



ADVANCING EMERGENCY CARE 

**TESTIMONY OF Gary R. Katz, MD, FACEP, President, Ohio Chapter, American College of Emergency Physicians, before the Senate Judiciary- Civil Justice Committee, June 10, 2009**

Chairman Seitz, Senators of the Committee,

Thank you for taking the time to hear testimony today in support of Senate Bill 86. My name is **Gary Katz and I am President-Elect of the Ohio Chapter of the American College of Emergency Physicians**, representing over 1,100 ER doctors, who treat the 5.9 Million ER patients each and every year in Ohio. I have been practicing Emergency Medicine for over 10 years and have been training future ER doctors for the last 8, so I am well aware of the troubles that face our patients each and every day.

From the lack of emergency medicine trained physicians to the lack of on-call doctors to assist in the care of the emergency patient, the state of emergency medicine is in crisis. In 2006 the Institute of Medicine noted that the nation's healthcare safety net, Emergency Medicine, is straining to the breaking point. Further, just this year the American College of Emergency Physicians gave our state less than stellar grades, particularly in the area of on-call availability, which was cited as particularly impactful in hindering access to emergency care. It is this lack of access to quality and timely emergency care that Senate Bill 86, Access to Emergency and Disaster Care, is designed to correct.

Our solution is data driven. It has already been proven effective in states that have implemented these standards

While emergency physicians are experts in providing stabilizing care, they do require specialty support from time-to-time. Other specialists providing essential on-call services to emergency patients are often in critically short supply, due largely to increased liability exposure, higher liability premiums and reduced reimbursements for providing emergency care. We have a serious lack of on-call specialists in Ohio's ERs, including specialists such as orthopedics, neurosurgery, ophthalmology, and others. State liability laws should act to encourage these specialists to provide vital on-call services to emergency patients, not inhibit them.

To underscore the severity of this problem, I would like to tell you about a case I saw recently and the Golden Hour. The Golden Hour, as you may know is the concept that the first hour of treatment is critical for the care of emergency conditions. The ideal is clear: The earlier one gets treatment, the greater the chance for a favorable outcome.

A patient, who I refer to as Jane Doe, seemed to be a previously healthy 64 year old lady, residing in an moderate size city right here in Ohio; served by a sizable hospital, she had no reason to believe that it couldn't meet her emergency medical needs.

On the day I saw her, she had the sudden onset of stroke symptoms and immediately called 9-1-1; with respect to seeking emergency medical care, she did everything right. However, because her local hospital had neither a neurologist nor a neurosurgeon on call, EMS transported the patient over an hour away, bypassing the local ER. By the time she arrived, the bleeding in her brain progressed to the point where she could not be saved. We maintained her on artificial life support until the family, a son and two daughters, could come and say their goodbyes. Though similar to the recent tragedy of Actress Natasha Richardson, this case was one of Ohio's own, who did what she should to get medical help, but the problem of inadequate on-call specialists prevented her from getting the care she needed to save her life.

Unfortunately this experience of Jane Doe is not an outlier. Rather, our Emergency Department receives many cases each day; patients who had to endure the pain, cost, and delay of a transfer caused by the lack of adequate on-call availability at their local hospital. The crisis in on-call specialists for emergency care is creating a danger for Ohio's citizens who need emergency care. The problem arises from the high cost of being on call. When electing to take ER call, a specialist is exposed to excess risk of litigation, decreased probability of getting paid, and a disruption to a regularly scheduled practice.

This is not to say that each hospital must provide all services, rather such a decision should be made because it is the strategy of the hospital to meet the needs of the community it serves, and not because these barriers prevent a willing hospital from finding a willing physician.

Finally, it has been reported that through the employment of office and ancillary staff, the average physician's office contributes over \$600,000 to the local economy. By reducing unreasonable barriers we can bring more quality physicians to Ohio and most importantly, provide excellent access to quality emergency care.

As I stated before, this measure is data driven, based upon what has proven safe and effective in other states. This bill closely parallels language of successful legislation in Texas and Georgia. Landmark similar reforms in Texas in 2003 created, by 2008, a record influx of physicians to the Texas Medical Board and are credited for increased access to all levels of care and specialty care services. In February 2009, the Texas College of Emergency Physicians and the Texas Medical Board reported that 76 Texas counties reported gains in emergency physicians—39 of those counties previously underserved in terms of emergency medicine. Imagine the economic benefit to Ohio, our communities and the healthcare access benefit if our legislation can achieve even ½ the influx of practicing physicians seen elsewhere.

