H.R. REP. 99-241(III)

Legislative History (Approx. 24 pages)

Document

H.R. REP. 99-241(III), H.R. REP. 99-241, H.R. Rep. No. 241(III), 99TH Cong., 1ST Sess. 1985, 1986 U.S.C.C.A.N. 726, 1985 WL 25931 (Leg.Hist.)

P.L. 99–272, **726 COMPREHENSIVE OMNIBUS BUDGET RECONCILIATION ACT OF 1986

DATES OF CONSIDERATION AND PASSAGE

House: October 24, 31, December, 5, 19, 20, 1985; March 6, 18, 20, 1986

Senate: November 14, December 19, 20, 1985; March 14, 18, 1986

House Report (Ways and Means Committee) No. 99–241(I),
July 31, 1985 [To accompany H.R. 3128]

House Report (Education and Labor Committee) No. 99–241(II),
Sept. 11, 1985 [To accompany H.R. 3128]

House Report (Judiciary Committee) No. 99–241(III),
Sept. 11, 1985 [To accompanying H.R. 3128]

Senate Report (Budget Committee) No. 99–146,
Oct. 2, 1985 [To accompany S. 1730]

House Conference Report No. 99–453, Dec. 19, 1985
[To accompany H.R. 3128] (rejected by the House on Dec. 19, 1985)

Cong. Record Vol. 131 (1985)

Cong. Record Vol. 132 (1986)

Related Reports:

House Report (Budget Committee) No. 99–300,
Oct. 3, 1985 [To accompany H.R. 3500]

(CONSULT NOTE FOLLOWING TEXT FOR INFORMATION ABOUT OMITTED MATERIAL. EACH COMMITTEE REPORT IS A SEPARATE DOCUMENT ON WESTLAW.)

HOUSE REPORT NO. 99–241, Part 3

September 11, 1985

*1 The Committee on the Judiciary, to whom was referred the bill (H.R. 3128) to make changes in spending and revenue provisions for purposes of deficit reduction and program improvement, consistent with the budget process, having considered the same, report favorably thereon with an

amendment and recommend that the bill as amended do pass.

* * * * *

*4 EXPLANATION OF COMMITTEE AMENDMENT

The Committee amendment clarifies the terms and scope of the new federal cause of action that would be established by § 124 of H.R. 3128. It also deletes the provision which would establish criminal penalties against responsible physicians who violate the requirements of § 124 and substitutes for these criminal penalties a new civil penalty of up to $25,000 per violation. Finally, the amendment *5 makes technical and clarifying corrections to the language of the provision.

BACKGROUND

In recent years there has been a growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured. Although at least 22 states have enacted statutes or issued regulations requiring the provision of limited medical services whenever **727 an emergency situation exists, [1] and despite the fact that many state court rulings impose a common law duty on doctors and hospitals to provide necessary emergency care, [2] some are convinced that the problem needs to be addressed by federal sanctions.

As a result of this concern, the Ways and Means Committe reported § 124 of H.R. 3128 (new § 1867 of title 42). This section requires a hospital which has a Medicare Provider Agreement and which operates an emergency department to provide an appropriate medical screening of any individual for whom a request for treatment is made. The purpose of this screening is to determine if an emergency medical condition exists or if the patient is in active labor. If the hospital determines that either condition exists, the hospital must provide further treatment to stabilize the individual or, if it determines to transfer the individual to another facility, it must properly complete this transfer.

Although § 124 covers only hospitals with medicare agreements, its requirements apply to all individuals for whom care is sought, whether or not the individual is covered by Medicare.

Section 124, as reported by the Ways and Means Committee, contained four sanctions in the event a hospital or physician violates its requirements:

1. The termination of the hospital's medicare provider agreement.

2. The imposition of civil penalties against the hospital of up to $25,000 per violation.

3. The establishment of a federal cause of action in the event of harm resulting from violation of its requirements.

4. As to the responsible physician, criminal penalties of not more than $100,000 and/or not more than 1 year imprisonment—unless the patient dies as a result of transfer, in which case

criminal penalties of not more than $250,000 and/or not more than five years imprisonment.

JUDICIARY COMMITTEE AMENDMENTS TO SECTION 124

The Judiciary Committee focused its consideration of H.R. 3128 on the two enforcement provisions of § 124 that brought the provision within the jurisdiction of the Judiciary Committee: (1) the establishment of a new federal cause of action for violations of its requirements and (2) the establishment of criminal penalties for physicians who violate its requirements.

*6 The Judiciary Committee shares the concern of the Ways and Means Committee that appropriate emergency room care be provided to patients faced with medical emergencies and in active labor. For this reason, the Judiciary Committee recommends that most of the provisions of § 124, as reported by the Ways and Means Committee, be adopted by the House.

However, the Judiciary Committee is also concerned that sanctions be designed to achieve the goal they address. There was little **728 evidence available to the Committee during its consideration of H.R. 3128 as to the scope of the problem addressed by § 124, since there have been no hearings in either the House or the Senate on this issue or on the language recommended by the Ways and Means Committee. Thus, the Committee is concerned that if penalties are too severe, some hospitals, particularly those located in rural or poor areas, may decide to close their emergency rooms entirely rather than risk the civil fines, damage awards, and, as to physicians, criminal penalties that might ensue.

The Committee is also concerned that there was no information available to it regarding the potential impact of these enforcement provisions on the current medical malpractice crisis.

All of these considerations led the Committee to conclude that § 124 as reported by the Ways and Means Committee might result in a decrease in available emergency care, rather than an increase in such care, which appears to have been the major goal of the section. For all of these reasons, the Judiciary Committee has reported an amendment to the House that would strengthen and clarify the requirements of § 124 in three respects.

First, the Judiciary Committee amendment would extend the civil fines provision to the responsible physician, so that the physician, like the hospital, could be fined for violating the requirements of § 124 by up to $25,000 per violation. The current provision allows this civil penalty to be assessed only against the hospital. The Committee believes the ability to assess this fine against the responsible physician as well as the hospital will be a strong incentive for both to respond to the medical needs of individuals with emergency medical conditions and women in active labor.

Second, the Judiciary Committee was concerned that the terms of § 124 which establish a new federal cause of action were somewhat vague. The language, as reported by the Ways and Means Committee, did not precisely identify which parties could bring actions under the provision, nor did

it identify those against whom the could bring such action. The vagueness of the provision would not only leave the rights and liabilities of parties unclear, it also would place an unnecessary burden on the courts to define these rights and liabilities.

Therefore, the Committee amendment makes it clear that the section authorizes only two types of actions for damages. The first of these could be brought by the individual patient who suffers harm as a direct result of hospital's failure to appropriately screen, stabilize, or properly transfer that patient. The second type of action could be brought by a medical facility which received an improperly transferred emergency patient (within the meaning of § 124) or a woman in active labor. It also clarifies that actions for *7 damages may be brought only against the hospital which has violated the requirements of § 124.

This amendment requires that, in order to bring a civil action, the hospital must show it suffered a financial loss as a direct result of a participating hospital's violation of this requirement. It is sufficient, for purpose of this showing, that a public hospital which receives State or local funds to deliver care to the uninsured demonstrate **729 only that it was required to commit any staff or other resources to the treatment of an individual transferred in violation of the requirement. The facility need not demonstrate an actual loss of revenues, net or gross.

This amendment also establishes a two-year statute of limitations for the filing of actions under this provision. Thus, any civil action for damages would have to be brought within two years of the incident which allegedly violated the requirements of § 124. The State Courts will have concurrent jurisdiction to hear and decide actions brought under this section.

Third, the Judiciary Committee amendment would delete that portion of § 124 which would impose criminal penalties on a physician who has professional responsibilities for the screening, examination, or treatment of a patient as required by the section. The Judiciary Committee understands and strongly supports holding physicians responsible for denying medical care. Indeed, it is for this reason that the Committee has recommended a provision in § 124 which would provide that a $25,000 fine may be imposed on a physician, as well as a hospital, who fails to properly respond to the genuine medical needs of individuals who come to emergency rooms.

The Committee deleted the criminal sanction because, in the Committee's judgment, it is unnecessary, and unwise, and raises serious Constitutional questions under the due process clause.

The criminal sanction is unnecessary because the other sanctions in subsection (d) of proposed § 124 as amended by the Committee will serve to deter violations of the standards of proposed § 124. As noted above, § 124 as amended by the Committee, provides for three sanctions, and these sanctions may be imposed against both hospitals and doctors. Subsection (d)(1) authorizes stripping a hospital of its medicare certification whenever a hospital fails to meet the requirements of proposed § 124. Subsection (d)(2)—as amended—authorizes the imposition upon a hospital or doctor of a civil penalty of $25,000 for each knowing violation of the requirements of proposed §

124. Finally, subsection (d)(3) authorizes an aggrieved party to sue a hospital, in federal or state court, for damages and other suitable relief. The principal purpose that a criminal sanction would serve in this area—deterrence of misconduct—is fully served by the sanctions of subsection (d) as amended by the Committee.

