PUBLIC HEARING

before

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

To closely examine the findings and recommendations of the State Commission of Investigation (SCI) Report on Impaired and Incompetent Physicians, in order to determine the scope of the problem in this State and possible legislative actions that will address this problem

December 15, 1987
Room 403
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator Richard J. Codey, Chairman
Senator Francis J. McManimon, Vice Chairman

ALSO PRESENT:

Eleanor H. Seel
Office of Legislative Services
Aide, Senate Institutions, Health
and Welfare Committee

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Office of Legislative Services
Public Information Office
Hearing Unit
State House Annex
CN 068
Trenton, New Jersey 08625

RICHARD J. CODEY
Chairman
FRANCIS J. McMANIMON
Vice-Chairman
GABRIEL M. AMBROSIO
C. LOUIS BASSANO
JOHN H. DORSEY

New Jersey State Legislature
SENATE INSTITUTIONS, HEALTH
AND WELFARE COMMITTEE
STATE HOUSE ANNEX, CN-068
TRENTON, NEW JERSEY 08625
TELEPHONE: (609) 292-1646

November 24, 1987

NOTICE OF A PUBLIC HEARING

THE SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE
ANNOUNCES A PUBLIC HEARING ON
IMPAIRED AND INCOMPETENT PHYSICIANS

Tuesday, December 15, 1987
Beginning at 10:30 A.M.
Room 403, State House Annex
Trenton, New Jersey

The Senate Institutions, Health and Welfare Committee will hold a public hearing on Tuesday, December 15, 1987 beginning at 10:30 A.M. in Room 403 of the State House Annex, Trenton, New Jersey. The purpose of the hearing is to closely examine the findings and recommendations of the State Commission of Investigation (SCI) report on impaired and incompetent physicians in order to determine the scope of the problem in this State and possible Legislative actions that will address this problem.

Address any questions or requests to testify to Eleanor Seel, Committee Aide (609) 292-1646, State House Annex, Trenton, New Jersey 08625. Persons who wish to testify are asked to submit nine copies of their testimony on the day of the hearing. The chairman may find it necessary to limit the number of witnesses or the time available to each witness.

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SENATOR RICHARD J. CODEY (Chairman): Good morning. We are ready to start our public hearing today. This hearing is being held to elicit testimony on one of the most serious and important subjects to ever come before this Committee -- impaired and incompetent physicians. This is literally a matter concerning life and death. Those of you who read the SCI Report know the countless horror stories recounted in that report. Today, I hope we can focus on what can be done to weed those bad doctors out of practice. The danger, though, of a report like the SCI's, is that we tend to overstate the problem because of the horrible nature of the stories.

Two problems I think we should focus on especially are: The seemingly small number of physicians who face disciplinary action versus the number of malpractice claims, and the reluctance of any doctors to speak out on this problem. Incompetent doctors are responsible not only for life and death, but also the flood of malpractice claims and the increase in premiums.

It is our hope -- that is, the Committee's hope -- that out of today's hearing will come legislation to correct the problems in the systems that lead to the stories described in the SCI Report.

Our first witness this morning will be Dr. Molly Coye, Commissioner of Health. Good morning, Doctor.

C O M M I S S I O N E R M O L L Y J O E L C O Y E: Good morning, Senator. Let me begin by saying that the report itself was very disturbing, and we certainly are encouraged by the follow-up that is being given to this, both in the hearing today and the fact that the Medical Society has been in discussions with the SCI and the Board of Medical Examiners in follow-up. We hope very much that there will be new developments coming from that.

Personally, as a physician and as the Commissioner of Health, I feel strongly that it is the responsibility of the

State and the various agencies involved, to do the most they can to assure the consumers of health care in this State that they are getting the highest quality care, and that they are not at risk because of individual physicians who are impaired. Not only as Commissioner, but as a consumer of health care, especially in the next four or five months, I am particularly interested in making sure that the very highest quality care is available.

It is also important to me personally, as a physician, to know that physicians who are impaired will have every opportunity, both for rehabilitation under appropriate circumstances, including making sure that they are removed from providing care in inappropriate ways, and that they are afforded due process in addressing those problems.

I would point out that the Department of Health is not specifically involved in the evaluation of individual physicians' diagnostic and therapeutic actions under most circumstances. Generically, what we do contribute is through the monitoring of patterns of care -- of the processes of care -- and I will describe this in a little bit more detail, through some extensions of Health Department work, such as the Utilization Review Organization, quality checks at the local hospital level, and through the development of new methodologies at the Department of Health, to monitor the overall quality of care in the State. I will describe each of these in turn.

In more specific terms, our regulatory responsibility in the Health Department is for the quality of care administered by hospitals. We are not given regulatory responsibility for the private practice of medicine. The area where that overlap occurs is when physicians are practicing in hospitals. That is the area where we see the most overlap in the role between the Department of Health and the Board of Medical Examiners, which has authority over the private practice of medicine.

When physicians practice in the hospitals, certain aspects of their practice, more often the processes they follow than their actual therapeutic or diagnostic decisions, come under our purview. Let me give you an example of what I mean. If a physician -- an intern -- writes an order in the charts, the attending physician must countersign the intern's order. That is a process. It is actually a Board of Medical Examiners' regulation that requires it, and then later, piggybacked on it, a Department of Health requirement that requires that. But, basically, that is a process. We are not looking at whether the order itself is the correct order -- is the dosage the right amount? What we are looking at is whether everybody did what they were supposed to in terms of the signatures, etc. on the chart. Even in that area, we have had to request legislation to clarify it, not because there is any dispute between the Board of Medical Examiners and ourselves, but just to clarify our regulatory authority in that area.

The SCI Report is much more concerned with the quality of care provided by individual physicians in individual cases, or series of cases. That requires a professional evaluation of the appropriateness and the quality of care provided in these individual situations. Our departmental attention is to overall patterns in the State as a whole, or within hospitals, and to the process, as I was describing.

Now, I would like to point out what it means to look at the patterns of quality of care. For example, our Cardiac Services Task Force looked at the issue of whether a second cardiac surgeon is required during cardiac surgery, so that generically we could address the issue of whether a patient going in for cardiac surgery is getting the quality of care he or she needs, depending on which staff is present in the operating room. That is an example of a process issue that is very important from the quality point of view, which we do then begin to regulate, or to issue guidelines for. What we don't

get involved in is evaluating the individual operation performed in a specific hospital, to see whether the surgeon who did the operation was doing it the way he ought to or not. This is just a traditional distinction in our roles.

In the future, we will be -- as a matter of fact, we are right in the process of it now -- developing some important tools to look at what I am referring to as patterns of quality of care. For example, we are now in the process of developing a technique called, "Small Area Analysis." You may have read reports in other states of patterns where too many, for example, hysterectomies are done in one area, and a large number of tonsillectomies are done in another area, compared to the statewide average. This is a technique that allows you to look at those patterns to see if there are discrepancies that need to be investigated on a smaller level. So, there are ways we can look at patterns, identify potential problem areas, and then focus in on those problem areas. I think that is an appropriate role for the Department of Health.

Where we detect a problem with an individual physician, our appropriate role is to refer that to the Board of Medical Examiners. Very frequently and routinely, our staff does that. As a matter of fact, when we get phone calls from people saying, "I think my physician is doing X, Y, or Z that is wrong," they very often-- Our staff, in almost every case, will call the Board of Medical Examiners directly, and say, "We had such and such a case. Will you look into it?" We don't just tell the consumer calling in, "Oh, you should call the BME." We make the call ourselves. So, we do that on a very frequent basis. We will also be able to refer to the Board of Medical Examiners cases or problems that are identified by new methodologies that we developed, such as Small Area Analysis.

It is important to us, as a practical matter, that we maintain the distinction in roles between the Board of Medical Examiners and the Department of Health. So much of what we do

requires the cooperation and the compliance of physicians with public health practices, often asking them to undertake practices that are well beyond what they are reimbursed for, for example, in our medical system, that we think it is very important to maintain this distinction between the two systems. The Board of Medical Examiners has the enforcement obligation to examine the individual situations. We are not looking for an extension of our role in that regard.

Our generic patterns-- Our investigation of these patterns will not, and are not intended to, identify individual physicians who are incompetent or impaired. That is not the purpose of our generic activities, but it will show where there are potential problems that the Board of Medical Examiners might want to look at.

I am certainly willing to describe in detail the inspections of hospital records we do and the Utilization Review Organizations in response to your questions. Let me end by saying that we would strongly support any action taken as a result of either your work here at the hearing or the work that the Medical Society is doing with the SCI and the Board of Medical Examiners, to strengthen the Board of Medical Examiners' powers to investigate and act upon these situations. It certainly was clear from the report that there are areas in which progress could be made, and I think that steps are already under way to do that.

Let me stop with that.

SENATOR CODEY: Okay. Are there any questions? (no response) Commissioner, you mentioned in your testimony how your Department does not have any real jurisdiction over physicians, but you do, of course, have jurisdiction over the hospitals in which they practice. What do you think the responsibility of those facilities is, with regard to the monitoring of those physicians and the reporting of incompetent physicians, since you do have jurisdiction over those facilities?

COMMISSIONER COYE: Right. Well, you know we issued the forms back in 1984 for the hospitals to do the reporting. Those forms were sent to every hospital. Unlike what is in the SCI Report, I think 20 of those forms were sent to every hospital. Only two hospitals have required further forms. Normally, when our inspectors go in to inspect the records of the hospital, one of the things they look at is the Disciplinary Committee minutes. They don't look at all of the minutes any more than they look at every hospital chart, but they look at a sample of them. If they identify any disciplinary actions that were finalized, they then ask if they were reported.

I think one of the things the SCI Report points out, is that most hospitals don't take what would be, under a narrow interpretation, a finalized disciplinary action. They make recommendations for therapeutic leaves of absence, etc. So there has been, in our experience, almost never a finalized disciplinary action which our inspectors would hit upon and therefore check out whether it has been reported. I would say that this is--

SENATOR CODEY: The reason they don't take a final action is because it doesn't have to be reported.

COMMISSIONER COYE: That is the presumption about their motivation. We don't inspect that. But the result of this is that it is not a particularly effective system. There is no way in which our investigation of a small proportion of the disciplinary action minutes is a good reassurance that this reporting system is working. It just isn't capable of doing that.

SENATOR CODEY: So, it's obvious that the hospitals are reluctant to do anything in terms of reporting incompetent physicians who obviously, just by the sheer numbers, are at times practicing in those very hospitals. So, what role would the Department of Health have in coming down on those hospitals

which obviously are not taking the action and which are, in fact, jeopardizing the very life and death of the patient they are supposedly caring for?

