Chairman Wagoner, Senators,

My name is Michael Frank. I am a physician and attorney. I am board certified in emergency medicine and practiced emergency medicine in Ohio for 29 years. Along the way, I graduated from law school, and have been practicing law for the past 21 years. These days, I am primarily occupied with managing the legal affairs, including medical malpractice claims, of a group of 700 emergency physicians staffing 60 hospital emergency rooms in 12 states. Headquartered in Canton, we are responsible for 2.2 million ED visits a year, of which nearly 300,000 are in Ohio. In addition to understanding the ins and outs of clinical emergency medicine, I am intimately familiar with the good, the bad, and the ugly of our tort system, and with the requirements of EMTALA. I also bring one other perspective to bear on these issues. For the past 15 years, I have served as the Chairman of the Board of Trustees of my hospital, now part of the Summa Health System, and for the past 3 years have served on the Board of Directors of the Summa Health System. Wearing my Board hat, I have been exposed at the governance level to the problems of providing emergency care to a growing number of patients, overcrowding, and the difficulty of securing adequate on-call specialist coverage. I appreciate the opportunity to comment on Senate Bill 129.

Consideration of SB129 in 2011 is timely because this year marks the 25th anniversary of the federal statute which was originally part of the COBRA legislation (Combined Omnibus Budget Reconciliation Act) of 1986, which later became familiar to the health care world as EMTALA, the Emergency Medical Treatment and Active Labor Act. It's probably worth taking a moment to briefly describe the statute and what it requires.

COBRA was originally enacted to prevent hospitals from "dumping" indigent patients who required emergency care. The solution the US Congress adopted was to create an unfunded mandate requiring that any patient who presents to a hospital, insured or not and without regard to their ability to pay, must be evaluated as thoroughly as necessary to determine whether or not they have an emergency medical condition, and if they do have an emergency, the hospital must go further and provide the treatment necessary to stabilize it.

The EMTALA burden extends far beyond the emergency room and emergency physicians. If a CAT scan, a surgical procedure, or a consult with a specialist, is required to

determine whether there is an emergency medical condition, then those things must be provided as part of the evaluation required under EMTALA. In order to assure that this is accomplished, hospitals are required to have specialist physicians available on-call in every specialty routinely offered by the hospital under non-emergency circumstances. For example, if a hospital routinely performs orthopedic surgery, orthopedists must be on-call to provide back-up orthopedic care for emergencies.

A key feature of EMTALA is that it an economic non-discrimination statute. The care and treatment for a given illness must be the same whether the patient is rich or poor, insured or uninsured. In order to assure that discrimination does not take place, federal rules provide that asking a patient to pay an emergency room fee or physician fee before the initial evaluation is completed, or asking a patient to pay before their emergency medical condition is stabilized, are *per se* EMTALA violations, punishable by fines or termination of Medicare participation, either of which can be imposed on hospitals or physicians.

The current medical malpractice standard which applies to all physicians in Ohio requires proof that a physician made a mistake that a reasonable physician would not have made, and that the mistake injured a patient. That is the usual negligence standard in medical malpractice. We are asking that for mistakes occurring in the circumstances of EMTALA-related care, proof of "reckless disregard" should be required. There are many different explanations of how the reckless disregard standard should be applied, but it is fair to say that the common theme of these explanations is that more is required than just proof of a mistake. Rather proof is required of both carelessness and an indifference to the consequences of one's actions. Will this more stringent standard of liability provide Ohio physicians with a "license to kill" resulting in not better, but poorer care for patients who will then be without any remedy against careless incompetent physicians? While I believe, based on my experience with physicians and hospitals, that this is not a realistic concern, I know that there are more than a few cynics who would scoff at such assertions. So I will offer much more elegant proof.

The Ohio legislature has seen fit to provide civil liability immunity protections 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). 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.