Moreover, the criminal sanction provision in the bill as reported by the Committee on Ways and Means raises serious questions of policy and Constitutionality. The criminal sanction provision holds doctors criminally liable for tort negligence. Thus, for example, a doctor is guilty of a crime for failing to provide treatment of a patient (when that failure represents a gross deviation from the prevailing local standards of medical practice), if the doctor had *8 reason to know (but did not in fact know) that a patient had an emergency medical condition.

This 'reason to know' standard sets forth a civil law negligence standard. Liability for negligence is not unknown to the criminal law, but criminal negligence involves more than a mere failure to know; criminal negligence requires that the failure to know involve **730 a gross deviation from a standard of reasonableness. [3] Moreover, as a general proposition, a criminal negligence standard is used only rarely. [4] Indeed, there is a body of opinion that holds that criminal sanctions should not apply to negligent conduct. [5] The criminal sanction provision in subsection (d) as reported by the Committee on Ways and Means unwisely holds doctors criminally liable on a civil negligence standard, thereby making it possible to convict a doctor of a crime for a simple mistake.

Finally, the criminal sanction provision as reported by the Committee on Ways and Means has constitutional problems. That provision, as reported by the Committee on Ways and Means, makes a doctor criminally liable for failure to conduct an 'appropriate' medical screening examination, if that failure constitutes a gross deviation from the 'prevailing local standards of medical practice.' Since the provision does not specify what is 'appropriate' and what are the 'prevailing local standards of medical practice,' and since those terms may mean different things to different people, the provision raises serious questions under the void for vagueness doctrine.

> The standards of certainty in statutes punishing for offenses is higher than in those depending primarily upon civil sanction for enforcement. The crime 'must be defined with appropriate definiteness.' There must be ascertainable standards of guilt. Men of common intelligence cannot be required to guess at the meaning of the enactment. The vagueness may be from uncertainty in regard to persons with the scope of the act, or in regard to the applicable tests to ascertain guilt. [6]

During its consideration of § 124, the Committee also considered an amendment which would have stricken both the new federal cause of action and the new criminal penalties and, instead, required the Secretary of the Department of Health and Human Services to conduct a study as to whether these two sanctions were needed. This amendment was defeated by a roll call vote of 16–18.

**731 *9 RECOMMENDATION

The Judiciary Committee recommends that § 124, as amended by the Committee, be retained as a provision of H.R. 3128.

COMMITTEE VOTE

(Rule XI, clause 2(1)(2)(B))

On September 10, 1985, a quorum being present, the Committee on the Judiciary favorably reported by voice vote the portions of the bill H.R. 3128 which fall within the jurisdiction of the Committee with amendments.

OVERSIGHT STATEMENT

(Rule XI, clause 2(1)(3)(A))

The Committee on the Judiciary exercises its oversight responsibilities with reference to federal causes of action and criminal law and penalties. The Committee has determined that section 124 of H.R. 3128 should be favorably reported as amended.

BUDGET STATEMENT

(Rule XI, clause 2(1)(3)(B))

Section 124 of H.R. 3128 does not directly provide budget authority nor does it involve new or increased tax expenditures contemplated by clause 2(1)(3)(B) of Rule XI.

OVERSIGHT FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE ON GOVERNMENT OPERATIONS

(Rule XI, clause 2(1)(3)(D))

No findings or recommendations of the Committee on Government Operations were received as referred to in clause 2(1)(3)(D) of Rule XI on section 124 of H.R. 3128.

INFLATIONARY IMPACT

(Rule XI, clause 2(1)(4))

In compliance with clause (2)(1)(4) of Rule XI, it is stated that the committee recommendations will have no inflationary impact on prices and costs in the operation of the national economy.

COSTS

(Rule XIII, clause 7(a)(1))

The costs are those outlined in the cost estimate of the Congressional Budget Office included in this report.

**732 *10 U.S. CONGRESS,

CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 11, 1985.

Hon. PETER W. RODINO, Jr.,
Chairman, Committee on the Judiciary,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed the amendment to H.R. 3128 as ordered reported by the Committee on the Judiciary. This amendment provides substitute language for certain enforcement and penalty provisions of Section 124 of H.R. 3128, the Deficit Reduction Amendments of 1985.

Based on this review, it is expected that no additional cost to the government will be incurred as a result of enactment of this amendment. Section 124 of H.R. 3128, as reported by the Committee on Ways and Means on July 31, 1985, establishes responsibilities of Medicare hospitals in emergency cases. The CBO expected that Section 124 would result in no additional cost to the government. This amendment changes only the enforcement and penalty provisions of Section 124. Therefore, no additional costs are incurred as a result of this amendment.

We would be pleased to respond to any questions you may have on this estimate. Your staff may contact Jack Rodgers (226–2820) with detailed questions.

With best wishes,
Sincerely,

ERIC HANUSHEK,
(For Rudolph G. Penner, Director).

* * * * *

***15** The following documents were submitted to the Judiciary Committee regarding § 124 of H.R. 3128.

SUBMISSION BY THE LAW FIRM OF KENNY NACHWALTER & SEYMOUR

(The following letter was sent by the law firm of Kenny Nachwalter & Seymour to the Honorable Peter W. Rodino, Jr., on September 4, 1985.)

KENNY NACHWALTER & SEYMOUR,
Miami, FL, September 4, 1985.

Re: Deficit Reduction Amendments of 1985 (H.R. 3128)—Responsibilities of Medicare Hospitals in Emergency Cases.

Honorable PETER W. RODINO, Jr.,
Chairman, Committee on the Judiciary, Hosue of Representatives, 2137 Rayburn House Office Building, Washington, DC.

DEAR MR. CHAIRMAN: I am writing in regard to Section 124 of the Medicare Reconciliation Amendments of 1985 (Title I of the Deficit Reduction Amendments of 1985 [H.R. 3128]) which sets forth certain responsibilities of Medicare hospitals with respect to the provision of emergency

medical services.

The Deficit Reduction Amendments were reported out of the Committee on Ways and Means on July 31, 1985, and Section 124 **733 was referred to the Committee on the Judiciary for its consideration before September 11, 1985.

We represent a number of health care providers and a large fiscal intermediary in the State of Florida, and our interest in this subject flows from our involvement with many of the legal and economic issues relating to the provision of medical services to the indigent, and more particularly, with the difficult questions often raised by the subject of patient transfers. I am not writing on behalf of any specific client, but I thought that our perspective from an operating vantage point in which we often deal with the day-to-day challenges faced by both hospitals and physicians in the treatment of indigent patients might be of some interest to you and to the other members of the Judiciary Committee.

Section 124 requires all Medicare provider hospitals, as a condition of participation, to provide an 'appropriate' medical screening examination to any person who requests to be examined, and it expressly prohibits 'inappropriate' patient transfers to other medical facilities. A responsible physician who violates the Section's requirements may be imprisoned for as much as one year and fined $100,000, or, if a transferred patient dies as a result, the physician *16 may be sentenced to five years in prison and fined up to $250,000. Civil penalties are also prescribed.

I am sympathetic to the concerns for patient safety which prompted the adoption of Section 124 by the Ways and Means Committee. I am concerned, however, that its enactment may signal a new and dramatic departure from the basic philosophical approach of the Medicare Act and that the practical operation of Section 124 may unavoidably result in some confusion and ambiguity and may lead to a degradation in the quality of American medical care and particularly in the availability of health care services to the poor.

During the twenty years since the enactment of Medicare, it has been the general philosophy of the federal government to refrain from interfering with medical decision-making by individual physicians and institutional providers or from limiting a beneficiary's freedom to choose among alternative sources of health care. These basic concepts have been incorporated into the Act itself at Sections 1801 and 1802 (42 U.S.C. §§ 1395 and 1395a), respectively.

To the best of my knowledge, Section 124, if enacted, will represent the first time that the federal government has attempted to regulate directly the manner in which medical services are provided. Section 124 seeks to prohibit inappropriate patient transfers and to require a medical screening examination for each patient who requests one. As laudable as these objective are, however, their enforcement can only be obtained through the retrospective evaluation of intimate medical diagnostic and treatment decisions which have heretofore been left exclusively to the judgment of the physician and his patient. If section 124 becomes law, however, those decisions will be subject to the second opinion of federal prosecutors.

