ON-CALL CRISIS IN TRAUMA CARE: GOVERNMENT RESPONSES

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FOREWORD

This report was prepared in response to House Concurrent Resolution No. 229, S.D. 1, adopted during the Regular Session of 2005, that requested the Legislative Reference Bureau to identify and analyze any appropriate *government* response to the increasing unavailability of physician specialists for emergency call at trauma centers.

The Resolution has two distinct parts, with the Department of Health focusing on the on-call crisis as it relates to The Queen's Medical Center and the State of Hawaii and the Bureau focusing on government responses of the states. The Bureau and the Department will be submitting their respective components of the Resolution to the Legislature in separate studies.

The Bureau extends its appreciation to the Department of Health for its cooperation in coordinating the tasks requested by the Resolution.

Ken H. Takayama
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SUMMARY

What is a trauma center? *Emergency rooms and departments* are able to treat ill and injured people, while *trauma centers* are able to handle the most severe, life threatening situations. When an injured person is brought into a trauma center with a complex injury, a sophisticated, highly trained interdisciplinary team of health care professionals provides the services needed to save that person's life and prevent further disability or physical deterioration.

Physician specialists: an integral part of the trauma team. Trauma care requires a highly trained medical staff, functioning as a multidisciplinary team. Patients with traumatic injuries often require a level of care that involves the services of *physician specialists,* including neurologists, orthopedic surgeons, general surgeons, cardiologists, plastic surgeons, and anesthesiologists, to ensure appropriate screening, stabilizing, and treatment of trauma patients.

The problem: a shortage of physician specialists available for emergency call. For many years, many trauma centers across the nation have been facing a crisis securing physician specialists for emergency call. The on-call specialist shortage is particularly acute for The Queen's Medical Center since it is the lead and only trauma facility in the State of Hawaii. For complex care, there is nowhere else nearby to obtain treatment.

Impact of the shortage of physician specialists. With trauma injuries, seconds count; the chances of survival significantly decrease and the side effects of injury significantly increase if appropriate care is not given in the first hour immediately following the injury. A shortage of physician specialists can jeopardize a trauma team's ability to provide care. It also increases the risk of delay in patient treatment which in turn increases patients' risk of harm.

Typically, the cost of running an emergency department is far higher than the total payments received from patients treated.[1] According to the American Hospital Association, one-third of the nation's hospitals already operate in the red.[2] A significant percentage of hospitals are incurring high additional costs from having to pay physician specialists to provide emergency call coverage. Between 2000 and 2004, thirty trauma centers closed as hospitals faced volume increases, higher costs, liability concerns, and low or no payment for trauma services. Some of the cities that have seen trauma centers close include: Los Angeles, California; Tucson, Arizona; Birmingham, Alabama; El Paso, Sherman, and Texarkana, Texas; and Tulsa, Oklahoma.[3]

A weakened trauma center decreases a state's state of readiness to respond not only to a normal flow of critically injured patients but to unforeseen disasters and emergencies as well. The tragic events of September 11 and Hurricane Katrina illustrate that trauma readiness and availability is every bit as much an issue of public safety as police and fire services.

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1. Testimony of Rich Meiers, testifying in behalf of the Hawaii Health Care Association before the Committee on Health of the Hawaii House of Representatives (March 31, 2005).

2. Maureen Glabman, *Specialist Shortage Shakes Emergency Rooms; More Hospitals Forced to Pay for Specialist Care*, The Physician Executive (May-June 2005), p. 7.

3. Washington Health Care Association, *Trauma System Needs More Funds (*2005), p. 9.

Causes of the on-call physician specialist shortage. The reasons why fewer physician specialists are taking emergency call tend to fall into four categories:

- **Uncompensated care.** Across the nation, the costs of practicing medicine and delivering trauma care have steadily increased, while reimbursements to physicians -- from health plans, managed care, Medicare, Medicaid, and safety net programs for the uninsured -- have dramatically decreased. A Hawaii orthopedist notes, for example, that over the last decade reimbursement for knee surgeries has dropped from $4,000 to $1,400. Orthopedic surgeons are now paid less for a total hip replacement than they were in 1976.

  According to the American College of Emergency Physicians, about half of all emergency services provided in the country are uncompensated and about forty-two per cent are significantly underpaid or paid only after considerable delays. While hospitals and physicians have absorbed uncompensated costs in the past by shifting them to patients who could pay, it has become increasingly difficult to recover those costs with the flat fees provided by many health plans.

- **Lifestyle.** Few would envy the life of an on-call physician specialist. They are often called to emergency departments many times a day to deal with complex cases, taking them away from their practices and families and limiting their ability to see their own patients. Because of the shortage of specialists, those who do take call often share a heavier call schedule. In hopes of achieving a better work-life balance, many specialists have reduced or eliminated emergency call.

- **Supply and demand.** There is a national shortage of specialists in many areas critical for trauma coverage. The physician workforce is aging and physicians are retiring, slowing down, relocating, or leaving the practice. An increasing number of physician specialists no longer need to have staff privileges at hospital emergency rooms because they work in outpatient surgical centers and specialty hospitals. Over the past decade, the number of physician training slots also has declined.

- **Medical liability concerns.** Rising malpractice liability insurance premiums, in combination with lower reimbursement rates, render the practice of certain specialties less and less cost effective. There is increasing pressure from malpractice insurers for physicians not to provide emergency room coverage. Several liability insurers have simply stopped providing medical liability coverage for certain physician specialties.

  During malpractice crises, concerns are expressed that liability costs will drive high-risk specialist physicians from practice, creating access-to-care problems. Indeed, liability pressures may be leading to greater consolidation of high-risk specialty care services in a smaller number of providers. While the problem is multi-factorial, with reimbursement and managed care arrangements contributing significantly, physician specialists perceive liability to be the strongest driver.

Government responses to improve the availability of physicians for emergency call. The states have employed many strategies to help trauma care and improve the availability of on-call physician specialists, including:

- **Developing dedicated public sources of funding** to reimburse physician specialists for uncompensated trauma services. These funds were found to be effective and essential for maintaining trauma centers and ensuring the on-call availability of physician specialists. However, trauma fund moneys cover only a small fraction of uncompensated trauma costs. Additional funding sources are direly needed. Current revenue sources for dedicated trauma funds include: surcharges tacked onto fines for convictions for traffic violations and substance abuse- and firearm-related offenses; surcharges tacked onto fees for driver's licenses, motor vehicle registration renewals, and the sale, lease, or transfer of motor vehicles; taxes on cigarette sales; tobacco settlement funds; sales and development taxes; and budget appropriations.

- **Implementing tort reforms**, such as caps on damage awards in malpractice lawsuits, that place limitations on traditional legal rules and practices to decrease claim filings and damage award amounts. Underlying this response is the presumption that too many malpractice claims are filed and that damage awards tend to be excessive. These reforms may have a positive effect on physician supply in some instances and may reduce the number of lawsuits filed, the value of awards, and insurance costs. However, evidence on how premiums were affected is mixed and findings are at best inconclusive. In this regard, researchers who study the tort system have found only a loose connection between changes in claim filings and outcomes and premium spikes. Policy makers should be wary of exaggerated and misdirected statistics offered in support of partisan positions.

- **Implementing patient-centered and safety-focused reforms** that strive to reduce the incidence of medical error. Underlying these reforms is the realization that capping damages on the back end of litigation does not address all of the factors on the front end that lead to litigation. These reforms also recognized that:

    - Tens of thousands of people die in hospitals each year as a result of preventable medical error, yet a malpractice claim is filed by only one of every eight negligently injured patients;

    - Most claims are resolved at great expense and too slowly to correct mistakes;

    - Most medical errors do *not* result from individual incompetence or recklessness, but from faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them; and

    - Ineffective communication with patients – not poor treatment or negligence – puts physicians at most risk of malpractice lawsuits.

Patient-centered and safety-focus reforms ensure that "adverse events" and errors are reported, tracked, and analyzed so that physicians and hospitals can identify system weaknesses and learn from their mistakes before more consequential events occur. These reforms encourage open, frank communications between patients and physicians, apologies, and quick resolution of claims through mediation to avoid bitter and protracted lawsuits. For example, a growing number of states are passing laws that protect an apology from being used against the physician in court.

- **Improving state licensing boards** to enable quick investigation and prosecution of physicians who have demonstrated a pattern of negligence. State medical boards are accountable for the quality of health care provided by physicians within their jurisdictions and for assuring that physician licensees are competent to practice medicine. They have been criticized for taking too long to investigate negligent providers; for not dispensing stiff penalties for those found guilty of negligence; and for not providing adequate public information about those physicians who have had disciplinary action taken against them. These boards can only perform their mission if they are properly organized, effectively empowered, and adequately funded.

- **Improving the ability of insurance commissions** to review and evaluate rates and malpractice trends. This includes developing systems to ensure the collection and tracking of comprehensive data on medical malpractice claims, including, for example, the number of claims filed, the losses associated with these claims, premium amounts, and the number of open and closed claims.

- **Implementing stop gap strategies, such as premium subsidies and state-run insurance programs** to help physician specialists meet immediate insurance premium obligations and find liability insurance in the short term. Typically thought of as short-term or providing an option of last resort, these strategies may not solve the systemic issues that exist in the medical liability insurance market.

Mandatory call: pros and cons. Neither federal nor state law affirmatively requires an individual physician to serve on-call. Most hospitals mandate some level of on-call coverage as a condition of staff membership. While hospital-mandated call is effective in many states, many hospitals are reluctant to enforce call mandates for fear of losing or repelling physicians. A mandated approach, whether imposed by a hospital, a state licensing board, or state law, may backfire if other on-call issues, such as physician burnout, uncompensated care, and liability insurance availability and affordability, are not addressed.

Conclusions. Having more than one cause, the shortage of on-call physician specialists at trauma centers clearly requires more than one solution. Pursuant to the Resolution that requested this study, the Department of Health will be submitting a separate study with Hawaii-specific information on these issues. With this information, policy makers will be able to begin the process of determining what short- and long-term solutions to apply in their efforts to improve the on-call availability of physician specialists to The Queen's Medical Center, the only trauma center in the State of Hawaii.

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INTRODUCTION

Scope of Work

During the Regular Session of 2005, the Legislature adopted House Concurrent Resolution No. 229, S.D. 1 (hereafter "Resolution"), entitled "Requesting the Legislative Reference Bureau to Coordinate Studies, with the Assistance of the Department of Health, to Evaluate the Impact of the Physician "On-Call" Crisis on the Queen's Medical Center Trauma Center to Provide Emergency Medical Services in the State of Hawaii, and to Recommend Any Appropriate Government and Private Sector Responses to the On-Call Crisis to Ensure Continued Access to Trauma Level Care." (See Appendix A.)

The Resolution recognized that a trauma center for treating life-threatening injury is essential to the health and well-being of the community. It further recognized that, while emergency departments and hospitals across the State and the nation have experienced a reduction of on-call physician specialists, the crisis is particularly acute for The Queen's Medical Center since it operates the only trauma center in the State of Hawaii.

The Resolution directed the Department of Health (Department) and the Legislative Reference Bureau (Bureau) to respectively evaluate the impact of the physician on-call crisis on the ability of The Queen's Medical Center Trauma Center to provide emergency medical service in the State of Hawaii and identify and analyze appropriate government and private sector actions in response.

The specific task of the Bureau is to identify and analyze any appropriate *government* response to the on-call crisis including:

- The experience and response of other states and cities facing a similar on-call crisis;
- Options to address trauma/emergency department medical services that go uncompensated;
- Options to address liability concerns faced by on-call physicians; and
- An analysis of the pros and cons of mandating that physicians take call to obtain or maintain a license to practice medicine in the State of Hawaii or receive privileges to admit patients to a hospital located in the State of Hawaii.

Shortly after the adjournment of the 2005 Legislative Session, the Department and Bureau discussed their respective roles and concurred that the Resolution falls into two distinct parts, with the Department focusing on The Queen's Medical Center and the State of Hawaii and the Bureau focusing on government responses in other states. Accordingly, the Department and

the Bureau agreed, through their respective representatives, to submit separate studies to the Legislature.

This study begins with a primer on the on-call crisis in trauma care to familiarize policy makers with trauma centers and what they do and the issues that hospitals and physician specialists face with respect to emergency call. The study then discusses the experiences and responses of state governments to this crisis, presenting a sampling of strategies employed in response to the uncompensated care and medical liability issues that physician specialists on emergency call face. Finally, the study discusses the pros and cons of mandatory call.

With the information gained from the Department of Health's Hawaii-specific study and the array of strategies presented by this study, policy makers will be able to begin the process of determining what solutions to apply to improve the on-call availability of physician specialists to The Queen's Medical Center.

Research

To meet the foregoing objectives, we reviewed health policy and legal literature, state statutes, newspaper articles, memoranda, press releases, and other reports.

Organization

This chapter provides the direction and task set forth by the Resolution and research undertaken by the Bureau. The following Chapter 2 provides a primer on the on-call crisis in trauma care. Chapter 3 discusses the causes of the on-call physician specialist shortage. Chapter 4 focuses on state government responses to uncompensated trauma care. Chapter 5 focuses on state government responses to medical liability concerns for on-call physician specialists. Chapter 6 discusses the pros and cons of mandatory on-call. Finally, Chapter 7 contains the Bureau's conclusions.

Chapter 2

THE ON-CALL CRISIS IN TRAUMA CARE – A PRIMER

What is a Trauma Center?

Over the years, states have developed systems of specialized centers of care for the seriously injured. The objective is not necessarily to direct injured persons to the nearest hospital, but to the hospital best prepared to care for the type of injury sustained.[1]

Emergency rooms and *emergency departments* are able to treat ill and injured people: stitching cuts, setting broken bones, and relieving pain and discomfort.[2] *Trauma centers* are able to handle the most severe, life threatening situations, where highly skilled, quick and intensive intervention within the early period of trauma may mean the difference between life and death.[3] General hospitals are required to have an emergency department, but they are not required to have a trauma center.[4]

Levels of Care

There are four basic levels of trauma center care:

- *Level I* centers are able to provide total care for *all* types of injuries.
- *Level II* centers provide total care for *all but the most complicated* cases.
- *Level III* centers provide *initial care and stabilization* while arranging transfer to a level I or II center. They are generally found in rural areas and are required to have *continuous general surgical coverage*.
- *Level IV* centers provide *initial evaluation and stabilization*. They are required to have *continuous emergency coverage by a physician*.[5]

1. John Duval, *Trauma: The Canary in the Mine*, Arizona Health Futures (Fall 2001), p. 2.
2. *Ibid*.
3. *Ibid*.
4. *Ibid*.
5. *Ibid*., p. 3. Hospitals use criteria developed by the American College of Surgeons to evaluate the level of care provided to injured patients at trauma centers.

Only One Trauma Center in the State of Hawaii

In some geographic areas a level II center serves as the lead trauma facility. The Queen's Medical Center, a level II trauma center, is the lead and only trauma facility in the State of Hawaii. For complex care, there is nowhere else nearby to obtain treatment.

> *The Queen's Medical Center is the only American College of Surgeons Certified Trauma Center in the State of Hawaii. In this capacity we treat most of the major trauma cases that occur in the State of Hawaii. Every day of the year patients are transported to our Medical Center from around the state with life threatening trauma. Every hour of the day we mobilize a highly skilled trauma team consisting of doctors, nurses, technicians and other ancillary personnel. In order to support this program we need to be able to mobilize physicians from over 20 medical specialties at a moments notice, we need nurses skilled in multiple aspects of patient care, technicians to maintain heart pumps, take x-rays, MRIs and CT scans, a fully staffed Operating Team, and a virtual army of support personnel.*
>
> *In trauma seconds count and we need to be able to act as soon as the patient arrives at our emergency room door. For this reason we have Trauma Surgeons, Anesthesiologists, Intensivists, Hospitalists, Nurses and Technicians who must be resident in our hospital 24 hours a day, 365 days a year. When seconds count there is no time to wait.*
>
> *Because of the nature of trauma we never know what body systems may be involved. We never know what skills will be required. Therefore, we need to have specialists available to deal with every aspect of the human body. We need Trauma Surgeons, Neurosurgeons, Cardiovascular Surgeons, Ear Nose and Throat Surgeons, Urologists, Anesthesiologists, Ophthalmologists, Plastic Surgeons, Cardiologists, Gastroenterologists, Pulmonologists, and many more.*[6]

On-Call Physician Specialists: A Necessary and Mandatory Component of Trauma Care

As the foregoing exemplifies, trauma care requires highly trained medical staff, functioning as a multidisciplinary team. Because each member is an integral part of the team, a personnel shortage in any area can jeopardize the team's ability to provide care.