COMMISSIONER COYE: I think that since the core of this problem, at least as identified by the SCI, is an issue of the interpretation of when an action is taken that is a finalized disciplinary action, it is not something I can see that we will have a very effective way of checking on. I have with me Charlotte Kitler, who is our Director of the Office of Legal Affairs. She can speak to our specific regulations. But if the hospital disciplinary committee makes a decision that this particular physician does not merit what would be called, in their narrow interpretation, a finalized disciplinary action -- like a suspension of privileges -- there is no way we can check whether they reported it, because they are not required to report it. So, when you go in and you look at a sampling of the minutes, if there aren't very often actions against physicians to start with, and those are very rarely finalized, there is nothing for us to check on. So, I don't think there is any way we could devise a system that would be more effective at the level of Health Department inspectors looking at the minutes of meetings. You know, I just don't see a way. The problem, I think, is a couple of steps before that, if there is one.

SENATOR CODEY: Doctor, how about the Department of Health having a role on the Board of Medical Examiners, such as an individual from the Department on the Board?

COMMISSIONER COYE: I think that might be something that would improve coordination, to some extent. I still don't think it would involve us as deeply in the individual-- In other words, we aren't in any process of our hospital inspections-- In none of those situations, do we go through every single record of anything. We are always sampling. So, the bulk of the role would still be for the BME. But I think

that if we had a seat on the BME, it might improve coordination. We certainly have had good staff-to-staff relations, in terms of the referrals of cases. I have personally called the head of the BME to thank him for the recent action on AIDS and, you know, some of these other issues. So I think that would be -- if it is acceptable to the BME -- something that would be helpful.

SENATOR CODEY: But, as you can see by the amount of calls your Department gets, the layman thinks to go to the Department of Health in many instances, to complain about physicians. It's a natural.

COMMISSIONER COYE: Right, yeah.

SENATOR CODEY: And yet you stated that you have no real jurisdiction.

COMMISSIONER COYE: Right. I certainly will be more comfortable if we keep the distinction where what we appropriately do with individual physician cases is make the referral. Perhaps the coordination would be improved if we had a seat on their Board, but I think they have, in most cases, as far as I know, certainly been very-- When we call up, they have been very accepting about the need to look into these cases. However, we have no way of following up on that.

SENATOR CODEY: Doctor, has any hospital in the State of New Jersey ever been fined or penalized for allowing incompetent physicians to continue to practice within their facility?

COMMISSIONER COYE: Again, I would ask Charlotte Kitler to oversee us. I don't think our authority is to fine them for allowing the physician to continue to practice. What we would do is fine them for not reporting that. As I explained, I think very few final disciplinary actions are taken by hospitals, and the chances of our inspectors finding that when looking at a sampling of the minutes just doesn't lead to any cases where we would fine them on that. We

certainly haven't done that. But I don't think that is a very good screening system, frankly.

SENATOR CODEY: Yeah, but it's obviously a loophole they use, by not making it "final." Seemingly, they have no legal obligation to have done anything else. So, if they allow them to continue to practice, it is perfectly legal, because there was never a final determination. Therefore, the doctor's incompetency is allowed to go on.

COMMISSIONER COYE: So, we have no legal basis to fine them. There is nothing we can do in these cases, unfortunately. Frankly, they do not come to our attention because, again, most of these are not in Disciplinary Committee minutes in a way that our nurses, who are doing the inspections, are going to be able to say, "We don't think the right decision was made in this case." I mean, we are not in the business of second-guessing their decisions, usually.

SENATOR CODEY: What recommendation would you make as the Commissioner of Health to close those loopholes?

COMMISSIONER COYE: I think whatever changes are made, are going to have to be made in terms of the definition of a disciplinary action that requires reporting, so that a broader range of actions are required to be reported. As I understand it, part of the problem may be the narrowness of the interpretation of the disciplinary action which is reported, so that if in the future physicians who are given therapeutic leaves of absence had to be reported, then there would be something for us to check on, and we could issue a fine if it weren't reported. But the way the situation is now, I don't think there is going to be much more we can do.

DEPUTY COMM. CHARLOTTE KITLER: One of the problems is the narrow language that is used directly in the statute, which requires the reporting only of actions taken by the governing body, not necessarily by any sub-groups or committees, and the reporting of actions that directly results

in some diminution of the credentials or privileges of the physician to practice in the hospital.

There may be actions which result in a temporary suspension -- okay? -- pending some other action, taken by committees of the hospital, and that, under the language of the statute, would not be subject to reporting. That, I think, is what Dr. Coye has been saying. It is the statute itself and the specific wording that is used that is rather restrictive. It does not leave great flexibility to this Department to promulgate regulations that would be more directly responsive to some ways in which the statute could be worked around, or avoided.

SENATOR CODEY: Do you have any questions, Senator McManimon?

SENATOR McMANIMON: Yes. In your beginning presentation, Doctor, you made the statement that attending physicians must countersign. Will you please explain that a little more?

COMMISSIONER COYE: Oh, okay. That was just an example of the kind of regulations that are process regulations we enforce. There are regulations that require that an intern's orders -- and you understand that an intern is a person who has only had the four years of medical school, and then has begun to do his first year of a residency program-- Their orders, because they are still very young in training, should be countersigned by the attending physician, meaning that the attending physician has checked those orders to make sure they are good. That is the kind of thing that when our nurses go in on inspections of hospitals, they go through a sub-sample of the charts, to see if the interns' orders were signed by the attending physicians.

SENATOR CODEY: Thank you very much, Doctor.

COMMISSIONER COYE: Thank you.

SENATOR CODEY: Our next witness will be Mr. James Morley, Executive Director of the State Commission of Investigation.

J A M E S J. M O R L E Y: Thank you, Mr. Chairman. With me today is the Commission Deputy Director, Robert J. Clark, who served as counsel to the Commission for the investigation that resulted in our report.

The State Commission of Investigation commends your decision to conduct a public discussion of the important issues raised by our report on impaired and incompetent physicians, and appreciates the opportunity to address you on those issues.

Since we believe the Commission's report itself fully documents the many problems we found in the reporting and monitoring of physician impairment and incompetency, we intend here to only briefly summarize our investigative findings, and to respond to misinterpretations of those findings that hve been brought to our attention since the report was issued. In addition, we would like to emphasize the importance of certain of the many statutory and regulatory reforms that we have proposed.

In essence, the Commission's investigation fully confirmed that a "conspiracy of silence" exists to evade moral and statutory obligations to report impaired or incompetent physicians to the State Board of Medical Examiners. Indeed, even Dr. David I. Canavan, the Director of the Impaired Physicians Program of the Medical Society of New Jersey, conceded in his testimony before the Commission that the so-called conspiracy exists, and he described it as follows:

"The conspiracy of silence is people being afraid to report to anybody, even to us" -- that is, the Impaired Physicians Program. "People are afraid to report to us, a therapeutic program, because of a fear of anger or hostility -- the fear of loss of friendship, fear of suit for libel or slander. There are all sorts of phantom doubts there."

The Commission's report reveals that violations of the spirit and intent of our State's abysmally inadequate reporting statutes represent a very real threat to public safety, since they enable too many impaired and otherwise incompetent doctors to continue practicing without adequate oversight or restriction. There is no question, as Dr. Canavan acknowledged, that many physicians are not reporting impaired colleagues.

The report also documents the manner in which certain hospitals are utilizing loopholes in the reporting laws by arranging leaves of absence, rather than suspending problem doctors and by ensuring that disciplinary actions against physicians are taken below the level of their governing boards. This enables hospitals to evade their statutory provisions that mandate reporting to the Medical Board. Although a number of impaired physicians have been brought to the attention of the Impaired Physicians Program by hospitals, the program itself too often fails to investigate such referrals adequately, and just as often fails to closely monitor the rehabilitation process or to properly supervise or restrict those who subsequently resume their practices.

Our report cited over a score of examples of physician misconduct and patient mistreatment that the health care industry has shielded from regulatory scrutiny. Indeed -- and contrary to public statements by representatives of the Medical Society -- there are at least 115 other cases of impaired physicians in the files of the program that similarly reflect questionable activity or inactivity by the program in its almost single-minded quest to salvage the careers of errant doctors. Certainly there is no question that the interest in saving doctors' careers is a legitimate one, but our concern in our report was that it does not seem to be adequately balanced by a concern for the public's safety.

The Commission believes strongly that the Board of Medical Examiners, which is statutorily empowered to monitor impaired and incompetent physicians, should be provided with sufficient resources to carry out its duties. Questions about the capability of impaired doctors to resume or continue their practices during or after treatment should not be decided exclusively by entities which have no official role in the regulatory system and insufficient resorces to function adequately. This is not to say that the services of the Impaired Physicians Program are not valuable, for they most certainly are. But the program's rehabilitative efforts should be supervised by a medical director for the Board of Medical Examiners, whose physician representation is tempered by the participation of three lay members. Despite the program's apparent fears, the Commission has found the Board to be willing and capable of striking a proper balance between rescuing salvable medical careers and protecting patients.

Meanwhile, certain hospital spokesmen have persistently asserted that they are obeying the reporting laws, contrary to what the Commission's report concludes. This is a blatant misrepresentation of the practice of circumventing the law by various administrative subterfuges so that hospitals cannot be accused of violating the reporting statute. Such evasions by hospitals of their moral, as well as legal, responsibility to report errant doctors to the Medical Board, is a primary reason why such doctors can be described by our report as a potentially lethal threat to unsuspecting patients.

Some overall observations before we conclude this summary: As has been stated frequently, both in our report and by you, Mr. Chairman, the Commission's investigation focused on a minority of doctors since, as our report stressed, most physicians are devoted to the highest standards of medical practice. Rather than limit its proposed reforms to the small percentage of doctors who are believed to be dangerously

impaired or incompetent, the Commission would apply its recommendations to the entire health care profession, including nurses, dentists, optometrists, pharmacists, and all other practitioners who are licensed and otherwise regulated by the various professional boards in the Attorney General's Division of Consumer Affairs. The proposed reforms recognize the need for a certain degree of confidentiality in the regulation of impaired health care professionals, both as an incentive for early voluntary reporting and to avoid the publication of allegations pending due process hearings. However, they also recognize that, while conceding the importance of rescuing hard-earned professional careers, the primary objective of any officially sanctioned regulatory program in the health care field must be to safeguard public health and safety.