The enforcement of Section 124 will also be an extraordinarily complex task inasmuch as patients may be appropriately transferred to other facilities for a variety of legitimate reasons, not all of which are related to the patient's medical condition. A patient ****734** may be transferred because he or she belongs to a pre-paid health insurance plan or to a health maintenance organization which requires as a condition of coverage that the patient be hospitalized in a particular facility. A patient may be transferred because his or her personal physician is on the staff of a different hospital or because the patient has established a prior relationship with a particular health care provider. Sometimes patients request to be transferred because they are eligible for free medical care at a government hospital or at another public facility or because they wish to be treated at a location that is nearer to their residence, family and friends.

Individual decisions to transfer a patient often take place under the most difficult and time-sensitive circumstances. It may, for example, occasionally be the case that an emergency physician may redirect a patient to a different hospital on the basis of a brief examination when it is obvious that the transferring facility lacks the capability to provide for the patient's needs. The time required to examine the patient fully, complete a written determination that transfer is necessary and inform the receiving facility may literally mean the difference in some cases between life and death. At small or rural hospitals, a physician on call and away from the ***17** hospital may be required to authorize the transfer of a patient based upon the initial evaluation of an attending nurse. Section 124 may ultimately force small hospitals to choose between either closing their emergency departments or hiring additional, fulltime medical personnel.

In addition, new modes of delivering emergency services have evolved during the past ten years which contemplate that patients will be routed to the nearest appropriate hospital, often on the basis of radio contact with rescue units or paramedics at the scene of an emergency. Regional trauma centers are specifically designed to direct patients among a number of different medical facilities so that patients may receive the best possible medical care as quickly as possible.

All of these developments and all of these possible transfer situations are entirely legitimate in the sense that the patient's ultimate welfare is thereby protected. Patient transfers take place for a wide variety of reasons, but Section 124 fails to take account of the fact that not all transfers are initiated for improper reasons. By sweeping all transfers into a single net, Section 124 may inadvertently penalize physicians who have actually served a patient's best interests by approving a transfer. It may encourage some emergency physicians to attempt procedures that they otherwise would not, and it may generally discourage transfers in all circumstances, even when motivated by a concern for the patient's best medical interests.

Section 124 is thus dangerously overbroad. Its enactment may contribute directly to a reduction in the quality of emergency medical services generally and indirectly to an increase in the overall costs of health care in the United States.

In addition to its overbreadth, important parts of Section 124 are extremely vague. It is not at all

clear, for example, what is meant **735 by 'appropriate medical screening examination' as set forth in proposed Section 1867(a). If a patient is brought to a hospital suffering from a depressed skull fracture and the hospital has no neurological staff, is the examining physician nonetheless required to have the patient brought into the energency department for an examination prior to the patient's transfer to an appropriate facility? Is a medical screening examination conducted by a nurse always 'inappropriate'?

There is no guidance in Section 124 as to what satisfies the requirement of a written determination by a physician of the relative risks and benefits to the patient of a transfer to another medical facility as set forth in proposed Section 1867(c)(1)(A), and there is no indication of what purpose such a determination would serve. This requirement appears to constitute nothing more than an additional layer of regulatory paperwork, and it may result in a delay in treatment while the necessary forms are completed. More seriously, the language of Section 1867(c)(1)(A) would seem to prohibit any transfer of a patient until a physician can be summoned, a particular problem for hospitals which do not maintain full-service emergency departments.

I am particularly concerned by the requirement of proposed Section 1867(c)(2)(A)(ii) that the agreement of the receiving facility be obtained prior to transfer in all cases. We have encountered instances *18 in South Florida where administrative personnel at receiving hospitals have arbitrarily refused to accept patient transfers that have already been agreed to between the responsible physicians. This provision would effectively mean that any hospital could unilaterally bar all patient transfers, regardless of medical necessity. In addition, there are occasions in which a patient's condition may be so critical that an immediate transfer is indicated and notice to the receiving facility can only be given once the patient is actually on the way. Proposed Section 1867(c)(2)(A)(ii) would prohibit such urgent transfers in all circumstances.

At the very least, to the extent that certification requirements and criminal penalty provisions are incorporated into the final act, I would suggest that such provisions should be made reciprocal. Any receiving hospital should be required to document the fact, that it does not have available space or qualified personnel for the treatment of the patient, and criminal panalties should be imposed for the violation of this requirement.

Section 124 provides for the civil enforcement of its requirements at proposed Section 1867(d)(3) by 'any person or entity that is adversely affected . . .' I assume that this provision was inserted to create a cause of action on behalf of receiving medical facilities, a remedy which may seriously aggravate relations among hospitals in particular localities, but it is at least arguable that it will also inspire claims by ambulance companies and rescue services and many even be interpreted to include, for example, an individual who may be struck by an ambulance carrying a patient from one hospital to another.

The same paragraph stipulates that an action to recover damages for a violation of Section 1867 may be brought 'in an appropriate court of general jurisdiction of the State in which the hospital

****736** is located or in the appropriate Federal district court . . ..' If this language is interpreted to create concurrent federal jurisdiction, the result will be a geometric increase in the number of garden-variety medical malpractice cases handled by the federal courts with all of the consequent burdens of time and expense for the federal judiciary.

Proposed Section 1867(d)(3) also contemplates the imposition of equitable relief to 'deter subsequent violations.' The standards under which injunctions are to be issued to restrain future violations of the Section are not spelled out, however, and this particular remedy would appear to be available to prevent future transfers of other patients not before the court. Inasmuch as patient transfer decisions are typically unique to the medical condition and personal circumstances of each patient, it should prove to be very difficult for the courts to frame appropriate orders and virtually impossible for them to monitor compliance. Because medical decision-making in any particular case is inherently a non-replicable type of activity, equitable sanctions would seem to be peculiarly inappropriate.

The primary test of physician criminal culpability spelled out in proposed Section 1867(d)(4)(A) is whether the physician's conduct represents 'a gross deviation from the prevailing local standards of medical practice.' To the best of my knowledge, this is a new formulation without any history of interpretation by the courts. In ***19** Florida, for example, the 'accepted standard of care for a given health care provider [is] that level of care, skill, and treatment which is recognized by a reasonably prudent similar health care provider as being acceptable under similar conditions and circumstances.' Florida Statutes Section 768.45(1). How Section 124's definition will be applied in practice is unclear. It may turn out to be the case that juries will simply continue to award damages and will begin to convict physicians on the basis of their visceral sense of whether a patient has suffered any damage and how likely it is that civil penalties will ultimately be paid by malpractice insurers.

The availability of insurance coverage for violations of Section 124, however, is questionable. Most policies specifically exclude coverage for damages incurred as the result of criminal acts, and insurance in such circumstances may otherwise be prohibited as a matter of state public policy.

Proposed Section 1867(d)(4)(A)(iii) sets forth the Section's criminal penalties. It provides that a responsible physician may be imprisoned for up to five years and fined as much as $250,000 'if, as a direct result of the violation of this paragraph, the patient dies . . .' It is at least conceivable that the heightened penalties may be invoked in some instances because of substandard medical care rendered at a receiving facility which results in a patient's death. The net effect may be to make physicians at the transferring facility insurers against medical malpractice committed by a different medical facility.

I further believe that most of the definitions contained in proposed Section 1867(e) are inadequate and will lead to unfortunate results in practice. Both the definitions of 'emergency medical condition,' and 'active labor' are very liberal. They would each ****737** appear to include

situations in which a patient's true medical condition could not reasonably be detected by an examining physician prior to transfer. Indeed, the definition of 'active labor' set forth at proposed Section 1867(e)(2)(C) would seem to include women with high-risk pregnancies who might actually be several months away from their expected dates of delivery.

The terms 'to stabilize' and 'stabilized' set forth at proposed Section 1867(e)(4) stipulate that sufficient medical treatment must be rendered 'to assure' that no material deterioration in the patient's condition will take place as the result of a transfer. This type of medical guarantee is ordinarily impossible to make in actual practice; sometimes patients must be moved to other facilities for medical reasons despite the fact that the patient's condition might deteriorate in transit.

I am also troubled by the sweeping inclusion in proposed Section 1867(e)(5) of 'any person employed by (or affiliated or associated, directly or indirectly with)' a hospital among those capable of triggering liability. I am sure what this definition contributes to the Section other than to expand the potential circumstances under which liability may be imposed.

Finally, Section 124, by its terms, is scheduled to take effect on October 1, 1985. This is an extraordinarily rapid effective date and will undoubtedly result in the Section's application to physicians and hospitals who are completely unaware of the Section's existence.

***20** With respect to the enforcement provisions set forth at proposed Section 1867(d), I am generally very skeptical as to wisdom of the civil enforcement and criminal penalties provided for at proposed Sections 1867(d)(3) and 1867(d)(4). It seems to me to be peculiarly inappropriate to use the Medicare Act as the vehicle for the introduction of new criminal sanctions against physicians, particularly when those sanctions can be invoked on behalf of patients who are not even eligible for Medicare benefits (as specified at proposed Sections 1867(a) and 1867(b)).