Patients with traumatic injuries often require a level of care that can be obtained only through close interaction between emergency physicians[7] and *physician specialists*. Physician

6. Testimony of Dr. Richard Friedman, Vice President of Medical Affairs, The Queen's Medical Center, testifying on behalf of The Queen's Medical Center before the Hawaii House of Representatives, March 31, 2005.

7. *Emergency physicians* have special training in emergency medicine and typically staff emergency departments around-the-clock. Though adept at handling most situations, they cannot possibly know everything about every specialty.

specialists include the general surgeon called upon to operate on a patient with appendicitis, the ophthalmologist called upon to operate on a severe eye injury, the hand surgeon called upon to reattach an amputated finger, and the cardiologist called upon to perform emergency angioplasty for a heart attack. The *on-call* or as needed availability of physician specialists and back up physician specialists ensures appropriate screening, stabilizing, and treatment of trauma patients.

The Problem: A Critical Shortage of On-Call Physicians

Historically, hospitals had few problems ensuring emergency department backup coverage. Physician specialists provided on-call services to hospitals to build their practices and hospitals either required them to be on call as a condition of hospital privileges or relied on their voluntary call participation.[8]

Today, some physician specialists have reduced their multiple staff affiliations by foregoing hospital privileges or reducing privileges from "active" to "courtesy," refusing to sign up for emergency call, restricting the scope of their practice, and resigning from medical groups that accept on-call coverage responsibility.[9] Dependent on the cooperation of physicians, hospitals are disinclined to enforce bylaws for physicians remaining on active staff.

Trauma centers nationwide face difficulty securing on-call specialty coverage:

- In a national survey conducted in 2004 by the American College of Emergency Physicians (ACEP),[10] emergency directors from nearly 1,000 of the 1,500 hospitals surveyed said they have a shortage of on-call specialists.[11]

- In a national survey conducted in 2005 by ACEP, physicians refusing to take call was the number one complaint found.[12]

- In a national survey of hospital administrators and emergency department heads conducted in 2001 by the Schumacher Group,[13] thirteen per cent of those responding

8. California, Senate Office of Research. *Stretched Thin – Growing Gaps in California's Emergency Room Backup System* (May 2003), p. 21.

9. *Ibid.*

10. The American College of Emergency Physicians exists to support quality emergency medical care and to promote the interests of emergency physicians. *See* www.acep.org.

11. Glabman, p. 9. ACEP's survey involved the participation of about a third of the acute care hospitals in the United States. The survey was conducted in conjunction with researchers from Johns Hopkins University and funding from the Robert Wood Johnson Foundation. *See* American College of Emergency Physicians. *On-Call Specialist Coverage in U.S. Emergency Departments* (September 2004).

12. *Ibid.*, pp. 6-7.

13. The Schumacher Group is a nationwide emergency department management firm that provides staffing of over 600 physicians in hospitals across the country. *See* http://www.dbi-tech.com/Customer_Comments/Ryan_Klym_Schumacher_Group.htm

indicated that lack of specialty coverage posed a significant health care risk to patients.[14]

- Press coverage documents instances of physicians refusing to provide on-call coverage in several states, including Oregon,[15] Florida,[16] New Jersey and Arizona,[17] to name a few.

A shortage of physician specialists willing to take emergency call has been reported in the State of Hawaii. *The Honolulu Advertis*er reported in May 2005 that:

- Kapiolani Medical Center for Women and Children in Honolulu has no orthopedic surgeons taking emergency calls on a regular basis.

- Castle Medical Center in Kailua, Oahu has orthopedic surgeon coverage for only half the week.

- Hilo Medical Center has one orthopedic surgeon on call for eight days a month, leaving three weeks without surgical care coverage for victims with bone injuries.

- The Queen's Medical Center has only two orthopedic surgeons on call daily to cover major cases, meaning these surgeons are on call every other night.

- Overall, the number of orthopedic surgeons in the state has dropped twenty-nine per cent over the past decade to forty-eight today.[18]

Meanwhile, emergency department usage grows. For example, The Queen's Medical Center experienced a fifty per cent increase in emergency visits – from 29,000 to 44,000 between 1999 and 2004.[19]

Impact of the Shortage of On-Call Physicians

Increased potential for treatment delays and risk of harm. A national study of 1,500 hospital emergency departments conducted in 2004 found that specialist backup is causing risk of harm to patients who need specialist care, delays in patient treatment, and increased patient transfers between emergency departments. As a consequence, trauma patients are not treated

14. California, Senate Office of Research, p. 8.

15. *Ibid.*, p. 9, citing *Local Doctors are Tired of Filling Emergency Care Gap*, The Business Journal of Portland (December 18, 2000).

16. *Ibid.*, citing *State Takes Notice of Doctors Rejecting On-Call Care in ERs*, Orlando Sentinel (July 19, 2001).

17. *Ibid.*, citing *Valley Doctors Shun ERs; Hospitals Scrambling for Help*, The Arizona Republic (June 3, 2001).

18. *Hawai`i Losing Its Doctors*, The Honolulu Advertiser (May 9, 2005).

19. Gary Okamoto, M.D., President and Chief Executive Officer of The Queen's Health Systems, testifying before the Committee on Health of the Hawaii House of Representatives on March 30, 2005.

quickly when quick treatment is critical to success and a cascading effect is created, pushing neighboring emergency departments to their capacity limits.[20]

The "golden hour" is trauma center terminology for the first hour immediately following an injury. Chances of survival significantly increase and the side effects of injury, such as disability and physical deterioration, significantly decrease if appropriate care is given in the golden hour.[21]

When injuries are serious, the specialized equipment and prompt access to physicians available in trauma centers can make a significant difference in the patient's health outcome. Trauma centers have been shown to reduce preventable deaths by more than twenty per cent as compared to other hospital care.[22]

In the United States, as many as thirty-five per cent of trauma patients die because optimal acute care was not available.[23] The following anecdotes, while isolated, illustrate what can occur when there are gaps in on-call coverage:

- A California emergency physician states:

  > *It happens every day in California hospitals. I've had patients lose their limbs and lose their lives over failure to respond.*[24]

- Recalling the plight of a man in his twenties who came into a hospital with a vascular injury to his leg artery from a gunshot wound, an emergency physician in San Antonio, Texas states:

  > *We had six hours to repair vascular circulation or risk losing the limb. There was a doctor on call but he was tied up in surgery. Another surgeon on call was in another operation. The patient was uninsured and no hospital wanted to take him. Ultimately he was transferred to a city hundreds of miles away. By the time he arrived, his leg was dead and had to be amputated.*[25]

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20. American College of Emergency Physicians. *On-Call Specialist Coverage in U.S. Emergency Departments* (September 2004), p. 3.

21. Duval, p. 3.

22. Virginia Joint Legislative Audit and Review Commission. *The Use and Financing of Trauma Centers in Virginia* (December 2004).

23. Centers for Disease Control and Prevention National Center for Injury Prevention and Control. Available at: www.cic.gov.

24. Clinical Initiatives Center, *Cause for Concern – Ensuring Adequate and Timely On-Call Physician Coverage in the Emergency Department* (2000), p. 4.

25. Glabman, p. 10.

- An emergency department physician at a 250-bed hospital in West Virginia states:

> *At least two middle-aged patients who arrived at Wheeling Hospital in West Virginia with hypertension-related brain hemorrhages likely died from lack of prompt care. . . . They didn't make it through the 55-mile trip to Pittsburgh, the nearest facility with neurosurgeons. The transfers were necessary because between 2000-2003, Wheeling lost all three of its neurosurgeons. . . . Two retired, one moved to Minnesota.*[26]

- In February 2002, two patients died in the emergency room of a rural hospital in the Galveston Region of Texas after the hospital tried unsuccessfully for six hours to transfer the patients to a major trauma center. At least one of these deaths was probably preventable.[27]

Increased costs to society. Trauma care reduces the burden of injury by saving lives and returning those individuals who are seriously injured to productivity.

The Oklahoma State Department of Health notes that trauma is the leading cause of death for persons aged 1 to 44 years and the fifth leading cause of death overall in Oklahoma. It costs the state more years of productive life than all other diseases combined.[28]

The Texas State Department of Health notes:

- Since trauma is the leading cause of death in persons aged 1 to 44 years, the years of potential life lost are staggering: 290,000 in 1993. Using a per-capita income of $19,189, this represents a phenomenal $5.6 billion in lifetime income lost and a loss to the state in lifetime tax revenues of $518 million for that one year of trauma mortality alone.

- Mortality is not the only side of this issue; for every trauma victim who dies, at least six are seriously injured. Total years of productive life lost to disability are not currently known but would add greatly to the figures above. In addition, many persons with severe disabilities resulting from injuries may be dependent to some degree on federal, state and local assistance.[29]

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26. *Ibid.*, p. 11.

27. Gulf Coast Trauma Planning Task Force. *Final Report* (August 26, 2002), p. 1.

28. Oklahoma State Department of Health. *Plans to Move Forward to Improve Oklahoma's Trauma System; May is National Trauma Awareness Month*, OSDH News (May 19, 2005). Available at www.health.state.ok.us/program/hpromo/news/traumamonth.html.

29. Texas State Department of Health. *Texas Trauma Systems History* (May 9, 2001).

Increased costs for hospitals. The federal Emergency Medical Treatment and Labor Act (EMTALA)[30] requires hospitals with emergency services to maintain a twenty-four-hour/seven-day roster of physicians available for on-call care or consultation that includes all specialists and subspecialists represented on the medical staff.[31] Hospitals with these specialized capabilities are required to receive emergency patients from facilities lacking these capabilities. Hospitals failing to meet EMTALA mandates risk the loss of substantial federal subsidies, license revocation, termination of Medicare and Medicaid provider agreements, and the imposition of monetary penalties.

Typically, the cost of running an emergency department is far higher than the total payments received from patients treated.[32] According to the American Hospital Association, one-third of the nation's hospitals already operate in the red.[33] A significant percentage of hospitals are incurring high additional costs from having to pay physicians specialists to provide emergency call coverage. Between 2000 and 2004, thirty trauma centers closed as hospitals faced volume increases, higher costs, liability concerns, and low or no payment for trauma services. Some of the cities that have seen trauma centers close include: Los Angeles, California; Tucson, Arizona; Birmingham, Alabama; El Paso, Sherman, and Texarkana, Texas; and Tulsa, Oklahoma.[34]

Weakened state of readiness to respond to emergencies and disasters. A weakened trauma center decreases a state's state of readiness to respond not only to a normal flow of critically injured patients but to unforeseen disasters and emergencies as well. The tragic events of September 11 and Hurricane Katrina illustrate that trauma readiness and availability is every bit as much an issue of public safety as police and fire services. Skilled trauma services with the capacity to handle a surge in demand are a fundamental necessity in responding to natural disasters and man-made disasters.

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30. EMTALA was enacted by the U.S. Congress as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd). Also known as the federal "anti-dumping law," it ensures the provision of appropriate care to all persons seeking emergency services regardless of whether they have insurance or are able to pay. EMTALA requires all hospitals receiving Medicare and Medicaid funding to provide a medical screening examination to determine the presence or absence of an emergency medical condition. Hospitals also must stabilize the medical condition within the capabilities of the staff and facilities available at the hospital, prior to patient discharge or transfer.

31. *See* Health Care Financing Administration State Operations Manual (42 U.S.C. §1395cc(a)(1)(I)(III). The Health Care Financing Administration is the federal agency that administers the Medicare, Medicaid, and Child Health Insurance programs. The 24-hour/7-day on-call roster requirement may not be imposed when the hospital is unable to secure an agreement with specialists to take call round-the-clock due to reasons such as a dearth of specialists in the area or the distance from a specialist's home to the hospital.

32. Testimony of Rich Meiers, testifying in behalf of the Hawaii Health Care Association before the Committee on Health of the Hawaii House of Representatives (March 31, 2005).

33. Glabman, p. 7.

34. Washington Health Care Association, *Trauma System Needs More Funds* (2005), p. 9.

Chapter 3

CAUSES OF THE ON-CALL PHYSICIAN SPECIALIST SHORTAGE

The reasons why fewer physicians are taking emergency call tend to fall into four categories:

- Uncompensated care;
- Practice and lifestyle;
- Supply and demand; and
- Legal concerns.

Uncompensated Care

> *Society is exceeding the good will of doctors to be able to cope financially. Many doctors would just as soon quit practicing than continue to work for free.*[1]

Nationwide, while the costs of practicing medicine and delivering trauma care have steadily increased, reimbursements to physicians and hospitals have dramatically decreased. Cost containment has been the principal policy objective of both private insurers and the Medicare program since the 1980s. According to the National Foundation for Trauma Care:

> *Managed care has long since forsaken its role as an engine of innovation to become a bureaucracy devoted to cost cutting.*[2]

The Institute of Medicine of the National Academies[3] reports:

> *Over the past 25 years, public policies to control health care costs, including the promotion of competitive health care markets, have constrained the amounts that insurers pay to providers. This has eroded the financial support that allowed providers to subsidize their uncompensated care. The effects of this erosion have*

1. Maureen Glabman, *Specialist Shortage Shakes Emergency Rooms; More Hospitals Forced to Pay for Specialist Care*, The Physician Executive (May-June 2005), p. 11, quoting Jack Lewin, M.D., Chief Executive Officer, California Medical Association.

2. National Foundation for Trauma Care, *Crisis in Trauma Care? Bleeding Red Ink, Trauma Centers Threaten to Close*, The Trauma Care Connection (Spring 2001).

3. The Institute of Medicine of the National Academies is a nonprofit organization specifically to serve as adviser to the nation to improve health. The Institute provides unbiased, evidence-based, and authoritative information and advice concerning health and science policy to policy-makers, professionals, leaders in every sector of society, and the public at large.

> *been felt more strongly in communities with large or growing uninsured populations. . . .*[4]

Indeed, lack of payment and underpayment associated with on-call services typically extend to all payers – health plans, Medicare, Medicaid, and safety net programs for the uninsured. Typical problems experienced include:

- Downcoded fee reimbursements from health plans.

- Medicare reimbursements cuts. Medicare reimbursements were significantly cut by the Balanced Budget Act of 1997 and further decreased by 4.7 per cent in 2005. An additional decrease of almost 30 per cent is projected over the next five years.[5]

- Billing codes that fail to reflect the time and skill required to resuscitate and care for seriously injured patients.

- Emergent, night, and weekend care that is paid at the same rate as routine, scheduled care despite the difficulty of trauma care and its disruption to physicians' elective practices.

- The refusal of health plans to pay for services provided by specialists who do not have a contract with the health plan, even in instances where federal Emergency Medical Treatment and Labor Act (EMTALA) rules obligated the specialist to provide the services because of the unavailability of a health plan-employed specialist.[6]

As a result of the foregoing cost containment policy objectives, physician specialists and hospitals have been facing increased uncompensated trauma care costs. For example:

- A general surgeon practicing in Phoenix, Arizona notes that in the late 1980s a general surgeon was reimbursed about $1,000-$1,200 per case. Today, the reimbursement is about $550 per case.[7]

- A Hawaii orthopedist notes that over the last decade reimbursement for knee surgeries has dropped from $4,000 to $1,400. Orthopedic surgeons are now paid less for a total hip replacement than they were in 1976.[8]

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4. Institute of Medicine. Statement of Arthur L. Kellermann, M.D., M.P.H., co-chair of the Committee on the Consequences of Uninsurance, in testimony before the United States Senate (April 30, 2002).

