IN THE UNITED STATES DISTRICT COURT
FOR SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, Plaintiff, v. RICHARD HODGES, et al., Defendants.	Case No. 1:15-cv-568 Judge Michael R. Barrett

DECLARATION OF NORMAN SCHNEIDERMAN, M.D.

I, Norman Schneiderman, M.D., pursuant to U.S.C. § 1746, declare under penalty of perjury that the following is true and correct:

A. Background and Qualifications

1. I spent my career as an Emergency and Trauma Center physician at Miami Valley Hospital ("Miami Valley") in Dayton, Ohio. As an "attending physician," I provided direct patient care and supervised residents. I have forty years of experience providing emergency care at Miami Valley, which is the busiest emergency department in the state of Ohio[1] and the only Level 1 Trauma Center in the Dayton area.[2]

[1] The emergency department has 72 beds and sees an average of 95,000 patients annually, twice as many as the next largest emergency department in the Dayton area. Volume increased this year due the recent closure of Good Samaritan Hospital. The emergency department is staffed by approximately 35 staff ("attending") physicians and almost 200 nurses, in addition to resident physicians. At the busiest times, there are four full-time attending physicians and approximately 6 emergency resident physicians, as well as residents from other departments, including obstetrics and gynecology ("OBGYN") residents, working simultaneously in the emergency department.

[2] To be certified as a Level 1 Trauma Center by the trauma division of the American Board of

2. I have held multiple leadership positions in Miami Valley's emergency department. I served as the Associate Director of the Emergency and Trauma Center from 1983 to 1990, and then as the Director of the Emergency and Trauma Center for the next decade, until 2000. In addition, between 1988 and 1998, I rotated between serving as the Chairman and Vice-Chairman of Miami Valley's Department of Emergency Medicine. I have also served as the risk manager for Miami Valley's emergency medicine practice group.

3. In addition to my leadership roles in emergency medicine at Miami Valley, I have held senior hospital-wide positions, including Chief of Staff for all Miami Valley medical staff between June 2000 and June 2002.

4. I previously served as the medical director for two urgent care centers in Ohio. I was the medical director at Health Maintenance Plan-Urgent Care Center from 1986 to 1992 and the medical director at Huber Heights Health Center from 1983 to 1989.

5. I have worked as a medical legal consultant, including providing testimony in medical malpractice lawsuits relating to emergency medicine. I have testified on behalf of both plaintiffs and defendants.

6. I graduated from Columbia University in New York in 1971. I earned my M.D. from SUNY Downstate Medical School in Brooklyn, New York, in 1975. I then did my internship and residency in emergency medicine at Akron General Medical Center in Akron, Ohio. After completing my residency, I began working at Miami Valley, where I remained until

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Surgeons a hospital must meet several requirements, including having in-house acute care surgeons and anesthesiologists 24 hours per day, designated operating rooms, available CT scanners, trauma-accredited nursing staff, surgical critical care, 24/7 blood bank operation, and immediate availability of subspecialists like neurosurgeons and orthopedic trauma surgeons. In addition to meeting all of these requirements, Miami Valley is also the regional burn unit for the area.

my retirement in April of 2019. I held active medical licenses in Ohio and North Carolina until my retirement and was board-certified in emergency medicine for 36 years.

7. In addition to practicing emergency medicine at Miami Valley, I have been a clinical professor in the Department of Emergency Medicine at Wright State University School of Medicine since 1987. I have published and presented on best practices and risk management within emergency medicine. I was a member of the American College of Emergency Physicians from 1977 through 2014 and a member of the Ohio Chapter of the American College of Emergency Physicians from 1978 through 2014.

8. My education, training and experience are set forth in my curriculum vitae, a copy of which is attached hereto as Exhibit A.

9. I provide the following opinions as an expert in emergency medicine. The opinions herein are based on my education, training, decades of clinical experience in emergency medicine, decades of leadership experience in Ohio emergency departments and hospital administration more generally, membership in professional groups relating to emergency medicine, familiarity with the medical literature relating to emergency medicine, and attendance at and participation in related conferences.