I teach my residents, every day, do what's right for the patient.

Reducing the barriers for physicians to take call is proven to increase the number of trained specialists available in our society. Improving access to quality care is what is right.

I thank you for your time and welcome any questions.

**TESTIMONY OF Catherine Marco, MD, FACEP, Government Affairs Chair, Ohio Chapter,  
American College of Emergency Physicians, before the Senate Judiciary- Civil Justice  
Committee, June 10, 2009**

Chairman Seitz and Committee Members:

My name is Catherine Marco, M.D. and I am here to testify as a proponent of Senate Bill 86, *Access to Emergency and Disaster Care*. This bill proposes amending Ohio statute to provide limited liability protection for physician health care providers in disaster and emergency situations.

I work as an Emergency Physician, an "ER Doc". I work in the Emergency Department at the University of Toledo Medical Center and I am also the Residency Director. I am the Chair of the Government Affairs Committee of the Ohio Chapter of the American College of Emergency Physicians. Our organization, Ohio ACEP, represents over 1100 emergency physicians in Ohio. Members of our organization staff the Emergency Departments, the "ER's," in Ohio's hospitals. We take great pride in our work of saving lives and caring for the health of Ohioans every day, 24/7. We care for every type of patient who comes to our ERs, including everything from heart attacks and major trauma, to minor illnesses and injuries. Emergency physicians and on-call specialists who provide emergency care work in a unique environment with specific challenges. They care for patients under the federal law EMTALA, which requires that all patients presenting to emergency departments be evaluated for emergency medical conditions. They care for all patients, regardless of insurance status or ability to pay.

Many of the patients who come to our ERs lack access to primary medical care. They come to us because we are always open and we are always willing and happy to see anyone and everyone who comes through our doors. Many of our patients are uninsured and rely on the safety net of the ER. As a result, many ERs face crisis situations daily.

Ohio ranks above the national average for ER visits per capita, and this number continues to rise every year. Ohioans seek emergency care 25% above the national average, per capita. (516 patients per 1000 compared to national 401 per 1000 population; <http://www.statehealthfacts.org/profileind.jsp?ind=388&cat=8&rgn=37>). The uninsured account for the largest fraction of this growth - twice as high as the average growth. (20% compared to 9.5%) [http://www.nbc4i.com/cmh/news/local/article/-CMH\\_2008\\_01\\_07\\_0011/1973/](http://www.nbc4i.com/cmh/news/local/article/-CMH_2008_01_07_0011/1973/)). Despite this rapidly increasing demand on Ohio's ERs, there continues to be a shortage of board certified emergency physicians. Nationally, only 65% of doctors working in ERs are board certified in Emergency Medicine. Only 65%.

On one of my typical shifts last week, our ER was completely full. Every gurney was occupied, with patients with heart attacks, injuries, blood infections, pneumonia, preterm labor, and the list goes on. We also had patients on gurneys lining the hallways of our ER. You can imagine how uncomfortable it would be to come to the ER, sick or injured, and be placed on a gurney in the hallway, with no privacy, next to the nursing station with a parade of noisy passersby. Not a restful scenario to be treated in. I treated one patient for anaphylactic shock after a bee sting, a life threatening condition, in the hallway. Fortunately, she and the other patients we treated that day were successfully treated. Not all patients are so lucky. Many patients suffer bad outcomes because of ER crowding.

ER Crowding is a critical problem in our Emergency Departments in Ohio. Many factors contribute to the problem of crowding, including the shortage of board certified emergency physicians, and the shortage of on call specialists to care for our patients.

In addition to all the other stresses that accompany the world of emergency medicine, our uniqueness also comes at a great financial cost. A 2003 report from the AMA's Center for Health Policy Research drawing on 2001 survey data and estimates of health care bad debt borne by physicians estimated that the average annual amount of EMTALA-mandated uncompensated care per physician was \$12,300, but that when the burden on ER docs alone was calculated, the amount was \$138,300 per doc per year. (Kane, CK: *The impact of EMTALA on physician practices*; AMA Center for Health Policy Research; February 2003.) Given the increase in the ranks of the uninsured, the increase in annual ER visits, and the increase in the total amount of health care bad debt since 2001, the actual uncompensated care burden on emergency physicians today is undoubtedly much greater.