5. Testimony of John Hill M.D., chairman of the Organized Medical Staff Section of the California Medical Association at the March 2005 meeting of the EMTALA technical advisory group.

6. American College of Emergency Physicians. *On-Call Physicians* (2005), p. 3.

7. John Duval, *Trauma: The Canary in the Mine,* Arizona Health Futures, Fall 2001, p. 14.

8. *Hawai`i Losing Its Doctors*, The Honolulu Advertiser, May 9, 2005.

According to a 2003 American College of Emergency Physicians survey, about half of all emergency services in the country are uncompensated and about forty-two per cent are significantly underpaid or paid only after considerable delays.[9] While hospitals and physicians have absorbed uncompensated costs in the past by shifting them to patients who could pay, it has become increasingly difficult to recover those costs with the flat fees provided by many health plans. Further, although the issue of declining public payments is not unique to physicians on trauma call, it is compounded for trauma physicians because they serve a disproportionate number of uninsured patients, which leaves them with only a small pool of patients paying market rates. There are only so many hours in the day for physicians to make a living. Time taken up by activities that do not generate income constitute a direct cost to the physician.

Practice and Lifestyle

> *[Physician specialists] are frequently called to the ER [emergency room] multiple times a day to deal with difficult and complex cases. These patients take time away from their busy practices and limit their ability to see their own patients. While this is happening they must maintain their own office staffs, pay office rent, and cover expenses.*
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> * * *
>
> *When physicians are called to the ER at night they frequently must spend hours dealing with complex cases. Yet they must be prepared to carry a full patient load the next morning.*[10]

The work-life balance has become a driving factor for more physicians, with many striving to tailor the work environment to fit a more desired lifestyle.

Supply and Demand

There is a national shortage of specialists in many of the areas critical for trauma coverage. Reasons for the shortage include the following:

- The physician workforce is aging. Doctors are retiring, slowing down, relocating, or leaving the practice. According to a 2001 survey by the California Medical Association, forty-three per cent of the physicians surveyed planned to leave practice within three years, and twelve per cent planned to reduce the amount of time they

9. Washington State Hospital Association. *Trauma System Needs More Funds* (2004), p. 5.

10. Testimony of Dr. Richard Friedman, Vice President of Medical Affairs for The Queen's Medical Center, testifying before the Committee on Health of the Hawaii House of Representatives on March 31, 2005.

spent practicing medicine.[11] A general surgeon in practice in Phoenix, Arizona explains:

> *The retirement age for surgeons in the 70s and 80s was 65-70 years old, but now it's down to 57-60 years old. Why? You have to work twice as hard just to stay even, see more patients you don't get paid for, and are expected to be on call constantly.*[12]

- More physicians specialists are doing work in outpatient surgical centers. These physicians may no longer need to have staff privileges at hospitals with emergency department call requirements attached. In addition to ambulatory surgery centers and specialty hospitals, doctors have also expanded office-based clinical capabilities.

- Training slots for physicians have declined. For example:

  - Nationally, the number of residency training programs declined from 157 in 1995 to 152 in 2000;

  - Nationally, the number of training slots for individual doctors declined from 3,228 to 2,043;

  - The number of anesthesiology graduates in the United States declined from 1,740 in 1993 to 891 in 1999;

  - Only 50 new cardiologists are currently being trained nationally, despite a nationwide need for 300 new cardiologists each year.[13]

- Many medical specialists are practicing subspecialties. For example, plastic surgeons practicing mostly cosmetic surgery have little desire for trauma care; orthopedic surgeons performing hand, joint, or sports medicine are increasingly uneasy with complex trauma cases.[14]

Legal Concerns

Penalties for violating EMTALA. Physicians who commit to being on-call at an emergency department must respond to emergency calls within a timely manner or risk federal financial penalty. Medicare-participating physicians who violate EMTALA could be sanctioned

11. California, Senate Office of Research. *Stretched Thin. Growing Gaps in California's Emergency Room Backup System* (May 2003), p. 33.

12. Duval, p. 13.

13. California, Senate Office of Research, p. 31.

14. National Foundation for Trauma Care, *U.S. Trauma Center Crisis – Lost in the Scramble for Terror Resources,* (February 2004), p. 8.

with termination from participation in the Medicare and Medicaid programs and civil monetary penalties up to $50,000 per violation.

Malpractice liability concerns. Rising malpractice liability insurance rates, in combination with lower reimbursement rates, render the practice of certain specialties less and less cost effective. As one San Antonio, Texas emergency physician points out:

> *Why would anyone in his right mind want to suffer liability exposure for no pay? It rubs salt in the wound.*[15]

Following are examples of the extent to which malpractice liability insurance rates have risen:

- Since 2001, the average liability insurance premium for orthopedic surgeons rose forty-five per cent to as much as $59,000 per year, according to figures from the Medical Insurance Exchange of California, which insures a third of Hawai`i physicians. [16]

- Since 2000, malpractice insurance premiums for internists, general surgeons, and obstetricians have skyrocketed nationwide, jumping twenty to twenty-five per cent in 2002 alone.[17]

- Specialists in some states have seen one-year malpractice insurance premium increases of seventy-five per cent.[18]

- In Pennsylvania, the cost of a standard policy for general surgeons at the largest insurer had risen from $33,684 in 2000 to $72,518 in 2003. [19]

Finding affordable liability insurance is particularly difficult for specialists doing emergency call:

> *There is increasing pressure from malpractice insurers for physicians not to provide ER coverage. Some carriers are threatening to remove coverage from physicians who provide this care. Other carriers have increased the cost of such*

15. Glabman, p. 11.

16. *Hawai'i Losing Its Doctors*, The Honolulu Advertiser, May 9, 2005.

17. *Rising doctors premiums not due to lawsuit awards*, The Boston Globe (June 1, 2005). Available at http://www.boston.com/business/globe/articles/2005/06/01.

18. *Malpractice Crisis Under the Microscope: New Health Affairs Study Finds That Malpractice Payouts Have Not Grown Substantially*, Health Affairs Online (May 31, 2005). Available at http://www.healthaffairs.org/press/mayjune0504.htm.

19. Amanda Gardner, *Doctors' Legal Woes Changing U.S. Health Care*, Health Day Reporter (May 31, 2005).

> *coverage. For specialty physicians the cost of this coverage may amount to many hundreds of thousands of dollars a year.*[20]

On-call physicians often assume greater liability when treating emergency patients. The potential severity of unassigned patients' medical condition and outcome and their lack of an established relationship with the on-call physician may increase the physician's liability exposure.

During "malpractice crises," concerns are expressed that liability costs will drive high-risk specialist physicians from practice, creating access-to-care problems. Indeed, liability pressures may be leading to greater consolidation of high-risk specialty care services by a smaller number of providers. While the problem is multi-factorial, with reimbursement and managed care arrangements contributing significantly, physician specialists perceive liability to be the strongest driver.[21]

20. Testimony of Dr. Richard Friedman, Vice President of Medical Affairs for The Queen's Medical Center, testifying before the Committee on Health of the Hawaii House of Representatives on March 31, 2005.

21. *Ibid.*

Chapter 4

UNCOMPENSATED TRAUMA CARE: GOVERNMENT RESPONSES

In light of the value of trauma centers to individuals and society, a few states helped their trauma centers by developing dedicated public sources of funding to address uncompensated trauma care. California, Maryland, Mississippi, Oklahoma, Texas and Washington established trauma funds that specifically address reimbursements to physicians for uncompensated trauma services. This chapter focuses on a sampling of states that have addressed uncompensated trauma care, starting with a general discussion of the funding mechanisms established, then proceeding to a state-by-state discussion of each state's experiences and responses.

Trauma Funding: In General

States vary in terms of which groups of providers will benefit from their trauma funds. Some opt for comprehensive legislation that provides funds at several levels, i.e., trauma centers, physicians, emergency medical first responders, state and regional trauma system administration, and trauma-specific public information and education. Maryland is an example of a state with a separate Trauma Physicians Service Fund to specifically address physician reimbursements for uncompensated trauma care.

Trauma funding is generally available to physicians with specialized skills used at a disproportionately high rate for trauma cases. Maryland reimburses trauma surgeons, orthopedic surgeons, neurosurgeons, critical care physicians, and anesthesiologists.[1] Mississippi reimburses the following: anesthesiologists who are financially affected when the patient chooses not to pay, general/trauma surgeons, orthopedic surgeons and neurosurgeons.[2]

All of the states studied maintain their trauma care funds in their state treasuries and administer them through the Department of Health or an equivalent agency. Involvement by the Department of Human Services or its equivalent is often necessary to address Medicaid reimbursements and to leverage federal matching funds. Funds are generally distributed to regional agencies, who disburse the funds to providers. Most trauma funds authorize disbursement only to state- or county-designated trauma centers and only for patients who qualify as trauma patients in the state or local trauma registry.[3]

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1. Code of Maryland, §10.25.10.

2. Mississippi State Department of Health, *Mississippi Trauma Care Trust Fund; Reimbursement for Uncompensated Care Process Manual* (January 2005), p. 12.

3. Currently, thirty-seven states, including Hawaii, maintain a trauma registry that includes information on patients treated within designated trauma centers. Health Resources and Services Administration. *A 2002 National Assessment of State Trauma System Development, Emergency Medical Services Resources, and Disaster Readiness for Mass Casualty Events* (2002), p. 16-17. Available at *ftp://ftp.hrsa.gov/hrsa/trauma/nationalassessment.pdf.*

The rationale for public support of uncompensated trauma services is the same as for critical police and fire services; a trauma system is a necessary public service that ought to be publicly supported.

Funding Sources

States use state, local, and federal funds to support their trauma programs. Typically, more that one funding source is needed.

Surcharges. Funding sources for trauma care are often closely associated with activities that have a high potential for causing traumatic injuries. In the United States, motor vehicle crashes are the leading cause of unintentional injury deaths in ages one through sixty-four.[4] States added surcharges for trauma care onto fines for convictions for traffic violations and fees for driver's license and motor vehicle registration renewals and the sale or lease of new or used motor vehicles. Surcharges are also tacked onto fines for convictions for alcohol and other substance abuse-related offenses and firearm use and possession offenses. For example:

- In Illinois, supplemental funding to assist levels I and II state-designated trauma centers is collected from:
    - A $5 surcharge on moving violation fines that amount to $55 or more;[5]
    - A $105 surcharge for every conviction or suspension for driving under the influence of alcohol or drugs;[6] and
    - A $100 surcharge for every conviction of unlawful use or possession of weapons by felons or persons in the custody of the Department of Corrections Facilities and illegal discharge of a firearm or illegal possession of a controlled substance.[7]
- The State of Oklahoma's Trauma Care Assistance Revolving Fund:
    - Receives one-half of the fine assessed for conviction of certain motor vehicle offenses when committed by a person who does not have a valid driver's license.
    - Adds a $100 to $200 surcharge onto the fines assessed for convictions for certain drug- or alcohol-related offenses.[8]

4. Sierra-Sacramento Valley Emergency Medical Services Agency. "California's Trauma Care. Trauma Fund Utilization: A Followup Report to the California Legislature. Lessons Learned and Future Need," (June 2004), p. 6. Available at http://www.ssvems.com.
5. Illinois Compiled Statutes §27.6.
6. Illinois Compiled Statutes §5-9-1.1 and §16-104b.
7. Illinois Compiled Statutes §5-9-1.10.

Tax on cigarette sales; tobacco settlement funds. Several states combined trauma care and anti-smoking initiatives, generating revenues for trauma care by imposing additional taxes on cigarette sales or by tapping into tobacco settlement funds. For example:

- The State of Mississippi appropriated $6 million in 1999 from its Tobacco Settlement Fund to the Trauma Care Trust Fund, a portion of which is allocated for the reimbursement of eligible hospital and physicians for treating uncompensated trauma cases.[9]

- The State of Texas appropriated $4 million in 2001 from earned interest on its Tobacco Settlement Fund, allocating $250,000 for an extraordinary emergency reserve and the rest for indigent care.[10]

Sales and development taxes. Alameda County, California assesses an additional half-cent sales tax for trauma care. Los Angeles County assesses an annual tax of three cents per square foot of improvements on developed property for trauma care.[11]

Subsidies to increase Medicaid reimbursements. In 2004, Oklahoma appropriated $5.7 million to increase Medicaid reimbursements for trauma care.[12] Washington provides supplemental payments for trauma services to Medicaid clients at level I, II, or III facilities, based on the relative amount of trauma care provided per quarter to Medicaid recipients.[13]

State budget appropriations. Several states made budget appropriations to supplement dedicated funding sources. In 2002, the California Legislature appropriated $25 million for specialty physician on-call coverage, indigent care, and trauma registry improvement.[14] In 2005,

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8. *See* Oklahoma Statutes §63-1-2530.9 (Trauma Care Assistance Revolving Fund established) and §§21-1220, 47-6-101, 47-17-101, 47-17-102, 63-2-404, 63-2-405, 63-2-406, 63-2-407, and 63-2-407.1 (assessments and surcharges). Available at http://www2.lsb.state.ok.us/tsrs/os_oc.htm.

9. Mississippi Department of Health, Emergency Medical Services. *Trauma Care Trust Fund*. Available at http://www/ems/doh.ms.gov/trauma/trauma_trust_fund.html.

10. Dedicated Funding for State Trauma Systems. Available at http://www.mass.gov/dph/oems/trauma/ppt/funding.ppt.

11. Sierra-Sacramento Valley Emergency Medical Services Agency. *California's Trauma Care – Trauma Fund Utilization: A Followup Report to the California Legislature – Lessons Learned and Future Need* (June 2004), pp. 23-24.

12. Maureen Glabman, *Specialist Shortage Shakes Emergency Rooms; More Hospitals Forced to Pay for Specialist Care*, The Physician Executive (May-June 2005), p. 9.

13. Wyoming Health Care Commission, *Unreimbursed Catastrophic and Trauma Care Study*, (October 28, 2004), p. IV-5.

14. Dedicated Funding for State Trauma Systems. Available at http://www.mass.gov/dph/oems/trauma/pt/funding.ppt.

$10 million in general fund moneys was approved in the Governor's Budget for trauma center funding.[15]

Experience and Response of Other States

Following is a case-by-case study of the experience and response of a sampling of states with trauma fund statutes that specifically address reimbursements to physicians for uncompensated trauma services.

California

California's emergency-care system has been in crisis for many years. Emergency departments and trauma centers are overcrowded, underfunded, and distressed. Most are in the red, with losses totaling in the hundreds of millions of dollars each year. From 1996 to 2004, sixty-eight California hospitals closed and numerous hospitals closed or reduced their emergency departments.[16]

In 2001, by AB 430, the California Legislature established the Trauma Care Fund in the state treasury to ensure the availability of services through emergency medical services (EMS) agency-designated trauma centers.[17] The Fund provides for indigent care, physician on-call panels, trauma registries, and infrastructure needs. In 2005, its focus was amended to emphasize the preservation or restoration of specialty physician and surgeon call coverage essential for trauma services within a specified hospital.

Fund moneys are allocated to EMS agencies in counties with at least one designated trauma center in their jurisdictions. The amount provided to each county EMS agency is in the same proportion as the total number of trauma patients reported to the county trauma registry for each agency's area of jurisdiction compared to the total number of all trauma patients statewide.

Each county is authorized to establish and administer its own EMS fund for the receipt of Trauma Care Fund moneys. Up to ten per cent of county EMS funds may be used for fund administration. Of the remaining funds, fifty-eight and twenty-five per cent are allocated for reimbursement to physicians and hospitals, respectively, for uncompensated emergency and trauma care.