Finally, it should be noted that the Commission has called upon the vast majority of truly honorable and caring physicians of our State to assist whatever legislative efforts are made to implement our corrective recommendations. While a number of doctors have privately indicated their endorsement of our reform proposals, the profession as a whole appears willing to at least make an objective assessment of our findings and to propose its own corrective steps. I can tell you that only yesterday we were approached by representatives of the Medical Society, who confirmed that they not only would make such a positive study, but would also come forward with their own recommendations, including some which may be alternatives to our proposed reforms. The Commission staff will, of course, continue to consult with the Society during this process, and the Commission has agreed to look at the recommendations or alternative proposals the Society might come forward with and, if appropriate, will certainly give its support to those recommendations.

Certain of our recommendations, such as enhancing the resources of the Board of Medical Examiners, already appear to

have such broad professional support as to warrant immediate consideration. In addition, some hospital administrators have told us that they would subscribe to a more stringent reporting procedure, provided they would be protected from legal harassment. And the malpractice insurers, who have cooperated fully in our inquiry, have stated that they would also support legislation that would improve the reporting activity by them.

The Commission looks forward, Mr. Chairman, to working with the Board of Medical Examiners, the hospital groups, the insurers, and also the Medical Society, to reach some solution to this disturbing problem.

Thank you.

SENATOR CODEY: Thank you. Mr. Morley, could you tell us exactly how you came by the information that was contained within your report?

MR. MORLEY: I think Mr. Clark can probably explain that more fully for you.

R O B E R T J. C L A R K: Well, basically you can divide that into two categories, Mr. Chairman: One would be impaired physicians, and much of the information pertaining to impaired physicians, that is, those with dependency on alcohol or drugs, with certain mental illnesses, and the like, came with the cooperation of the Medical Society's Impaired Physicians Program. I think they recognize that they lack the resources and that they, perhaps in some instances, lack authority. They were perfectly amenable to our looking at the processes that apply in their program.

SENATOR CODEY: So, you're saying you did not have to subpoena any information?

MR. CLARK: My belief is that there was, as is the case with all private witnesses, that is, non-public witnesses, a subpoena. But my impression was that it was unnecessary, and that the cooperation came without the necessity of a subpoena. However, as a matter of routine -- as a matter of course -- we

give a subpoena, except to public officials, who are required to testify before us by law.

In the case of the incompetency -- that would be a lack of skill or judgment in properly dealing with patients -- we obtained the information, again, with a good deal of cooperation from the insurance companies which handle medical malpractice, and also from a review of information available at the Administrative Office of the Courts.

SENATOR CODEY: Mr. Morley, could you prioritize the recommendations contained in your report?

MR. MORLEY: I think the most significant recommendation is, something has to be done to discourage, or to eliminate, what I think is commonly characterized -- it is not a phrase of our invention -- the "conspiracy of silence." Right now, there is no legal responsibility for anyone, other than the hospital governing boards, to report problem doctors, either incompetent -- just out and out unskilled doctors -- or impaired doctors -- doctors who have drug, psychiatric, alcohol problems, or whatever.

The focal point of our report is that the Board of Medical Examiners is not getting the information it needs to perform its function. All of our recommendations really center on that -- opening up the channels of information to the Board of Medical Examiners, not only by requiring health care professionals to report problems among their colleagues, but also to change the malpractice reporting requirements, which now place an artificial $25,000 floor on the reporting of claims. That enables a lot of claims to be settled for $24,999.

I think all of the recommendations go to the same purpose -- getting information to the Board of Medical Examiners.

SENATOR CODEY: Mr. Morley, do you have any evidence that this conspiracy of silence exists to any extent among other licensed health care professionals?

MR. MORLEY: We did not undertake an investigation of any of the other professions. We do know that there is a mandatory reporting statute for nurses. I would assume that the Legislature, at some point, made a determination that that statute was necessary. I assume that was based on a finding that there was a similar conspiracy of silence. I have no reason to believe that other professionals are similarly unwilling, for whatever reason, including the fear of suit, to report colleagues. So, I would suspect it is a problem that is not unique to physicians.

SENATOR CODEY: That is a regulation, as opposed to a statute?

MR. MORLEY: I'm sorry, but that is the case.

SENATOR CODEY: Senator, do you have any questions?

SENATOR McMANIMON: No, thank you.

SENATOR CODEY: Thank you very much.

MR. MORLEY: Thank you, Mr. Chairman.

SENATOR CODEY: Our next witnesses will be Mr. Herbert Stern, Special Counsel to the Medical Society of New Jersey, along with Mr. Vincent Maressa, Executive Director of the Medical Society of New Jersey, and Dr. Edward Cardin, National Advisory Committee on Impaired Physicians, American Medical Association. Gentlemen? I know who you are, Mr. Stern. I do not know the other gentlemen.

H E R B E R T S T E R N, E S Q.: Well, this is Mr. Maressa, Executive Director of the Medical Society, and Dr. Cardin from the American Medical Association. We thank you for giving us the opportunity to appear before you today.

Senator, I was heartened by the way you began, as you opened the proceedings, in which you stated that some of the findings of the SCI appear to you to be overstated. This is a statement with which we hardily agree. Obviously, in any field, in any profession, no matter how sacred, no matter how devoted, whether it be the clergy, who tend to our needs

spiritually, or physicians, or lawyers, even public officials in public service-- No matter how devoted such a group may be, there are always some small few who are aberrant. That is not to say that this is not a problem. But, it is also fair to say that it is grossly unfair to seize upon some small incidence of that, and then proclaim it to be a national disaster, for it is not. As even our friends at the SCI, I think, have stated before you, the overwhelming majority of those who provide health care to the people of New Jersey are self-sacrificing, dedicated, caring, and competent professionals.

Now, we are confronted by a report which was promulgated in secret, on the basis of testimony that no one knows about. It is bottomed on only such excerpts as the SCI cares to put in the report; edited as they care to do it.

SENATOR CODEY: It sounds a little like "60 Minutes."

MR. STERN: Maybe like five and a half minutes -- (laughter) -- because there may have been 60 minutes, but we don't see them all. That is not to say that the SCI is not a good organization, or that it doesn't do well. Of course, it does. But we suggest to you that the proper way to confront the situation of health care in New Jersey, is not on the basis of secret testimony and conclusions reached without anybody really knowing what they are based on.

I think the SCI recognizes that, because we did have a meeting with them yesterday, as Director Morley indicated to you, in what I believe to be the most unprecedented action ever taken by the State Commission of Investigation, for I have been watching them closely for many years in my service as United States Attorney even in the early '70s, and late '60s, as kind of a prosecuting attorney here. I have never before seen them do what they have agreed to do in this instance, which is, in effect, to reopen consideration. As you have heard Director Morley state, they have agreed to consider such proposals as we care to make, even though they may be alternative -- which I

gather means different from their own -- with an open mind. This bespeaks well for them, because this subject is far too serious. We represent people who are not sometimes soldiers in this war against disease. The physicians, the dentists, the optometrists, and the nurses are not part-timers. They devote every day of their lives to the public and to caring about people. Upon all of their behalves, although I speak now only for the Medical Society, I categorically reject this notion of any kind of a conspiracy, much less a conspiracy of silence.

Your question, Senator, in my view, was very apt. You asked Mr. Morley: "How did you come by the information which you have selected from and put into this report?" I notice Mr. Morley turned to his colleague, Mr. Clark, to answer that. And, finally, the answer did come. It came from us, the medical people of New Jersey. We are the ones who gave it to them, and there was no necessity, Senator, for any subpoena, because we are anxious and willing to work with anyone, particularly with your body here today. As good as our program is, as excellent as it is, as we are going to show you, in our view, if there is one incompetent physician, one impaired physician, that is one too many. We who care -- we care about the people of New Jersey everyday -- are willing to work with everyone and anyone to see if we can't be the best.

We have with us today Dr. Cardin, who comes from the American Medical Association. He is prepared to testify before you on the basis of a national oversight. We are prepared to document before you that New Jersey, to date, is the leader -- nationally, the leader, the most vigorous -- in the detection, the most committed in the intervention, the most careful in the monitoring of any impaired or incompetent physician, and that our program stands today -- he shall tell you on behalf of this national organization -- as the best program in the United States. We are also here to tell you that we are not satisfied. We will never be satisfied, not as long as there

remains any step that can be taken to really give more protection. We are prepared to view, in the most open-minded kind of way, and to work with you, and again the SCI, which has agreed to reopen its consideration, to come up with anything that will even better protect the public of New Jersey. But, we must also say to you: Any tampering with a program which has become nationally recognized as the best in the United States, should be done with care, with caution, and with circumspection, because there is an old saying, "If it ain't broke, don't fix it."

Still, we will pledge you to leave no stone unturned to reexamine and reconsider everything and, in the end, to work with your staff, Senator, if you will have us, to assist your Committee in coming up with legislation which I believe will put us not just first, but way out front in the United States. We -- the Medical Society -- hope that all of the other professions that are licensed in the State, whether they are lawyers, such as the attorneys for the SCI, or any other profession, will be as caring and as forward-looking in terms of making certain that its membership is as competent as the doctors and the other medical providers in New Jersey are, and intend to continue to be.

I would like to introduce Mr. Maressa to you, if I may, Senator, the Executive Director of the Medical Society of New Jersey, who may care to address you briefly.

V I N C E N T A. M A R E S S A: Mr. Chairman, Senator McManimon: We are pleased to have the opportunity to present a few comments to you, on both the report and where the Medical Society would hope the report leads the State of New Jersey.

First of all, in terms of the report itself, I am constrained somewhat to point out to you that in the presentation just given by Mr. Morley, there was significant criticism, for example, of the hospitals and their failure to report. But, you will notice that at no point did he mention

that in the investigatory process they went to the hospitals and asked them whether, in fact, they had reported. There was also no mention in his presentation of the fact that the Impaired Physicians Program, for example, has reported some 38 cases to the Medical Board within five years, wherein we requested that they consider licensure action.

The Commission, when they came to us, indicated a desire to look at the issue of impairment, and also the overall disciplinary system in the State of New Jersey. At no time in the course of their investigation, though, did they ask us to list cases that we reported to the Medical Examiners that did not involve physicians who were disabled or impaired by the disease process.

I can assure you that there are extensive numbers of such files that we have forwarded to the Board of Medical Examiners. Some of them involve complaints by patients; some involve complaints by doctors. They do not go into the impaired physicians' process, because they don't involve a physician suspected of having a disease problem that produces impairment. So, there are other elements that we believe we have to bring to the Commission to give them a broader picture of the problem and the possible solutions.