More fundamentally, there already exist a variety of sanctions for detering and punishing improper physician conduct, including the authorization of inappropriate patient transfers. I need not belabor the impact of medical malpractice liability on physician decision-making. Suffice it to say that virtually all states now recognize a duty on the part of both physicians and hospitals to render emergency medical assistance to those in need who present at a hospital emergency department. Delaware was perhaps the first state to establish such a duty as a part of its common law. *Wilmington General Hospital* v. *Manlove*, 174 A.2d 135 (Del. 1961). Many states, including Florida, have expressly enacted such requirements by statute. The Florida statute provides, in pertinent part, as follows:

> No general hospital licensed under this part, and no speciality hospital with an emergency room, shall deny any person treatment for an emergency medical condition which will deteriorate from a failure to provide such treatment. (Florida Statutes Section 395.0143.)

****738** By imposing affirmative obligations to render emergency treatment to all patients, regardless of financial status, most states have already enacted the means for attaining Section

124's objectives.

The Committee should also bear in mind that most states require the revocation of a medical license upon convinction of a felony related to the practice of medicine. In Florida, such a requirement is incorporated at Florida Statutes Section 455.227(1)(c). Thus, the violation, purposeful or inadvertent, of Section 124 by a physician will almost always result in that physician's permanent removal from the profession.

I understand the concerns which motivated Section 124, and I believe that there are ways in which the section's objectives can be met. In particular, the review of patient transfer decisions as a matter of course should logically constitute one of the functions of the utilization and quality control peer review organizations established by Sections 1151 through 1163 of Title 11 (42 U.S.C. §§ 1320c–1320c–12).

Otherwise, I fear that Section 124 is overboard in its application, vague in its requirements and unnecessarily severe in its sanctions. I would hope that the Congress would chose to consider this important subject in a deliberate fashion and not attempt to enact prophylactic legislation in haste and without an opportunity for public comment.

I am grateful for your tolerance for the length of my comments, and I hope that they may prove useful to you and the other members of the Committee. If I can be of any other service on this matter, please do not hesitate to let me know.

***21** With best regards.

Very truly yours,

PAUL M. BUNGE.

LETTER SUBMITTED BY THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

(This following letter was sent by the American College of Emergency Physicians to the Honorable Peter W. Rodino, Jr. on August 30, 1985.)

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS,

Dallas, TX, August 30, 1985.

Hon. PETER W. RODINO, Jr.,

Chairman, Committee on the Judiciary, U.S. House of Representatives, Rayburn House Office Building, Washington, DC.

DEAR MR. CHAIRMAN: The House Medicare/Medicaid Budget Reconciliation package, H.R. 3128, as approved by the House Ways and Means Committee, includes Section 124 pertaining to responsibilities of Medicare hospitals in emergency cases. That section addresses all patient transfers, not just transfers of Medicare patients. The American College of Emergency Physicians shares the Committee's concerns and does not condone inappropriate patient transfers, some of which have recently come to light in the television and newspaper media. However, turning a few selected cases into federal criminal offenses does raise a number of problems. Section ****739** 124 of H.R. 3128 has been referred to the House Judiciary Committee until September 11.

American College of Emergency Physicians is a national medical specialty society that was founded in 1968 to further the discipline of emergency medicine. Since that time, our membership has grown to more than 11,000 physicians who practice their specialty in emergency facilities across the country. Each year, approximately 77 million visits are made to emergency facilities by patients who depend on emergency care providers to evaluate and treat their illnesses and injuries and the stabilize all life—and limb—threatening conditions. Emergency physicians must be available 24 hours a day, seven days a week to provide such unscheduled, episodic care.

From working in hospital emergency departments, emergency physicians have first-hand experience in providing emergency care and in dealing with the many factors in a patient transfer decision. We also are currently providing much of the medical care that indigent patients are receiving. Every day, we see price-competitive incentives being built into the health care system that work against the poor and medically indigent patient. All third-party payers, including Medicaid, insurers, and employers, are implementing cost saving measures, and they are succeeding. We are concerned about the effects on care for the poor and the near poor.

Although we are in agreement with the objective of the legislation (i.e., to eliminate inappropriate patient transfers), we believe the statutory language is excessively punitive to emergency physicians without truly addressing the patient transfer problem. The language as approved by the Ways and Means Committee is so intimidating to emergency physicians that transfers which are in the *22 best interest of patient care may be avoided or delayed. Because of the undertain nature of the practice of emergency medicine and because of the retrospective standards of liability of this provision, emergency physicians may avoid transfers in order to protect themselves against criminal penalties and ultimate loss of their medical licenses because of the potential of felony convictions. Extreme caution could also result in prolonged detentions and unnecessary admissions. Neither is in the interest of patient care and both would increase health care costs.

Emergency physicians never know what types of cases will come into the emergency department. They must make rapid decisions regarding appropriate treatment, the need for hospitalization, and the type of consultation that may be needed. Time is often critical. The practice of emergency medicine is the challenge of making the best judgments under stressful conditions with limited information. This aspect also leaves the emergency physician most vulnerable to retrospective judgments as to what the physician ‘knows' (or has reason to ‘know’) at the time multiple decisions are being made in the interest of emergency care. The course of a patient's injury or illness is often unpredictable. Yet, the definition of ‘stablized’ used in H.R. 3128 is not a medical (clinical) definition, but, rather, serves more as a warranty against ‘material deterioration of the condition.’ When is something ‘likely’ to happen? In retrospect, if it did not happen, then it was not likely, but if something did **740 happen in the course of time, then was it likely? Hindsight is always clearer than foresight.

Emergency physicians are central figures in the continuum of patient care. Emergency are begins in the prehospital setting, continues in the emergency facility, and concludes when the patient is

discharged or when responsibility for the patient is transferred to another physician or facility. In most cases, emergency physicians do not have hospital admitting privileges and, therefore, are dependent upon hospitals and attending physicians to provide ongoing care to patients beyond the capacity of the emergency department. Only in very limited situations do emergency physicians provide inpatient services.

As central figures in the continuum of patient care, emergency physicians have become acutely aware of the patient transfer issue, as well as the more global problem of funding for indigent care. Insurers, employers, governments, physicians, and hospitals are all affected by this problem. The American College of Emergency Physicians has been and will continue to be committed to providing emergency care to indigent patients. ACEP has long held to the principle that all patients are entitled to emergency care, regardless of their ability to pay. We agree that all patients are entitled to have medical screening and stabilization. The College has established transfer guidelines which were recently expanded and updated, and we feel transfers are appropriate if they adhere to these guidelines. A copy of ACEP's patient transfer guidelines is attached. However, we as individual physicians cannot be held responsible for more than we can reasonably be expected to assure.

The conduct the proposed legislation is attempting to address is more appropriately governed by medical malpractice laws. Defensive medicine and medical malpractice are already recognized as *23 major problems. Expanding the jurisdiction over malpractice claims into federal courts, as this bill does, will exacerbate the current medical malpractice crisis. Reprehensible as true malpractice may be, we feel it is unfair to single out emergency physicians for federal criminal penalties while allowing states to address all other forms of malpractice. We also feel strongly that the proposed approach is an intrusion into areas properly left to the states, namely standards of medical practice.

We note that Medicare started with paying medical bills for the elderly. The proposed provision brings us to the point of federal standards of medical care for the non-elderly backed by criminal penalties. This bill is also precedent-setting in that it attempts to set standards for non-Medicare patients.

Under the proposed legislation, criminal penalties are being imposed in haste as part of a budget reconciliation process when the provisions is not a monetary item. The patient transfer provision was approved by the House Ways and Means Committee without hearings. If the intent of this legislation is to incorporate emergency care into Medicare participation critera, the penalties should reflect already-existing sanctions within the Medicare Conditions of Participation for Hospitals. We believe hospital administrations, hospital governing boards, and hospital medical staffs should jointly **741 develop plans that demonstrate how hospitals will handle patient transfer cases. Hospitals should be responsible for providing medical screening and stabilization, as defined medically, to all emergency patients who present for treatment. All hospitals should demonstrate they have established provisions for care by members of the medical staff for any patients who need admission, particularly when they are not eligible for transfer within the

guidelines. All hospitals should also demonstrate they have established adequate disciplinary actions for violations of the transfer guidelines by members of the medical staff.

Because we feel the proposed legislation is extremely vague, and appears to be open to numerous interpretations, the American College of Emergency Physicians asks that time be taken to formulate a solution that will result in optimal patient care in these potential transfer situations. We are more than willing to work with you in developing alternative solutions and offer our assistance, and that of Virginia Pitcher, Director of the College's Washington Office, in addressing the patient transfer issue. Ms. Pitcher may be contacted at 2000 L Street, NW., Suite 200, Washington, DC 20036, telephone $^{202}/_{861}$–0979.

