the order and format of the Interpretive Guidelines as published on May 13, 2004.

INTERPRETITIVE GUIDELINES

TAG A404

Regulation Provisions:

§489.20(r)(2) A list of physicians who are on call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize and individual with an emergency medical condition;

§489.24(j) *Availability of on-call physicians.*

- (1) Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians.

Interpretive Guidelines:

- **Hospitals have the ultimate responsibility for ensuring adequate on-call coverage.** On-call coverage is a decision made by hospital administrators and the physicians who provide on-call coverage for the hospital. Each hospital has the discretion to maintain the on-call list in a manner that best meet the needs of the hospital's patients who are receiving services required under EMTALA in accordance with the resources available to the hospital, including the availability of on-call physicians.

AANS/CNS Comment: We generally support this provision. However, we continue to have some concerns that the "best meet the needs" requirement is a vague standard, which may invite a whole new body of litigation aimed at defining this requirement. The stated purpose for revising the EMTALA regulations and guidelines was to better clarify the law's requirements to ensure hospital and physician compliance, and the TAG may therefore wish to provide further guidance on the "best meet the needs" requirement.

- **Individuals must be listed on the call list.** Physicians' group names are not acceptable for identifying the on-call physician. Individual physician names are to be identified on the list.

AANS/CNS Comment: We support this provision.

- **No physician is required to be on-call at all times.** On-call coverage should be provided for within reason depending upon the number of physicians in a specialty.

AANS/CNS Comment: We support this provision, particularly its recognition that in many areas of the country there simply aren't enough physicians, particularly neurosurgeons, available to serve on-call to hospital emergency departments. According to the American Hospital Association Statistics (2005 edition), there are 4,079 emergency rooms in the United States, while at the same time there are only approximately 3,400 actively practicing neurosurgeons (AANS data). It is obvious that there are not enough neurosurgeons to provide full on-call emergency coverage to all the hospitals with dedicated emergency rooms in this country 24 hours per day, 7 days per week, 365 days per year.

Although we support the fact that the new regulations and guidelines explicitly provide hospitals and physicians with the flexibility to determine how best to maximize available physician resources, we fear that the regulations and guidelines do not go far enough to protect on-call physicians from nevertheless being required by hospitals to provide continuous emergency on-call coverage. For example, in some 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 these hospital requirements so as 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. Indeed, according to a recent AANS/CNS survey, 41 percent of private practice neurosurgeons and 18 percent in full-time academic centers report difficulties in negotiating emergency call schedules with their hospitals.

While we recognize that CMS is attempting to be helpful by providing hospitals and their medical staffs with some flexibility to comply with EMTALA's on-call requirements, and CMS does not want to get in the middle of contract negotiations between hospitals and their physicians, we nevertheless believe that CMS must provide physicians, especially those who are in short manpower supply, with some additional protections that are not included in the current regulations and guidelines. Therefore the TAG should consider recommending that CMS adopt an affirmative rule *prohibiting* hospitals from requiring physicians to provide 24-7-365 emergency call coverage. The language could be amended to read: "Hospitals are prohibited from requiring physicians, including specialists and subspecialists, to be on call at all times." At the very least, CMS should consider establishing some sort of grievance process whereby physicians can appeal unreasonable hospital on-call requirements. Given the inescapable fact that there is a shortage of neurosurgeons available to cover hospital emergency departments, it is totally unreasonable for hospitals to force individual neurosurgeons to provide continuous on-call coverage as part of their hospital privileges.

- **There is no pre-determined ratio that CMS uses to identify how many days a hospital must provide on-call coverage based on the number of physicians on staff for that particular specialty.** In particular, CMS has clarified that there is no rule stating that whenever there are at least three physicians in a specialty, the hospital must provide 24 hour/7 day coverage in that specialty.

AANS/CNS Comment: We support this provision and commend CMS for once and for all putting to rest the “rule of 3” urban legend.

- **All relevant factors will be considered in determining EMTALA compliance,** including the number of physicians on staff, other demands on these physicians, the frequency with which the hospital’s patient 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. CMS has stated that “We are aware that practice demands in treating other patients, conferences, vacations, days off, and other similar factors must be considered in determining the availability of staff.”