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15. California Emergency Medical Services Authority. *Report on Trauma System Planning*. Available at http://www.emsa.ca.gov?def_comm/x_092105.asp.

16. California Hospital Association. *The Emergency Services and Tobacco Tax Act Ballot Initiative Fact Sheet* (September 2005).

17. California Code §1797.199.

When determining trauma center distribution amounts, the counties consider:

- The volume of uninsured trauma patients treated at the trauma center;
- The existence of a high percentage of uninsured trauma patients relative to the total number of trauma patients treated at the trauma center; and
- The acuity mix of uninsured trauma patients treated at the trauma center.[18]

Claims for reimbursement are specifically limited to patients who cannot afford to pay for those services and for whom payment will not be made through any private coverage or by any program funded by the federal government.[19]

In California, trauma care is funded by the following funding sources:

- *Penalty assessment*: Each county is authorized to levy a penalty assessment to obtain moneys for their EMS funds.
- *Tobacco tax*: In 1988, California voters passed Proposition 99, the Tobacco Tax and Health Promotion Act, increasing the state tobacco tax by 25 cents on a pack of cigarettes (to 35 cents per pack) and 42 cents on other tobacco products. Deposited into the Cigarette and Tobacco Products Surtax Fund, these revenues support anti-smoking education programs, tobacco-related diseases research, and indigent health care and public resources. Ten per cent of the Fund is distributed to pay emergency physicians, obstetricians, and pediatricians for uncompensated care provided to indigent patients. In fiscal year 2004, the Fund received $314 million in revenues and roughly $31 million was made available statewide to physicians for uncompensated care.[20]

  In 2004, a statewide ballot initiative, Proposition 67, proposed *dedicated* funding of about $32 million per year in Proposition 99 tobacco tax funds to reimburse physicians and community clinics for uncompensated care. The initiative failed with seventy-two per cent of the vote against it. The failure may be attributed to

18. *Ibid.*

19. Billing conditions include the following:
    (1) The physician or surgeon must have asked the patient if there is a responsible third-party source of payment and billed for payment; and
    (2) Either:
        (a) Three months have passed since billing, during which time no reimbursement for any portion of the bill has been obtained despite at least two attempts by the physician or surgeon to obtain reimbursement; or
        (b) The physician or surgeon has received notification from the patient or responsible party that no payment will be made. California Code §1797-98a.

20. Health Services Cost Review Commission. *III. The Feasibility of Establishing a Hospital-based and University-based Physician Uncompensated Care Fund*, p. 8. Available at http://mhcc.maryland.gov/legislative/hb805/ch3.pdf

opposition to a joint proposal in Proposition 67 that would have increased the monthly surcharge that supports the State's 911 emergency telephone number system (by three per cent on telephone calls made within California). Opponents stressed that the proposal would increase phone taxes by four hundred per cent, with no cap for small business phones or cell phones, and was misleading since less than one per cent of the revenues would go to improving the 911 system.[21]

- *Tobacco Litigation Master Settlement Agreement.* Pursuant to the 1998 Tobacco Litigation Master Settlement Agreement, California is expected to receive $25 billion through the year 2025. A portion of these funds is used for physician uncompensated care.[22] The Settlement Agreement does not restrict how tobacco revenues may be spent. Orange County dedicated fifty per cent of its settlement payments to health care programs and in FY 2001 distributed $7.9 million of settlement revenue to emergency room physicians and on-call physician specialists for services for nonpaying patients.

- *Tax on improvements on developed property.* In 2002, Los Angeles County voters approved a ballot measure imposing an annual tax of three cents per square foot of improvements on developed property. The measure is projected to generate $174 million annually and demonstrates the public's willingness to tax themselves to maintain trauma services.[23]

- *Sales tax.* In Alameda County, voters approved an additional half-cent sales tax to help trauma services. Estimated to generate $95 million annually, seventy-five per cent of tax revenues is allocated for Alameda County Highland Hospital, a trauma center, and twenty-five per cent may be used for other purposes, including uncompensated care.[24]

- *State budget allocations.* The Legislature and Governor acknowledged the importance of trauma care by appropriating $27.5 million in funding for FY 2001-2002 and $20 million for FY 2002-2003. Due to California's critical budget shortfalls, trauma care funds were not included for the 2003-2004 state budget.[25] On July 19, 2005, $10 million in general fund money was approved in the Governor's Budget for trauma center funding.[26]

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21. California Secretary of State. *Propositions – Arguments and Rebuttals.* Available at http://www/voterguide.ss.ca.gov/propositions/prop67-arguments.htm.

22. Tobacco revenues are split evenly between the state and local governments. Ten per cent of the local government allocation is directed to the Los Angeles, San Diego, San Francisco and San Jose, each of which had separate lawsuits against the tobacco industry, and the remaining forty per cent is then divided between fifty-eight counties based on population.

23. Sierra-Sacramento Valley Emergency Medical Services Agency, p. 23.

24. *Ibid.*, p. 24.

25. *Ibid.*, p. 6.

26. California Emergency Medical Services Authority. *Report on Trauma System Planning.* Available at http://www.emsa.ca.gov?def_comm/x_092105.asp.

Current situation in California. A 2004 report found that:

- Trauma Care Fund dollars were essential for maintaining trauma centers with a large number of uncompensated patients. University Medical Center (Fresno) spent ninety-four per cent of its trauma care funds on indigent care and Los Angeles County-USC Medical Center, King-Drew Medical Center, Harbor UCLA Medical Center, UCLA Medical Center, Cedars-Sinai Medical Center and University of California Irvine Medical Center spent all trauma care funds on indigent care and physician on-call panels.

- Trauma Care Fund dollars stabilized some trauma care systems in danger of collapse (avoiding the domino effect to other trauma centers), thus allowing additional time to establish a statewide trauma system.

- California continues to lack a statewide coordinated trauma system due to insufficient funding for needed infrastructure and trauma hospital and physician readiness. Without adequate funding, trauma care will remain inconsistent across the State, with some areas lacking access to trauma care. Uncompensated and under-compensated care remain underfunded.[27]

The California Hospital Association in its report, *2005-2010 Public Policy Environment and Update to View of the Future*, notes that, in the 2005-2010 timeframe, the fundamental health care policy dilemmas of the last five years – e.g., adequacy of payments, safety-net funding, costs, coverage, access, management of care, and unfunded regulatory mandates – will remain dominant themes. Moreover:

- Inadequate trauma and emergency capacity and an acute shortage of on-call specialist physicians will further erode an already fragile emergency system.[28]

- Emergency departments will experience increasing shortages of specialists, including neurosurgeons and orthopedic surgeons, willing to take call. More hospitals will face increasing pressure to pay stipends or guarantee payment for services, but payment will not be a panacea because the problem is more than economic. Evolving changes in expectations about work increasingly will influence physicians' choices about medical practice.[29]

- In late 2004, the impending closure of another trauma unit was reported, reducing to twelve the number of trauma centers serving Los Angeles County's ten million people. The County had twenty-three trauma centers in 1985. The latest trauma unit

27. Sierra-Sacramento Valley Emergency Medical Services Agency, p. 8.

28. California Hospital Association. *California Health Care 2005-2010 Public Policy Environment and Update to View of the Future* (2005), p. 5.

29. *Ibid.*, p. 7.

closure will increase the burden at other already jammed emergency rooms, slowing care and adding to the diversion by ambulance of patients to other hospitals in the area. County-wide, Los Angeles 911-receiving hospitals were shut to ambulances thirty-six per cent of the time in January 2004. Similar diversion problems occur in other parts of the State.[30]

Illinois

In 1993, the Illinois Legislature established the Trauma Center Fund, a special fund in the state treasury, to assist levels I and II state-designated trauma centers with the cost of providing care to severely injured patients.[31]

The Trauma Center Fund receives revenues from:

- A $5 surcharge imposed on moving violation fines of $55 or more;[32]
- A $105 surcharge for every conviction or suspension for driving under the influence of alcohol or drugs;[33] and
- A $100 surcharge for each conviction of unlawful use or possession of weapons by felons or persons in custody at Department of Corrections facilities and illegal discharge of a firearm or illegal possession of a controlled substance.[34]

The surcharge is paid to the clerk of the court, who is authorized to retain 2.5 per cent of the surcharge to defray administrative costs.

The funds collected are divided between the Illinois Departments of Public Health and Public Aid. Department of Public Health funds must be distributed in the geographic region in which the violation occurred on a per trauma case basis. Department of Public Aid funds are based on the number of Medicaid trauma patients, with matching funds provided by the federal government. Hospitals designated by the Department of Health as level I or II trauma centers are eligible to receive funds.

In late 2005, the Governor of Illinois announced the distribution of $14 million collected from traffic fines and drunk driving convictions to more than one hundred trauma centers in the

30. The Emergency Medical Care Initiative, *King-Drew Hospital Announces Closure of Its Trauma Unit; Underscroing Need for Proposition 67 (*September 13, 2004).

31. Illinois Compiled Statutes §3.225.

32. Illinois Compiled Statutes §27.6.

33. Illinois Compiled Statutes §5-9-1.1 and §16-104b.

34. Illinois Compiled Statutes §5-9-1.10.

State. Since FY 1994, the Departments of Public Health and Public Aid respectively distributed $42.7 million and $84.2 million to the State's trauma centers.[35]

Maryland

In 2003, having reached a financial crisis point, three of the Maryland's eleven trauma centers were in danger of closing down because of increased demands for reimbursement by on-call physicians, inadequate insurance and Medicaid reimbursement rates, and relatively large numbers of trauma patients who failed to pay their bills. One hospital reported that a $1 million shortfall could close it down in July 2003 if state financial help was not made available.[36]

Senate Bill 479, enrolled during the 2003 Maryland Legislative Session, established the Maryland Trauma Physician Services Fund to provide:

- Reimbursement to physicians for trauma services provided to patients without health insurance of up to one hundred per cent of the Medicare rate for the Baltimore carrier locality;

- Increased reimbursement rates to physicians providing trauma care to Medicaid enrollees;

- Reimbursement to trauma centers for stipends paid to call panels; and

- Inclusion of trauma center physician stand-by costs in hospitals' state-recognized rates.[37]

The Maryland Health Care Commission and the Health Services Cost Review Commission are the designated state agencies responsible for implementing the law and maintaining the funds collected for physician reimbursement.

Trauma surgeons, orthopedic surgeons, neurosurgeons, critical care physicians, and anesthesiologists are eligible for fund moneys.[38] Physicians practicing emergency medicine may be reimbursed for trauma services provided to uninsured patients, though funds for this purpose are capped at $250,000 annually. On-call expenses are reimbursed up to allowed ceilings, and reimbursement can be obtained on a semiannual basis.

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35. Office of the Governor of the State of Illinois. *Gov. Blagojevich announces $4.9 million for Illinois trauma centers; Traffic fines give Illinois trauma centers a boost to help critically injured* (September 30, 2005). Available at http://www.illinois.gov/PressReleases.

36. Allen Powell II, *Hospitals: Crisis in funding could close trauma centers*, Capital News Service (March 21, 2003). Available at http://www.dimensionshealth.org/dhs_pre_32103.shtml.

37. COMAR, Chapter 33. *See also* Maryland Health Care Commission. *Maryland Trauma Physician Services Fund Fact Sheet* (January 29, 2004). Available at http://mhcc.maryland.gov/trauma_fund/_trauma.htm.

38. COMAR 10.25.10.

The law defines an uninsured patient as someone without private health insurance, including Medicare Part B coverage, federal Veterans Administration health benefits, military health benefits, worker's compensation, or Medicaid (traditional and managed care). Funds for uncompensated care will be considered only for physician practices that have exhausted their collection policies and procedures for services rendered.[39]

The Fund is financed with a $5 surcharge on new vehicle titles and vehicle registration renewals. Physicians and trauma centers are eligible for uncompensated care and on-call reimbursements for services provided to patients on the Maryland trauma registry beginning October 1, 2003.[40]

Beginning in November 2003, the Maryland Health Care Commission launched a statewide outreach campaign to educate potential beneficiaries about the Fund, obtaining physician directories from all nine trauma centers and sending letters about the program to over six hundred fifty physicians. Educational seminars were conducted in several Maryland cities. The Commission maintains Fund information on its Internet site and periodically releases Physician Information Bulletins clarifying particular aspects of the Fund.

Current situation in Maryland. The Fund has been an efficient method of subsidizing uncompensated care. The current question, however, is how to fund a broader base of physicians with uncompensated costs. In FY 2003, uncompensated physician costs at hospitals in under-served areas of Maryland totaled $48.4 million.[41] The Fund's size in 2003 was $11 million.[42] Maryland law provides no formula for increasing Fund collections in future years.[43]

Mississippi

House Bill 966, enrolled during the 1998 Mississippi Legislative Session, requires the assessment of an additional $5 on all moving traffic violations for deposit into the Trauma Care Trust Fund. The bill requires funds to be appropriated annually for:

- State and regional trauma system administration;
- State trauma-specific public information and education; and

39. *See* Senate Bill 479 (2003 Maryland Regular Session).
40. Maryland Health Services Cost Review Commission. *III. The Feasibility of Establishing a Hospital-based and University-based Physician Uncompensated Care Fund* (2003), p. 7.
41. Department of Legislative Services, Maryland General Assembly. *Fiscal and Policy Note for House Bill 1313* (2004 Session).
42. *Ibid.*
43. Maryland Health Care Commission. *Report to the Maryland General Assembly on the Maryland Trauma Physician Services Fund – Operations from October 2004 through June 2004* (2004), p. 10.

- Hospital and physician uncompensated care funding to trauma care centers designated or provisionally designated by the State.

Additionally, in 1999, the Mississippi Legislature appropriated an additional $6 million to the Trauma Care Trust Fund from the Tobacco Settlement Trust fund.[44]

Only treatment of patients qualified for entry in the trauma center's trauma registry that also meets the definition of "uncompensated"[45] may be submitted for reimbursement from the Trust Fund. Currently, the only specialists qualified to apply for fund moneys are: anesthesiologists who are financially affected when the patient chooses not to pay, general/trauma surgeons, orthopedic surgeons, and neurosurgeons.[46]

Seventy per cent of fund moneys is allocated to hospitals and thirty per cent is allocated to eligible physicians. In 2003, $2.253 million was paid to physicians, i.e., $1.87 million to surgeons and $381,438 to anesthesiologists.[47]

Oklahoma

The Oklahoma Trauma Care Assistance Revolving Fund provides reimbursement to eligible emergency medical service, hospital, and physician entities in cases that meet major trauma clinical criteria and remain uncompensated after reasonable collection efforts are exhausted.[48] Annually, fund moneys may also be transferred to the Oklahoma Health Care Authority to maximize the Medicaid reimbursement for trauma care and, in combination with federal matching funds, to reimburse hospitals, ambulance service providers and physicians for trauma care for severely injured Medicaid participants.

The Fund is a continuing fund, available from year-to-year. Fund moneys are distributed by the State Department of Health on a pro-rata basis after costs are established and ineligible cases are subtracted.

Sources of revenue for the Fund include renewal and reinstatement fees for driver's licenses and fines for convictions for driving under the influence, driving without a license,

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44. Mississippi law allows interest generated from the Tobacco Settlement Trust Fund to be appropriated for state-run health-care programs.

45. A claim is considered to be uncompensated if, after the provider's due diligence to collect moneys due, total payment from any source (including third party payers of five per cent or less) has been made on the total trauma-related gross charges. Claims paid *in any part* by Medicaid cannot be submitted for reimbursement from the fund. Mississippi State Department of Health, *Mississippi Trauma Care Trust Fund; Reimbursement for Uncompensated Care Process Manual* (January 2005), p. 16.

46. Mississippi State Department of Health, *Mississippi Trauma Care Trust Fund; Reimbursement for Uncompensated Care Process Manual* (January 2005), p. 12.

47. *Ibid.*, 2003 Surgeon Allocation Worksheet.

