Massachusetts College of Emergency Physicians

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TESTIMONY IN SUPPORT OF S.1012
"AN ACT RELATIVE TO EMERGENCY AND DISASTER PLANNING FOR HEALTH CARE PROVIDERS"
BEFORE THE COMMITTEE ON PUBLIC HEALTH
DECEMBER 17, 2013

The Massachusetts College of Emergency Physicians (MACEP) wishes to be recorded in strong support for S.1012, "An Act Relative to Emergency and Disaster Planning for Health Care Providers." MACEP thanks Senator James Eldridge for his sponsorship and support for this important legislation.

S.1012 would grant qualified civil immunity to physicians, nurses, and other healthcare professionals who provide emergency medical services, except in the case of willful or wanton misconduct or reckless disregard.

The bill would also require that, in the situation of a governor declared emergency, or during other locally declared emergency situations, there would be a general waiver of liability of court or regulatory agency administrative sanctions against health care providers to ensure that providers are able to care for patients quickly without worry about liability concerns.

To understand the importance of this bill, it is important to understand how emergency care is delivered, and emergency physicians' role as safety-net providers in the health care system. Emergency physicians staff hospital based emergency departments (EDs) 24 hours per day, 7 days per week, 52 weeks per year. Emergency physicians examine and treat anyone who presents to the ED – insured or uninsured, citizen or illegal alien, Medicare or Medicaid patients, children or adults. This is a federal mandate. The Emergency Medical Treatment and Labor Act (EMTALA), enacted in 1986, requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination, and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition. The legislation also mandates care for women who present in active labor.

EMTALA applies to healthcare workers who are on the hospital's medical staff or who have privileges at the hospital, or who are on staff or have privileges at another hospital participating in a formal community call plan, available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions.

Passage of S.1012 is necessary because emergency medicine is a high risk practice. Patients present to the ED suddenly, often in extremis, needing immediate medical attention. Emergency physicians have no preexisting relationship with the patients and no advance knowledge of their underlying medical problems. Acuity can be very high and adverse outcomes or death is not uncommon. Less than 10% of patients presenting to emergency departments are now considered as non-urgent.

Emergency physicians often practice with limited resources and specialty physician back-up. Technology and resources such as CT scanning, ultrasound, 24-hour radiology services, and on-call backup services, such as trauma surgeons or obstetricians are frequently unavailable due to economics or liability issues. For all these reasons, emergency physicians are at increased risk of lawsuit.

Emergency physicians, hospital emergency departments, and on-call physicians are subject to ordinary malpractice negligence claims under state laws just like all other health care providers. However, they are also subject to an additional distinct and independent system of regulatory and civil liability under EMTALA for screening, stabilization, and transfer of emergency department patients.

Under EMTALA, physicians and hospitals are potentially liable for civil monetary penalties of $50,000 for ordinary negligence regardless if any harm comes to the patient. These fines are not covered by malpractice insurance and some insurance carriers will not even defend the physicians in actions by the government to impose the fines.

Hospitals may be sued under EMTALA for any harm that occurs to an individual as a result of a physician or the hospital violating the law. EMTALA makes hospitals directly liable for acts of its emergency physicians and on-call physicians, and hospitals may recoup those losses from the responsible physician under state law indemnity provisions or contractual indemnity. EMTALA lawsuits are statutory liability claims; they are specifically NOT malpractice or negligence claims, though the damages available under EMTALA claims are those damages available in the state in which the hospital and the physician work. Thus, whether an emergency physician is sued under EMTALA (indirectly through the hospital) or under ordinary state law, it's the state's tort system that determines available damages.

S.1012 will also protect "on-call" specialists, who are oftentimes called into the hospital on off hours to treat emergency patients with a medical condition requiring a particular medical expertise.

An increasing number of hospitals are having difficulty providing specialty emergency care, particularly neurosurgery, thoracic surgery, orthopedics, psychiatry, hand or plastic surgery, and ear, nose and throat surgery, or must transfer patients they could treat because physicians decline to participate in hospital ED on-call lists. Physicians are unwilling to provide on-call ED coverage, particularly those practicing in high-risk specialties, because of malpractice liability concerns.

Loss of on-call physician services delays patient access to necessary emergency care and increases the number of patients that must be transferred to obtain the required services. Additionally, on-call physicians are necessary for the larger hospitals to be able to accept patients in transfer from emergency physicians in the smaller hospitals that don't have such specialty resources on a regular basis. The decreasing availability of on-call physicians means patients have fewer services available.

By setting a higher standard for pursuing a lawsuit against EMTALA providers, this bill will benefit the public, emergency physicians, hospitals and Massachusetts emergency care system, in the following ways:

- **Reduce the costly practice of defensive medicine by emergency physicians.**
- **Encourage specialists to provide needed services in a hospital environment, thus making such services available for emergency department patients**
- **Enhance recruitment of physicians to hospitals in Massachusetts, thereby enhancing the availability of such emergency and specialist physicians to serve in the Commonwealth's emergency departments**
- **Enable smoother operation of the Commonwealth's EMS system through availability and**

stabilization of emergency physicians and specialists available to hospital emergency departments

- **Reduce wait-time for patients needing emergency or specialist physician care through improving the availability of physicians at hospitals. Such improved availability of physicians will also reduce the number of medically necessary transfers between hospitals. This increased availability of prompt medical care will benefit patient care.**
- **Ensure that our first responders (i.e. emergency medicine professionals in and out of the hospital setting) are available in the event of a weapons of mass destruction event.**

This bill is modeled after similar legislation that was passed in Texas, Georgia, Arizona, Utah, Florida, Oklahoma, West Virginia, and South Carolina. It is pending before at least a dozen other states.

MACEP urges the Public Health Committee to support S.1012 and to advance the bill out of committee favorably.