AANS/CNS Comment: We support this provision and commend CMS for acknowledging that physicians have many legitimate reasons for not being available to serve on-call to the hospital emergency department.

- **On-call physician must go to the emergency department if called.** A determination as to whether the on-call physician must physically assess the patient in the emergency department is the decision of the treating emergency physician. The decision as to whether the on-call physician responds in person or directs a non-physician practitioner (e.g., physician assistant) as his or her representative to respond to the ED is made by the on-call physician. The on-call physician is ultimately responsible for the individual regardless of who responds to the call.

AANS/CNS Comment: We support this provision.

- **Patients cannot be transferred to the physician’s office for treatment.** When a physician is on-call for the hospital and seeing patients with scheduled appointments in his private office, it is generally not acceptable to refer emergency cases to his or her office for examination and treatment of an emergency medical condition. The physician must come to the hospital to examine the individual if requested by the treating emergency physician.

AANS/CNS Comment: We support this provision and the exceptions stated in the Interpretive Guidelines.

- **Repeatedly directing patients to be transferred to another facility may be an EMTALA violation.** If a physician who is on-call does not come to the hospital when called, but rather repeatedly or typically directs the patient to be transferred to another hospital where the physician can treat the individual, the physician may have violated EMTALA.

AANS/CNS Comment: We generally support this provision. The TAG should be aware, however, that there are many circumstances when it is clearly in the patient’s best interest to be transferred to the hospital where the on-call physician is located since such transfers may actually prevent delays in treating emergency medical conditions. This is particularly true for neurosurgeons and other specialists who are in short manpower supply and may be serving the needs of patients at multiple hospitals. CMS

has acknowledged that such transfers may indeed be appropriate when the benefits of transfer outweigh the risks, and we urge the TAG to continue to support this concept.

- **Response time must be stated in “minutes”.** Hospitals are responsible for ensuring that on-call physicians respond within a reasonable period of time. The expected response time should be stated in minutes in the hospitals policies. Terms such as “reasonable” or “prompt” are not enforceable by the hospital and therefore inappropriate in defining physician’s response time.

AANS/CNS Comment: We have serious concerns about this provision. While it is true that terms such as “reasonable” and “prompt” are somewhat vague, requiring response time to be expressed in minutes may be a slippery slope. For example, if the medical staff bylaws and/or hospital policies require response within 30 minutes and the neurosurgeon arrives in 31, would this be an EMTALA violation? What if the neurosurgeon is delayed because of reasons beyond his or her control, such as a traffic jam? If a patient suffers damages and alleges that these occurred because the on-call neurosurgeon did not arrive at the hospital within the published guidelines, this could be construed as a technical violation of EMTALA, subjecting the neurosurgeon and hospital to potential fines and damages. We therefore urge the TAG to recommend some modifications to this provision of the Interpretive Guidelines, to wit: (1) response time can be stated in a *range* of minutes (e.g., between 30-60 minutes), and (2) exceptions should be explicitly permitted in situations when the on-call physician cannot respond within the stated time frame because of circumstances beyond his or her control. In other sections, the guidelines do state that hospitals should have policies and procedures in place when a physician cannot respond because of circumstances beyond his or her control. These provisions should also be referenced in the section dealing with the response time requirements so it is clear that in certain circumstances it is not an EMTALA violation if a physician does not respond within the required time frame.

- **Physicians that take “selective” call may violate EMTALA.** Physicians who refuse to be included on a hospital’s on-call list but take calls selectively for patients with whom they or a colleague at the hospital have established a doctor-patient relationship, while at the same time refusing to see other patients (including those individuals whose ability to pay is questionable), may violate EMTALA. If a hospital permits physicians to selectively take call while the hospital’s coverage for that particular service is not adequate, the hospital would be in violation of its EMTALA obligation by encouraging disparate treatment. If a physician on call does not fulfill his obligation to the hospital, but the hospital arranges for another staff physician in that specialty to assess the individual, and no other EMTALA requirements are violated, then the hospital may not be in violation of the regulation. However, in this circumstance, the physician who has agreed to take call and does not come to the hospital when called may have violated the regulation.

AANS/CNS Comment: As written, we believe this provision can be interpreted in several ways, some of which are in direct conflict with other aspects of the EMTALA regulations and guidelines; hence modification of this provision is warranted.