10. I am aware that Ohio Rev. Code Ann. §§ 3702.303-04 requires that all ambulatory surgical facilities ("ASF"), including abortion clinics, obtain a written transfer agreement ("WTA") with a local hospital in order to obtain and maintain an ASF license from the Ohio Department of Health ("ODH"). I am also aware that the Ohio legislature has banned abortion clinics—and only abortion clinics—from obtaining this required WTA from any "public hospital." Ohio Rev. Code Ann. § 3727.60. I understand that it is extremely difficult, if not

impossible, for many abortion clinics in Ohio, including Women's Med Center Dayton ("WMCD"), to obtain a WTA with a local hospital that is not a public hospital.

11. I also understand that the Ohio legislature created a special process for ASFs that are unable to obtain a WTA to apply for a variance from that requirement. Specifically, the legislature requires that any ASF applying for a variance of the WTA requirement enter into an agreement with at least one "backup" physician with admitting privileges at a local hospital, who agrees to ensure admission and care for patients in the event of a complication. I further understand that when WMCD submitted its variance applications in 2015 identifying two backup doctors, the Ohio Department of Health ("ODH") informed the clinic that the application required three backup doctors; and when WMCD then submitted a new variance application identifying three backup doctors, ODH informed the clinic that the application required four. I understand that WMCD has not been able to identify a fourth backup doctor. I further understand that, because of these circumstances, WMCD is in immediate danger of losing its ASF license and will be forced to stop providing abortion services in Dayton, absent this court granting relief. If this court does not grant relief, I understand WMCD will be forced to close.

12. I have reviewed WMCD's most recent variance application and patient transfer policies and procedures.

13. It is my opinion, based on my training, experience, and professional familiarity with emergency medicine and emergency transfer and transport procedures, that there is no medical reason for (1) the WTA requirement; (2) the requirement that abortion clinics without a WTA identify at least one (let alone four) backup doctors with admitting privileges at a local hospital; (3) revoking WMCD's ASF license for inability to meet either of these requirements.

B. Provision of Emergency Medical Care

1. *Emergency Ambulance Transport*

14. Following a 911 call, paramedics and emergency medical technicians (EMTs) are trained to transport patients to the nearest appropriate hospital.[3] In many cases, the nearest appropriate hospital will be the one that is the shortest distance away. However, in some situations, such as where there is severe trauma but the patient is not in or near cardiac arrest, the paramedics might bypass the nearest hospital in order to take the patient to a Level 1 Trauma Center. Based on my decades of experience treating patients who arrive by ambulance and working with paramedics, emergency medicine technicians ("EMTs"), and other emergency transport providers, I do not have any reason to believe that their decisions about where to take patients are influenced by the existence or nonexistence of transfer agreements or backup agreements between facilities and individual physicians. Indeed, to my knowledge, most emergency transport providers, EMTs, and paramedics are not even *aware* of the existence or nonexistence of such agreements between an ASF and a particular hospital or individual physician.

15. In my experience, paramedics, EMTs, and other emergency transport providers rarely, if ever, deviate from the practice of taking patients in need of emergency care to the closest appropriate hospital.

[3] In the Dayton metropolitan area, there are three adult hospitals that provide the bulk of emergency medical care: Grandview Medical Center, Miami Valley, and Kettering Medical Center. There are two smaller hospitals in the South Dayton area: Southview Medical Center and Sycamore Medical Center, which are both part of the Kettering Hospital Network. Other hospitals providing emergency care in the area are Children's Hospital, which treats only children, and Wright Patterson Hospital, which treats only military personnel.

16. On rare occasions, some hospitals engage in "diversion," which means instructing ambulances to reroute emergency patients to other hospitals.[4] In the rare instance that a hospital is diverting emergency patients, where patients are routed will have nothing to do with the presence or absence of a transfer agreement. Patients with conditions that would not allow them to be safely rerouted, such as if they are in or near cardiac or respiratory arrest, will be taken to the nearest hospital. Patients with less severe conditions will be rerouted, regardless of whether there is a transfer agreement in place, if the nearest hospital is so inundated that it cannot accept emergency patients.

2. *Treating Patients in Emergency Departments*

a. Emergency Department Practices

17. The first step in treating a patient who comes in to the emergency room is "triage." Triage refers to the initial assessment in which the patient's vital signs are taken and medical staff ascertains the severity of the patient's problem. The initial assessment may reveal that the patient needs immediate treatment in the emergency department, or that the patient is stable enough to wait for further diagnosis and treatment. All patients go through triage. A patient coming by ambulance will usually be triaged in the emergency department, while patients who arrive through their own means will typically go through triage before they are sent to a designated bed in the emergency department.