Physicians in other specialties can place caps on how many patients they treat, but Emergency Physicians have no such privilege. We treat all patients, no matter what, no matter how many, no matter how crowded the ER is. The downturn in Ohio's economy is resulting in an even higher number of uninsured and an increased reliance on Ohio's Emergency Departments. In severe emergencies, we must do this even without access to critical medical records and information, such as past medical history, allergies, medications, and other important information. Everyone will need emergency care at some point, whether they are young or old, rich or poor, insured or uninsured. It is imperative that the emergency care system remains viable and capable of providing high quality lifesaving care to the entire population. The federal mandate requires that emergency care is provided to everyone. In order to fulfill that mandate and meet the safety net needs of our communities, the state should provide liability protection similar to the protection it provides other private entities that perform a public service. SB 86 offers a no-cost way to support community access to vital emergency and disaster medical services.

We can work together to provide quality Emergency care for the patients of Ohio by improving access to care through this proposed legislation.

**TESTIMONY OF Michael Frank, MD, JD, Ohio Chapter, American College of Emergency Physicians, before the Senate Judiciary- Civil Justice Committee, June 10, 2009**

My name is Michael Frank. I am a physician and attorney. I am board certified in emergency medicine, I've practiced emergency medicine in Ohio for almost 30 years, and law for almost 20. I am now primarily engaged in managing the legal affairs of an emergency physician group headquartered in Canton. We see 1.7 million ER patients a year, more than 300,000 of them in Ohio. I manage all the medical malpractice claims and am intimately familiar with the damage those claims cause to both physicians and the safety net which our emergency care system has come to be. I appreciate the opportunity to comment on Senate Bill 86.

In order to successfully sue a physician for medical malpractice, Ohio law currently requires the patient to prove that the physician made a mistake, a mistake that a reasonable physician in the same circumstances would not have made, and that the mistake injured the patient. This is the standard of "ordinary negligence", a standard which has proved to be so flexible that the bar to entry is extremely low. Analysis of the results of this standard clearly show that the severity of a patient's medical condition, rather than whether the care provided was negligent, is the only reliable predictor of the outcome of malpractice lawsuits. (Localio AR *et al: Relation between malpractice claims and adverse events due to negligence*. N Engl J Med 325:245-251; July 25, 1991. Brennan TA *et al: Relation between negligent adverse events and the outcomes of medical-malpractice litigation*. N Engl J Med 335:1963-7; December 26, 1996.) This is a difficult concept for most physicians to accept, and encourages physicians to avoid situations where

patients are more likely to have medical problems which may lead to lawsuits regardless of how competently the physician acts. Those situations are found in abundance in the ER. Not surprisingly, it is becoming increasingly difficult to find specialists willing to be on call for the ER, and the number one problem facing ER groups such as mine is finding enough emergency physicians to staff the ER's. In a surprisingly candid, but somewhat understated admission, the Centers for Medicare & Medicaid Services (CMS) said, "We are aware that providing specialty on-call coverage can be challenging for a hospital because of the limited availability of specialty physicians who are willing or able to take call." (73 Federal Register 48662; CMS Final Rule Preamble CMS 1390-F 7/31/08, p. 873) And in what can only be described as an example of the axiom that no good deed goes unpunished, we are currently defending one of our ER docs who spent three hours calling multiple hospitals trying to find a hand specialist willing to take care of a patient with an amputated finger, but now is being sued because the reimplantation surgery failed because of the delay.