48. In 2004, Oklahoma House Bill 1554 added physicians to the list of providers eligible for reimbursement from the Trauma Fund.

failure to maintain mandatory motor vehicle insurance, violating the open container law, speeding, and drug-related offenses. For some offenses, the amount collected for the Fund from fines is fifty per cent of the fine collected. For other offenses, a $100 to $200 special assessment trauma care fee is collected in addition to the fine. Of each fee charged for issuance or renewal of an Oklahoma license, $5.50 is deposited to the Fund.[49]

The Oklahoma Tobacco tax is another source of revenue for the Fund. State voters approved this tax in 2004 by ballot initiative, State Question 713, with fifty-three per cent of the vote. A health initiative aimed at preventing smoking related diseases and deaths and increasing Oklahoma's health care standards, State Question 713 combined several tax and funding changes to appeal to a wide base of voters. Among other things, the initiative replaced the sales tax on cigarettes and other tobacco products with a new tax that would increase cigarette taxes by fifty-five cents per pack. Funds from the new tax are earmarked for uncompensated trauma care, the premium assistance program (designed to provide insurance coverage for more Oklahomans), the building of a new cancer center, long-distance medical care, aid to hospitals and ambulance services, and substance abuse and breast cancer services. Seven and one-half per cent of new tax revenues is allocated to the Trauma Fund.[50]

Last year the Oklahoma Trauma Care Assistance Revolving Fund dispersed $4 million dollars to offset uncompensated trauma care. This funding notwithstanding, an additional $21.5 million in expenses remained uncompensated.[51]

Texas

In 2003, with escalating demand for emergency services, the Texas trauma system was operating at or above capacity more than fifty per cent of the time. Fifty-five per cent of hospitals statewide and seventy-one per cent of level I and level II trauma centers experienced difficulty keeping specialty physicians on emergency call. Uncompensated trauma care significantly drained hospital resources. Uninsured trauma patients accounted for thirty-two per cent of trauma cases statewide and cost trauma facilities a minimum of $181 million to treat in 2001. This constituted an average of twenty per cent of all charges to patients who use emergency services.[52]

HB 3855, enrolled during the 2003 legislative session, was a 300-page bill that focused on state transportation issues. It also established a funding mechanism for trauma care and emergency medical services that looks to persons most likely to cause traumatic injuries to pay

49. Oklahoma State Senate. *Legislative Brief,* August 2004. *See, e.g.,* Oklahoma Statutes §§21-1220, 47-6-101, 47-17-101, 47-17-102, 63-2-402, 63-2-404, 63-2-405, 63-2-406, 63-2-407.1, and 63-2-407.

50. *See* Oklahoma Statutes §§68-302-5 and 68-402-3.

51. Oklahoma State Department of Health. *Plans Move Forward to Improve Oklahoma's Trauma System May is National Trauma Awareness Month* (May 19, 2005).

52. The Senate of the State of Texas, Senate Finance Subcommittee on Trauma Care, *Interim Report to the 78th Legislature* (November 2002), p. 5-8.

the price of uncompensated trauma care. Accordingly, HB 3855 establishes a driver responsibility program that increases fines for alcohol-related offenses by:

- Assigning points to drivers for traffic-related offense;
- Assessing a surcharge on driver's licenses based upon those points; for most offenses the surcharge will be $100 and up; and
- Assessing a surcharge of $1,000 to $2,000 for driving under the influence offenses.

The bill directs that 49.5 per cent of revenues collected be deposited in the General Revenue Dedicated Trauma Facility account, an account in the general fund of the state treasury. Ninety-six per cent of the amounts deposited may be used for, among other things, uncompensated care provided at designated trauma facilities and facilities in active pursuit of trauma facility designation.

Projected revenue gains from driver responsibility program surcharges include approximately $59.3 million in fiscal year 2004; $112.6 million in fiscal year 2005; and $165.9 million during each subsequent year.[53]

Current situation in Texas. In June 2005, *The Dallas Morning News* reported that, according to the Governor of Texas and a state audit, the two-year-old state program designed to fund trauma care was crippled by delayed start-up, uncollected fees, poor oversight by the Department of Public Safety and possible criminal mischief. In 2004, slightly more than $18 million was distributed to two hundred thirty-four trauma care facilities for uncompensated trauma care costs. This is a fraction of the more than $200 million in uncompensated care provided by these centers to trauma patients each year. University Hospital, for example, received $1 million, which amounted to seven cents on the dollar for the $13.6 million in uncompensated trauma care provided.[54]

To address ongoing needs for funds for uncompensated care, the Department of Public Safety created a task force to carry out recommendations made by the state auditors, including imposing more oversight and sanctions on the vendor and improving the agency's collection rate, which was projected to be sixty-six per cent. This includes revamping the driver's license system to address its inability to assess every new fine, accumulate points and properly indicate which driver's license holders should have been charged a surcharge under the new system.[55]

Trauma care funding in Texas has also suffered due to the Legislature's decision during the 2005 Legislative Session to hold $77 million in the trauma fund until 2007 to ensure a balanced 2006-2007 state budget.[56]

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53. This estimate assumes a compliance rate for the payment of surcharges of sixty-six per cent and 547,000 new surcharge cases per year for the first three years.

54. *Trauma fund in bad shape*, The Dallas Morning News, (July 15, 2005).

55. *Ibid*.

56. *Ibid*.

Virginia

In 2003, Virginia's fourteen trauma centers lost a combined $44 million and one trauma center downgraded its level II designation because of a shortage of doctors to cover trauma calls.[57] This prompted the General Assembly to direct the Joint Legislative Audit and Review Commission to study the use and financing of Virginia's trauma centers. The Commission proposed several options, giving the highest priority to increased Medicaid reimbursements to trauma centers and the physicians staffing them and inclusion of readiness costs in increased payment rates.[58]

HB 1143, enrolled in 2004, establishes in the state treasury a special non-reverting fund called the Trauma Center Fund to defray the costs of providing emergency medical care to victims of automobile accidents attributable to alcohol or drug use.[59] Current sources of revenue for the Fund include:

- A $50 surcharge payable by persons with repeat convictions of certain drug and alcohol offenses, including driving while intoxicated, under the influence, or after illegally consuming alcohol; and

- An additional fee of $40 paid prior to the granting or restoring of a license or registration, by persons whose driver's license or whose privilege to drive or register a motor vehicle has been revoked or suspended.[60]

The surcharge collected from second or subsequent drug- and alcohol-related offenses is estimated to yield about $200,000 per year. The additional fee for license and registration reinstatement is estimated to yield about $4.3 million per year.[61]

A hospital must be a state-designated level I, II, or III trauma center in good standing to receive Fund moneys. Eligible centers receive quarterly disbursements. Each designated trauma center receives a percentage of funds established on a yearly basis and based on inpatient admission days for those patients admitted under electronic codes related to motor vehicle crashes.

57. Joint Legislative Audit and Review Commission of the Virginia General Assembly. *The Use and Financing of Trauma Centers in Virginia*, House Document No. 62 (2004). Available at http://jlarc.state.va.us/Reports/Rpt313.pdf.

58. Virginia Hospital and Healthcare Association. *Trauma System Funding. 2005 Top-Tier Issue* (October 4, 2005).

59. Code of Virginia, §18.2-270.01.

60. The reinstatement fee funding source was authorized during the 2005 Legislative Session.

61. *A Tale of Two States: Virginia & Texas*, Riverside Online. Available at http://www/riverside-online.com/trauma/states.html.

Current situation in Virginia. While the General Assembly has been praised for its efforts, the funding resource needs to be expanded and strengthened. Current trauma center losses far exceed the projected annual designation from the Fund of $300,000 per trauma center. Some suggest that the scope of the funding law be broadened to encompass the significant number of motor vehicle accidents caused by reckless driving independent of substance abuse.[62]

Washington

In 1997, the Washington Legislature established the Emergency Medical Services and Trauma Trust Care System Trust Account to pay for trauma costs and offset losses for treating the uninsured, including:

- Reimbursement for trauma care services provided by designated levels I through III trauma centers;
- Increased Medicaid trauma care payments for services provided by designated levels I through III trauma centers; and
- Increased Medicaid trauma care payments to physicians that are members of the trauma team at any level of designated service.[63]

The Account is funded by an emergency medical services fee of $6.50 collected by the State Department of Licensing:

- From vehicle dealers upon the retail sale or lease of any new or used motor vehicle;
- At the time of application for an original title or transfer of title issued on any motor vehicle or offroad or nonhighway vehicle; and
- At the time of application for an original transaction or transfer or ownership transaction of a snowmobile.[64]

The Account is also funded by a surcharge of $5 per traffic infraction collected through county and city courts.[65]

The State distributes the funds through small grants and increased Medicaid payments. While the Department of Health is designated as the lead agency, a joint partnership was created between the Departments of Health and Social and Health Services' Medical Assistance Administration to attract federal matching funds.

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62. *Ibid.*
63. Revised Code of Washington §70.168.040.
64. Revised Code of Washington §46.12.042.
65. Revised Code of Washington §46.63.110.

For the 2003-2005 biennium, federal and state funds provided $41.2 million to support the trauma system. Of the total funds, $7.8 million went to physicians.[66]

Current situation in Washington. Key factors affecting the trauma system worsened since the 1990s. This includes:

- Volume growth. Hospital emergency departments, both urban and rural, report steady growth in emergency department visits (both non-trauma and trauma). Between 1995 and 2003, emergency department visits increased by 547,000 additional visits or thirty-three per cent. Hospitals are reporting high growth in trauma case volume. Between 2000 and 2003, level II trauma services in the urban parts of Washington increased by nearly thirty per cent.[67]

- Increasing Numbers of Uninsured. The number of uninsured in Washington State is rising. As more employers decide they can no longer offer health insurance or increase their health insurance deductibles and co-payments, more Washingtonians find it difficult to pay their medical bills.[68]

- Erosion of Physician Participation. In a recent survey of trauma medical directors in Washington, twelve of twenty-three respondents said their hospital had a reduction in the number of physicians in the hospital's geographic area. Seven of these respondents reported a loss of physicians in three or more specialties, and three noted physician losses in six surgical specialties.[69]

The Washington State Hospital Association believes funding for the Washington State Trauma Trust Account must be increased to maintain the trauma system's ability to save and restore lives. The Association recommends the dedication of an extra $6 million from state revenues to the trauma fund per biennium, providing $5 million for trauma facilities and $1 million for trauma physicians and other trauma providers. The new funds will offset new and ongoing problems of volume growth, on-call pay, rising numbers of uninsured patients, and disaster preparedness.[70]

66. Washington State Hospital Association. *Trauma System Needs More Funds* (2005), p. 3.

67. *Ibid.*

68. *Ibid.*

69. *Ibid.*

70. *Ibid.*

Chapter 5

MEDICAL LIABILITY CONCERNS FOR ON-CALL PHYSICIAN SPECIALISTS: GOVERNMENT RESPONSES

As more fully discussed in Chapter 3, several factors contribute to the decreasing on-call availability of physician specialists to emergency departments. Uncompensated trauma care contributes significantly. However, physician specialists perceive liability issues to be the strongest driver. In their view, the decreasing affordability and availability of liability insurance and the risk of lawsuits have rendered the practice of certain specialties less and less cost effective.

States' efforts to stem rising liability insurance premiums have focused on:

- **Tort reforms** that place limitations on traditional legal rules and practices to decrease claim filings and damage awards, including placing caps on damages awarded in medical malpractice cases, decreasing insurers' damage payments by amounts received from third party sources, limiting the amount of damages recoverable from each defendant to that defendant's proportion of fault, and decreasing the time injured people have to file a claim in court.

- **Patient-centered and safety-focused reforms.** More recently, several states extended their focus to pursue fundamental changes in the health care system that will decrease malpractice litigation by reducing the number of patients injured by malpractice acts and provide for prompt and fair compensation when safety systems fail. These patient-centered and safety-focused reforms focus on making practitioners more willing to disclose problems, compensate informally where possible, promptly feed back information for improvement, and resolve disputes expeditiously.

- **Short-term strategies to make liability insurance available and affordable.** Some states adopted stopgap strategies, such as premium subsidies and state-run insurance programs, to help physician specialists meet immediate insurance premium obligations and find liability insurance in the short term. These measures typically are thought of as short-term or providing an option of last resort and may not solve the systemic issues that exist in the medical liability insurance market.

- **Insurance-related strategies.** To address the need for comprehensive data on medical malpractice claims filed against various insurers and the losses associated with these claims, some states require medical malpractice insurers to include malpractice claim information in their annual reports to the insurance commissioner. At least one state has sought to ensure reasonable rates by establishing specific criteria that insurers must follow when setting insurance rates; mandating insurers to record and report loss, expense and reserve data; and expanding the authority of the

insurance commissioner to hold hearings on the premium increase and approve or disapprove of the increase.

Tort Reform Efforts

Underlying the states' response to rising liability insurance rates of the mid-1970s and mid-1980s was the presumption that too many malpractice claims are filed and that damage awards tend to be excessive. To reduce claim filings and damage awards amounts, states imposed limitations on traditional legal rules and practices. By decreasing uncertainty in the underwriting process, these reforms were expected to lower insurance premiums, increase profitability for insurers, and encourage insurers' willingness to underwrite specialty lines of business. A sampling of some of the types of tort reforms adopted by the states follows.

Types of Tort Reform

Capping non-economic damage awards. Caps on *non-economic* damages[1] are the centerpiece of several states' efforts to lower liability insurance premiums. Capping lowers the highest awards. In place in more than twenty states,[2] these caps vary in terms of:

- The types of cases to which they apply, e.g., personal injury cases, most medical malpractice cases, or only to physicians providing emergency care;
- The cap amount – typically from $250,000 to $750,000[3] – and whether that amount is fixed or will increase over time;
- Whether the cap is per claim or per defendant;
- Exemptions to the cap's application; and
- Whether the caps are tied to other malpractice reform mechanisms.[4]

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1. The main type of damages awarded in medical malpractice cases is compensatory damages. There are two types of compensatory damages. *Economic damages* are monetary losses resulting from an injury, such as medical expenses, lost wages, and rehabilitation costs. *Non-economic damages* are primarily damages for pain and suffering, medical anguish, disfigurement, loss of enjoyment of life, loss of consortium, and all other non-pecuniary losses or claims.

2. Non-economic damage award caps were adopted in Alaska, California, Colorado, Florida, Idaho, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, Virginia, West Virginia, and Wisconsin. *See Malpractice Crisis Under the Microscope: New Health Affairs Study Finds That Malpractice Payouts Have Not Grown Substantially*, Health Affairs press release, May 31, 2005. Hawaii is listed in several studies as having a non-economic damage cap; however, section 663-8.7, Hawaii Revised Statutes, which limited non-economic damages recoverable to a maximum award of $375,000 in certain tort actions, including medical malpractice, was repealed on October 1, 1995.

3. U.S. Congressional Budget Office. *The Effects of Tort Reform: Evidence from the States* (June 2004), p. 6.

Damage cap advocates believe caps will help to prevent excessive awards and overcompensation for malpractice injuries, ensure consistency among jury verdicts, and provide incentives for injured persons to settle claims rather than pursue litigation. They believe caps will lower insurance premiums by reducing uncertainty in jury awards.[5]

Cap opponents emphasize that:

- Caps impact injured parties only; the more pain and suffering an injured claimant has endured, the more a cap deprives him or her of entitled damages.

- Caps interfere with integral components of the civil litigation system, i.e., the jury as fact-finder and the validity of non-economic damages; the courts have traditionally thought juries competent to assess all types of complex cases and experts.

- By reducing financial accountability for mistakes and adverse outcomes, caps reduce incentives to prevent mistakes and adverse outcomes.