18. Under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), all hospitals are required to screen all patients who arrive on hospital grounds at any time and stabilize the patient to the best of their ability. EMTALA was developed to prevent hospitals

[4] About 8 years ago, leadership from all Dayton area hospitals came together and agreed to a plan that has greatly reduced—almost eliminated—the need to engage in diversion in our area. Now, Dayton area hospitals would only use diversion in very rare instances, such as a geographically localized disaster that has overburdened the hospital closest to the disaster.

from transferring or turning away patients in need of emergency care or in active labor without providing any care.

19. To meet the screening requirement of EMTALA, emergency departments will designate a physician, physician assistant, or nurse practitioner to assess the patient, take the patient's history, and conduct a physical exam to determine whether or not an emergency medical condition exists. Because a patient can be stable but still have an emergency medical condition (as defined by EMTALA),[5] this fuller assessment occurs after the initial triage at the vast majority of hospitals.

20. To meet the stabilization requirements of EMTALA, an institution must use its facilities and resources to provide stabilizing medical treatment to the patient to the best of its ability.

21. Once the patient is stabilized, the patient could be discharged if the patient needs no further hospital care; or, if the patient does need further hospital care, the patient will generally either be admitted to the hospital or transferred to another medical facility.

22. In my forty years of experience working in emergency departments, I have never seen or heard of medical staff referring to a transfer agreement while providing care. I have

[5] EMTALA defines an "emergency medical condition" as:

> "(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
> (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
> (ii) serious impairment to bodily functions, or
> (iii) serious dysfunction of any bodily organ or part; or
> (B) with respect to a pregnant woman who is having contractions—
> (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
> (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

never seen or heard of any patient being turned away from a hospital, or provided with suboptimal care, for lack of a WTA. Indeed, the vast majority of emergency room physicians and staff are not aware of any transfer agreements that might exist between their hospital and other medical facilities.

23. In my opinion, emergency physicians do not need to know that transfer agreements exist because transfer agreements have no clinical relevance. Emergency department physicians already know that they are required to see and stabilize all patients under EMTALA. Further, allowing WTAs to play a role in prioritizing patients in the emergency room would result in suboptimal care because that would prevent emergency departments from treating the most urgent patients first and cause a delay in care while emergency department staff locate and read transfer agreements.

24. I became aware of the existence of transfer agreements through my role as the Chair of the emergency department at Miami Valley. But I was only aware of them for managerial reasons; I would sometimes be consulted by the hospital administration about the clinical obligations that a transfer agreement contained, such as whether a particular provision was clinically feasible.

b. Patient Admission After Emergency Treatment

25. If the patient needs inpatient care, the emergency department will coordinate the admission of the patient.

26. Many patients who present to the emergency department do not have a pre-existing relationship with a physician at that hospital in the appropriate specialty area. If that is the case, the emergency physician will contact a physician on the hospital staff with expertise appropriate for that patient's medical situation. For example, if the patient is having a medical

problem related to pregnancy, the emergency physician will contact the obstetrics and gynecology ("OBGYN") resident on duty or the chief resident on call to care for that patient. The chief resident also has a backup "attending physician" (i.e., a supervising physician) available in the hospital at all times, who can see to the admission of patients if the chief resident is unavailable.

27. There is no difference between the quality of care received by a patient who has a pre-existing relationship with a physician with admitting privileges and the care received by a patient who does not.

28. It is very rare that a physician who treats a patient in the outpatient context, like a primary care physician, would admit or manage the care of a patient in the hospital, even if that physician has admitting privileges at the hospital where the patient is located. Most outpatient physicians rely on hospitalists—physicians who do not have a private practice outside of the hospital and only take care of patients who are admitted to the hospital—to admit and manage their patients' care while the patient is in the hospital.

29. Once the patient is admitted, furthermore, the care will come primarily from the medical staff of the department best-suited to care for the medical problem the patient is having. The hospitalist will manage care by checking in on the patient on a regular basis and coordinating care between different departments when necessary.

30. Transfer agreements do not and cannot ensure that a patient will be admitted to the hospital at any given time. If a hospital is unable to admit additional patients, additional patients will not be admitted regardless of whether a transfer agreement exists.