In terms of an evolving solution, I believe New Jersey stands on the threshold, at this particular time, of creating a licensing and disciplinary law that would do several things. In doing this, we can, and will, lead the nation, and develop the prototype. The two things that have to be kept in mind and given equal concern are: First of all, protection of the public. The public does, indeed, have to be protected and insulated. The second goal has to be to have the impaired individual -- the affected individual -- treated and salvaged, if you will, if that is possible, so that together the Legislature, the Medical Society, the Commission, and the various State agencies, including the State Board, the Attorney

General's office, and the Health Department, can move forward and really frame a meaningful solution to a very difficult problem.

As Mr. Stern indicated, the problem is, indeed, complex. We are, indeed, the largest program in the country in terms of the ratio of people we detect and move into treatment and, in effect, also move out of treatment at a given point, and also who we put into the disciplinary process at a given point. We are working very hard at this program. We admit it is not perfect, and we will, of course, take all relevant suggestions, and all meaningful suggestions, to make it not only responsible, but effective.

At this point, I would like to present to you Dr. Edward Cardin. Dr. Cardin is a member of the National Advisory Committee to the AMA Program on Impaired Physicians, and he is well-known nationally for his efforts to bring these programs, and programs of rehabilitation and concern into the medical community across the country.

D R. E D W A R D C A R D I N: Thank you, Vince. Mr. Chairman, Senators, ladies and gentlemen: The American Medical Association first became interested in the problem of impaired physicians in the late '60s, and issued their first report in 1971. I became involved with this effort in 1975, and was a founding member of the Advisory Committee when it was formed in 1982. In this position, I have had the responsibility of monitoring the entire country in terms of the various types and efforts that have been made by both medical societies and licensure boards, in trying to deal with the problem of the impaired physician.

The first concept I would like to accentuate is, impairment is not synonymous with incompetence. There are several causes for incompetence, such as moral turpitude, educational deficiencies, and so on and so forth, that I do not consider myself an expert on, and which I am not prepared to

discuss. The other thing I need to emphasize is, there are many stages of impairment where incompetence is not a factor. By impairment, we are talking about those diseases, those human processes, which cause human beings to be deflected from their otherwise human potential. It is quite obvious that in the earlier stages of many of these impairments, extremely capable people are only slightly deflected, and are, therefore, quite capable of performing in a competent or even super-competent fashion.

Any attempt to develop a global perspective on the problem of impaired physicians rapidly reveals that it is not a simple problem that requires a solution. Rather, it is a very complex dilemma which desperately needs management. When you analyze the conflicting social, political, and medical issues that surround this dilemma, there is one very apparent overriding factor; namely, that the welfare of society and the welfare of the individual impaired physician are inseparable. By that I mean, it is by establishment of programs which are confidential and primarily therapeutic, and then disciplinary only for non-responders, that society benefits. It benefits because it is then that the colleagues, the family, and the friends of the individual impaired physicians will report them earlier in their impairment, before they are incompetent, in order to obtain the effective intervention of such programs.

There is plenty of data on impairment which proves beyond question that the detection of this impairment is not amenable to legislative fiat. There have been many mandatory reporting laws that have been tried in the United States, and not one medical board has experienced any positive result from any of those mandatory reporting laws.

I take this, and interpret this human response to be due to the fact that the more pressure and the more threatening the forces are which are applied to cover this problem, the more likely people are to cover for the impaired physicians, in

order to protect them. It is part of the human condition. Perhaps it is as simple as our American way of being somewhat mistrustful of the power of bureaucracy.

The finest example of this complex problem, is the FAA and airline pilots. Despite the fact that they had all kinds of opportunities for mandatory medical inspection of their personnel, impairment among pilots was a huge problem until they did two things: Number one, waived the automatic lifetime grounding of any pilot, which occurred once a diagnosis of alcoholism or drug addiction was made. And number two, enlisted a cooperative and confidential effort by the American Airlines Pilots Association to detect and follow such pilots.

In fact, the networking needed to deal effectively with the impaired physician appears to be the cutting edge of those paradoxical forces that shape the good of society by protecting the rights and dignity of the individual. As in all human endeavors, risk cannot be eliminated, but can be managed to a tolerable minimum. Absolute confidentiality is the sine qua non of a successful medical society program. These programs need to be protected by a highly defined memorandum of understanding with their state boards that will guarantee the confidentiality of these programs, unless and until an independent investigation produces significant evidence of a pattern of malfeasance in the medical society program.

The backdrop for impaired physicians programs, as we are outlining them today, would be called employee assistance programs for professionals, who are generally self-employed. Now, the key ingredients of an employee assistance program are the following: First and foremost, we need active casualty surveillance. By that we mean, you don't wait until the primary victim is at the end stages of his or her impairment before you initiate some kind of intervention. Obviously, intervention itself is a very important ingredient of this activity. You then have referral for appropriate treatment,

followed by a pervasive policy of advocacy, provided the individual responds within reasonable clinical limits to the intervention and to the treatment.

Now, the most important part of this subject we are discussing today is the active casualty surveillance. That is an epidemiologic term that means, how do you get to the problem before it becomes a bigger problem? The first thing, of course, is case finding. That is made most eminently possible by the program's public image -- the generally appreciated image by the public involved -- that it is: a) effective; b) confidential; and c) that it will be the advocate of the individual impaired person.

The second phase of the active casualty surveillance is monitoring. Monitoring may seem like a very severe enforcement problem to some -- the uninitiated. But, in reality, the people especially who have chemical impairments, appreciate monitoring, because it reenforces their basic decision to stay well. Therefore, it is definitely within the humane process to have monitoring. It decreases both the incidents and the duration of recidivism, and that is the way the recovering people will view it.

Now, the second basic concept that needs to be considered, is that an effective employee assistance program cannot be created without the resources needed to hire and properly train individuals to do the job. The situation is somewhat analogous to that of job safety. Forty years ago, that was a new concept. Physicians devoted a large part of their expertise to those people who suffered from industrial accidents -- machines that blew up; people who made dumb mistakes and got hurt or killed. It was only after management realized that they could do something about this, that they could elevate the consciousness of the individuals involved, and hire and train people and give them the authority to do this kind of activity, that things improved, to the point now

where if you walk into any modern plant, or any modern project of any economic level, there is always a safety officer, and all kinds of action going on to keep the situation safe.

Now, there are several types of programs that have been developed in this country to deal with impaired physicians. First is the voluntary. This is what we have in Ohio, where I live and work. We have 22,000 licensees, and yet we deal with only about 25 cases per year. Obviously, there is a huge gap there between the problem and what we are able to do about it. The second type of program is one sponsored by the state board. The best example of this is in California. It is referred to as the Diversion Program. It was established by the Board of Medical Quality Assurance of California, and it has been operational since 1980. This program, in seven and a half years, has spent over $4 million. However, out of 65,000 active licensees in the state -- in other words, they have over 100,000 people with licenses, but 65,000 of them are active within the state and would be within the target population -- they have-- In seven and a half years, they have gotten only 460 cases out of all of those licensees.

Another type of program would be that oriented by a treatment center. This occurred in Georgia, where the Medical Society gave its stamp of approval to a particular individual who was working out of a treatment center, and received his--

SENATOR CODEY: Doctor, excuse me, but you seem to be going off the point of our hearing today, which is to respond to the SCI Report.

If I may, let me ask you a question: If a doctor were to have his license lifted in the State of New Jersey, could he practice in the State of Ohio?

DR. CARDIN: No.

SENATOR CODEY: Why not?

DR. CARDIN: Because the Federation of Medical Boards has established a process whereby there is communication

between the state medical boards, and they would automatically be--

SENATOR CODEY: What kind of communication?

DR. CARDIN: Pardon?

SENATOR CODEY: What kind of communication?

DR. CARDIN: Formal communication.

SENATOR CODEY: I mean, we are not even computerized with our Board of Medical Examiners, yet you're talking about medical societies-- Go ahead, Mr. Maressa.

MR. MARESSA: Well, Mr. Chairman, perhaps I can respond to that. Each medical board that disciplines a physician, be it through suspension or revocation, files a notice not only with the Federation of Licensing Examining Boards, which is the national entity, but they also advise all the individual licensing boards across the country. So, there is a letter report -- a notification, a list of suspensions and revocations that are routinely mailed out by the various licensing boards, in and among themselves. So, that information is readily available. It doesn't require computerization, because the numbers coming out can be managed on manual reporting systems. Computerization--

SENATOR CODEY: There are so few?

MR. MARESSA: Well, no, it is not that there are so few. They come in over a protracted interval. Computerization will help you manage a lot of data better, but if you have a bad system going in, computerization doesn't give you the answers. If you have a good information management system, computerizing it is very productive. If you have a bad management system, computerizing it is nonproductive.

An illustration, for example in New Jersey, is the license renewal situation, which is computerized. I can't think of a single year since we got into biannual registrations, that the license renewal forms went out consistent with the statutory date of June 1. They have

consistently gone out at episodic, erratic times. One year the Division of Motor Vehicles' computer is used; another year it is somebody else's computer. The end result is that this year, the license renewal applications, I believe, were sent out probably in September or October, along with a very sophisticated questionnaire with a number of questions.

So, computerization will help resolve one part of the problem, but there are other ways to go about it, and there is a wealth of information available.

DR. CARDIN: Senator, if I may respond to your question, I am not trying to intimate that there is nothing to be done. What I am trying to create is some perspective on what has been tried and the kind of results that have been obtained. Over 60% of the medical societies -- state medical societies -- in the United States have not even generated enough activity devoted to this problem to call it a line item in their budgets. With the Medical Society of New Jersey, it comprises approximately 12% or 13% of their annual budget.

There have been many other activities in California, New York, Florida, and so on, which have been launched, but they have not achieved anywhere near the success of this Medical Society program here in New Jersey. The State of California has spent a great deal more money and a great deal more time, yet they have only obtained about the same number of licensees from one-fifth the target population. The FAA, since 1971, has been involved in this, and yet they still-- In that length of time, they have come approximately as far as the Medical Society of New Jersey in five years.

SENATOR CODEY: Doctor, we are here to talk about impaired physicians. I would like you, if you could as you testify, to stick to the subject.

I would assume there are roughly about a half a million licenses throughout our country. There were 40,000 malpractice claims in one year. Your American Medical

Association estimated that at least 10% of those claims -- roughly 4000 -- would be valid. Okay? That leaves out, of course, many cases of malpractice that are not reported, or where people were unaware that there was malpractice done. Yet, in that same year, there were only 500 disciplinary actions against physicians. Your own society admits to at least 4000 cases of malpractice a year, yet--

DR. CARDIN: Senator, I don't believe you are so naive that you believe that malpractice and incompetence are synonymous. Everyone makes mistakes. There is no human being alive who doesn't make a mistake. Under the law, in certain circumstances, these mistakes are compensable.