As one small step toward resolving these challenges, we are asking that the medical malpractice standard be changed to require proof of willful or wanton misconduct. Ohio court decisions characterize this standard as requiring evidence of carelessness and an indifference to the consequences of one's carelessness. The Ohio legislature has adopted the willful or wanton misconduct standard for:

- police officers (ORC §9-86);
- firefighters (ORC §9-60);
- EMT's and paramedics (ORC §4765.49);
- school team doctors (ORC §2305.231);
- hazmat cleanup volunteers (ORC §2305.232);
- free clinic physicians (ORC §2305.234);
- the state fire marshal (ORC §3737.221);
- governmental employees and officers (ORC §2744.03);
- Good Samaritans providing emergency care (ORC §2305.23);
- ER docs on the radio directing emergency care provided by paramedics (ORC §4765.49); and
- drivers of ambulances and other public safety vehicles (ORC §4511.03).

In 2003, the Texas state legislature adopted an almost identical standard, requiring proof of "willful or wanton negligence" for physicians providing hospital emergency care. (Tx Civ Prac & Rem §74.153 & 74.154) And yet despite the immunities granted to these groups, there has been no crisis of reckless conduct among our firefighters, among our police officers, among our paramedics and EMT's. Nor has Texas experienced an epidemic of negligence in the ER.

We quite rightly refer to our emergency care system as a medical safety net. Unfortunately, the safety net is stretched to the breaking point, and I am fearful that many people, yourselves included, may not realize how serious and how close to home this problem really is. Over the past couple of years, there have been several high profile cases of patients who have expired in ER waiting rooms. These cases have garnered much publicity, and even more public outrage, mostly because of the lack of concern displayed by the hospital personnel in the face of the dire straits of these patients. While such indifference exhibited by hospital personnel is clearly more the exception than the rule, you would be wrong in concluding that waiting room deaths and injuries only occur where caring and compassion is lacking. In my ER group, we have defended

3 lawsuits against our physicians involving patients who died of cardiac arrest in the ED waiting room. And the experience in my group is hardly unique. In 2007, the American College of Emergency Physicians surveyed almost 1,500 ER docs, asking if they were aware of any patients who suffered harm, or died, as a result of waiting to be seen in an overcrowded ER. Over 700 of the ER docs said they had personal experience with a patient being harmed, and 200 had personal experience of a patient dying. (*ACEP Poll on the Critical Issues Facing Emergency Patient: August 29 – September 19, 2007.*) My point is that this is not someone else's problem. It is our problem and it is here now. We are asking for your help in solving that problem.

**TESTIMONY OF Mark E. Gebhart, MD, Ohio Chapter, American College of Emergency Physicians, before the Senate Judiciary- Civil Justice Committee, June 10, 2009**

Chairman Seitz and members of committee, my name is Dr. Mark Gebhart and I am here to testify today in support of SB 86, Access to Emergency and Disaster Care. I am an associate professor of emergency medicine at the Wright State University Boonshoft School of Medicine in Dayton, Ohio and a practicing emergency physician in the emergency department at Good Samaritan Hospital. I also currently serve as director of The National Center for Medical Readiness, a center of excellence dedicated to the present and future medical and health care providers, civilian and military, and their ability to respond to any challenges they are confronted with. I recall clearly a late summer day in August 2005 when I arrived in Gulfport, Mississippi. I was the physician deployed with Ohio Task Force 1 and was the first physician to arrive in the Gulfport area. As the days passed I recall how the physicians in Mississippi staffed hospitals, clinics, tents, vans, or whatever type of place they could find to practice their art.

During the past 4 years, Ohio has taken steps to prepare our health care system for a disaster. The Ohio Department of Health has funded nearly \$12 million dollars directed to developing significant surge capacity infrastructure for Ohio's nearly 10 million citizens. Our team at Wright State University has taken a department of defense, pre - 9/11 medical surge system designed for biological terrorism and transformed it from an on the shelf plan to an operational asset within the State of Ohio. At this very moment, our team at Wright State is responsible for 4,750 strategically placed patient visits across the State of Ohio. Simply put, Ohio now has a disaster medical system with no patients, no walls, and no staffing.

Staffing this disaster hospital system, or for that matter any other form of disaster medical facility is an enormously important issue. The funding that the Ohio Department of Health has spent to prepare this disaster health system would rely upon hundreds of physicians from every specialty to staff Ohio's influenza hospitals, to staff burn response teams, to care for our ever enlarging geriatric population and to ensure the health of millions of children. As the plan is currently envisioned, this asset, strategically placed in numerous homeland security regions across Ohio will not work without physicians being willing to extend their time and talent to preserve the health and well being of Ohioans or others who are unfortunate.