Sincerely,

BRUCE D. JANIAK, MD, FACEP, *President*.

Enclosure.

THE EXERGENCY PHYSICIAN AND INDIGENT CARE

Emergency medicine is a distinct medical specialty, with approximately 15,000 physicians treating more than 77 million patients annually. It was recognized as the 23rd medical specialty by the American Board of Medical Specialties in 1979, and the first board certification examination was administered in 1980.

***24** Today, 66 residency training programs in emergency medicine have graduated more than 1,500 physicians, with an additional 1,300 in training. More than 3,000 physicians are board certified in emergency medicine. The American College of Emergency Physicians, founded in 1968, is the medical specialty society representing more than 11,000 emergency physicians.

Emergency physicians practice full-time in hospital emergency departments throughout the country. Their practice is unique because they treat a wide range of medical conditions, from the victims of automobile or industrial accidents to children who have swallowed household detergent. Emergency physicians also must recognize and treat cases of child abuse and rape, in addition to working with burn victims, hypothermia victims, and patients suffering potentially deadly allergic reactions.

The emergency department often serves as an access point for patients entering the overall health care system. Emergency physicians serve as a conduit and evaluate, stabilize, and treat all patients who present to the emergency department. Inpatient treatment is almost always the responsibility of other specialists. Because most emergency physicians do not have admitting privileges to the hospital, their role ends when the patient is discharged or ****742** responsibility for the patient is transferred to the admitting physician or another facility.

Because they serve as the access point to the health care system, particularly for those who have no personal physician, emergency physicians are acutely aware of the indigent population in America. Because the indigent population frequently has nowhere to turn for medical care except

the emergency department, emergency physicians frequently treat indigent patients.

The reality of this situation was reflected in recent research conducted by Medical Economics. According to the March 5, 1985, issue of Medical Economics, emergency physicians' median net practice earnings are 8% less than the median for all medical specialists. The magazine states the 'principal explanation is that a high proportion of emergency department patients either can't or won't pay, while medical ethics and the policy of most hospitals require that they be treated.' Most states also have statutes or regulations requiring that patients who present to hospital emergency departments be seen without regard to their ability to pay.

The Medical Economics survey of physicians showed that the typical emergency physician in 1983 rendered more than $25,000 in uncompensated care, compared to approximately $17,000 in uncompensated care provided by all physicians surveyed. The Medical Economics data indicate emergency physicians as a specialty provided more than $380 million in uncompensated care in 1983. Emergency physicians accept uncompensated care as part in 1983. Emergency cause their overriding concern is the patient's welfare.

Frequently, patients are transferred to other facilities following evaluation and stabilization. Transfers occur in all economic strata for any number of reasons. There are often important considerations that may justify a transfer in individual cases that are not strictly related to the availability or suitability of post-emergency medical care in the transferring facility. Some of these consideration include:

*25 An established medical relationship may exist between the patient and the receiving facility, including a history of prior admissions for other or related complaints;

The patient's personal physician may have attending privileges at the receiving facility and not at the transferring facility;

The patient's prior medical records may be on file at the receiving facility;

The patient may prefer to receive post-emergency medical care at a different hospital;

The patient's family, relatives and friends may be inconvenienced by admission of the patient to the transferring facility because of the distance between that facility and the patient's residence; and

The availability of free medical care at a public or government-financed medical facility may obviate or reduce the economic burdens that the patient might otherwise incur.

According to the American College of Emergency Physicians Patient Transfer Guidelines, the emergency physician's role in patient transfers is to stabilize the patient and establish medical responsibility **743 for the patient with a physician at the receiving hospital before a transfer begins. Emergency physicians will make every effort to make the patient as comfortable as possible

before the transfer begins. However, patients cannot always be pain-free before transfer because the pain may be a primary symptom needed to help the receiving physician disagnose and treat the patient.

Emergency physicians believe indigent health care is a crucial issue facing the country today. Transfer of patients is only one facet of this difficult problem. We, we a society, need to address all aspects of indigent health care, particularly the most significant element of the issue—the funding of indigent care. Emergency physicians will continue to staff emergency departments throughout the country and provide medical care to every patient who presents, regardless of their ability to pay.

POLICY STATEMENT ON TRANSFER OF PATIENTS [7]

From time to time, patients in an Emergency Department are transferred to other facilities. The transfer may be to another Emergency Department or directly to an inpatient facility. Clearly, not all physicians or medical facilities have the capabilities to care for every patient. At times, patients, or those responsible for them, request transfer to another facility for various reasons (which may or may not be medical); at times patients are transferred to receive the benefit of more appropriate facilities and/or services than are available in the given hospital or Emergency Department; and at times patients are transferred because of economic consideration, which may include the availability of free or reduced-cost medical care at a public or other facility or in accordance with the requirements of pre-existing contracts for patients of *26 prepaid health plans that stipulate which facilities patients are to use.

Patients should not be transferred to another facility without first being stabilized. Stabilization includes adequate evaluation and initiation of treatment to assure the transfer of a patient will not, within reasonable medical probility, result in death, or loss or serious impairment of bodily parts or organs.

Stabilization of patients prior to transfer should include:

1. Establishing and assuring an adequate airway and adequate ventilation.

2. Initiating control of homorrhage.

3. Stabilizing and splinting the spine or fractures when indicated.

4. Establishing and maintaining adequate access routes for fluid administration.

5. Initiating adequate fluid and/or blood replacement.

6. Determining that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion. The vital signs should **744 remain within these parameters for a sufficient time prior to transfer to be reasonably certain they will not deteriorate while en route to the receiving hospital. However, there may be

times when stabilization of a patient's vital signs is not possible because the hospital or Emergency Department does not have the appropriate personnel or equipment needed to correct the underlying process (e.g., thoracic surgeon on staff or cardiopulmonary bypass capability). In these cases, numbers 1–5 of the above should be performed and transfer carried out as quickly as possible.

At times, a patient or those responsible for the patient, may request a transfer that seems medically inappropriate. The physician is obliged to explain the medical risks involved, and an informed consent should be signed by the patient (or those responsible for the patient such as a parent or guardian) and the physician. In the event of such a transfer, the physician should still use every resource available in an attempt to stabilize the patient prior to transfer.

The following guidelines should be observed for transfer of patients:

1. The patient should be transferred to a facility appropriate to the medical needs of the patient. The facility should have adequate space and personnel available to care for the patient.

2. A physician or other responsible person at the receiving hospital must agree to accept the patient transfer prior to the transfer taking place. Acceptable ‘other responsible persons' should be medical personnel who are designated by the hospital and given the authority to accept the transfer of the patient. The patient transfer should not be refused by the receiving hospital when the transfer is indicated and the receiving hospital has the capability and/or responsibility to provide care to the patient.

3. Communication between responsible persons at the transferring and receiving hospitals for purposes of exchanging clinical information should occur prior to transfer. Ideally, this communication should be physician-to-physician.

*27 4. Once a patient is accepted for transfer, an appropriate medical summary and other records (including lab results and copies of EKGs and X-rays) should be sent with the patient.

5. A patient should be transferred via a vehicle that has appropriately trained personnel and life-support equipment. At times, it may be necessary for additional specialized personnel from the transferring or receiving hospital to accompanying the patient.

At times, transfer of patients occurs routinely or is part of a regionalized plan for obtaining optimal care for patients at more appropriate and/or specialized facilities. In these situations there should be:

1. Written guidelines (e.g., types of cases appropriate for transfer) to govern the transfer of patients;

2. Pre-existing transfer agreements between the facilities, and;

3. Pre-transfer communication between appropriate responsible personnel.

**745 STATEMENT SUBMITTED BY THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

(The following statement was sent by the American College of Emergency Physicians to the House Judiciary Committee on September 6, 1985.)

STATEMENT

The American College of Emergency Physicians (ACEP) is a national medical specialty society that was founded in 1968 to further the discipline of emergency medicine. ACEP's membership now includes more than 11,000 emergency physicians who practice their specialty in emergency facilities throughout the United States. Each year, more than 77 million visits are made to emergency facilities by patients who depend upon the specialized training and expertise of emergency care providers to stabilize and treat virtually every type of serious illness and injury. Emergency physicians constitute the front-line of American medicine and, in many instances, they are effectively the only outpatient health care providers to a substantial portion of the nation's poorest citizens.