31. The vast majority of emergency department physicians and staff are not aware of whether one or more "backup physician agreements" exist between an ASF and physicians with

admitting privileges at the hospital. Such agreements are irrelevant to emergency department physicians, who have their own primary and backup systems for coordinating care for patients within the hospital. Having had experience as both the Chair of the emergency department and the Chief of Staff of Miami Valley, I can say with confidence that even physicians in higher levels of management are not aware of these agreements because they are so inconsequential. Indeed, I only became aware of the existence of WMCD's "backup physician agreements" with several physicians with admitting privileges at Miami Valley through this litigation.

c. Emergency Department Care for Abortion Complications

32. Virtually all hospitals in Ohio have OBGYNs available at all times to handle the most common emergency OBGYN problems that could arise from an abortion complication, such as endometritis (an inflammation of the uterine lining), infection, or hemorrhage. Indeed, in my experience, an emergency department is much more likely to see these complications as a result of a full-term delivery than an abortion—and are well-equipped to resolve such complications either way.

33. Other complications that an abortion patient might experience, such as an allergic reaction or a complication related to anesthesia, present often in hospital emergency departments as a result of *other* (non-abortion) medical procedures. Any emergency department in Ohio would be well-equipped to deal with these complications.

34. In short, I am not aware of *any* potential complication from abortion that would not be within the capabilities of any Ohio emergency department, using standard practices and processes, without the need for a transfer agreement with the abortion clinic or backup agreements with any individual physicians.

3. *Patient History and Medical Records in Emergency Medicine*

35. Emergency physicians are trained to treat patients with little to no information. The vast majority of patients do not have their medical records with them when they arrive at the emergency department. This is true for patients coming to us based on their own determination of need as well as patients who are transferred or referred to the emergency department by their treating physician. It is my understanding that a patient who presents to the emergency department for abortion-related care hours or days after the procedure will often be arriving from home, and may or may not bring medical records. This is the same for any patient presenting to an emergency department for care after leaving the facility where they had *any* type of medical procedure performed. And because emergency physicians are well-trained in the efficient assessment and treatment of emergency conditions, only a limited amount of information is needed to provide optimal care to a patient in the emergency room.

36. First and foremost, the physician will try to get a history directly from the patient if possible or, if that is not possible, from someone familiar with the patient's condition. The patient is the best source of information for the emergency physician as they can tell the physician how they are feeling and the circumstances that led to them coming to the emergency department, as well as what tests have been performed and what treatment has been given (even if only in broad strokes). If the patient is unable to provide this information for any reason—for instance, if the patient is unconscious— this information might come from a family member or friend who is with the patient, or from another physician, if the patient was sent by a treating physician or transferred from another medical facility.

37. If the patient was referred by a treating physician or transferred from another medical facility, the treating physician may call with background information on the patient.

38. The presence or absence of a transfer agreement in no way facilitates such communication between emergency departments and transferring facilities. Physicians from facilities without transfer agreements will sometimes call and physicians from facilities with transfer agreements may not call. In most cases where a patient is transferred or referred by a treating physician, the emergency department has the ability to contact the treating physician, if the care team feels such contact is warranted. In many cases, care can and does proceed without contacting the referring physician.

39. It would be impossible for an agreement between an ASF and a back-up physician to facilitate this communication as the backup physician would not possess any of the relevant information. A backup physician would need to call the ASF to obtain the relevant information, but an emergency department physician can make that same call, if necessary, and thus obtain any relevant information directly and more quickly. Contacting a backup physician in this scenario would unnecessarily delay care and only complicate this communication.

40. Medical records may or may not accompany a patient who is arriving from another facility by ambulance. The presence or absence of the WTA required by Ohio law in no way facilitates the transfer of relevant medical records. I understand that Ohio's WTA requirement does not specify that a transfer agreement must provide for the transfer of medical records. Thus, facilities without transfer agreements might send records, and facilities with transfer agreements may not. Regardless, medical records are of limited value in the emergency department, since records are usually technical and an emergency physician typically cannot delay the treatment of the patient in order to read them.

41. Moreover, in many cases, patients will not be arriving directly from the facility and the facility may thus be unaware that the patient is presenting at the emergency room. As

stated above, the vast majority of patients arrive without records and still receive quality treatment.