SENATOR CODEY: But, out of 4000 that the American Medical Association agrees are valid, only 500 had any form of disciplinary action.

DR. CARDIN: Do you think that everybody who makes a mistake should be disciplined?

SENATOR CODEY: I don't know. I haven't looked at each and every one of the 40,000 claims per year. I am not sophisticated enough to know.

DR. CARDIN: I'm glad you mentioned that, because I think there is a part of the human condition which recoils against punishing people for honest mistakes, as long as they are not--

SENATOR CODEY: But I do know, Doctor, that in many cases, it is a matter of life and death.

MR. STERN: No one, Senator, wants mistakes in the operating room. What we are attempting to show you, is that nationally, the Medical Society of New Jersey has the most effective program in the United States. We are not here to tell you that that is necessarily the last word, but we think it should be of significance, even pride, to the Legislature of New Jersey, to know that the physicians of New Jersey lead the nation in their concern and in doing something about it.

As I said during my statement, we welcome -- welcome -- the opportunity to make even more improvements. But, I suggest to you in the strongest possible way, Senator, that the fact that New Jersey, with one-fifth of the medical population of California, disciplines at least as many physicians as California, is, I think, some relevant evidence even of pride that we can take in what is going on here.

Now, as you know, I am a member of the legal profession. I see lawyers make mistakes all the time. I venture to say that even within these sacred halls, people make mistakes from time to time. As between an innocent person and someone who makes a mistake, you give the innocent person some money. That doesn't automatically mean, Senator, that you revoke the other person's license.

SENATOR CODEY: The good thing about these halls, though, Mr. Stern, is that my mistakes are a matter of public record.

MR. STERN: Well, I'm glad you feel that way about it, Senator. We are trying very hard to see that there should be no more mistakes, at least in this profession. All we are trying to tell you is, discipline doesn't automatically follow because someone nods. People have to make lots and lots and lots of decisions in a lifetime of practice. If they do make a mistake and someone is injured, that person should be compensated. It doesn't automatically mean that discipline should follow; it doesn't automatically mean it shouldn't, either. We are not here to defend every decision by every physician. We are here to tell you that while we are willing, even anxious, to work with you, you have a program in place that you ought to know is a leader in the field nationally, and that is what the representative of the American Medical Association has come to say. He is going to tell you -- if you will let him -- that it is better than they have in Ohio; better than they have in California. I think that is a matter of interest.

SENATOR CODEY: Mr. Maressa, since a voluntary system of reporting by physicians does not seem to be effective, what would you think about a mandatory system, such as has been placed on nurses by regulation?

MR. MARESSA: Well, Senator, I am not sure I understand the basis of the premise that a voluntary system is not effective. I think it has been dramatically effective in this particular State. I think the SCI believes it is not effective, but I am not sure they really understand the problem.

Three hundred and eighty-three cases in a five-year period seems to me to be very effective. A mandatory reporting system-- It depends on how it is structured and what the outcomes are. I think it is a topic that has to be very carefully understood. A mandatory system is fraught--

SENATOR CODEY: Well, let me ask you this, Mr. Maressa: If--

MR. MARESSA: Senator, you asked a question. Do you want me to respond, or-- Okay, go ahead.

SENATOR CODEY: --a doctor sees incompetency on the part of another doctor, and he does not report it, then obviously a patient's life is at risk. Do you not think he has not only a moral obligation, but maybe he should have a legal obligation to report that?

MR. STERN: As I understand it, Senator, it is already a medical ethic. Correct me if I am wrong.

SENATOR CODEY: I said, "legal."

MR. STERN: Well, you said moral and legal, if I may break it into two. It is already an ethical standard which the Medical Society has placed upon itself. I know of no other profession that comes to mind that places that kind of a burden upon itself.

Mandatory reporting raises very many difficult kinds of problems. What the representative of the American Medical Association can tell you -- if you will let him -- is that on a

national basis where that has been tried, it has not worked as well. This subject is very complicated. What we are prepared to do, if you will let us, is meet with your staff, in an effort to suggest to you, perhaps, other ways -- the implementation of a county system of discipline, such as we have in the legal field, coupled with confidentiality during the adjudicatory process, which does not exist today. You may not realize this because it has not been brought to your attention, Senator, but the minute that any kind of a complaint is reached at the Board level against a physician, no matter how false it may be, it becomes a matter of public record.

SENATOR CODEY: Are they published, Mr. Stern?

MR. STERN: Yes, they are.

SENATOR CODEY: Where?

MR. STERN: Well, do you want to let the Executive Director answer that?

MR. MARESSA: The complaints that are brought to the attention of the Board, which the Board then lists for investigation, are reported in minutes which are available for public inspection, and the minutes are routinely mailed out. They can be accessed by any member of the public, and by any reporter.

DR. CARDIN: This is just the tip of the iceberg. Frankly, we think that together we can make some real headway. You have been generous with your time. We are here to tell you, I guess in substance, that while we have the best program in the country -- and this is a physician before you now who does not represent the parochial interests of the doctors in New Jersey -- we stand ready, willing, and able to do whatever can be done to make it better.

SENATOR McMANIMON: Mr. Chairman?

SENATOR CODEY: Go ahead, Senator.

SENATOR McMANIMON: I am sitting here listening, and I am trying to take this all in. After hearing a particular

statement in Mr. Morley's report, and after listening to you, Mr. Stern, and you, Mr. Maressa, one of the major problems that the SCI was concerned with, was basically how to eliminate the conspiracy of silence. I will accept that maybe we do have the best program throughout the country, and yet, Dr. Canavan, Director of the Impaired Physicians Program of the Medical Society of New Jersey, conceded in testimony before the Commission that such a conspiracy does exist. This is a major problem. You say we are the best in the country. My God, what is going on in the other states?

MR. MARESSA: Are you asking me a question, Senator?

SENATOR McMANIMON: I'm bringing this to your attention. I appreciate the fact that this has been constructive, and that Dr. Canavan himself had taken a positive position. I do have to more or less agree with you. I think we do have an excellent program in the State of New Jersey.

But, we are here to make it even better. That is part of my intent as a legislator participating in this hearing. We do need your guidance; we do need your cooperation.

MR. STERN: We are prepared to work with you, Senator, in an open-hearted way, because, as I say, the conspirators are the people who devote their lives to saving lives everyday. I must say to you, to call the doctors, the nurses, the optometrists, the dentists, the pharmacists, and every health care provider in New Jersey a co-conspirator, is outrageous. I know what co-conspirators are, Senator. I used to put them in jail. These men and women are not co-conspirators; they are devoted to the public.

I, here today before you, with the Society, pledge to work with you.

SENATOR McMANIMON: Well, then, come on stronger in that tone, because I have a report here from the SCI. I have no alternative. I read this report, and I want to find out all the facts.

MR. STERN: I know you do.

SENATOR McMANIMON: Then, go right at the heart of it. Let's not play games with one another. You know, you are very effective at that. I think this is what we are here to accomplish.

MR. STERN: Well, Senator, I'll tell you what: If you will prevail upon the SCI to give us the transcripts -- which we don't have -- we can address the basis of their report. That is why I think the SCI has agreed to--

SENATOR McMANIMON: That may be interesting at that. I think that is a justifiable question.

MR. STERN: I'm sorry, Senator?

SENATOR McMANIMON: I think that is a good question.

MR. STERN: They won't let us have it, Senator. We have asked them for it. They won't give it to us. But, they have agreed, generously, I must say, for the first time in the history of the SCI, to take another look at a publicly filed report, and that is not easy for them to do. Now, maybe we are so used to seeing them investigating organized criminals, we--

SENATOR McMANIMON: Well, I don't always concur with the SCI methods either, Mr. Stern, you know.

MR. STERN: I understand, Senator. Sometimes they do excellent work. They have uncovered a lot of wrongdoing in organized crime. But we forget sometimes when we use the word "conspiracy," that it may have a special kind of meaning.

In any event, we accept the welcome which we hear from this Committee to work with you, side by side -- the doctors, nurses, and all the others -- not as co-conspirators with you, but as people who care about other people, to do the best job we can.

DR. CARDIN: Senator, if I may recommend to you a subject for your scrutiny, it is to evaluate an area which is just as dramatic and just as frightening as that of an impaired physician; that is, the airline pilots. One of the worst

dreams you could get into is going onto a plane-- Critically evaluate the experience they have had, using force, using legal measures, and so on and so forth, versus clinical measures. This is a complex issue. It is not amenable to simple solutions. Please believe that.

SENATOR CODEY: Mr. Maressa?

MR. MARESSA: Yes, sir?

SENATOR CODEY: The Impaired Physicians Program-- Should the decision of when to report a physician to the Board be left in the hands of one man, as it is now?

MR. MARESSA: No. Actually, we have a working agreement in effect, that says when a physician is in the program, and the physician, for example, has been before the Board of Medical Examiners and the Board has indicated an interest, that at any point when that physician breaks with his or her treatment plan, they are reported immediately to the Board. In addition, for physicians not ever having been before the Board, the agreement says that whenever they break with their plan, they will be reported to the Board. We have followed that particular format.

We are now talking to the Board of Medical Examiners about an enhancement of that process, whereby all these cases would be reported to a committee of the Board of Medical Examiners. They, in turn, would make the decision as to whether the case should promptly be brought to the full Board. We have not finalized the details of that agreement, but it is part of the work we are doing at the present time.

SENATOR CODEY: Mr. Maressa, the malpractice claim settlements--

MR. MARESSA: Yes, sir?

SENATOR CODEY: --where the requirement is to report over $25,000, and we have so many of these cases incredibly settled at $24,999, obviously to get around that reporting circumstance, what would you think of reporting all settlements of all claims?

MR. MARESSA: Well, I don't have any particular problem with reporting all closed malpractice claims. However, I really have to look at the SCI information as a bit jaundiced. Senator, you and I have dealings with lawyers, and we know that a lawyer with a $35,000 claim isn't going to settle for $24,999 so it doesn't get reported.

SENATOR CODEY: Oh, if a physician feels strongly enough about not being reported, I'm sure--

MR. MARESSA: No. The SCI didn't say how many cases fell into that particular category, but as a practical matter, Senator, having followed medical malpractice since 1967, I can tell you that there just aren't many cases at that particular number. As a matter of fact, there aren't many cases at any particular number. The most significant cases, the ones that will raise the serious concerns about the physicians' capacity, will be those cases where the amount of damages are, indeed, well in excess of $24,999. But, I have no problem if you want to lower the threshold to reporting all closed files -- as long as they are closed.