- Caps may make it more difficult for injured patients to obtain legal counsel under contingency fee arrangements.[6]

Limiting punitive damages. Punitive damages are awarded not to compensate plaintiffs but to punish and deter particularly egregious conduct on the part of defendants that is more than negligence or even gross negligence.[7] In place in more than thirty states,[8] caps on punitive damages vary in terms of:

- Amount of the cap, e.g., two or three times the economic damages (which cover medical costs and lost wages) or a fixed amount from $250,000 to $10 million;

- The circumstances under which punitive damages may be awarded;

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4. Connecticut General Assembly*: Legislative Program Review and Investigations Committee. Medical Malpractice Insurance Rates* (December 2003), p. 33.

5. United States General Accounting Office, *Medical Malpractice – Effects of Varying Laws in the District of Columbia, Maryland, and Virginia* (October 1999), pp. 6-7.

6. U.S. Congressional Research Service. *Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages* (Updated April 11, 2005), p. CRS-3.

7. *Ibid*, at p. CRS-4, citing W. Page Keeton, *Prosser and Keeton on To*rts, §31 (5th ed. 1984). While punitive damages are non-economic by nature, state statutes usually treat punitive damage caps separately from non-economic damage caps.

8. Following is a sampling of states with some form of punitive damage cap: Alabama, Alaska, Arkansas, Colorado, Florida, Georgia, Idaho, Indiana, Kansas, Mississippi, Nevada, New Jersey, North Carolina, North Dakota, Oklahoma, Pennsylvania, and Texas. Congressional Research Service. *Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Non-economic Damages* (Updated April 11, 2005).

- Applying an elevated burden of proof for recovery of punitive damages, e.g., by "clear and convincing evidence" rather than a mere "preponderance of the evidence";

- Requiring punitive damage liability to be determined in a separate proceeding to make it more difficult for plaintiffs to pursue punitive damages; and

- Requiring payment of a portion of punitive damage awards to the government or a fund that serves a public purpose instead of to the plaintiff.[9]

Supporters of punitive damage caps believe that these awards "are often unfair, arbitrary and unpredictable, and result in overkill . . . ."[10] Though punitive damages are awarded in only a small percentage of cases, supporters of caps contend that punitive damages may adversely impact individual defendants and the economy significantly.

Cap opponents contend that punitive damage awards are a "necessary tool in the effective control of socially undesirable conduct"[11] and are justified as a useful deterrent to negligent behavior. They point out that trial and appellate judges already have the authority to reduce punitive damage awards that are excessive.

Modifying the collateral source rule. This rule allows recovery of damages from a physician even if the injured party is also entitled to recovery from collateral sources, e.g., health insurance. The rationale of the rule is to hold the provider causing the malpractice injury responsible for all damages he or she caused. States have modified or eliminated the rule by permitting evidence of collateral source payments to be admitted at trial or allowing awards to be offset by collateral source payments. In Hawaii, for example, section 663-10, *Hawaii Revised Statutes*, requires courts to account for reimbursements due to collateral sources before any judgment or stipulation to dismiss the action is approved.

Proponents of reform contend that the rule may enable double recovery for the same harm and may withhold information useful to the jury.

Reform opponents note that, typically, double recovery is prevented by states' subrogation rules, which require collateral sources to be reimbursed from damage award proceeds. They stress that elimination of the rule may unduly benefit liability insurers at the expense of health insurers since collateral health insurance payments may reduce liability insurance payments; however, malpractice insurance, rather than health insurance, should bear the financial risk of malpractice acts.[12]

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9. U.S. Congressional Budget Office. *The Effects of Tort Reform: Evidence from the States* (June 2004), p. 6.

10. U.S. Congressional Research Service, *Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages* (Updated April 11, 2005), p. CRS-5, citing Lisa M. Broman, *Punitive Damages: An Appeal for Deterrence*, 61 Nebraska Law Review 651, 680 (1982).

11. *Ibid.*

12. U.S. General Accounting Office, *Medical Malpractice – Effects of Varying Laws in the District of Columbia, Maryland, and Virginia* (October 1999), p. 8.

Limiting joint and several liability. Under this common law rule, if two or more parties cause harm, any of them may be held responsible for all of the victim's damages, regardless of the relative degree of fault or responsibility. The rationale underlying the rule is full and quick compensation for the victim; if the individual actions of multiple defendants were necessary for the injury to occur, then it is appropriate for each defendant to face the full value of the victim's losses, instead of the victim having to recover less compensation if some defendants are unable to pay. Any defendant paying more than its share of the damages may seek contribution from other liable defendants.

Reform advocates argue that joint and several liability operates inequitably, sometimes holding defendants with only a small percentage of fault responsible for paying all the damages. Elimination of this rule may also lower plaintiffs' expected benefit from a claim, which may result in fewer claims being filed.

Some states eliminate joint and several liability only for non-economic damages or only for defendants responsible for less than a specified percentage of the plaintiff's harm. Under Hawaii law, if a defendant's degree of negligence is less than twenty-five per cent, then non-economic damages recoverable against that defendant is in direct proportion to the degree of negligence assigned.[13]

Limiting attorneys' contingency fees. In exchange for representing a plaintiff in a tort suit, attorneys may agree to be paid by contingency fee, i.e., accepting a percentage of the recovery if the plaintiff wins or settles but receiving no fees if the plaintiff loses. Over twenty states implemented amendments to contingency fee arrangements, regulating them by sliding scale, establishment of maximum percentages, or providing for court review of the reasonableness of attorneys' fees.[14]

Advocates of contingency fee reform believe that these fee arrangements cause juries to inflate damage awards, result in windfalls for lawyers, and prompt lawyers to file frivolous law suits in hopes of settling.[15]

Opponents of reform stress that injured persons faced with medical bills and lost wages would not be able to finance complicated and time-consuming medical malpractice cases if they had to pay all attorneys' fees up front or by the hour. Thus, attorney contingency fee limitations inhibit injured persons from pursuing valid causes of action.[16]

Reducing statutes of limitation. The statute of limitation is the period within which a lawsuit must be filed, typically two or three years under state law. Traditionally, the period starts running from the date of injury. However, states with a "discovery rule" allow the period to start running when the plaintiff discovers or reasonably should have discovered the injury or the

13. Section 663-10.9, Hawaii Revised Statutes.

14. U.S. Congressional Research Service, Henry Cohen, *Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages* (April 11, 2005), p. CRS-8.

15. *Ibid.*, pp. CRS-8 to CRS-9.

16. *Ibid.*, p. CRS-9.

injury and its cause. States amended their statutes of limitation by setting an overall time limit or modifying their discovery rule. Shortening the time for filing claims reduces insurers' costs by reducing the number of claims filed.

Opponents of statute of limitation reform contend that shortened statutes of limitation can prevent some injured people who have no way of knowing that they were the victims of malpractice from having a legal remedy.

Impact of Tort Reform Efforts

Definitive empirical evidence on the effects of tort reform is uncommon and findings are not sufficiently consistent to be considered conclusive.[17] As a practical matter, the separate effects of each type of reform are difficult to distinguish when states typically bundle reforms in packages. Additionally, controlling for differences between reform states and non-reform states is also difficult, since more than one factor may change during a time period in any state.[18] The debate is heated, and policy makers should be wary of exaggerated and misdirected statistics offered in support of partisan positions.

Impact on claims filed, the value of awards and insurance costs and profitability. Limited evidence shows that tort reforms, such as damage caps, may reduce the number of lawsuits filed, the value of awards, and insurance costs.[19] Other studies suggest that damage caps increase insurers' profitability.[20]

Impact on premiums inconclusive. Evidence on how premiums were affected is mixed. As explained by the United States General Accounting Office in its study on the multiple factors that have contributed to premium rate increases:

> *Tort reforms and other actions that reduce insurer losses below what they otherwise would have been should ultimately slow the increase in premium rates, if all else holds constant. But several years may have to pass before insurers can quantify and evaluate the effect of the laws on losses from malpractice claims and before an effect on premium rates is seen.* [Emphasis provided.][21]

According to one national study, during the 1991 to 2002 time period, although non-economic caps slowed down payout increases, many insurers did *not* pass those savings on to

17. *Ibid.*

18. *Ibid.*

19. U.S. Congressional Budget Office. *The Effects of Tort Reform: Evidence from the States* (June 2004), p. vii.

20. *Ibid.*

21. U.S. General Accounting Office. *Medical Malpractice Insurance – Multiple Factors Have Contributed to Premium Rate Increases* (October 2003), p. 16.

physicians.[22] The study speculates that insurance premiums may have continued to increase for the following reasons:

- Insurers in states with caps may have already been on the path toward faster rate increases even before the caps were legislated.

- Between 1991 to 2002, medical costs rose seventy-five per cent and previous premium increases had not kept pace with this inflation.

- National Association of Insurance Commissioners data indicate that liability insurers have been under-reserving since 1997. Thus, premium increases may have been needed to shore up reserves for policies in force.

- Investment income declined by 23 per cent in 2001 and an additional 2.5 per cent in 2002.

Indeed, while tort reform efforts have assumed that insurance rates are closely linked to claim outcomes, researchers who study the tort system have found only a loose connection between changes in claim filings and outcomes and premium spikes. The following provides some explanation of why this is so:

> *[F]inancial flows in liability insurance consist of premium payments and investment income entering, and claims payments and administrative costs leaving. Of these components, claims are by far the most important. They should be – they are the raison d'être for liability insurance. The main complicating factor . . . is that long periods of substantial uncertainty elapse between when premiums are collected and when claims are paid. As a result, trends in lawsuits and awards do not map cleanly onto trends in premiums or insurance availability.*[23]
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> *Perceptions drive the insurance side of the malpractice system as much as the clinical (or legal) sides. . . . [P]ricing is determined by the incentives and objective functions of corporate managers, the competitiveness of particular markets, the division of power within organizations, and whether particular employees feel optimistic or pessimistic about their businesses.*[24]
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> * * *

22. Weiss Ratings. *The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage* (June 2003).

23. William M. Sage, *Medical Malpractice Insurance and the Emperor's New Clothes*, Depaul Law Review, vol. 54:463 (March 24, 2005), p. 470.

24. *Ibid.*, p. 472.

> *Litigation behavior and malpractice claim payments did not change in any significant, systemic sense between 1970 and 1975, between 1981 and 1986, or between 1996 and 2001. What changed, instead, were insurance market conditions and the investment and cost projections that the insurance market built into medical malpractice insurance premiums over those periods. Insurers that had offered low prices based on rosy scenarios in 1970, 1981, and 1996 switched to high prices based on pessimistic scenarios in 1975, 1986, and 2001.*[25]

In attempting to analyze the impact of liability reforms, the United States General Accounting Office has noted the lack of comprehensive data on medical malpractice claims.

> *For example, comprehensive data that would have allowed us to fully analyze the frequency and severity of medical malpractice claims at the insurer level on a state-by-state basis did not exist. As a result, we could not determine the extent to which increased losses were the result of an increased number of claims, larger claims, or some combination of both. In addition, data that would have allowed us to analyze how losses were divided between settlements and trial verdicts or between economic and noneconomic damages were not available. Insurers do not submit information to the National Association of Insurance Commissioners on the portion of losses paid as part of a settlement and the portion paid as the result of a trial verdict, and no other comprehensive source of such information exists.*[26]

It is likely that states will need systems in place to ensure access to such data.

A positive effect on physician supply. Tort reforms, such as damage caps, do appear to have a positive effect on the physician supply. A recent national study found that:

- Between 1985 and 1995, physician supply rose by two to three per cent more in states that adopted direct liability reforms, such as caps on damage awards, abolition of punitive damages, and collateral source rule reforms.

- The difference in supply came mostly from older doctors putting off retirement in reform states and new physicians entering practice there, not from physicians moving between states to reduce their insurance premiums. Thus, direct reforms have a greater effect on entry and retirement decisions than on the movement of physicians between states.

- Reforms have a larger effect on physician supply three or more years after their adoption than two years or less after adoption.

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25. Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, DePaul Law Review, Vol. 54:393 (May 10, 2005), p. 394.

26. U.S. General Accounting Office. *Medical Malpractice Insurance – Multiple Factors Have Contributed to Premium Rate Increases* (October 2003), p. 15.

- Positive effects of direct reforms are greater in high- versus low-managed care states.[27]

Caps on non-economic damages may not reduce overall award amounts. According to a 2005 study, which analyzed approximately five hundred fifty jury verdicts from twenty-two states, damage caps on non-economic damages do not significantly and systematically reduce overall awards. The study identified a "cross-over" effect between economic and non-economic damages, finding that, in states with non-economic damage caps, a high component of economic damages was often included in cases where very large awards were given.[28]

Patient-Centered and Safety-Focused Reforms

In the midst of the heated tort reform battle, a significant concern remains. Capping damages on the back end of litigation does not address all of the factors on the front end that lead to litigation.[29]

The medical malpractice legal system was designed to deter substandard medical care, by requiring compensation to patients wrongfully injured by health care providers through a dispute resolution process that offers justice. The effectiveness of this system in achieving these public policy objectives is being called into question for the following reasons:

- **Too many preventable injuries occur.** The Institute of Medicine[30] reported in 1999 that at least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical error that could have been prevented. Even using the lower estimate, preventable medical errors in hospitals exceed attributable deaths from motor-vehicle wrecks, breast cancer, and AIDS. High error rates with serious consequences are most likely to occur in intensive care units, operating rooms, and emergency rooms.[31]

- **Few patients injured by medical malpractice make claims and fewer still collect.** Despite the frequency of medical error, the Harvard Medical Practice Study reported

27. Daniel P. Kessler, et al., *Impact of Malpractice Reforms on the Supply of Physician Services,* Journal of the American Medical Association, (June 1, 2005).

28. Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps,* New York University Law Review (May 2005).

29. Joint Commission on Accreditation of Healthcare Organizations. *Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury* (2005), p. 4.

30. The Institute of Medicine of the National Academies is a nonprofit organization specifically to serve as adviser to the nation to improve health. The Institute provides unbiased, evidence-based, and authoritative information and advice concerning health and science policy to policy-makers, professionals, leaders in every sector of society, and the public at large.

31. Institute of Medicine. *To Err is Human: Building a Safer Health Syst*em (November 1999).

that only one in eight negligently injured patients file a malpractice claim.[32] Accordingly, the study concluded that, "we do not now have a problem of too many claims; if anything there are too few."[33]

- **Claims are resolved at great expense and too slowly to correct mistakes.** Most medical liability cases take from three to five years to come to closure. As a result, opportunities for swift intervention to address unsafe practices are often lost. An estimated $28 billion is spent each year on the inter-related combination of medical liability litigation and defensive medicine. These costs are increasingly indefensible, in the absence of evidence that such expenditures improve patient safety and health outcomes.[34]

- **Most medical errors result from faulty systems, processes, and conditions, rather than from incompetence.** The majority of medical errors do not result from individual recklessness or the actions of a particular group. Safety researchers report that most errors are slips or lapses made by competent people. All doctors, even the nation's best doctors, make mistakes. More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them.[35]

- **Need for disclosure and improved communication.** Understanding the causes of medical error requires their prompt disclosure. Near miss and error reporting is an essential component of safety programs across safety-conscious industries. However, the current tort system encourages suppression of the very information necessary to build safer systems of health care delivery. Without assurances of legal protection, many providers are reluctant to participate in systematic efforts to be open about errors and engage in patient safety activities. Research also shows that ineffective communication with patients – not poor treatment or negligence – puts physicians at most risk of malpractice lawsuits.[36] Factors leading people to file medical malpractice lawsuits against physicians include the family's perception that the physician was not completely honest; the inability of family members to get anyone

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32. The Harvard Medical Practice Study established the standard by which adverse events are measured and laid the groundwork for policy discussions on patient safety in several countries. The Study defined the incidence of adverse events to evaluate whether the tort system was effective in rewarding those who are injured as a result of their care in hospitals and assessing the economic consequences of such injuries.

33. U.S. Congressional Research Service. *Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages* (April 11, 2005), citing Barry J. Nace, *Changing medical malpractice liability will not reduce health care costs*, National Law Journal (October 11, 1993).