42. I have reviewed the emergency transfer protocols of WMCD, including the protocol for contacting the emergency department prior to the patient's arrival and providing the patient's relevant medical history. Under these protocols, an emergency physician would have the information needed to provide optimal care to patients. The procedures described are similar to those of urgent care centers, which routinely transfer patients to the emergency department.

43. Moreover, it is important to underscore that while obtaining some information about a patient's medical history can be helpful, it is not essential to providing emergency medical care. As I noted above, it is not uncommon for patients to present at the hospital without medical records, without a treating or referring physician (or without a treating or referring physician who can be quickly reached), and even without the ability to communicate (e.g., because the patient is in seizure or unconscious). Part of our core training as emergency physicians is in (1) triaging and stabilizing a patient to address the patient's most pressing medical needs, such as severe hemorrhage or infection, regardless of whether we know the cause, and (2) using physical assessments, tests, and medical technology to trace the patient's symptoms to their root cause. Having some information about the patient's medical history can expedite the process, but is not essential to provide emergency medical care.

C. Ohio's WTA Requirement, Backup Doctor Requirements and Related Provisions Are Medically Unjustified

1. *WTAs are Not Necessary for Optimal Patient Care*

44. It is my expert opinion that transfer agreements are unnecessary and do not and cannot improve the quality of care patients receive in the hospital. As discussed above,

emergency departments are well-equipped, and emergency department staff is well-trained, to provide optimal care to patients who present at the emergency department.

45. Transfer agreements have no effect on determining where a patient will be routed in case of an emergency. Patients are almost always routed to the closest appropriate hospital. In the rare case that a hospital is on diversion, a transfer agreement will not prevent a patient from being rerouted.

46. A transfer agreement is not necessary to ensure compliance with EMTALA. Any patient who presents at a hospital emergency department, including those who arrive with an abortion-related complication, will be triaged and screened, and then stabilized and discharged, admitted, or transferred.

47. A transfer agreement is unnecessary to ensure that an emergency department physician will treat an abortion complication. Emergency department physicians will treat a patient presenting with an abortion complication the same as any other emergency patient, just as EMTALA requires us to do.

48. Transfer agreements do not facilitate communication or the transfer of medical records between the transferring facility and the hospital; any necessary communication occurs as a matter of course. If a patient is transferred directly from or referred by another facility, that facility can call the hospital and send the patient's records with or without a transfer agreement in place. If the patient is not coming directly from or referred by another facility, the hospital can contact the clinic to obtain information and medical records if necessary.

49. Emergency departments have extensive policies and procedures in place to ensure that medical staff evaluate, prioritize, and provide optimal care to the patients they see. Transfer agreements will not alter and cannot improve upon this system. Under no circumstances would a

transfer agreement give certain patients priority over others. Our system is designed to provide care to the sickest people first. If transfer agreements allowed certain patients to skip the line, the hospital would fail in its obligation to provide optimal care to both its individual patients and the broader community it serves.

2. *Back-Up Physician Agreements are Not Necessary for Optimal Patient Care*

50. It is my expert opinion that requiring one (let alone four) backup physicians is unnecessary and does not and cannot improve the quality of care patients receive in the hospital. As described above, emergency departments have their own system for ensuring quality care, which include access to physicians in every major specialty area, including OBGYN.

51. Backup agreements between an ASF and individual physicians with admitting privileges at the hospital have absolutely no effect on the treatment a patient receives in the emergency room. A patient presenting with an abortion-related complication would be cared for in the same manner as any patient presenting in the emergency department. The emergency physician would provide emergency care, including contacting the abortion provider and OBGYN department if needed.

52. Further, a backup physician would not, and could not, play a useful role in communicating information to hospital staff or aiding in the transfer of medical records. In my experience, hospital staff are not aware of any agreements between ASFs and a backup physicians. However, even if they were, a backup physician will not have relevant information about the patient's current condition or access to a patient's medical records—they would need to contact the ASF for that information, which would only add inefficiency to communications between the emergency department and the ASF.

53. Backup agreements also have absolutely no effect on whether a patient receives inpatient care or the quality of inpatient care. Hospitals have procedures in place to ensure that all patients who need inpatient care are admitted in a timely manner, regardless of whether that patient has a preexisting relationship with a physician who has admitting privileges at that hospital. Once the patient is admitted, care would be provided primarily by the medical staff of the OBGYN department and managed by a hospitalist, as described above.

