

regulations be revised to authorize such a physician to decline to come in when called if he or she believes that another physician can more competently care for the patient and should be called in.

Another commenter suggested that while subspecialists may be better qualified in their general specialties than emergency physicians, generalists may not necessarily be equally competent for all patients. For example, an ophthalmologist specializing in corneal or retinal surgery may have greater expertise in general ophthalmology than an emergency physician, but a fully competent general surgeon may nevertheless not have the specialized training and experience needed to perform emergency surgery on an infant. The commenter recommended that the regulations be revised to make it clear that, in such cases, the on-call physician is permitted to fulfill his or her on-call obligation by calling in another physician who has the necessary skills to care for the patient. The commenter also recommended formation of a private-public work group, similar to that described in proposed legislation (H.R. 3191, the "Medicare Appeals, Regulatory, and Contracting Improvement Act of 2001") to assist in resolving on-call issues. Another commenter recommended that the regulations be revised to state that physicians are not required to respond to calls for types of care for which they do not hold privileges.

Response: We agree with the commenter who stated the general principle is that patients should receive the best emergency care available. However, as pointed out by another commenter, a physician who is in a narrow subspecialty may, in fact, be medically competent in his or her general specialty, and in particular may be able to promptly contribute to the individual's care by bringing to bear skills and expertise that are not available to the emergency physician or other qualified medical personnel at the hospital. While the emergency physician and the on-call specialist may need to discuss the best way to meet the individual's medical needs, we also believe any disagreement between the two regarding the need for an on-call physician to come to the hospital and examine the individual must be resolved by deferring to the medical judgment of the emergency physician or other practitioner who has personally examined the individual and is currently treating the individual. We understand the concern of the commenter who believed the final rule should state that physicians are not

required to respond to calls for types of care for which they do not have privileges. However, we do not agree that a revision to the regulation is needed. On the contrary, we believe that it is the responsibility of the hospital that is maintaining the on-call list to ensure that physicians on the list are granted whatever privileges they would need to furnish care in the facility. Therefore, we are not revising the final rule as recommended by this commenter.

Comment: Some commenters recommended that the EMTALA regulations be revised to state explicitly that there may be situations in which a transfer to another medical facility, which may be either a hospital or a physician office, would be appropriate because the skills and experience of the local on-call physician may not be ideal for a particular individual. One commenter explained that such a clarification would help avoid inconveniencing on-call physicians, who might otherwise be required to come to a hospital to attend to relatively minor needs.

Response: While we agree that there may be some cases in which it is more beneficial to an individual to be transferred to another facility because of the greater availability of specialty physician services, we do not believe any change to the regulations is needed to acknowledge this possibility. On the contrary, existing regulations at § 489.24(c)(1) (now § 489.24(d)(1) in this final rule) make it quite clear that an appropriate transfer is one in which the expected benefits of appropriate medical treatment at another facility outweigh the risks associated with transfer. We also do not believe that individuals being seen in emergency departments would regard their emergency medical conditions as minor needs. Therefore, we are not making any changes in the regulations in this final rule based on these comments.

Comment: One commenter recommended that proposed § 489.24(j) be further revised to state that specialty hospitals, particularly those without dedicated emergency departments, are not required to maintain on-call lists under EMTALA.

Response: Existing regulations at § 489.20(r)(2), which implement the requirement for an on-call list, make it clear that this requirement does not apply to any hospital other than one with a dedicated emergency department. Therefore, we do not believe a change in the regulations is needed to clarify this point.

8. Other On-Call Issues

Comment: Some commenters stated that some physicians may choose to come to a hospital to see private patients at times when they are not shown as being on call under the listing the hospital maintains for EMTALA purposes. The commenters believed such physicians should not be considered to be on call under EMTALA simply because they come to the hospital under these circumstances, and expressed the belief that such a policy would be consistent with EMTALA interpretive guidelines stating that physicians are not expected to be on call whenever they are visiting their own patients in a hospital.

Response: We understand that physicians may sometimes come to a hospital to see their own patients, either as part of regular rounds or in response to requests from the patient or the patient's family, and agree that visits of this type should not necessarily be interpreted as meaning that the physician is on call. On the other hand, some physicians have in the past expressed a desire to refuse to be included on a hospital's on-call list but nevertheless take calls selectively. These physicians might, for example, respond to calls for patients with whom they or a colleague at the hospital have established a doctor-patient relationship, while declining calls from other patients, including those whose ability to pay may be in question. Such a practice would clearly be a violation of EMTALA. Because it may be difficult to distinguish the two practices from one another outside the context of a careful review of patient records, we are not making any revision to this final rule based on this comment. However, we will keep it in mind as we develop the interpretative guidelines and training materials for implementing EMTALA.

Comment: One commenter expressed approval of the preamble statement (67 FR 31478 of the May 9, 2002 proposed rule) that exempting senior medical staff from on-call responsibilities does not necessarily violate EMTALA. However, this commenter believed that statement should also be reflected in the text of the final regulations.

Response: We continue to believe such exemptions are not necessarily inconsistent with EMTALA, but they were mentioned in the preamble to illustrate rather than define the types of flexibility a hospital may exercise in maintaining its on-call list in a way that best meets patient needs. Thus, we do not believe this one example of