34. "Defensive medicine" involves the excessive ordering of non-essential tests and treatments solely for risk management purposes.

35. Randall R. Bovbjerg and Robert A. Berenson, *Surmounting Myths and Mindsets in Medical Malpractice*, Health Policy Briefs (October 2005), p. 3.

36. Carol B. Liebman and Chris Stern Hyman, *Medical Error Disclosure Mediation Skills, and Malpractice Litigation*, The Project on Medical Liability in Pennsylvania (2005). Available at medliabilitypa.org/research/liebman0305/.

> to tell them what happened; the sense among family members that the physician would not listen; and their being told by someone, often a health care professional, that they should sue.[37]

Mandatory reporting systems. Proponents of mandatory reporting systems believe such systems would protect the public by ensuring that errors are reported and responded to and would induce providers to invest in, and thus improve, patient safety.

Florida, Nevada, New Jersey, and Pennsylvania are among the states that have disclosure statutes that require notification to patients about adverse incidents that result in serious harm to the patient and mandate the collection of information about adverse events.

The Project on Medical Liability in Pennsylvania. The Project on Medical Liability in Pennsylvania, an independent initiative financed by The Pew Charitable Trusts and conducted by the Columbia Law School in New York, was developed to explore the value of mediation and open, frank communications of medical errors as a means to avoid bitter and protracted lawsuits. The project recognized that:

> *In the past decade, the cost of medical malpractice insurance has skyrocketed in Pennsylvania. Physicians in high-risk specialties are reported to have moved, closed practices or retired . . . . Insurance companies have pulled out of state. Serious medical errors are occurring. At the same time, doctors and hospital officials, fearful of lawsuits, have enraged patients and relatives by stonewalling and offering only barebones explanations for serious medical errors. Research shows this situation creates a vicious circle: Frustration, anger and a search for information often motivate patients or their families to file medical malpractice suits.*
>
> * * *
>
> *Confrontational litigation is antithetical to meaningful communication after an error or adverse event. Instead of mistrust and anger, patients and survivors need to feel understood and respected. Delay takes an emotional and financial toll on both sides. Timely communication helps physicians and hospitals receive valuable information relevant to patient safety. Both sides can receive emotional gratification from good communications, sometimes leading to non-monetary settlements such as lectures in the patient's name or improvements in hospital procedures. If a monetary payment is appropriate, it should be paid within weeks or months instead of years, as occurs in litigation*.[38]

37. Carol B. Liebman and Chris Stern Hyman, *A Mediation Skills Model to Manage Disclosure of Error and Adverse Events to Patients* (July 28, 2004). Available at www.medscape.com/viewarticle/483263.

38. Carol B. Liebman and Chris Stern Hyman, *Medical Error Disclosure Mediation Skills, and Malpractice Litigation,* The Project on Medical Liability in Pennsylvania (2005).

As a result of the Project, Pennsylvania enacted disclosure requirements (under the Medical Care Availability and Reduction of Error Act) to provide the impetus for improving communication between physicians and patients. The Act:

- Establishes a Patient Safety Authority to collect, analyze, and evaluate serious patient safety events and incidents. A "serious event" is defined in the law as an event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient.

- Requires hospitals, birthing centers, and ambulatory surgical facilities to, among other things:

    - Report serious patient safety events and incidents to the Department of Health, the Patient Safety Authority, and the facility's patient safety committee for systemic correction of the problem leading to the event.

    - Notify patients in writing of serious patient safety events.

- Provides for an insurance discount for medical facilities that utilize the Department of Health certified patient safety programs that reduce medical error.[39]

The New York Patient Occurrence Reporting and Tracking System. The New York Patient Occurrence Reporting and Tracking System (NYPORTS) is an adverse event reporting system implemented pursuant to New York State Public Health Law Section 2805-1, Incident Reporting. NYPORTS was created to simplify reporting, streamline coding, coordinate with other reporting systems to reduce duplication, and most importantly, allow hospitals to obtain feedback on their own reporting patterns and compare them with other facilities in the region and the State. Occurrences requiring reporting include unintended adverse and undesirable developments in an individual patient's condition, such as a patient death or impairment of bodily functions in circumstances other than those related to the natural course of illness, disease, or proper treatment, in accordance with generally accepted medical standards. Most occurrences reported are tracked and trended as groups and are reported on a short form. NYPORTS has evolved into an Internet based system with all the required security measures included in its construct. Hospitals can query the database to compare their experience with reported events to the statewide, regional, or peer group experience. For events with significant negative or lasting impact on patients, New York law requires facilities to: conduct internal investigations into the system of care to identify root causes for such events; build in back-up, "fail-safe" procedures to prevent reoccurrence; and monitor the implementation and effectiveness of these improvements through quality assurance activities. For events of lesser patient consequence, hospitals are

39. Act 13 is an omnibus reform measure that also, among other things, caps punitive damages, determines when an individual can testify as an expert, and deducts collateral source payments from damage awards for lost earning or past medical expenses paid from other sources.

expected to collect and aggregate data regarding these occurrences to identify system weaknesses before more consequential events occur.[40]

Apologies. When physicians take responsibility for an error and offer a genuine apology, trust builds and patients and family members have less inclination to sue. An apology also can lead to open discussion from which the hospital may obtain information that will help avoid similar errors in the future.

A growing number of states are passing laws that protect an apology from being used against a doctor in court. The following states are among those that have made apologies and similar gestures by health care providers inadmissible in court as evidence of liability: Arizona, California (expression of sympathy or general sense of benevolence inadmissible; statement of fault admissible), Colorado, Georgia, Illinois, Louisiana (expressions of apology, sympathy, or compassion inadmissible; statement of fault admissible), Maine, Massachusetts, Montana, Oregon, South Dakota, Texas (expressions of sympathy or general sense of benevolence inadmissible; a communication, including an excited utterance, concerning negligence or culpable conduct admissible), Virginia, and West Virginia.[41]

State licensing board reform. Some doctors do practice beyond their competence, and effective action needs to be taken against these problem physicians. State medical boards are accountable for the quality of health care provided by physicians within their jurisdictions and for assuring that physician licensees are competent to practice medicine. State medical boards, however, are often criticized for: taking too long to investigate negligent providers; not dispensing stiff penalties for those found guilty of negligence; and not providing adequate public information about those physicians who have had disciplinary action taken against them or were accused of malpractice. These Boards can only perform their mission if they are properly organized, effectively empowered, and adequately funded. Several states, including California, Delaware, Florida, Georgia, Pennsylvania, Virginia, and Louisiana have adopted legislation to improve the ability of these boards to quickly investigate and prosecute physicians who have demonstrated a pattern of negligence.[42] For example, in 2002, the State of Pennsylvania enacted legislation to strengthen the state medical board's power by granting it enforcement authority to investigate physicians.

Mediation. Pennsylvania is the site of a Pew-sponsored demonstration project that encourages mediated dispute resolution. As part of this model, physicians are encouraged to disclose adverse events to their patients and to apologize. Patients or their families are provided with an early and fair offer of compensation and the opportunity for mediation to resolve

40. New York State Department of Health. *NYPORTS – The New York Patient Occurrence Reporting and Tracking System Annual Report 2000/2001*. Available at http://www.health.state.ny.us/nysdoh/hospital/nyports/annual_report/ 2000-2001.

41. *See* National Conference of State Legislatures. *Medical Malpractice Tort Reform – 2005 State Introduced Legislation* (October 2005); Carol B. Liebman and Chris Stern Hyman, *Medical Error Disclosure, Mediation Skills, and Malpractice Litigation*, The Project on Medical Liability in Pennsylvania (2005), Appendix A.

42. *See* National Conference of State Legislatures. *Medical Malpractice Tort Reform – 2005 State Introduced Legislation* (October 2005).

disputes. This model recognizes that patients and their families are often concerned about more than money; they often want to know what happened and what is being done to prevent a recurrence. The benefits of arbitration are that it takes less time to come to resolution and costs less for both sides to defend.

Enterprise liability proposed by Institute of Medicine. The Institute of Medicine proposes a strict liability administrative system approach to resolving medical malpractice claims, similar to the mechanisms used to address worker's compensation claims. This would provide a no-trial, administrative resolution process based on determination of responsibility and avoidability, rather than on negligence. The enterprise liability system shifts the legal liability for medical injuries from the individual to the health care institution, e.g., hospitals, clinics, integrated health systems, and health plans. The health care institution would be liable in a malpractice lawsuit for any medical errors committed in the institution by physicians practicing there. The benefit of enterprise liability is that, by removing the fear of personal physician liability, it could eliminate the incentives to hide errors and encourage physicians and other health care providers to report mistakes with the appropriate reporting system. An early settlement – or compensation offer – would be an important component of this strict liability model, addressing the needs of patients, providers, and practitioners for swift resolution of claims. Compensation values could be based on a fee schedule that has predetermined rates based on the avoidable event and its concomitant injury, thus eliminating the random variability of award judgments. Discussions on this approach are ongoing.[43]

Short Term Strategies

Some states adopted stopgap strategies, such as premium subsidies and state-run insurance programs, to help physician specialists meet immediate insurance premium obligations and find liability insurance in the short term. These measures typically are thought of as short-term or providing an option of last resort and may not solve the systemic issues that exist in the medical liability insurance market.

Patient Compensation Funds

Patient Compensation Funds (PCFs) are public medical malpractice insurance plans that offer insurance for medical malpractice liability that *exceeds* the threshold amounts covered by the insured provider's primary insurance policy or qualified self-insured plan.[44] These funds are public organizations created by state law and organized as either a state agency or a trust fund. Some states use the existence of a PCF as a recruitment tool to attract doctors to the state.[45]

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43. National Governors Association. *Issue Brief – Addressing the Medical Malpractice Insurance Crisis* (December 2005), p. 4.

44. Unless otherwise indicated all information on patient compensations funds was taken from Sloan, Frank A. et al., *Public Medical Malpractice Insurance: An Analysis of State-Operated Patient Compensation Funds,* DePaul Law Review, Vol. 54:247, March 22, 2005, p. 247.

45. *Ibid.*, p. 257.

PCFs have been established in Indiana, Kansas, Louisiana, Nebraska, New Mexico, New York, Pennsylvania, South Carolina, and Wisconsin.[46] Eight states created their PCFs in the mid-1970s. The PCFs of these states provide excess medical liability coverage for hospitals and physicians. New York's PCF, the exception, does not cover hospitals. Required limits of primary coverage provided by PCFs range from $100,000 in Louisiana to $1.3 million in New York. Coverage limits have been updated by the states over time.[47] The upper limit on liability varies from $500,000 per occurrence in Pennsylvania to unlimited medical expenses per occurrence in Louisiana, New Mexico, South Carolina, and Wisconsin.[48]

In principle, the benefits of PCFs include the following:

- Public sponsorship ensures the availability of coverage. PCFs do not withdraw from the market during crisis periods because their provision of coverage is not guided by prospective rates of return.[49]

- PCFs help provide adequate compensation for injured patients and decrease volatility in insurance losses by covering losses at the higher end of the loss distribution.[50]

Except for New York, PCFs are funded from premiums paid by physicians, hospitals, and investment income, not from state subsidies. Assessments are paid directly to the PCF or as part of the premium paid to primary insurers. Assessments are generally structured as a fraction of the premium paid for primary coverage. PCFs may also vary charges by specialty, either reflecting physicians' primary insurance classification (as in Pennsylvania) or establishing a few specialty-based risk classes (e.g., four in Wisconsin).

Primary medical malpractice insurance is not usually experience-related. In contrast, PCFs in some states discontinue coverage or charge providers increased premiums in response to their experience-rating.

PCFs also differ in whether they reserve for anticipated losses or operate on a pay-as-you-go basis (like the Social Security program). Pay-as-you-go requires lower pay-outs initially, thereby affording immediate relief from high malpractice premiums. However, as claims are paid out, annual increases in PCF assessments rise much faster than traditional premiums do under a loss-reserving approach.[51] All states but one (Pennsylvania)[52] with pay-as-you-go systems have changed to the loss-reserving approach.[53]

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46. *Ibid.*, p. 248.

47. *Ibid.*, p. 257.

48. *Ibid.*, p. 258.

49. *Ibid.*, p. 265.

50. *Ibid.*, p. 250.

51. *Ibid.*, p. 253.

52. Legislation was passed in 2002 to reconfigure Pennsylvania's fund and eventually dissolve it. Financing high unfunded liabilities under the pay-as-you-go approach from past incidents is a source of concern. Randall R.

PCF participation is usually voluntary, providing coverage as a last resort. However, PCF participation is mandatory in Kansas, Pennsylvania, and Wisconsin.

While it is difficult to link PCFs with increased availability and affordability of malpractice insurance, private insurance was available in all PCF states. Premiums have increased dramatically in some states, including some PCF states, but the increases may be due to reasons beyond the control of PCFs. Loss paid by PCFs, based on 1998-2002 data, had considerable trend variation. Trends in claim frequency are similar between PCF and non-PCF states. PCFs reduce the loss volatility experienced by private medical malpractice insurers, thus making PCF states more attractive to primary insurers. PCFs have low administrative expenses. Establishing limits on non-economic and total loss for medical malpractice is useful for PCF loss control. PCFs are seen a passive financial intermediaries; there is little relationship between having a PCF and patient safety, loss prevention, and claims management.[54]

Premium Assistance

In 2004, the State of New Jersey established the Medical Malpractice Liability Insurance Premium Assistance Fund to preserve access to quality medical care for New Jersey patients, by providing direct relief towards the payment of medical malpractice liability insurance premiums to certain health care providers in certain high-risk specialties in New Jersey, who are finding it difficult to remain in practice due to escalating medical malpractice liability insurance premium rates.[55] This is a three-year program.

To be eligible for premium assistance from the Fund, a practitioner must:

- Practice in the specialties or subspecialties annually determined to be eligible by the Commissioner of Banking and Insurance. Eligible specialties and subspecialties are determined based on:
    - The level of premium rate increase for the specialty or subspecialty; and
    - Whether the insufficiency in the number of practitioners practicing in that specialty or subspecialty is at a level that threatens access to care for New Jersey patients;
- Agree to remain practicing in their specialty or subspecialty in New Jersey for two years after receipt of the subsidy payment;

Bovbjerg and Anna Bartow, *Understanding Pennsylvania's Medical Malpractice Crisis*, Pew Project on Medical Liability (2003).

53. Sloan, p. 270.

54. *Ibid.*, pp. 261-265.

55. *See* New Jersey Medical Care Access and Responsibility and Patients First Act, P.L. 2004, c.17 (2004).

- Have paid their annual charge of $75 or claimed a valid exemption from paying the charge;

- Have active licensee status with their respective licensing board.

For 2004, the specialties and subspecialties eligible for fund assistance included obstetric/gynecology (practices otherwise limited to gynecology alone are excluded), neurosurgery, and diagnostic radiology.

The amount of subsidy paid per eligible practitioner is dependent upon the number of applicants in each eligible specialty or subspecialty, the amount of increases in premium rates to the eligible applicants in those specialties or subspecialties, and the amount of funds actually collected for the Fund by the State Treasurer.

Revenue sources for the Fund consist of the following:

- An annual surcharge of $3 per employee for all employers subject to the New Jersey unemployment compensation law;

- An annual charge of $75, imposed by the State Board of Medical Examiners, on every physician and podiatrist licensed by the Board;

- An annual charge of $75, imposed by the State Board of Chiropractic Examiners, on every chiropractor licensed by the Board;

- An annual charge of $75, imposed by the New Jersey State Board of Optometrists, on every optometrist licensed by the Board; and

- An annual fee of $75, assessed by the State Treasurer and payable by each person licensed to practice law in the State of New Jersey.

Sixty-five per cent of the foregoing revenues is dedicated to premium relief, with the remainder benefiting hospital charity care, New Jersey Family Care, and student loan reimbursement for obstetricians and gynecologists who are committed to practicing in New Jersey.