The United States Congress is currently considering the enactment of legislation which would regulate the provision of emergency medical services on a national basis. Section 124 of the Medicare Budget Reconciliation Amendments of 1985 (Title I of the Deficit Reduction Amendments of 1985 [H.R. 3128]) sets forth certain requirements and procedures to be followed by Medicare provider hospitals with respect to the provision of emergency medical treatment and imposes criminal penalties for the knowing violation of the section's requirements.

In general, ACEP believes that the objectives of Section 124 (proposed section 1867 of Title XVIII) in attempting to prevent the arbitrary transfer of patients who may suffer serious medical consequences as a direct result are laudable. There can be no question but that the health and safety of each patient is of paramount importance and that no patient should be denied access to emergency medical treatment simply because he or she may lack the ability to pay. ACEP has consistently emphasized the responsibility of all *28 physicians to adhere to the highest standards of medical care and ethics and to contribute to the health care needs of the medically indigent. Emergency physicians in particular have discharged their obligations in this regard with the utmost attention to the professional standards of their discipline and the public interest.

ACEP is very concerned, however, with the means proposed by Section 1867 for discouraging inappropriate transfers and most particularly with the criminal sanction provisions set forth at Section 1867(d)(4). In general, Section 1867 provides insufficient guidance to physicians and other responsible medical personnel as to their duties and obligations under the law, and its enactment may unintentionally result in the imposition of harsh criminal penalties on physicians who have fully conformed to the highest standards of medical ethics in the treatment of patients with emergency medical **746 conditions. In addition, ACEP believes that the practical effect of the law's application may be actually to reduce the quality and availability of medical services to the poor and to raise health care costs generally, results which were not in the contemplation of

Section 1867's sponsors.

As a consequence, ACEP believes that the enactment of Section 1867 as currently formulated would be highly inadvisable. ACEP's specific concerns with this legislation can be grouped into the following categories:

1. The subject of inappropriate patient transfers can best be dealt with as a part of the larger issue of indigent health care generally. Patient transfers are only one aspect of this overall problem which deserves the attention and consideration of the Congress.

2. A variety of effective mechanisms already exist for discouraging transfers which may endanger a patient's health or well-being, and the civil and criminal sactions embodied in Section 1867 are therefore largely redundant.

3. In practice, the implementation of Section 1867's requirements may lead to a host of interpretive difficulties which may result in its unfair application in individual instances and in a general degradation of medical practice and emergency health care.

4. Acceptable and effective alternative solutions exist which could reduce the incidence of inappropriate patient transfers while preserving the independence and professional integrity of the treating physician.

It is not ACEP's position that appropriate legislation cannot be formulated to deal with some of the problems associated with patient transfers. ACEP believes, however, that the subject is a complex one, that its nature and dimensions vary widely among localities and that a comprehensive solution cannot be arrived at in siolation without addressing the broader issues of indigent health care and its overall financial requirements.

1. *Indigent Health Care*.—No one understands the full dimensions of indigent health care needs in the United States or the degree to which those needs are being met. There are no comprehensive data on the subject and only fragmentary analysis of the impact of indigent medical care requirements in specific communities.

We do know, however, that recent changes in the health care industry have probably affected the delivery of medical services to *29 the poor in an adverse fashion. The rapid introduction of competitive forces into the delivery of health services during the past few years has made it increasingly difficult for the private sector to absorb the costs of uncompensated care. Most notably, the implementation of the Prospective Payment System for Medicare reimbursement has exerted significant downward pressures on all hospital charges, eliminating the margin that used to be available for other purposes including the financing of indigent health care.

In addition, both consumers and third-party payors throughout the United States have become increasingly cost-conscious, and organized health care coalitions and new forms of group medical coverage such as preferred provider organizations and HMOs have reduced **747 hospital

utilization rates and cut average patient lengths of stay.

There is also a decreasing emphasis upon the provision of inpatient hospital services generally. Alternative health care delivery systems such as ambulatory surgical centers, freestanding emergency facilities and outpatient services of every sort have served to reduce hospital operating revenues and further limit the resources available for treatment of the poor.

The net effect of these developments has been to raise serious challenges to the continued financial viability of many hospitals. Some have already been forced to close; others can be expected to do so in the coming years. The impact in terms of indigent health care has been to make it even more difficult for the private sector to absord the costs of uncompensated medical services. Despite this fact, America's community hospitals have continued to contribute their fair share: it has been estimated that the value of uncompensated hospital services rendered to the poor exceeds $6 billion annually.

It is within the context of these sweeping changes in the health care industry that the issue of patient transfers must be considered. Realistically, the economic pressures generated by new competitive forces have increased the incentives to transfer patients to publicly-supported facilities where those patients may be eligible to receive free or reduced-cost medical care that is subsidized by tax revenues. Many private hospitals no longer have the option of admitting stabilized indigent patients to their facilities in every instance inasmuch as the fiscal stability of most hospitals has been undermined without providing an alternative source of funding for indigent health care costs.

Indeed, many public hospitals throughout the United States readily acknowledge the public nature of their responsibilities and accept indigent patients from private institutions as a matter of course. The overall prevalence and impact of indigent patient transfers from private institutions, however, is unknown. Much attention has recently been focused upon the anecdotal experiences of a few large public hospitals in major cities where it may well be the case that transfers are becoming a serious problem. There is reason to believe, however, that the nationwide incidence of inappropriate transfers is relatively slight and that many public hospitals are entirely able to accommodate patient transfers with no serious repercussions.

*30 It is important to note, in this context, that an individual patient may be safely and appropriately transferred for a variety of reasons, not all of which are related to that patient's medical needs. It is not unusual for patients to be transported over long distances (occasionally across continents) with no perceptible risk to the patient involved. Patients may request to be transferred because they belong to pre-paid health plans which require their hospitalization in certain designated institutions. Patients may prefer to be hospitalized in a facility with which they have established a pre-existing relationship, because their personal physicians or medical records may be located at a different hospital, or because they simply wish **748 to avoid the inconvenience and expense of an extended stay at a facility which is inconvenient or distant from their residence, family or friends.

In this regard, a patient's concern with the avoidance of debt likely to be incurred as a result of hospitalization at a private facility should not be discounted. While a patient's desire to seek admission to a public hospital may be motivated by economic concerns, ACEP believes that such a decision can be a legitimate one when free medical services are available and that the patient's preferences in this regard should be respected. Indeed, no medical facility can purport to retain a patient contrary to that patient's expressed intention to refuse treatment and seek admission elsewhere. In such a circumstance, a medical facility has no choice but to assist the patient in arranging a safe transfer once it is clear that the patient's condition will not be adversely affected as a result.

The central point is that the subject of patient transfers is a subtle and complex issue whose full dimensions are not clearly understood. It is not a topic which is susceptible to quick and universal solution. ACEP is concerned, however, that Section 1867, by mandating a nationwide regime of transfer standards enforced with criminal penalties, may inadvertently result in the exascerbation of the very situation it seeks to remedy.

In particular, ACEP fears that the enactment of Section 1867 may serve to discourage patient transfers under almost all circumstances. Faced with the prospect of substantial fines and possible imprisonment, many physicians may be understandably reluctant to authorize a transfer even when there may be a medical justification or when the patient has specifically requested to be transferred. The incentives to practice ‘defensive medicane’ will become all the more compelling with the threat of criminal sanctions, and the consequent impact on health care costs generally may be unfortunate.

ACEP would consider such a development to be inconsistent with the standards of medical care and ethics and the goal of efficient health care delivery that it supports. This is particularly true inasmuch as ACEP believes that there are already existing mechanisms which strongly discourage inappropriate patient transfers in almost all cases.

2. Existing Disincentives to Inappropriate Patient Transfers.—ACEP is troubled by the implicit assumption of Section 1867 that severe criminal penalties are necessary to prevent physicians from arbitrarily transferring seriously ill and injured indigent patients ***31** to public facilities. There is no dispute that occasionally such transfers do take place, but ACEP suspects that their incidence may have been overstated in the popular media. By and large, the vast majority of physicians take their ethical responsibilities very seriously and render a singificant amount of medical care without regard to a patient's ability to pay. Emergency physicians alone render an estimated $300 million in uncompensated medical services each year.

****749** In addition to each physician's personal ethical standards, the subject of patient transfers has been addressed by a number of professional medical organizations. Both the American Hospital Association and the Joint Commission on Accreditation of Hospitals have guidelines relating to this area. A hospital which allows inappropriate transfers risks the possible loss of its

accreditation. The American College of Emergency Physicians has itself recently adopted revised guidelines concerning patient transfers from emergency departments, and a copy of those guidelines accompanies this statement.

Of more immediate impact to the individual physician is the ever-present threat of liability in tort. It is now well established that a physician who authorizes a transfer which endangers a patient's life or health may be sued as a result for medical malpractice. Typical of recent cases in this area is *Thompson v. Sun City Community Hospital*, 141 Ariz. 597; 688 P.2d 605 (1984), in which the Arizona Supreme Court held that an aggrieved patient could recover from a hospital for any damages sustained as the result of an improper transfer.