One could interpret this statement as meaning that if a neurosurgeon takes call for his or her patients or for a colleague’s patients that neurosurgeon must also provide coverage for the hospital’s emergency department, even if the neurosurgeon is not on the hospital’s call roster. Physicians have a responsibility to respond to calls or emergency situations that arise with their own patients, regardless of whether or not they are on a

hospital's call list. Not to do so would be irresponsible, unethical, and contrary to good patient care. For CMS to suggest that neurosurgeons in this situation are subject to an EMTALA violation is clearly unacceptable and outside the scope of the requirements of the EMTALA law. Indeed, other sections of the guidelines (see below) specifically state that physicians are not required to be on-call for their specialty for emergencies whenever they are visiting their own patients if they are not on the call list.

The statement could also be interpreted as suggesting that EMTALA mandates that physicians serve on call. Such an interpretation clearly exceeds the authority of the EMTALA statute, which mandates that *hospitals* maintain an on-call list. The law itself does not directly require physicians to serve on-call. In addition, various provisions of the regulations and Interpretive Guidelines specifically state that physicians are not required to be on-call and hospitals and physicians have the discretion and flexibility to set forth on-call schedules that best meet their needs. Further, the guidelines note that hospitals are permitted to exempt certain medical staff members (such as senior physicians) from their call schedules.

We believe that the Interpretive Guidelines should be amended to distinguish between two situations: (1) physicians who are on a hospital's call list and who selectively respond to emergency room calls when on-call; and (2) physicians who, for legitimate reasons, do not accept call at a particular hospital, but who do respond to calls relating to patients with whom they or their colleagues have an established physician-patient relationship. The first situation is clearly one in which an EMTALA violation could be incurred. The latter situation, however, does not violate EMTALA. The TAG should therefore recommend that CMS clarify that a physician who is not on-call at a particular hospital may nevertheless respond to emergency calls relating to a patient with whom they have an established physician-relationship without incurring an EMTALA violation.

Regulation Provisions:

- §489.24(j)(2) The hospital must have written policies and procedures in place—
- (i) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control

Interpretive Guidelines:

- **Physicians are not considered on-call just because they are visiting their own patients.** Physicians are not required to be on-call for their specialty for emergencies whenever they are visiting their own patients in the hospital if they are not on the on-call list.

AANS/CNS Comment: We support this provision.

- **Hospitals must have back-up plans when the on-call physician is not available.** The hospital must have policies and procedures (including back-up call schedules or the implementation of an appropriate EMTALA transfer) 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.

AANS/CNS Comment: We support this provision. While the regulations and guidelines only mention back-up call schedules and transfer agreements, CMS has stated orally that such a back-up plan can include going on diversion status. There are often times

that no neurosurgeons are able to provide back-up call coverage and transfer agreements are not always feasible. We therefore urge the TAG to recommend that CMS specifically identify diversion status as an acceptable back-up plan when a particular specialty is not available to provide emergency services. It may also be useful for the Interpretive Guidelines to further expand the list of examples for what constitutes “circumstances beyond the physician’s control” and we therefore encourage the TAG to develop such a list.

Regulation Provisions:

§489.24(j)(2) The hospital must have written policies and procedures in place—

- (ii) To provide that emergency services are available to meet the needs of patients with emergency medical conditions if it elects to permit on-call physicians to schedule elective surgery during the time that they are on-call or to permit on-call physicians to have simultaneous on-call duties.

Interpretive Guidelines:

- **Physicians are permitted to perform elective surgery while on-call.** However, a hospital may have its own internal policy prohibiting elective surgery by on-call physicians to better serve the needs of its patients seeking treatment for a potential emergency medical condition. When a physician has agreed to be on-call at a particular hospital during a particular period of time, but has also scheduled elective surgery during that time, that physician and the hospital should have planned back-up in the event that he/she is called while performing elective surgery and is unable to respond to the situation or the implementation of an appropriate EMTALA transfer.

AANS/CNS Comment: We generally support this provision and commend CMS for explicitly incorporating this in the regulation and guidelines. We are concerned, however, that if hospitals themselves are permitted to prohibit elective surgery while the physician is on-call to the emergency department, neurosurgeons and their patients will not reap the benefits of this change in the regulations. 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, such a restriction 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. We therefore urge the TAG to consider recommending that CMS revise the Interpretive Guidelines to *prohibit* hospitals from implementing policies that prevent physicians from performing elective surgery while on-call.

