HOUSE INSURANCE COMMITTEE
PUBLIC HEARING
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House Bill 2299

Hello, my name is Ralph Riviello. I am an emergency physician at Drexel University College of Medicine in Philadelphia, and the current president of the Pennsylvania Chapter, American College of Emergency Physicians.

I want to thank Chairman Micozzie, Chairman DeLuca, and fellow members of the House Insurance Committee for the opportunity to speak to you today about House Bill 2299.

I have been providing emergency medical care for the past 15 years. In that time, I have willingly provided emergency care to the uninsured, to high-risk patients, to patients physically unable to provide me with their medical history, and to patients who have been turned away from other specialty providers.

My emergency physician colleagues and I, as well as on-call physician specialists, provide emergency care in a unique environment with specific challenges. We care for patients under a federal mandate, the Emergency Medical Treatment and Active Labor Act, or EMTALA.

Adopted in 1986, EMTALA was passed to protect patient safety and to create an environment where patients in need of critical emergent medical care are medically assessed and stabilized, no matter their insurance status or their ability to pay.

This EMTALA mandate has held emergency care providers to a higher standard for the past 26 years, and has inadvertently created some growing rifts in our ability to efficiently provide care.

On a daily basis emergency physicians and on-call physician specialists often make life and death decisions in a very short time frame, with no prior patient history, knowledge, or relationship — and then we are held liable for not having this critical information. In the current litigious environment, lack of information opens the door to legal action.

Emergency medicine is a critical component of health care in Pennsylvania and nationwide. We are the patient's safety net. Yet there are a number of threats to our ability to provide quality emergency care, including: overcrowded emergency departments and hospitals, patient boarding, a diminishing physician workforce, liability premiums, and a fear of lawsuits that has not only created a trend of defensive medicine, but discourages physician specialists from providing on-call services to emergency patients.

High risk specialties, such as those providing care in the areas of ophthalmology, orthopedics, neurosurgery, neurology and obstetrics/gynecology are opting out of providing on-call services to the emergency department.

As emergency physicians, we do not have the choice of "opting out" of providing care to emergency patients. Non-emergency physicians are able to choose their patients and can decline to care for the high-risk, litigious, uninsured or underinsured patients. Physician specialists are negotiating fewer on call hours or declining privileges in certain areas that typically originate in the emergency department. At times, patients are forced to be transported many miles to receive the care they need because a specialist physician will not take an on-call shift, or will not treat patients in the emergency department. This delay often places patients at greater risk.

The lack of specialty care in emergent care situations endangers patients' long-term health and is detrimental to the recovery process.

The emergency department needs to be an environment where specialists are comfortable providing the much needed care without fear of such high liability. A 2006 American College of Emergency Physicians study corroborated that on-call coverage in the nation's emergency departments has deteriorated significantly. Seventy-three percent of emergency department directors reported problems with inadequate specialist coverage and 42% more specialists were negotiating for fewer on-call duty hours in 2005, compared to 18% in 2004.

In addition, emergency departments are understaffed, and access to emergency health services is declining.

There were over 6 million emergency department visits in Pennsylvania as of June 2011, compared to 5.4 just five years ago. While the visits continue to increase, more and more emergency departments are closing their doors. The Pennsylvania Department of Health reports 158 emergency departments in 2011, compared to 168 five years ago, and more troubling, compared to 190 ten years ago. So in 32 areas throughout Pennsylvania, patients now need to travel longer distances to get the emergency care that used to be available closer to home. With more patients and less space, it is more important than ever to retain both emergency physicians and on-call specialists, and as it stands today, the outlook is dismal.

It is becoming increasingly difficult for providers of medical care to function in this environment, and patients cannot receive even the safety net care that EMTALA was intended to protect. The medical liability environment has improved in Pennsylvania, but additional action is needed to ensure that the emergency physicians and on-call physician specialists who make up the important medical safety net are protected, and to ensure that a consistent quality of emergency care will be available to patients when it is needed most.

I believe that HB 2299 takes a step forward to ensure a future where quality emergency care will continue to be available to all Pennsylvania citizens.

HB 2299 changes the standard of proof required in emergency medical care liability claims from the current standard of 'preponderance of the evidence' in all medical malpractice matters to 'clear and convincing evidence.' In cases involving true emergencies, emergency medicine and on-call physicians would not be held to the same standard of practice as a physician who has treated the plaintiff patient in the past or who has had time to prepare for a certain care plan or treatment.

PaACEP strongly supports restitution to injured patients affected by medical malpractice. If HB 2299 is enacted, patients will still have legal recourse and physicians will still be liable for their actions. This legislation is about protecting emergency care providers from the threat of lawsuits by removing liability related to unknown medical histories. Doing so will increase the quality of patient care in emergency situations. More on-call specialists will provide quicker treatment, resulting in higher quality care for the patient. When defensive medicine is reduced, health care costs are reduced. When liability rates are reduced, monies are freed for the hospital to invest in more advanced technologies, clinics and medical care for underserved populations.

I plan to continue practicing in Pennsylvania for the next 20 years. In these coming years, I will continue to make medical treatment decisions about patients with whom I have little medical history, and every second counts. I want to be a part of the safety net of emergency care medicine, to help those who need it and who don't have anywhere else to go. I believe that HB 2299 will protect this vital public service by putting emergency care providers on equal ground.

Thank you for your time and consideration.

Pennsylvania Chapter, American College of Emergency Physicians
777 East Park Drive, PO Box 8820
Harrisburg, PA 17105-8820
877-373-6272
717-909-2686