MR. STERN: You will find, as we work together -- if you will let us -- that there is no effort here to cover anything. The Society does not oppose that recommendation. We are prepared even to come forward with some ideas of our own that the SCI has not yet considered, but I think soon will, because we will be working with them. Over and over again I say to you, we have been in the forefront of this effort, and long after the hearings are over, it is the medical profession which will continue to be in the forefront of guaranteeing proper medical treatment in New Jersey.

SENATOR CODEY: By the way, Mr. Stern, as you well know, the SCI is not a legislative body.

MR. STERN: I know.

SENATOR CODEY: Senator?

SENATOR McMANIMON: No questions.

SENATOR CODEY: Okay. Gentlemen, thank you very much. We look forward to working with you, Mr. Stern.

MR. STERN: Thank you, Senator.

SENATOR CODEY: Our next witness is Dr. Edward Luca, representing the New Jersey Board of Medical Examiners. Also testifying will be Mr. James Barry, Director, Division of Consumer Affairs, Department of Law and Public Safety. I said Dr. Luca. He is who we had on our witness list. And your name, sir?

D R. F R A N K J. M A L T A: I am Dr. Frank J. Malta, President of the Medical Board. Dr. Luca could not be here today. I am here in his stead.

Senator Codey, members of the Committee: As President of the Board of Medical Examiners, I am here to address the Board's response to the State Commission of Investigation on impairment and incompetency. The State Commission of Investigation acknowledged that the majority of the licensed physicians are honorable, competent, and caring physicians and professionals. It has also recognized the important role that the State Board of Medical Examiners has played in disciplining deficient physicians. It further recognizes the national recognition that the Impaired Physicians Program of the Medical Society of New Jersey has received for its model program on physician impairment.

The SCI, through its hearings and testimony, concluded that there are many recommendations that offer reasonable and comprehensive improvement over the present system for coping with physicians' incompetency and impairment. It is the Board of Medical Examiners' position that regardless of the percentage of impairment that one wishes to speculate upon, the public needs to be protected -- regardless of whether the figure is 3% or 16%.

The SCI has recommended that identification of problem professionals be improved. To accomplish this objective, the

Board of Medical Examiners will be supportive of legislation that will require that every health care professional report to the Division and the Board of Medical Examiners any professional who has engaged in conduct, used a substance, or suffered a condition which may have jeopardized the public or violated a statute or a regulation.

The new statute would require the professional personnel in the Impaired Physicians Program to report to the regulatory body with assurance of confidentiality. Since the inception of the Impaired Physicians Program, the Board of Medical Examiners has been utilizing the program for the referring of impaired physicians for treatment, while at the same time issuing an order to a licensee restricting or revoking the license until such time as rehabilitation has occurred, for the safeguarding and protection of the public.

The Impaired Physicians Program has been instrumental, through its voluntary program, in confronting and assisting physicians in obtaining treatment of their impairment. The Board of Medical Examiners and the Impaired Physicians Program recognize some of the weaknesses that have occurred both with the Board and with the Impaired Physicians Program. The Board of Medical Examiners and the Impaired Physicians Program have been making efforts, with the program's Chairman, Dr. David Canavan, to reach some understanding of the mutual responsibility of protecting the public. The Impaired Physicians Program has reported individuals in accordance with the program, when individuals have posed a threat to the public and were not in compliance with their program.

There has to be a place for a repository of data on the reporting of impairment in which confidentiality is protected and, at the same time, triggering mechanisms need to be in place that would immediately refer it to the Board's attention. The Board must have ultimate authority in determining the final action that must be taken to protect the

public. The Board would be interested in having regular reporting of the number of cases in various categories of impairment, and the various characteristics of the cases, such as specialties, sex, geographic location, etc., as well as a list of cases reported with non-identifying information, and the ability of the Board to be able to attain more information on borderline cases that may be identified to protect the public.

The Board, in the immediate future, contemplates meeting with the Impaired Physicians Committee to work out the criticisms which were brought to light in the SCI Report. The Board will make efforts to obtain, if possible, the cases referred to in the report which were allegedly not handled properly, for Board review and action.

There is a need for the continuation of a voluntary program for impaired physicians to seek help without the immediate threat of disciplinary action that might have a chilling affect on physicians reporting, or entering the program. The Board feels it will not be able to meet its responsibility through the mandatory reporting of all impairments. There must be a mechanism for confidentiality, utilizing a triggering mechanism to report those who would endanger the public in conferences with the Board in cases of concern, with the Board having the ultimate responsibility to protect the public.

The Board would support statute changes that would provide sanctions for failure to report impairments, as well as statutes extending confidentiality, protection, and immunity to those who report such conduct by any health care professional. The Board would also support a statute requiring pharmacists to report to the Division any refusal to fill a prescription. The Board needs amendments to existing statutes that would give express authority to order reeducation or supervised practice as a condition of licensure -- or continued licensure.

Individuals reported by statute requirements should be defended in a civil suit by the Attorney General's office, at the State's expense.

The SCI was critical of hospitals not reporting actions, taking exception when such actions were approved of by the governing board. The reporting law needs to be modified so that all actions taken by departments and medical staffs will be reported to the Medical Board, that are a result of a lack of competency or judgment. Reporting of disciplinary actions should be applied to all of the health care professionals, including health care organizations. Appropriate fines need to be levied for failure to report, with enforcement authority being given to the Commissioner of Health.

The SCI Report addressed the malpractice actions, reporting them as being ineffective as a means of recognizing competency and impairment in sufficient time to amply protect the public. The Board of Medical Examiners supports changes that would report all claims or actions settled, as well as the filing of actions which might trigger the identifying of an incompetent. A new statute would be needed to apply to all health care professionals, as well as the reporting of terminations, denials, and surcharges of insurance coverages. These measures would be of help in identifying incompetency at an early stage.

A meeting will be sought with professional liability carriers in the State, in an effort to obtain information that would be useful, recognizing that some such information may not become readily available except through corrective legislation.

The Board of Medical Examiners would be supportive of Federal and State regulations to encourage cooperative exchanges of information among peer and utilization review organizations. New statutes in the criminal codes would make the practicing of a health care profession without a license a crime of the third degree, including the expungment of such a

conviction, and a retaliation against a person who reported misconduct or impairment a crime of the fourth degree. Alteration of a medical record should be supported by statutes that would make that a crime of the fourth degree.

The Board is supportive of regulatory revisions that would require registration of residents in training programs, as well as credentially validating procedures and background checks to be implemented by the Department of Health, with respect to the health (indiscernible).

Finally, the Board recognizes the heavy burden of responsibility it has and the increased need for administrative investigative support in carrying out the increased work load. To this end, it has increased its biannual registration fees, and has requested the necessary manpower and computerization needed. The Board is studying, and will implement, those recommended changes that can be done without legislative changes.

On behalf of the Board, I wish to thank the Senate Committee for allowing this testimony to be presented here today.

SENATOR CODEY: Thank you, Dr. Malta. Mr. Barry?

J A M E S J. B A R R Y, J R.: Mr. Chairman and members of the Committee: The SCI Report is welcome. It is certainly going to act as a catalyst for change. I want to assure this Committee that the Board of Medical Examiners, Division of Consumer Affairs, through the Attorney's General's office, is prepared and anxious to work with you, as you consider a number of proposals that will lead to change in this very important area.

The SCI has suggested that all of their recommendations be applied to health-related professions. I certainly endorse that position. Our concern is not only with licensees of the Medical Board, but dentists, nurses, and the others. The Division of Consumer Affairs, which operates

within the Department of Law and Public Safety, has 21 licensing boards. We are responsible for licensing and regulating 42 different professions. I would suggest that as we consider this -- the need for change to address the issue of impairment and the issue of incompetence -- we might also want to take a look at the other licensing boards within the Division. An impaired engineer poses a threat just a surely as the impaired physician. Whether we are prepared to go that far at this moment or not, is something that will have to be decided as we review this issue. But, certainly the Division has to be prepared to deal with these issues as they affect all of the licensing boards.

What I would like to suggest, is that some consideration be given to establishing a program that might serve as a supplement to that which we already have, to deal with the issue of impairment. That suggestion would include the creation of an assistance program that might be based in the Division of Consumer Affairs, run by professionals who are well-versed in the management of impaired cases. The licensees would be reported to the assistance program, either by, in the case of a medical matter, a hospital, by a group of professionals, like an association, or certainly by the licensee himself. The responsibility of this assistance program would be to evaluate the licensee's condition, and to refer that licensee to an appropriate treatment provider. Perhaps even more importantly, the responsibility of that assistance program would be to monitor the progress of the licensee in the treatment program, and to be prepared to report any failure in the treatment process to the appropriate licensing board, where action against the licensee could be taken.

The issue of confidentiality and the issue of the chilling effect that reporting impairment cases to a licensing

board has, are very real issues, and have to be considered. An alternative to reporting directly to the licensing board might be to report to an assistance program that could be a part of this licensing operation within the Division. If the assistance program were staffed in such a way as to review the licensee referred to the assistance program to determine whether or not the health and safety of the public were in jeopardy immediately, a decision could be made at that level to restrict the practice, or to turn the matter over to the licensing board for more dramatic action.

But, I do think there needs to be consideration given to dealing with this issue in the broadest possible way. Number one, the health care professionals. Establishing a program within the Division is an alternative. It is a complex alternative. It is one that involved funding; it is one that involves skillful management -- competent management. But it is an alternative that could work, as long as coupled with this concept is change in reporting laws to require that any licensee who participates in a treatment program, whether it is a direct referral through the State or on his own to a privately funded program-- There must be reporting by the licensee to an agency within the State. In this case, I recommend a newly created assistance program.

I have simply laid before you one of what I am sure will be many alternatives. I simply ask that some consideration be given to that concept. I again want to assure you that we are prepared to work with you in any way to develop this idea further, or to work with you in a different direction which you might think is particularly appropriate.

SENATOR CODEY: Thank you, Mr. Barry. Doctor, how many licensed positions in the State of New Jersey?

DR. MALTA: There are over 29,000 licensees aboard.

SENATOR CODEY: How many licenses are removed every year?

DR. MALTA: I don't have the actual statistical numbers on that. The Board office has that, but it certainly would be in the category of, you know, a handful.

SENATOR CODEY: When you say a handful -- five, six?

DR. MALTA: Twelve, fifteen -- somewhere in that area.

SENATOR CODEY: Per year. How much Medicaid fraud by physicians?

DR. MALTA: I would say probably again maybe eight or ten -- in that category.

SENATOR CODEY: And roughly how many are impaired as a result of either alcohol or drug abuse?