- **Physicians may be on-call simultaneously at more than one hospital.** When the on-call physician is simultaneously on-call at more than one hospital, all hospitals involved must be aware of the on-call schedule as each hospital independently has an EMTALA obligation. The medical staff bylaws or policies and procedures must define the responsibilities of the on-call physicians to respond, examine and treat individuals with emergency medical conditions, and 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 because the hospital is ultimately responsible for

providing adequate on-call coverage to meet the needs of individuals who presents to its dedicated emergency department.

AANS/CNS Comment: We support this provision and commend CMS for including this in the revised regulations and Interpretive Guidelines. As the TAG is 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, and so this provision is one of the most important elements of the revised EMTALA regulations.

TAG 406

Regulation Provisions:

§489.24(a)(1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) “comes to the emergency department”, as defined in paragraph (b) of this section, the hospital must--

(ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.

Interpretive Guidelines:

- **EMTALA does not apply to hospital inpatients.** The existing hospital Conditions of Participation (COPs) rules protect individuals who are already patients of a hospital and who experience an emergency medical condition. Hospitals that fail to provide treatment to these patients may be subject to further enforcement actions. If it discovered during an investigation that a hospital did not admit an individual in good faith with the intention of providing treatment (i.e., the hospital used the inpatient admission as a means to avoid EMTALA requirements), then the hospital is considered liable under EMTALA and actions may be pursued.

AANS/CNS Comment: We support this provision. The AANS and CNS have long been proponents of the proposition that EMTALA does not apply to hospital inpatients and commend CMS for amending the regulation to reflect this fact by adopting this bright-line rule. While we are sensitive to CMS's concern that hospitals not evade their EMTALA obligations by simply admitting patients to the hospital, we believe there are numerous other safeguards in place to protect patients from premature discharge or inpatient transfers to other hospitals, including the COPs requirements and other legal, licensing and professional obligations with respect to the continued proper care and treatment of inpatients. EMTALA was intended to fill a gap that did not previously exist in law, and to expand its reach to the inpatient setting would only create further confusion and add a redundant layer of rules, regulations and remedies that are not necessary to protect

patients with emergency medical conditions. We therefore recommend that the TAG support this provision.

TAG A411

Regulation Provisions:

§ 489.24(f) Recipient hospital responsibilities. A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

Interpretive Guidelines:

- **Recipient hospitals only have to accept a patient if the patient requires the specialized capabilities** of the hospital and the hospital has the capacity to treat the individual. If the transferring hospital wants to transfer a patient, but the patient does not require any “specialized” capabilities, the receiving (recipient) hospital is not obligated to accept the patient unless the individual presents at the recipient hospital. If the patient requires the specialized capabilities of the intended receiving (recipient) hospital, and the hospital has the capability and capacity to accept the transfer, but refused, this would be an EMTALA violation.

AANS/CNS Comment: We support this provision. Notwithstanding this rule, however, anecdotal evidence suggests that many academic medical centers and other level 1 or level 2 trauma centers are experiencing a significant increase in transfers of neurosurgical emergency cases from community hospitals. According to a recent AANS/CNS survey, 62 percent of neurosurgeons in full-time academic practice reported an increase in transfers during the past two years and 33 percent of respondents in private practice noted the same. While there are a number of reasons for these transfers, including a lack of on-call physicians and medico-legal concerns, the TAG should continue to monitor this issue to ensure that patients who are transferred do indeed require the specialized capabilities of these recipient hospitals.

CONCLUDING THOUGHTS

The Emergency Medical Services (EMS) system is in the midst of a growing crisis, in part because of overcrowding, but also because of a recognized shortage of on-call specialists. The AANS and CNS are optimistic that the recent changes to the EMTALA regulations and Interpretive Guidelines will help ease the burdens on hospitals and physicians and will encourage, rather than discourage, neurosurgeons’ participation in the emergency healthcare delivery system; thereby improving patient access to emergency medical services.

Thank you very much for considering our comments and recommendations. We look forward to continuing to work with the TAG throughout its 30-month charter period.