TESTIMONY OF

PENNSYLVANIA ASSOCIATION FOR JUSTICE

HB 2299

OCTOBER 15, 2012

Health Bill 2299 provides that, in professional liability cases arising out of emergency health care, no physician or other health care provider shall be held liable for any act or failure to act unless it is proven by clear and convincing evidence that the physician or health care providers acts or omission were grossly negligent. This Bill attempts to limit the rights of patients in two ways. One, by elevating the standard of negligence to gross negligence, and two, by going backwards to a clear and convincing burden of proof. There is no data that evidences this Bill would improve access to healthcare, or improve patient safety. Clear and convincing is untenable and archaic, and a step backward instead of forward. This immunity is not only limited to emergency room physicians and other medical personal, but also extends to prehospital emergency care by a medical command physician, emergency care in a hospital emergency department, or obstetrical unit or emergency care in an surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department. All treatment prior to a patient being "stabilized" would be subject to this level of immunity. There is no objective or empirical data cited to warrant these extreme infringements on the rights of patients.

Currently in the Mental Health Professionals Act, there is a gross negligence standard for malpractice cases against a psychiatrist. However, even that standard does not require clear and convincing evidence. A clear and convincing standard is not used in any other area of the law aside from possibly guardianship at this time. The concept of gross negligence could lead to more punitive damages claims, and possibly make providers uninsurable under their current policy.

The current standard of care in an action brought against the emergency room physician is already measured against the standard of care by physicians who work in the emergency room. The standard of care, the type of medicine, the requirements for making a diagnosis, the emergent nature are already taking into account. Additionally, emergency room physicians are specifically trained to work in the emergency room to handle emergency patients. Specific training through residency and board certification are qualifications required of most emergency room physicians in this day. Why should these patients be less protected then others when they are the most vulnerable? Why should these physicians be less protected then other physicians in other areas of medicine? This is the current state of the law now, and it is working. The standard of care should continue to be set by similarly situated physicians and not legislated.

This Bill also fails to take into account the true nature of emergency rooms at the present time which often <u>are not</u> confronted with emergency situations due to insurance or lack of insurance issues, or at times convenience, many people use emergency rooms for common colds or non-emergent issues. We repeatedly hear stories of patients sitting in a waiting room sometimes for hours. Would this be considered an emergency, and if it is an emergency then why wait for two hours for care? That is a different problem. In this instance would the burden of proof be different?

Since MCARE Reform medical malpractice filings have been steadily reduced, but patient safety has gone the other way. In the years since the MCARE Reform, physician population has increased dramatically and there is no longer a shortage of physicians in Pennsylvania. We are seeing more patient injuries in serious events done by physicians in the hospital setting, and less medical malpractice claims.

The Pennsylvania Supreme Court defines Standard of Care as,

> The Standard of Care required of a physician or surgeon is well settled . . .a physician who is not a specialist is required to possess and employ in the treatment of a patient the skill and knowledge usually possessed by physicians in the same or similar locality, giving due regard to the advanced state of the profession at the time of treatment; and in employing the required skill and knowledge he is also required to exercise the care and judgment of a reasonable man. However, a physician or surgeon is not bound to employ any particular mode of treatment of a patient and, where among physicians or surgeons of ordinary skill and learning more than one method of treatment is recognized as proper, it is not negligent for the physician or surgeon to adopt either such methods.

Donaldson v. Maffucci, 156 A.2d 835 (Pa. 1959).

Additionally, pursuant to Pennsylvania Rule of Civil Procedure 1042.3 dealing with Certificate of Merit, "(1) an appropriate licensed professional must have supplied a written statement that there exists a reasonable probability that the care, skill or knowledge exercised or exhibited in the treatment, practice or work that is subject of the Complaint, fell outside acceptable professional standards and that such conduct was a cause in bringing about the harm." Pa.R.C.P. 1042.3 Certificate of Merit. The Certificate of Merit must be supplied by the expert that will actually testify at trial and

additionally an appropriate licensed professional must have sufficient education, training, knowledge and experience to provide credible, competent testimony. Id.

The MCARE Act requires the expert to possess an unrestricted physician's license to practice medicine in any state or the District of Columbia and be engaged in or retired within five years from active clinical practice or teaching in addition to being substantially familiar with the applicable Standard of Care for the specific care at issue at the time of the alleged breach of Standard of Care and practice in the same sub-specialty as the Defendant physician or in a sub-specialty which has substantially similar Standard of Care for the specific care at issue. 40 P.S. § 1303.512. The MCARE Act further provides that a Defendant physician who is certified by an approved Board requires expert testimony from a Board Certified physician serving in the same or similar Board. Id.

It is inaccurate to say that a physician who has treated the patient for years or decades would be judged by the same standard of care as a physician who has treated the patient in a true emergency. A family physician who treats a patient in a true emergency is still judged by the standard of a treating family physician who treats a patient in a true emergency, not by the standard of an emergency room physician.

This year the Supreme Court noted it was ten years since the MCARE Act was enacted requiring Certificate of Merit and venue requirements showed a drop in the number of filings over the last ten years.

In trying to determine what prompted this legislation, Milliron Associates webpage from May 25, 2012, indicated, "Milliron Associates, on behalf of the Pennsylvania Chapter, American College of Emergency Physicians (PET), lobby to have HB2299 introduced. HB2299 changes the standard of proof for emergency physicians and personnel from "preponderance of the evidence to clear and convincing" evidence (i.e. a higher proof making it more difficult for an award in a lawsuit". HB2299 was introduced on May 9 and the House will hold a Hearing on this topic over the summer months." This bill originated from a group of emergency physicians and not out of any objective data or real need. A 2012 study from Public Citizen shows that medical malpractice payments sunk to a record low in 2011. However, medical errors showed no such decline.

According to the Patient Safety Advisories 2011 Annual Report, the number of reports increased from 2010, reports of unsafe conditions and harmful events did as well. From 2010 to 2011 alone there was a 7.1% increase in serious events involving medication errors, equipment, supplies or devices, falls, errors related to procedures, treatments or tests, complications of procedures, treatments or tests, skin integrity, etc.

In the past, physicians lobbied to cap the number of students admitted to medical schools. With the increasing age population due to the baby boom it appears as though the number of the aging population compared to physicians is less but this was through the own efforts of the profession and has nothing to do with medical malpractice.

Finally, wide-spread use of electronic medical records; family, social, allergies and past medical history are often readily available even before the patient is seen. The preponderance of evidence is the current standard, and already is an elevated burden to the plaintiff over the defendant. Why would we tip the scales so unfavorably toward one side or the other?