The specter of malpractice liability has profoundly affected the practice of medicine in recent years. Most physicians are at least cognizant of the potential legal risks associated with virtually all medical procedures and some have accordingly adopted extremely conservative diagnostic and treatment modalities. The result has unfortunately exerted some pressure on health care costs throughout the nation, and the recent tendency of juries to award large verdicts in malpractice cases has dramatically increased insurance premiums. Annual malpractices insurance premiums in obstetrics and some surgical specialities now approach $100,000 in some states, and the availability of coverage for some disciplines is increasingly in doubt.

Faced with mounting insurance costs and the increasing prevalence of patient lawsuits, some physicians have reluctantly decided to abandon or restrict their practices. There can be no question but that physician accountability through the legal system has improved, but it has not been without cost. ACEP is concerned that the introduction of criminal penalties as an additional sanction for physician error may accelerate the departure of some physicians from the profession altogether and otherwise increase costs to the public at large.

From its perspective as the representative of the nation's emergency physicians, ACEP considers the existing disincentives to improper patient transfers to be sufficient. It is almost inconceivable that any emergency physician or hospital would knowingly run the substantial risks of civil liability that would result from a decision to transfer a patient contrary to that patient's best medical interests. ***32** ACEP acknowledges the fact that inappropriate transfers are, however, sometimes made. The existing legal system and the profession's standards of conduct, however, are capable of rectifying those mistakes when they occur and ensuring a just compensation for any patient who may suffer as a consequence.

****750** *3. Practical Problems in Implementing Section 1867*.—In addition to ACEPs belief that Section 1867 provides for remedies that may not be necessary or that may be counterproductive in operation, ACEP is concerned by the section's lack of definitive guidance as to the precise conduct prohibited. In general, the implicit premise underlying Section 1867 is that medical diagnosis is an exact science, susceptible in every case to precise, retrospective evaluation. Such, unfortunately, is not always the case. Emergency physicians, in particular, are often called upon to make rapid,

difficult decisions concerning a patient's treatment which may include judgments as to the medical advisability of a transfer to another facility. Not every physician may agree in all instances as to the proper course of treatment, but the existence of professional disagreement does not necessarily indicate sub-standard care.

The difficulty with Section 1867 is that it is nondiscriminating in its application. Physicians may face the prospect of imprisonment and fines despite the fact that they have rendered the best possible care under the circumstances. The test of 'gross deviation from the prevailing local standards of medical practice' as set forth in Section 1867 is inherently capable of a variety of interpretations.

Most disturbing is the fact that Section 1867 will, in fact, be interpreted and enforced not by medical peers but by U.S. Attorneys. ACEP believes that the interjection of non-physician review of the most intimate diagnostic decision-making is not only inadvisable as a matter of policy but contrary to the admonition of Section 1801 of the Medicare Act, 42 U.S.C. § 1395, that '[n]othing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided . . .'

Further, the practical operation of Section 1867 in many cases will be to place emergency physicians in the intractable position of having to provide extended care to emergency patients who might encounter some risk in transport. Most emergency physicians do not have admitting privileges in the hospitals where they practice. Should an emergency physician be unable to locate a staff doctor willing to admit and accept responsibility for the treatment of a patient, the emergency physician will then be faced with the impossible choice of either transferring the patient and risking eventual prosecution or retaining the patient in the emergency department, effectively on an inpatient basis.

Section 1867 will have a particularly harsh impact on the nation's small and rural medical facilities. Many hospitals of this sort operate emergency departments, but many of them are not fully staffed by physicians on a twenty-four hour basis and depend instead upon the services of skilled nurses who initially evaluate the patient's condition and on physicians who are on call outside the hospital. These hospitals sometimes provide the only first-aid and life-saving facilities in their communities, but they will be particularly vulnerable because of their limited resources to inadvertent *33 violations of Section 1867's requirements. A physician who is not physically present in such an emergency department but who is nonetheless on call and a 'responsible physician' as defined in Section 1867(d)(4)(B) will be confronted with the prospect of criminal **751 sanctions if he or she should authorize a patient transfer because it appears to be in the patient's best medical interests in light of the resources available at the transferring hospital at the time the patient is seen.

In addition, it is not clear from the language of Section 1867(a) what 'an appropriate medical

screening examination' is or who is required to provide it. The practice of emergency medicine has undergone considerable change in the past decade as new delivery systems such as regional trauma centers and areawide telecommunications networks have evolved for the purpose of directing patients to the nearest appropriate medical facility as quickly as possible. It is sometimes the case that preliminary evaluations of a patient's condition must take place on an urgent basis and occasionally by means of radio contact with rescue units on the scene. The requirement of providing a complete medical screening examination prior to transfer may simply be impossible to fulfill in all circumstances and may often be contrary to the patient's best medical interests in obtaining prompt medical attention at the most appropriate facility.

ACEP is also concerned by the requirement of Section 1867(c)(2)(A)(ii) that the agreement of the receiving facility be obtained in all circumstances before a patient transfer is initiated. There have been instances in which non-physician administrative personnel at some medical facilities have intervened to block or countermand patient transfers already agreed upon between responsible physicians. It is ACEP's position that a decision as to medical advisability of any transfer is a medical determination to be made by the physicians on the scene and that administrative concerns should not interfere with that process. Just as the transferring hospital has a responsibility to conduct a patient transfer in a safe and appropriate manner, so too does the receiving hospital have a responsibility not to refuse a transfer arbitrarily when otherwise indicated.

ACEP believes that the civil enforcement provisions incorporated at Section 1867(d)(3) may potentially serve only to aggravate relations among hospitals in particular localities. The inclusion of 'any entity' among those eligible to claim damages as a result of an inappropriate transfer may lead to the unfortunate spectacle of hospitals brining suit against each other over patient transfer disagreements. The resolution of individual transfer situations can often best be handled on a more informal basis; the judicial system is particularly ill-equipped to mediate such disputes.

Further, ACEP is in doubt as to the potential implications of Section 1867(d)(3)'s stipulation that an action for damages may be brought 'in an appropriate court of general jurisdiction of the state in which the hospital is located or in the appropriate Federal district court.' This provision may simply be an acknowledgment that certain actions will inevitably be filed in the federal courts as a part of their diversity of citizenship jurisdiction. It may, however, also be interpreted to create a new federal question basis for district *34 court jurisdiction over cases arising out of Section 1867. If the latter, the result will be federal court adjudication of what are essentially **752 medical malpractice cases now handled almost exclusively in state courts.

At the very least, ACEP doubts whether it is appropriate to provide for equitable sanctions in addition to the fines and other penalties already set forth in Section 1867. Each patient must necessarily be evaluated and treated on an individual basis, and it is not likely to be the case that separate patient transfers will share many of the same characteristics. Nonetheless, if injunctive relief is entered to restrain future patient transfers, it will be very difficult for a court to frame such an order and for an affected hospital or physician to know precisely what conduct has been

restrained. The inevitable result may be continuing judicial supervision of ongoing medical decision-making, the kind of active judicial management of technical issues which most courts are reluctant to undertake.

The inherent ambiguity in many of Section 1867's provisions is illustrated by the definition of 'to stabilize' as set forth in Section 1867(e)(4)(A). That definition stipulates that emergency medical treatment must be provided to a patient sufficient 'to assure' that the patient's condition will not likely deteriorate as the result of a transfer. The practice of medicine is not, however, an exact science, and rigid guarantees and assurances as to the probable course of any illness or injury are simply not within the capacity of any physician to provide.

4. Alternative Solutions.—ACEP strongly believes that the subject of patient transfers and emergency medical care in general is sufficiently important to warrant careful and deliberate study by the Congress. The text of Section 1867 originated with the House Ways and Means Committee's deliberations on the Deficit Reduction Amendments of 1985, and no public hearings on Section 1867 have yet been held. The actual text of this legislation has been publicly available for only a few weeks. There is thus the distinct possibility that the bill may be enacted with virtually no opportunity for public comment and within the space of less than two months from start to finish.

Section 1867 is, however, a dramatic and controversial addition to federal law. ACEP believes that this legislation deserves careful and considered attention with an opportunity for the Congress to receive and evaluate the opinions of interested persons and organizations. It should not be enacted in haste as a part of the annual budget process.

Accordingly, ACEP would respectfully suggest that Section 1867 be severed from H.R. 3128 so that its merits and probable impact on American medicine can be separately evaluated. The subject is far too important to be resolved by the enactment of criminal penalties as the panacea for a situation which is inadequately understood.