DR. MALTA: Who have come before the Board? Again, Senator, I don't have that information here, but I'm sure it is certainly at least 20 or so -- in that category -- between a dozen and 20. It certainly isn't in any large numbers, in the sense of what we are looking at today from the perspective of reporting.

SENATOR CODEY: Doctor -- and, Jim, feel free to answer, if you would like to -- should the public know when a doctor has a serious charge presently pending against him?

DR. MALTA: Well, initially the complaint comes to the attention of the Board. At that level, they are in the process of obtaining an investigative complaint, to determine how the complaint should be handled from the standpoint of whether an appearance is required on the part of the licensee, or whether there will be an ongoing investigation. The public certainly would be informed at a point in time when the complaint had been finalized to the extent where either there was insufficient cause, no cause, or if there were a finding of fact.

SENATOR CODEY: My question was, when it was pending?

DR. MALTA: No, I don't believe so.

SENATOR CODEY: So, you don't think the public has a right to know?

DR. MALTA: I see no reason why the public should not know. On the other hand, I don't know whether at that point in time the Board would have the particular information that should be available for the public. It may very well be something that the Board--

SENATOR CODEY: Do you think it should be available to the public?

DR. MALTA: I think so. I think certainly if there is a complaint being filed, as long as it is indicated to me that the individual has a complaint, but there has been no finding of facts, or conclusion. It certainly would do great harm to anyone to make charges, and then to indicate -- to imply that maybe he has done something wrong. So, I think we must be very careful that when information is disseminated to the public, that we don't create harm in the process before someone has been found to be guilty of something.

Certainly, if the public calls and wants to know if their complaint is pending before the Board -- or a number of complaints, or what have you -- perhaps that information could be made available. I don't know, at this point in time, whether there is routine information.

SENATOR CODEY: Of course, the Department of Health, every year, does a summary of hospitals, and the rates of survival for certain medical problems. Similarly, Consumer Affairs does a lot of other things, restaurants, or whatever -- pending health violations. They are right on the restaurant wall as you walk in.

DR. MALTA: Yes.

MR. BARRY: Mr. Chairman, the problem with reporting what really may be nothing more than allegations could be a very serious and difficult one. What we need to do is be sure that we can process those complaints quickly. If action is appropriate, we should take that appropriate action. At that point, we would announce that the Board is moving forward.

When we get a complaint about a major retailer, that may come in from 10 different consumers, we don't report the fact that there are those complaints until we have had a chance to look at them and decide whether or not it would be appropriate to file a formal complaint. At that stage, it is essential that the public know there is a problem.

SENATOR CODEY: What would you say, though, to a family member who may have lost someone, where at the time they decided to let this particular doctor operate on their loved one he had some very serious charges pending against him?

MR. BARRY: It would be difficult to comment in general terms. I think obviously there are very serious issues raised when you are dealing with an incompetent physician. Certainly, the patient has a right to know. For instance, if you ask any nurse on the floor of a hospital if she would go to that surgeon, she will tell you yes or no, and you can be sure that if she says no, you better stay away from that licensee. The problem is, the Board is not apprised of all of these cases. I don't know whether we are talking about two or three, or 300 or 400. The problem is, we need to know where the problems exist. In order to get that information, I believe there must be some change in the laws that will provide some protection for those who are prepared to come forward, but are reluctant.

Beyond that -- or without that -- I am afraid we are not going to get the kind of reporting we need to take the action that should be taken against someone who is causing a risk to the public.

SENATOR CODEY: Jim, it would seem apparent from the SCI report that the Board is not adequately staffed; neither is it computerized. Would you support an increase in fees to bring it up to a more professional level in terms of staffing?

MR. BARRY: Certainly. In fact, the Board has recently -- in fact, just in the past few months -- increased

its fees to provide for a function that was reported in the SCI Report -- a medical malpractice unit, that is allowing us, through our Enforcement Bureau, to look at the malpractice cases that have been filed in court, and the malpractice claims that are reported by insurance companies. This is a new initiative of the Medical Board. I think the Board has expressed its support for expansion in any area that would provide a benefit to the public.

SENATOR CODEY: Thank you very much. Senator?

SENATOR McMANIMON: No questions.

SENATOR CODEY: Thank you both, gentlemen. Our next witness will be Mr. William Butler. Mr. Butler?

W I L L I A M B U T L E R: Senator Codey, the first thing I would like to comment on, sir, is, this is the first opportunity, this morning, that I have had to review at all the report and recommendations of the State of New Jersey Commission of Investigation on Impaired and Incompetent Physicians. And, just as a matter of public record, on page 70, up to the middle of the second column of page 71, I would like you to, again, at your convenience, take a look at that part of the report that says: "To improve the identification of problem professionals." I will try to do just that this afternoon as it includes psychiatrically handicapped people who have had to go to mental institutions in the State of New Jersey, in which you, sir, have some ongoing knowledge and records. So, I commend that, you know, to your personal knowledge.

Senator Codey, just over eight months ago, in this very same room, a public hearing was convened to determine existing conditions in New Jersey's State psychiatric hospitals. These hospitals, whose census accounts for 3200 patients statewide -- and this was a Division of Mental Health and Hospitals figure at the end of last year, 1986 -- house only a fraction of the 170,000 -- now that same Division

targets that figure closer to 200,000 -- total patients, the rest being served in community systems in the State of New Jersey. And yet, through negligence, improper care, and incompetence, at least 10 deaths have been attributed to the errors in judgment and skill that incompetence breeds.

Today, I come to you as a consumer leader who grieves over the deaths and atrocities that my friends have suffered. Briefly, there have been doctors in the State system who, at one time, have belittled and ridiculed me at the apex of my own personal illness. I was forced to take injectable medication in high quantities when a patient at ITU -- which stands for the Intensive Treatment Unit -- in Marlboro Psychiatric Hospital in 1979. Prior to that admission, all of the psychotropic medications that were prescribed were curtailed by the admitting physician, and an entirely different regimen of medication was given in their place.

In other cases, at the same institution, medications from the benzo-diasopane (phonetic spelling) family, which include among them Valium, Ativan, Sintrex (phonetic spelling), and Xanax, were given to drug abuse patients, the mica clients, and mentally ill chemical abusers, and thus further addictive symptom otology was experienced by these same patients.

Though it is a matter of public record that psychiatrists in the State system made only $65,000 a year, it is also as clearly known that few psychiatrists in the same system have, as their primary language, English. The changes in word meanings by inflection, idiomatic expressions, and other language barriers make it difficult to communicate ideas and feelings in the treatment regimen, as part of the treatment team, as well as the exclusive relationship between the doctors and the patients themselves.

We must go on toward a further question: Does impairment precede incompetence? The importance in asking this question is ingrained in the following statement: There are

excellent physicians at our State institutions who are of Turkish descent, Chinese, and Korean, who also serve in city and county hospitals close to those same State institutions. Impairment precedes incompetence, sir, only when the State system allows it to do so.

In meeting with my friends from South Jersey in a self-help group, I read public accounts that there was only one attending physician for the entire State facility where a patient died, after being placed in restraints for 84 hours of a 96-hour period of hospitalization. Proper restraint policies were not followed in the case of this patient.

A second matter of clinical incompetence was of a more medical nature in the case of a New Jersey woman who died from convulsions in a coma, when abnormally low levels of sodium were depicted, but no action was taken by the ward physician. According to accounts, which are public record in The Daily Register and the Asbury Park Press, several warnings signs which preceded this patient's coma and death were ignored.

These are but two of over 10 deaths when incompetent and unskilled practices resulted in this heinous final result.

A May 11, 1987 letter to the Honorable Alfred Slocum, Commissioner of the Public Advocate, by Dr. Drew Altman, Commissioner of Human Services, reads, in part: "With regard to the death of the two patients, the Department had already determined that inappropriate actions and judgments by staff had been involved. Second, as a direct outcome of our review of the deaths of these same two patients, disciplinary action was taken by the respective institutions against staff who violated hospital procedures or generally accepted medical practices.

"After review of these cases, however, I believe" -- and the I, of course, refers to Dr. Altman -- "that the disciplinary actions taken with regard to certain responsible employees was, indeed, inadequate."

With regard to the death of the second patient I mentioned in my testimony: "A clinical review of the medical record concluded that the physician's decision to discontinue monitoring the patient's low sodium levels constituted an error in professional judgment. A uniform policy will be implemented, requiring physicians to justify, in the patients' medical charts, actions or inactions related to reports of abnormal laboratory results."

Senator Codey, approximately one month and eight days after Commissioner Slocum received this particular letter, the mental health consumers of New Jersey staged a demonstration protesting the deaths of our friends at State institutions, and refer your attention to Dr. Altman's departmental actions and interpretation for your evaluation:

Number one, the establishment of an independent Clinical Review Board, on which a representative from the Department of Public Advocate was invited to serve, but no consumer of mental health services. We feel that this lack of representation is a grave injustice, as it is our friends who have died at the hands of incompetent physicians. We ask representation, and bring this matter to your personal attention for possible legislative means and matter.

Second, a Disciplinary Review Board was also established by the Commissioner of the Department of Human Services. Again, with regard to unusual deaths or serious incidents, uniform application of Department Administrative Order 4-08 does not include primary consumer or ex-patient representation.

Three, the Department of Human Services will require that when abnormal lab results are received by a physician, explanations for further action or a clear rationale for inaction must be entered into the patient's chart as a progress note. Failure to comply with this policy will be grounds for disciplinary action, in accordance with Administrative Order

4-08. The next time you stop by Marlboro Psychiatric Hospital, I invite you to pull some of those patients who would fit under this description, to see if they have, indeed, complied with this Administrative Order.

SENATOR CODEY: You never know when I will show up.

MR. BUTLER: Fourth and finally, Senator, the Department of Human Services will apply the recommendations of the Columbus Report, based on the Division of Developmental Disabilities and, after an (indiscernible) -- I have let go of some of the information -- required improvements will be made by July, 1987. So, they should have already taken effect.

I ask you, therefore, Senator Codey, that Commissioner Altman, in addition to the July requirements of the Columbus Report, outline the disciplinary actions of Administrative Order 4-08. Also, contact you as per the appointment of ex-patients on both the Clinical and Disciplinary Review Boards. It is my hope that you, as the ranking expert on mental health issues in the State Senate, will begin to move towards the greater needs of greater community care and funding of that care for seriously mentally ill patients in our State. To place our friends and loved ones in this restrictive environment has proven to be not only a denial of liberty, but death itself.