Further proof is available from the experience in other states. In 2003, the Florida and Texas state legislatures enacted statutes providing immunity protections for EMTALA-related care. Texas adopted a standard of "willful or wanton negligence" (*Tx Civ Prac & Rem §74.153 & 74.154*) while Florida adopted the same "reckless disregard" standard found in SB129. In fact the language of the Florida statute is virtually identical to that in SB129. (*Fla. Stat. § 768.13*). Neither Texas nor Florida have experienced an epidemic of emergency medical care negligence. While the fear of unleashing unscrupulous incompetent emergency physicians on a vulnerable patient public may make for sensational press, it is not a fear based in reality.

I would also like to address the claim that providing immunity to physicians for emergency and disaster care will disproportionately impact and deprive the poor who crowd our ER's of remedies to which they might otherwise be entitled for injuries received through malpractice. This claim displays a flawed understanding of what is actually happening in our ER's.

This flawed understanding stems from a claim that has been bandied about so often it is often accepted as dogman: "ER's are overcrowded because of inappropriate usage by patients, usually uninsured, who abuse the ER with their minor problems when they should be waiting to see a doctor in an office or clinic, at a much lower cost to boot." Emergency physicians have known better for years, and what we have known for years was dramatically demonstrated in a study published in the Fall of 2008 in the *Journal of the American Medical Association*. (Newton MF, Keirns CC, Cunningham, R et al: *Uninsured adults presenting to US emergency departments: assumptions vs data*; JAMA. 2008;300(16):1914-1924.) After examining the claims of those who blame overcrowding on the uninsured and comparing those claims with available data, the authors concluded: "Available data do not support assumptions that uninsured

patients are a primary cause of ED overcrowding, present with less acute conditions than insured patients, or seek ED care primarily for convenience." What the authors did find is that the large majority of patients seek ED care appropriately, and that this cuts across socioeconomic classes. This should put to rest the claim that SB129 will disproportionately impact and deprive the poor who crowd our ER's of remedies to which they might otherwise be entitled.

Why limit immunity protections to emergency physicians and specialists providing care to emergency patients? Why aren't such protections desirable for all medical care, for all physicians?

The circumstances in which emergency care is provided are dramatically different from the care which is provided in almost every other medical setting. In non-emergency circumstances, physicians decide which patients to accept, when, and under what circumstances. We take all comers, we do it 24/7, we usually don't even know whether they have insurance at all, much less what kind, and we don't even care if they're Democrats or Republicans. In an office practice, when the appointment book is full, patients can either wait for the next day the doctor has a free slot, or, more likely, go to the ER. We wouldn't know what to do with an appointment book, and if all the ER treatment rooms are full, we start seeing patients in the hallways. If the office doctor is called away to the hospital, the receptionist apologizes to the patients in the waiting room and tells them they'll have to make an appointment for another day. If another emergency comes through our doors, nobody goes out to the waiting room and tells all the patients to go home. If a patient is sent to see an office-based specialist and her past medical records haven't arrived, the patient's appointment is rescheduled, so the specialist doesn't have to risk making a wrong decision based on incomplete information. Incomplete information is our natural environment, and we don't have the luxury of rescheduling visits to another more convenient day. Despite incomplete information, decisions, often life-or-death decisions, must be made, and made quickly. This is the world of emergency medicine and it is unlike any other area of medical practice. It is unique, with features more akin to the uncertainties and challenges faced by our paramedics on the streets, who do have immunity protections, than by our physician colleagues in their offices, who do not.

Lastly, I would suggest to the Committee that the problem which prompts SB129 is not someone else's problem, but is right at our collective doorstep. Over the past couple of years, there have been several high profile cases of patients who have expired while in ER waiting rooms. While you may think that these cases are outrageous isolated incidents which could never occur in your hospital, nothing could be further from the truth. 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*.) In my ER group, we have defended 3 lawsuits against our physicians involving patients who died of cardiac arrest in the ED waiting room. In another case, we defended our emergency physician against a claim of delayed care after he spent several hours calling 5 different hospitals trying to find a hand surgeon to repair a patient's amputated fingers. My point is that this is not someone else's problem, it is all of ours. My fear is that the belief that this is someone else's problem, or that the problem is not really so severe, will allow us to shrink back into inaction. The safety net provided by our emergency care system is important to us all, it is in jeopardy, and SB129 provides you with an opportunity to address the problem.