On October 25, 2005, the New Jersey Commissioner of Banking and Insurance announced the issuance of the first subsidy checks from the Fund. Subsidy payments were made to 1,200 practitioners in the amount of nearly $11,000 per practitioner.

Medical Malpractice Insurance Assistance Account

In 2004, the Wyoming legislature responded to the withdrawal of one of the major malpractice insurance companies doing business in the State by establishing the Medical Malpractice Insurance Assistance Program. Under this program, the state Department of Health

may make loans to physicians or groups of physicians to purchase prior acts medical malpractice coverage, which covers exposures under a prior policy that are not covered by a current policy, or help cover the costs of initial physician participation in a risk retention group. The program is designed to assist physicians affected by the withdrawal from Wyoming of a medical liability insurance company and forced to purchase insurance from a new company. To be eligible for loan funds, physicians, among other things, must agree to practice in the State of Wyoming in his or her area of specialty or subspecialty for a minimum of three years and repay the loan within five years.[56]

Medical Malpractice Insurance Fund

The State of West Virginia established its own state-run medical malpractice insurance program. It is administered by the Board of Risk Management and Insurance, which is the state entity charged with providing insurance to all state agencies. Physicians can purchase up to $2 million per claim in coverage, with a $4 million annual limit. The plan offers coverage to any health care provider, group practice, clinic, hospital, and ambulance service that cannot obtain coverage at an approved rate from a commercial carrier.[57]

Insurance-Related Strategies

To address the need for comprehensive data on medical malpractice claims filed against various insurers and the losses associated with these claims, some states, including Ohio, Virginia, and Montana, require medical malpractice insurers to include malpractice claim information in their annual reports to the insurance commissioner. To this extent, Montana requires insurers' annual reports to include information for the previous year on the number of medical malpractice insureds, the amount of premiums written and paid, the number of malpractice claims made, the total amount of direct losses paid for all closed claims, the number of still-open claims with no direct losses paid, the number of claims filed in state and federal courts (including the number of claims that were closed with settlement and without settlement and the number of claims that went to trial and resulted in a judgment or verdict), and other information and statistics that the insurance commissioner requires.

In 2005, Arkansas passed comprehensive insurance reform legislation that included provisions to prevent the establishment of excessive, inadequate, or unfairly discriminatory malpractice insurance rates. Senate Bill 233 establishes specific criteria that insurers must follow when setting insurance rates, such as only considering past and prospective loss experienced within the state. The bill requires the insurance commissioner to mandate insurers to record and report its loss, expense and reserve data. Insurers must publish notice in a newspaper and notify the commissioner when proposing a premium increase of twenty-five per

56. Senate File 1011, to be codified at Wyoming Statutes §§35-1-901 through 35-1-903.

57. National Governors Association. *Issue Brief – Addressing the Medical Malpractice Insurance Crisis* (December 2002), p. 12.

cent or more. This bill authorizes the commissioner to hold hearings on the premium increase and approve or disapprove of the increase.

Chapter 6

MANDATORY CALL: PROS AND CONS

Neither federal nor state law affirmatively requires an individual physician to serve on-call. Rather, under the federal Emergency Medical Treatment and Labor Act (EMTALA), the responsibility to provide specialty medical coverage rests with the facility that offers emergency services.

Reports indicate that many hospitals mandate some level of on-call coverage, which may apply to anything from full panel coverage to just one specialty. In many communities, specialists are expected to take call as a condition of medical staff membership.

Hospital-mandated call is effective in many states. Many hospitals, however, are reluctant to enforce call mandates. Decreased physician satisfaction with mandated call policies and procedures leads to decreased retention. Physicians faced with unfunded mandates may simply leave the medical staff or give up their active staff privileges in favor of courtesy privileges to which mandatory call requirements often do not pertain.[1] A nationwide survey found that forty-eight per cent of specialists and thirty-six per cent of surgeons and other proceduralists would move some or all of their business if they had to take call.[2] A loss of physicians further increases the on-call burden for those physicians that remain.

The following anecdotes, while isolated, illustrate what may happen when mandatory call is enforced:

- In 2002, University Medical Center in Las Vegas, Nevada, closed its trauma center for ten days because fifty-eight orthopedic doctors temporarily quit in response to the hospital board's decision to eliminate voluntary on-call policies and require private physicians with privileges at the medical center to cover mandatory hospital shifts in the emergency and trauma center. The Board approved the change in policy in an effort to keep the area's only emergency trauma center operating without interruption. Physician specialists said they were having trouble finding liability insurance and affording high liability insurance rates.[3]

- In 2003, ten of twenty-one general surgeons who take emergency room call at Desert Springs Hospital Medical Center in Las Vegas, Nevada quit because there were not

1. *Report of the Council on Medical Service; On-Call Physicians,* CMS Report 3-I-99 (December 1999).

2. *On-Call Physicians at California Emergency Departments: Problems and Potential Solutions* (January 2005), p. 5.

3. *Doctors denied leave of absence,* Las Vegas Review Journal (June 19, 2002) at www.reviewjournal.com/lvrj_home_/2002/June-19-Wed-2002/news/19005180.html.

> enough general surgeons to take call at the facility and call became even more frequent as doctors continued to depart.[4]

The American College of Emergency Physicians (ACEP) has suggested that state licensing boards could positively impact the number of physicians taking emergency department call by the imposition of a uniform on-call requirement for licensed physicians. However, ACEP also recognizes that this requirement could easily discourage physician licensure in that particular state, if done in isolation.[5]

Similarly, the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group[6] defeated a proposal recommending that physicians be required to serve on-call as a condition of participation in Medicare, because it believed that forcing physicians to serve on-call will not solve the problem of on-call physician shortages and would only further divide the hospitals and physicians. The American College of Emergency Physicians pointed out, in addition, that this approach may decrease the overall number of Medicare providers and adversely impact pediatric coverage.[7]

Proposed California state legislation mandating that physicians take and answer emergency department call has not been successful. In California, mandatory call essentially became untenable after the California Medical Association issued a policy statement opposing it.

Clearly, a mandated approach may backfire if other on-call issues, such as physician burnout, uncompensated care, and liability insurance availability and affordability, are not addressed. Mandates would appear to work best when there is an adequate number of physicians to share the mandated call, the mandate is reasonable (e.g., no more than two weekends a month), managed care plans are diligently paying for services provided, there are not a large number of uninsured patients, and when initiated in concert with intensive staff education.[8]

In the absence of legislative mandates, medical staffs and governing boards can come up with creative, cooperative, and mutually acceptable solutions to emergency call coverage. The medical staff organization in each hospital is well suited to know which specialties are encountering shortages and what call solutions will work for what specialties and for the medical staff overall.

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4. *Specialists spurn area's hospitals,* Las Vegas Review-Journal (March 1, 2003) at www.reviewjournal.com.vrj_home/2003/mar-01-Sat-2003/news/20792212.html.

5. American College of Emergency Physicians. *Availability of On-Call Specialists* (May 2005).

6. TAG is charged with seeking advice from the public and considering and recommending changes to the Secretary of Health and Human Services through the Centers for Medicare and Medicaid on the implementation of EMTALA.

7. American College of Emergency Physicians. *Availability of On-Call Specialists* (May 2005).

8. *Report of the Council on Medical Service; On-Call Physicians,* CMS Report 3-I-99 (December 1999).

Chapter 7

CONCLUSIONS

Many trauma centers across the nation are facing a crisis securing physician specialists for emergency call. This shortage of specialty coverage is causing delays in patient treatment that increase patients' risk of harm. With trauma injuries, seconds count; the chances of survival significantly decrease and the side effects of injury significantly increase if appropriate care is not given in the first hour immediately following the injury. A weakened trauma center decreases a state's state of readiness to respond not only to the normal flow of critically injured patients but to unforeseen disasters and emergencies, such as a terroristic attack or a hurricane.

Causes of the On-Call Physician Specialist Shortage

The reasons why fewer physician specialists are taking call tend to fall into four categories: the significant amount of uncompensated trauma care, lifestyle choices for doctors, a national shortage of specialists, and medical liability concerns.

Strategies Employed by the States

The states have employed many strategies to help trauma care and improve the availability of on-call physician specialists, including:

- *Developing dedicated public sources of funding* to reimburse physician specialists for uncompensated trauma services.

- *Implementing tort reforms*, such as caps on damage awards in malpractice lawsuits, that place limitations on traditional legal rules and practices to decrease claim filings and damage award amounts.

- *Implementing patient-centered and safety-focused reform*s that strive to: reduce the incidence of medical error; ensure that errors are reported and analyzed so that physicians and hospitals can learn from their mistakes; encourage open, frank communications between patients and physicians; and develop efficient systems for resolving claims.

- *Improving state licensing boards* to enable quick investigation and prosecution of physicians who have demonstrated a pattern of negligence.

- *Improving the ability of insurance commissioners* to review and evaluate malpractice insurance rates and malpractice trends.

- *Implementing stop gap strategies, such as premium subsidies and state-run insurance programs*, to help physician specialists meet immediate insurance premium obligations and find liability insurance in the short term.

Mandatory Call: Pros and Cons

Neither federal nor state law affirmatively requires an individual physician to serve on-call. Most hospitals mandate some level of on-call coverage as a condition of staff membership. While hospital-mandated call is effective in many states, many hospitals are reluctant to enforce call mandates for fear of losing or repelling physicians. A mandated approach, whether imposed by a hospital, a state licensing board, or state law, may backfire if other on-call issues, such as physician burnout, uncompensated care, and liability insurance availability and affordability, are not also addressed.

Conclusions

Having more than one cause, the shortage of on-call physician specialists at trauma centers clearly requires more than one solution. Clearly, detailed information about the on-call situation at The Queen's Medical Center and the State of Hawaii is needed to figure out which strategies will work best for this State. Pursuant to the Resolution that requested this study, the Department of Health will be submitting a separate study with Hawaii-specific information on these issues. With this information, policy makers will be able to begin the process of determining what short term and long term solutions to apply in their efforts to improve the on-call availability of physician specialists to The Queen's Medical Center, the only trauma center in the State of Hawaii.

Appendix A

HOUSE OF REPRESENTATIVES
TWENTY-THIRD LEGISLATURE, 2005
STATE OF HAWAII

H.C.R. NO. 229 H.D. 1 S.D. 1

HOUSE CONCURRENT RESOLUTION

REQUESTING THE LEGISLATIVE REFERENCE BUREAU TO COORDINATE STUDIES, WITH THE ASSISTANCE OF THE DEPARTMENT OF HEALTH, TO EVALUATE THE IMPACT OF THE PHYSICIAN "ON-CALL" CRISIS ON THE QUEEN'S MEDICAL CENTER TRAUMA CENTER TO PROVIDE EMERGENCY MEDICAL SERVICES IN THE STATE OF HAWAII, AND TO RECOMMEND ANY APPROPRIATE GOVERNMENT AND PRIVATE SECTOR RESPONSES TO THE ON-CALL CRISIS TO ENSURE CONTINUED ACCESS TO TRAUMA LEVEL CARE.

WHEREAS, a trauma center for treating life-threatening injury is essential to the health and well-being of our community; and

WHEREAS, The Queen's Medical Center operates the only trauma center in the State of Hawaii with a Level II Trauma Center designation from the American College of Surgeons; and

WHEREAS, several hospitals across the State provide emergency medical services at their facilities; and

WHEREAS, the federally-mandated Emergency Medical Treatment and Labor Act requires that hospitals medically screen patients that come to an emergency department to determine if an emergency medical condition exists, and if so, to stabilize the patient; and

WHEREAS, the Emergency Medical Treatment and Labor Act allows the transfer of a patient to another hospital after all possible stabilizing efforts have been made, if the patient's condition requires a "higher level of care" not available at the original hospital; and

WHEREAS, while many hospitals across the State rely on physicians to be on-call to address the emergency medical needs of patients who come into the emergency room, the need for specialists to be on-call at The Queen's Medical Center is particularly acute because of the demands required to maintain the Trauma Center; and

WHEREAS, the specialists that are needed to meet the trauma and emergency medical needs of the State include, among others, neurosurgeons, orthopedic surgeons, hand surgeons, plastic and reconstructive surgeons, and general trauma surgeons; and

WHEREAS, several factors have had a negative impact on the availability of physicians to be on call for emergency services and trauma care, including a negative effect on the physician's private practice and the physician's personal quality of life, uncompensated care, low reimbursement rates, and liability and medical malpractice concerns; and

WHEREAS, the reduction in the number of physician specialists willing and available to be on-call has created a crisis for emergency departments at hospitals across the State of Hawaii and across the nation; and

WHEREAS, the Department of Health has the statutory authority and responsibility to establish, administer, and maintain a State Comprehensive Emergency Medical Services System to serve the emergency health needs of the people of the State under part XVIII, chapter 321, Hawaii Revised Statutes; and

WHEREAS, the Department of Health also has the power and duty to regulate health care facilities, including hospitals and their components and emergency departments and trauma centers, and thus needs to adopt a leadership role in addressing the "on-call" crisis; and

WHEREAS, increasingly, hospitals across the nation are looking to government for assistance in addressing this crisis; and

WHEREAS, in Hawaii, the need exists to review the problem and the State's response thereto, and there is some indication that private entities may be willing to provide some funding towards conducting this review; now, therefore,

BE IT RESOLVED by the House of Representatives of the Twenty-third Legislature of the State of Hawaii, Regular Session of 2005, the Senate concurring, that the Legislative Reference Bureau and the Department of Health are requested to conduct studies in coordination with each other, to evaluate the impact of the physician on-call crisis on the ability of The Queen's Medical Center Trauma Center to provide emergency medical services in the State of Hawaii and to recommend any appropriate government and private sector actions in response; and

BE IT FURTHER RESOLVED that Department of Health, in its part of the study, is requested to include, in particular, an analysis of the pertinent issues including:

(1) A description of the on-call issue and its impact on the Level II Trauma Center;

(2) Identification of the factors that have contributed to the on-call issue becoming a crisis;

(3) The response of The Queen's Medical Center to address this crisis and keep the Trauma Center operational;

(4) The role of the Trauma Center in the state comprehensive emergency medical services system;

(5) A description of the impact, if any, of the on-call crisis on the delivery of non-trauma emergency medical services at select hospitals across the State including neighbor island hospitals; and

(6) An analysis of how the decision to transfer patients is made, including a description of the transfer process, and recommendations to improve this process, if any, to enhance patient outcomes;

and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau, in its part of the study, is requested to identify and analyze any appropriate government response to the on-call crisis including:

(1) The experience and response of other states and cities facing a similar on-call crisis;

(2) Options to address trauma/emergency department medical services that go uncompensated;

(3) Options to address liability concerns faced by on-call physicians; and

(4) An analysis that looks at the pros and cons of mandating that physicians "take call" in order to:

(A) Obtain or maintain a license to practice medicine in the State of Hawaii; or

(B) Receive privileges to admit patients to a hospital located in the State of Hawaii;

and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau and the Department of Health are requested to interview and seek the input of as many stakeholders as possible for their respective parts of the study including:

(1) The Department of Health;

(2) The John A. Burns School of Medicine;

(3) The Hawaii Health Systems Corporation;

(4) The Healthcare Association of Hawaii;

(5) The Queen's Medical Center/The Queen's Health Systems;

(6) Kaiser Permanente;

(7) Hawaii Pacific Health;

(8) Emergency medical service providers at the county level;

(9) Medical malpractice insurance providers;

(10) The Hawaii Medical Services Association; and

(11) The Hawaii Medical Association;

and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau and the Department of Health may contract with private contractors to facilitate the completion of this study; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau and the Department of Health are both requested to report their findings and recommendations, including any necessary proposed legislation, to the Legislature no later than twenty days prior to the convening of the Regular Session of 2006; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Director of the Legislative Reference Bureau, the President and Chief Executive Officer of The Queen's Medical Center, and to the Director of Health, who in turn is requested to transmit copies to other interested entities.