In this regard, ACEP would support legislation directing the Secretary of Health and Human Services to undertake a comprehensive study to determine the scope and dimensions of indigent health care needs in the United States. Such a study would constitute an invaluable contribution to our understanding of an important **753 *35 aspect of American health care. There is insufficient information on the degree to which the medical requirements of the poor are now being met, and it is time that a careful analysis be conducted of the impact on indigent health care of recent changes in the health care industry. One part of this study could appropriately be devoted to an examination of the incidence and effects of patient transfers.

With specific regard to emergency medical treatment, ACEP supports the concept that all hospitals should be required to develop plans governing the provision of emergency medical services and setting forth the procedures to be followed when transferring a patient to another facility. If necessary, such a requirement could be included as a condition of participation for Medicare reimbursement. The objective would be to ensure that every patient is provided with

appropriate emergency medical treatment regardless of that patient's ability to pay.

Many states now enforce such standards either through legislation or by judicial interpretation, and the enforcement of such state legislation and the adjudication of claims on behalf of aggrieved patients should continue to be matters of administrative action and civil litigation. There is very little indication that these remedies have proven to be inadequate in the past. The use of federal criminal sanctions in a field such as emergency medicine which is characterized by subjective judgment and urgent decision-making is peculiarly inappropriate. The potential penalties are draconian in degree. Not only may some physicians be faced with lengthy prison terms and substantial fines for a mistake in judgment, but their future livelihood may effectively be destroyed. Most states automatically revoke a medical license upon conviction of a felony. The addition of criminal penalties to civil liability to loss of the ability to practice medicine amounts to the sort of cumulative sanctions that are both unnecessary and extraordinarily harsh.

If enacted as currently written, Section 1867 will take effect on October 1, 1985, only days after it is likely to be signed into law. There will be virtually no time for physicians across the country to know and understand their duties under the law and the possible penalties they may encounter. ACEP believes that the goals and objectives of Section 1867 are worthy of support, but that the means proposed may unfortunately prove to be disastrous in application.

The American College of Emergency Physicians firmly believes in the right of every patient to be treated with dignity and compassion. Adequate medical care should be available to every individual, regardless of economic status. As the national professional society of emergency physicians, ACEP will continue to support measures designed to strengthen and improve the provision of emergency medical services and to attain the goal of a society in which access to medical care is available to every person in need. Inappropriate patient transfers are only one manifestation of the fact that America has not yet reached that goal. A resolution to this issue can be found, but it must be a solution which combines concern for the rights and dignity of the individual patient with an appreciation for the difficult and demanding challenges of the profession of emergency medicine.

****754** ***36** The American College of Emergency Physicians stands ready to work with the Congress in formulating a reasonable and effective solution to this important issue.

POLICY STATEMENT ON TRANSFER OF PATIENTS [8]

From time to time, patients in an Emergency Department are transferred to other facilities. The transfer may be to another Emergency Department or directly to an inpatient facility. Clearly, not all phyiscians or medical facilities have the capabilities to care for every patient. At times, patients or those responsible for them, request transfer to another facility for various reasons (which may or may not be medical); at times patients are transferred to receive the benefit of more appropriate facilities and/or services than are available in the given hospital or Emergency Department; and at times patients are transferred because of economic considerations, which may include the

availability of free or reduced-cost medical care at a public or other facility or in accordance with the requirements of pre-existing contracts for patients of prepaid health plans that stipulate which facilities patients are to use.

Patients should not be transferred to another facility without first being stabilized. Stabilization includes adequate evaluation and initiation of treatment to assure the transfer of a patient will not, within reasonable medical probability, result in death, or loss or serious impairment of bodily parts or organs.

Stabilization of patients prior to transfer should include:

1. Establishing and assuring an adequate airway and adequate ventilation.

2. Initiating control of hemorrhage.

3. Stabilizing and splinting the spine or fractures when indicated.

4. Establishing and maintaining adequate access routes for fluid administration.

5. Initiating adequate fluid and/or blood replacement.

6. Determining that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion. The vital signs should remain within these parameters for a sufficient time prior to transfer to be reasonably certain they will not deteriorate while en route to the receiving hospital. However, there may be times when stabilization of a patient's vital signs is not possible because the hospital or Emergency Department does not have the appropriate personnel or equipment needed to correct the underlying process (e.g., thoracic surgeon on staff or cardiopulmonary bypass capability). In these cases, numbers 1–5 of the above should be performed and transfer carried out as quickly as possible.

At times, a patient or those responsible for the patient, may request a transfer that seems medically inappropriate. The physician is obliged to explain the medical risks involved, and an informed consent should be signed by the patient (or those responsible for the patient such as a parent or guardian) and the physician. In the event of such a transfer, the physician should still use every resource ***37** ****755** available in an attempt to stabilize the patient prior to transfer.

The following guidelines should be observed for transfer of patients:

1. The patient should be transferred to a facility appropriate to the medical needs of the patient. The facility should have adequate space and personnel available to care for the patient.

2. A physician or other responsible person at the receiving hospital must agree to accept the patient transfer prior to the transfer taking place. Acceptable ‘other responsible persons' should be medical personnel who are designated by the hospital and given the authority to accept the transfer of the patient. The patient transfer should not be refused by the receiving hospital when

the transfer is indicated and the receiving hospital has the capability and/or responsibility to provide care to the patient.

3. Communication between responsible persons at the transferring and receiving hospitals for purposes of exchanging clinical information should occur prior to transfer. Ideally, this communication should be physician-to-physician.

4. Once a patient is accepted for transfer, an appropriate medical summary and other records (including lab results and copies of EKGs and X-rays) should be sent with the patient.

5. A patient should be transferred via a vehicle that has appropriately trained personnel and life-support equipment. At times, it may be necessary for additional specialized personnel from the transferring or receiving hospital to accompany the patient.

At times, transfer of patients occurs routinely or is part of a regionalized plan for obtaining optimal care for patients at more appropriate and/or specialized facilities. In these situations there should be:

1. Written guidelines (e.g., types of cases appropriate for transfer) to govern the transfer of patients;

2. Pre-existing transfer agreements between the facilities, and;

3. Pre-transfer communication between appropriate responsible personnel.

1 'Emergency Room Statutes: A State-By-State Roundup' p. 485, Clearinghouse Review, vol. 18, No. 5, October 1984, p. 482.

2 Supra, p. 490.

3 Thus, when this Committee drafted legislation to recodify federal criminal laws, it defined criminal negligence to be a failure to recognize a risk that a circumstance exists or a result will occur where the risk is of such a magnitude that the failure to perceive it constitutes a gross deviation from a standard of reasonable care. H.R. 6915, 96th Cong., 2d Sess. § 301(e) (1980). The Senate similarly defined criminal negligence in the bill it passed to recodify federal criminal laws. S. 1722, 96th Cong., 2d Sess. § 302(d) (1980).

See H.R. Rept. No. 1396, 96th Cong., 2d Sess. 34 (1980) ('Although the terms 'reckless' and 'negligent' are terms drawn from the civil law, their definitions in the proposed code are significantly different from civil law definitions.'); Sen. Rep. No. 553, 96th Cong., 2d Sess. 65 (1980) ('. . . in requiring a 'gross deviation,' the standard for criminal negligence is stricter than that for ordinary tort negligence.').

4 This Committee, in the bill to recodify federal criminal law that it reported in the 96th Congress, did not use a criminal negligence standard in any of the offenses it defined.

5 *See* G. Williams, Criminal Law: The General Part 123 (2d ed. 1961); Hall, *Negligent Behavior Should Be Excluded From Penal Liability*, 63 Colum. L. Rev. 632 (1963).

6 *Winters* v. *New York*, 333 U.S. 507, 515–16 (1948) (citations and footnotes omitted).

7 Approved by the ACEP Board of Directors on August 13, 1985. These are guidelines and are not to be construed as standards of care.

8 Approved by the ACEP Board of Directors on August 13, 1985. These are guidelines and are not to be construed as standards of care.

(Note: 1. PORTIONS OF THE SENATE, HOUSE AND CONFERENCE REPORTS, WHICH ARE DUPLICATIVE OR ARE DEEMED TO BE UNNECESSARY TO THE INTERPRETATION OF THE LAWS, ARE OMITTED. OMITTED MATERIAL IS INDICATED BY FIVE ASTERISKS: *****. 2. TO RETRIEVE REPORTS ON A PUBLIC LAW, RUN A TOPIC FIELD SEARCH USING THE PUBLIC LAW NUMBER, e.g., TO(99-495))

H.R. REP. 99-241(III), H.R. REP. 99-241, H.R. Rep. No. 241(III), 99TH Cong., 1ST Sess. 1985, 1986 U.S.C.C.A.N. 726, 1985 WL 25931 (Leg.Hist.)

End of Document