54. I can think of no circumstances where any hospital would rely on a backup physician agreement between an ASF and an individual physician to ensure patient admission and optimal inpatient hospital care. Even if the backup physician were extremely familiar with the patient (which, based on my understanding, is not what ODH requires), modern hospital treatment does not depend on a single physician's familiarity with the patient needing hospital care. There are procedures in place to make sure that the physicians providing inpatient care have all the information needed to provide the best care to the patient. Hospitals do not rely on the continued presence of any specific individual physician to create conditions for optimal care.

55. Based on forty years of experience providing emergency care, I believe that requiring one, much less four, backup physicians is unnecessary to ensure that a patient gets optimal hospital care.

3. *No Medical Reason Exists to Revoke WMCD's or PPSWO's License Based on Their Inability to Comply with the WTA or Back Up Physician Requirement*

56. Because, as explained above, both the WTA requirement and the backup physician requirement are medically unnecessary and do not contribute to the provision of optimal patient care in the case of an emergency, it is my opinion that WMCD's inability to meet one or both of these requirements should not affect its ability to obtain an ASF license. Further, my review of the emergency transfer policies and procedures of WMCD indicates that the clinic

is well-prepared to provide and/or assist in providing optimal patient care in the rare event of an abortion complication necessitating hospital care—with or without a WTA and with or without any backup physician agreements.

Executed on 5/1/2019, 2019, in Dayton, Ohio

N. Schneiderman, M.D.

Norman Schneiderman, M.D.

EXHIBIT A

CURRICULUM VITAE

NAME:	**Norman J. Schneiderman, M.D.**
ADDRESS:	313 West 6th Avenue, Columbus, Ohio 43201
	Soon to change to 59 Mark Twain, Asheville, N.C. 28805
(937)-239-9140 (Cell)	
BIRTHPLACE:	New York, New York
DATE OF BIRTH:	January 2, 1949
MARITAL STATUS:	Wife: Suzanne
CHILDREN:	Sons: Harris Todd and Ross Mitchell Daughter: Ericka Mariah
HOSPITAL POSITIONS:	Emergency Physician- Miami Valley Emergency Specialists (MVES) Miami Valley Hospital One Wyoming Street Dayton, Ohio 45409 July 17, 1978 – April 21, 2019
	Risk Manager (MVES) June 12, 2002-Present
	Chairman, Bylaws Committee Miami Valley Hospitals June 2002-2016
	Member Board of Trustees Miami Valley Hospital June 1998-2012
	Member Medical Staff Executive Committee Miami Valley Hospital June 1996 - 2002
CORPORATE POSITIONS:	Member Premier Health Partners Board of Trustees Jan.2003 -2014

PAST POSITIONS:

Chief of Staff
June 2000 – June 2002
Miami Valley Hospital Medical Staff

Chief of Staff-Elect
Miami Valley Hospital
June 1998 – June 2000

Chairman
Department of Emergency Medicine
Miami Valley Hospital
June 1988 – June 1992
June 1995 - June 1998

Member
Board of Trustees
Miami Valley Health Foundation
Miami Valley Hospital
Elected - 1993 - 2003

Chairman, CPR Committee
Miami Valley Hospital
February 1992 - 2000

Vice-Chairman
Department of Emergency Medicine
Miami Valley Hospital
June 1991 – June1995

Director
Emergency & Trauma Center
Miami Valley Hospital
January 1, 1990 – May 31, 2000

Associate Director
Emergency & Trauma Center
Miami Valley Hospital
1983 - 1990

Chairman
Community Mutual Insurance Company State Quality Assurance Committee
June 1991 - January 1994

Medical Director
Quality Assurance and Risk Management
Wright Health Associates
1222 South Patterson Boulevard
Dayton, Ohio 45402
1986 – 1994

Medical Director
Health Maintenance Plan - Urgent Care Center
725 South Ludlow Street
Dayton, Ohio 45402
1986 - 1992

Medical Director
Huber Heights Health Center
8701 Old Troy Pike
Dayton, Ohio 45424
1983 - 1989

EDUCATION:

Undergraduate College
Columbia University
New York, New York
1967 - 1971
Degree: Pre-Med B.A.
Honors: Admissions Committee (1970 - 1971)
Ted Kramer Society

Medical School
Downstate Medical School
Brooklyn, New York
1971 - 1975
Degree: M.D.