An essential element to enabling the physician workforce in Ohio to participate in this or any other form of disaster response is the freedom to practice medicine, deliver lifesaving emergency care and to do so with increased liability protection. The delivery of this care must be delivered in compliance with EMTALA.

Despite the fact that many states are attempting to break legal hurdles that prevented hundreds of doctors and nurses from volunteering to help Hurricane Katrina victims in 2005 with legislation that would allow physicians to quickly offer medical help such as The Uniform

Emergency Volunteer Health Practitioners Act, we have yet to support Ohio's own physicians in their ability to respond without impediment or threat of penalty at home.

I wholeheartedly support the proposed language amending Ohio statute in SB 86 to provide limited liability protection for physician health care providers in disaster and emergency situations.

Mr. Chairman, members of the committee, this opportunity is good for Ohioans and good for those physicians providing emergency and medical care in times of great burden. We have built a model disaster surge capacity system in Ohio. I now urge you to take the necessary steps to allow Ohio's physicians the freedom to fulfill their professional responsibilities. I urge you to support Senate Bill 86.

**PROPONENT TESTIMONY FOR S.B. 86:  
MEDARD LUTMERDING, MD, FACEP  
REPRESENTING THE CENTRAL OHIO TRAUMA SYSTEM  
& THE COLUMBUS MEDICAL ASSOCIATION  
September 16, 2009**

Thank you for letting me speak with you today. My name is Medard Lutmerding and I am here to testify on behalf of the Central Ohio Trauma System and the Columbus Medical Association as proponents of Senate Bill 86---the bill that addresses Physician Qualified Immunity for Emergency & Disaster Care. The Central Ohio Trauma System is a 501(c)(3) non-profit whose mission is to reduce injuries and save lives by improving and coordinating trauma care, emergency care and disaster preparedness systems in Central Ohio. COTS works with 27 hospitals and 40-plus EMS agencies across 18 counties to improve the emergency care given to patients, including to victims of disasters. The Columbus Medical Association is the professional association for physicians in Franklin County, representing over 2,000 doctors of various disciplines, practice environments and specialties. My "day job" finds me practicing emergency medicine at Mount Carmel East and West hospitals in Columbus, where I have taken care of thousands of patients in my years of practice.

In September 2005 just a few days after Hurricane Katrina's ravaging siege on the Louisiana coast, the Central Ohio Trauma System---or "COTS"---as part of its disaster preparedness response work, participated in a national conference-call with then-Health and Human Services Secretary Levitz. In response to the Secretary's request, COTS worked with Central Ohio hospitals and the Columbus Medical Association to establish a 112-person medical team ready for immediate deployment south to assist with emergency medical care needed by victims of the disaster. Five other such teams were established across the U.S.---the COTS' team the only one from Ohio at the ready.

We watched the news reports and saw desperate victims who needed medical care. We longed to go to New Orleans or elsewhere and help. But despite our preparations and willingness, we were never deployed. Why? A major hold-up was liability issues that, given the chaos in New Orleans, could not be ironed out within the State of Louisiana in relation to other states. In light of the liability concerns, we began to lose our medical volunteers and over time, we lost our ready-team.

Without the protections afforded by Senate Bill 86, *Ohio is just as vulnerable* to losing a “ready-team” of physicians capable of providing emergency care in the event of a disaster.

Hurricane Katrina is long past, but another disaster is unfolding as I speak to you today, and this one is in our own backyard. The H1N1 virus is here, and Ohio’s emergency departments are being flooded with patients symptomatic with influenza. Emergency physicians are at the forefront of medical care for victims surging into hospitals. How will we work to ascertain that our physician work force will continue to be present? Senate Bill 86 will assure emergency physicians that when they do their best, in the direst of circumstances, they will be protected. Senate Bill promotes access to emergency care for patients by supporting physicians who will provide that care.

Senate Bill 86 is an opportunity to do the right thing for our emergency medical workforce as well as the actual and potential victims of disasters that emergency physicians care for. It is a means of protecting a valuable resource of our healthcare system---that of the frontline medical teams who are called on to provide critical, emergency care.

Thank you for your attention. I am happy to answer any questions now or in the future.