Internship
Akron General Medical Center
400 Wabash Avenue, Akron, Ohio
1975 - 1976 (Flexible)

Residency
Emergency Medicine Residency
Wabash Avenue, Akron, Ohio
Akron General Medical Center400
1976 - 1978

LICENSURE: Ohio #39908/ North Carolina #35503

ACADEMIC APPOINTMENTS:

Clinical Professor, WSU Department of Emergency Medicine
October 1999 – present

Associate Clinical Professor, Emergency Medicine
Wright State University School of Medicine
1987 – 1999

CERTIFICATION:

Provider
Advanced Cardiac Life Support (ACLS)
1977-Early 2000s

Provider
Advanced Trauma Life Support (ATLS)
1983-Early 2010s

Board Certification in Emergency Medicine
1984
Board Recertification in Emergency Medicine
1994 and 2004

PUBLICATIONS:

Author of Forward for Continuous Quality Improvement for Emergency Departments. American College of Emergency Physicians 1994.

"Emergency Medicine/Risk Management, A Comprehensive Review." Patient Complaints,
Pg. 27-32, American College of Emergency Physicians, 1991.

Co-editor of ACEP Quality Assurance Manual
July 1987

Co-authored "Moonlighting in the Emergency Department: Risk Management Concerns."
Perspectives in Healthcare Risk Management.
Summer 1987.

Prepared "PCP Module for Toxicology Section Of Comprehensive Review of Emergency Medicine (CREM)." American College of Emergency Physicians (1981).

Co-authored "Materials for Emergency Department Laboratory." Emergency Medicine Clinics of North America. Vol. 4, No. 2,
May 1986.

PRESENTATIONS:

"Practice Management Lecture Series."
American College of Emergency Physicians
1988 - 1995
"Risk Management/Quality Assurance" Lecture. American College of Emergency Physicians
1983 Scientific Assembly and at Practice Management Seminars. It was repeated at the Scientific Assembly in Atlanta, Georgia in 1986

Presentations for ACEP Management Strategies
Course (given twice a year), 1985 - 1995.
--Quality Assurance and Risk Management
--Positive Patient Relations
--Occupational Medicine

PROFESSIONAL ACTIVITIES:

(NATIONAL)

Member, GHAA Medical Directors Division &
ACEP Liaison to Managed Care Organizations
Executive Committee
February 1991 - 1995

Chairman, Managed Care Subcommittee
American College of Emergency Physicians
1990 - 1993

Member, Practice Management Committee
American College of Emergency Physicians
September, 1989 – 1992

Member, Advisory Board
Civilian Medicine Advisory Panel for the
Defense Department (Quality Assurance in the Military)
1987 - 1990

Chairman, National Professional Liability
Committee American College of Emergency Physicians 1986 - 1988

Member, Professional Liability Committee
American College of Emergency Physicians
(1984 - 1988)

Oral Board Examiner, American Board of
Emergency Medicine
October 1988 - 1991

Member, Society of Teachers of Emergency
Medicine
1984 - 1990

Member, American College of Emergency
Physicians
1977

PROFESSIONAL ACTIVITIES:

(STATE/LOCAL)

Chairman, Health Group
United Way of Montgomery County
February 1993 - 1995

Member
Utilization Management Committee
Miami Valley Hospital
August 1994 - 1995

Chairman, Run Review Committee of the Montgomery County
Emergency Medical Services Council 1983

Member, Miami Valley Hospital Society
1981 - 1987

Member
Patient Education Committee
Miami Valley Hospital
1980 - 1982

Director of Education, Emergency Medicine
Miami Valley Hospital
1979 - 1985

Member - Active Staff
Miami Valley Hospital
1978 - Present

Board Member 2000 – 2002
Member 1978-1995
Montgomery County Medical Society

Member
Ohio State Medical Association
1978 - 1995

Member
Ohio Chapter, American College of
Emergency Physicians
1978

Ohio ACEP Board of Directors
2004

ACTIVITIES
AND AWARDS:

Certificate of Honorable Mention for Faculty
American College of Emergency Medicine
September, 1989

President
Beth Jacob Synagogue
Dayton, Ohio
1984 - 1987

James Agna Clinical Faculty Recognition Award
Emergency Medicine Residency
Wright State University School of Medicine
Dayton, Ohio
1982 and 2013