New Jersey, fortieth of 50 states in per capita funding of community programs for seriously mentally ill citizenry, is also impaired and incompetent in its myopic view of what is truly essential. This afternoon, Senator, I issue this challenge to you personally: Let us return our seriously mentally ill citizens to a life of productivity and potential. It is time to stop wasting money where incompetence is, indeed, so prevalent.

SENATOR CODEY: Thank you very much, Mr. Butler. I appreciate it. Our next witness will be Mr. Dimenna, Director of Governmental Affairs, Department of Higher Education.

G R E Y D I M E N N A, E S Q.: Good afternoon. My name is Grey Dimenna. I am the Director of Governmental Affairs at the Department of Higher Education. I am here on behalf of Chancellor Hollander, who, unfortunately, could not be here this afternoon. I wish to read a statement on his behalf:

"Thank you for providing me with the opportunity to appear before you today concerning the SCI's Report on Impaired and Incompetent Physicians.

"As you know, I have a longstanding interest in the licensure and regulation of medical practice in New Jersey. As Chancellor and a member of the Board of Medical Examiners, I have concerned myself particularly with the issue of physician education and its implications for standards of licensure and physician competence. Therefore, my comments today speak to the portions of the SCI Report dealing with strengthening the authority of the Board of Medical Examiners, and setting appropriate standards for initial licensure.

"The SCI Report documents numerous cases of physician incompetence that continue unchecked, resulting in harm, even death, to patients. There is definitely a need for improvement in our systems for reporting and tracking impaired physicians. However, a reporting system based upon cases of malpractice or misconduct can operate only after a few patients have already suffered. I am convinced that some cases of physician malpractice could be prevented from ever occurring by more careful screening of applicants for licensure, and through more thorough scrutiny of residents in the State's graduate medical education programs.

"Last year, a Joint Committee of the Board of Higher Education and the Board of Medical Examiners studied the current educational requirements for licensure in this State. The committee found that current educational requirements have not been updated since 1919. For instance, the requirements are so generous that they would allow licensure of a student

who finished two years of course work at a community college, without even meriting an associate degree, and who directly entered a foreign medical school which graduates physicians upon their completion of a condensed three-year curriculum. As a member of the Board of Medical Examiners' Credentials Committee, I am personally aware that many applicants present questionable educational careers and suspicious repeated failures on certification and licensure exams.

"The Joint Committee of the two Boards made a series of recommendations to strengthen New Jersey's physician licensure requirements. Among these are: An increase in the number of required undergraduate credits from 60 to 120; an increase in the minimum course of medical education from three years to four years; limiting repeated failures on licensure exams to three attempts; and lastly, requiring three years of graduate medical education before licensure, instead of only one.

"The testimony given before the SCI illustrates the difficulties of quickly detecting incompetence once physicians are outside an educational supervised setting. Other health professionals are unsure of their information, since they often have no direct relationship to the procedures or patients in question. The best opportunity for screening out inadequately prepared or inept physicians, is prior to licensure. For this reason, my staff and the Department of Higher Education have been working to improve educational standards in the State's graduate medical education system.

"I believe that through a combined effort, the Department of Higher Education and the Board of Medical Examiners can form the foundation of a truly preventative system. Therefore, I urge you to enact strengthened licensure requirements. I also believe the proposed system for registering residents in graduate medical education programs, currently awaiting review by the Board of Medical Examiners, merits your consideration and support.

"In closing, let me express my hope that this Committee will take seriously the need to support administrative reforms at the State Board of Medical Examiners. Both the staff and the members of the Board have served the State well with a minimum of resources. A substantial increase in those resources will be needed to bring about improved credentials review and physician monitoring.

"Thank you."

SENATOR CODEY: Sir, we look forward to working with you on those recommendations which need legislative action. Thank you.

MR. DIMENNA: Thank you.

SENATOR CODEY: Our next witness will be Mr. Craig Becker, of the New Jersey Hospital Association.

C R A I G B E C K E R: Mr. Chairman, Senator McManimon: With me today is Dr. Dean Kinsey, who is a physician and Director of Medical Affairs at the Memorial Hospital of Burlington County, which has, perhaps, one of the better peer review processes in the State. I asked him to come along today to perhaps give you an overview as to what actually goes on in the hospital.

We have read the SCI Report and, frankly, we think hospitals are not as bad as the report says. But, we are also savvy enough to know that we are not as good as we would certainly like to be. We believe firmly that it is totally appropriate that most of the disciplinary actions against physicians as a direct and effective manner of dealing with these problems, are best taken at the hospital level. Many matters are more rapidly and effectively handled this way. As I said, Dr. Kinsey will discuss this in greater detail.

We have heard the call for reporting prior to Board action, and, frankly, I am sure the Hospital Association will be supportive of that call. However, we would also like to see that coupled with certain immunities because, despite what the

SCI Report says, legal harassment certainly is a question that comes up every time, when it comes up in internal discussions in the Hospital Association.

Some of the specific recommendations we have had-- We have long supported an increase in staffing and funding for the State Board of Medical Examiners. We realize this could booster the effectiveness of the process that already exists, and could also further enhance the Board of Medical Examiners' reputation as one of the toughest disciplinarians of deficient physicians nationwide. We believe the State should not delay further in taking this action.

We have also been instrumental on the Federal level, working with Senator Bradley, on the Health Care Quality Improvement Act, which is legislation which will create a national physician data bank, whereby hospitals could more thoroughly check the credentials and past performance records of physicians applying for staff privileges at our hospitals. This is a particular problem with physicians coming in from out-of-state, where it is not always known of any disciplinary actions that were taken, short of Board of Medical Examiners level.

In addition, we would like to note that anyone who applies for staff privileges at our hospitals must not only be licensed by the State, but must pass the close scrutiny of the hospital medical staff's Credentialing Committee. Mandating the availability of information regarding records not only of out-of-state, but in-state physicians -- expecially for the credentialing review -- we believe is long overdue and would be welcome, and we continue to insist that that would better serve the public interest.

Finally, we have proposed State legislation that will assist the internal physician peer review process, by protecting hospital staff physicians and their minutes from litigation when they voluntarily report about other physicians'

inappropriate behavior. This also includes incompetent performance. We are hopeful that this important legislation will be endorsed, and I think we heard it earlier today.

At this time, I would like to turn it over to Dr. Kinsey, who would like to tell you a little bit about what happens with the internal peer review process in our hospitals.

D R. D E A N K I N S E Y: Mr. Chairman--

SENATOR CODEY: You are going to talk about your hospital?

DR. KINSEY: I am going to describe the process at our hospital, but I think there is certainly a movement around the State, particularly from some of the committees I have dealt with, to say that the quality assurance is being done. I think there has been a major effort to try to improve that process.

Dr. Coye, I think, started this hearing by saying that the State Department of Health looks at process. What we at the hospital level look at is the appropriateness. I think that is what is key. We are at the level to analyze the behavior of physicians. We have quality assurance processes in place. I think it is fair to say that around the State, it may not be at the same level that we have at this point, but I think there has been a serious effort to try to improve that. The Joint Commission mandates that as a condition for licensure, and it is clear to say that they are looking very carefully at the quality assurance process to see that it is taking place, that it is being documented, and that the results of the quality assurance process are being utilized in peer review. Our level of peer review is to be able to influence the staff appointment of a physician, plus beyond that, recommendations to the State Board.

My plea to you, certainly in response to the State Commission's report, would be that we need greater resources to do quality assurance better. Quality assurance is a labor-intensive process. It takes a lot of people to

scrutinize many charts. Beyond that is the computerization effort which I think is needed to be able to collate that data, and to be able to draw that data up so that we can utilize that data in the peer review process. I think hospitals are doing it. I think we are making a major effort to try to do it properly.

One of the problems with peer review, however, becomes what one does with the data. I am a little bit disturbed by the concept that every sanction, or every recommendation in the peer review process be reported. There are certain levels of sanction -- maybe not sanction, but certain recommendations coming out of the peer review process, that need to be handled in a different way. They need to be handled in an educational way. My job as a medical director is to try to influence the behavior -- influence the practice patterns of the physicians in my hospital, hopefully initially by education. If that doesn't work, then hopefully by sanction. I would hope it never has to come out of our hospital, because I would think that patterns of care would be maintained at a high level so we wouldn't have to go beyond that. I certainly think there is a level of incompetence, or a level of deviation from the standard of practice, that needs to be reported, but I don't think that every minor blip needs to be reported. I think that would defeat the purpose of our process, which is to modify behavior, and to improve the standard of care as it is practiced in the individual hospital.

I think we need more resources. I think we need certain recognition that quality assurance is new. We are expanding our capabilities, but we have limited resources in which to expand our capabilities, because it is not being recognized that these are new and important processes that need to be instituted at the hospital level.

I would echo what Craig said. I don't think hospitals are as bad as the report would seem to indicate. I think we

are making a serious and conscious effort to try to improve the standard of care.

SENATOR CODEY: Mr. Becker, would you agree that there is some reluctance on the part of hospitals to report both incompetence and impaired physicians?

MR. BECKER: I don't believe there is a reluctance once it gets to the Board level. In fact, it is statutorily mandated. However, I think there is a reluctance until it has run its course to do so; that is, the process below that, yes.

SENATOR CODEY: Wouldn't it be true that the hospital is leery of upsetting the medical staff?

MR. BECKER: I would suspect that a hospital would be more leery about keeping a bad actor on board and damaging its reputation and its liability standing.

SENATOR CODEY: Well, how many times have hospitals reported practices of both imparied and incompetent physicians to the Board, regardless of any statutory requirement about a "finalized report"?

DR. KINSEY: How often are physicians reported?

SENATOR CODEY: By the hospitals?

DR. KINSEY: By the hospitals? Basically, the statute is that any governing body action is reported, and they clearly are reported.

SENATOR CODEY: No, I am talking about, how many times have they reported? Forget about the strict law requirement in terms of a finalized report. I am talking about on their own initiated action to say, "Hey, here we have someone who is obviously incompetent or impaired, and he should not be practicing, whether it be at our hospital or any other hospital."

DR. KINSEY: It probably is not done to a great extent.

SENATOR CODEY: It probably doesn't exist, am I correct?

DR. KINSEY: I think it occasionally does, but I think what happens is-- Certainly at our hospital, we have a level of sanctioning so that we can control behavior; so that we can provide assurances to the public, certainly, that physicians who are exhibiting patterns of care which may deviate from the standard--

SENATOR CODEY: Yeah, but you may remove him from-- He may not practice at the hospital, but he is still practicing on patients, though. If the Board does not know, no action is taken against him.

DR. KINSEY: We put assurances into our own internal mechanisms, so that we can assure that the practice of medicine as practiced in our hospital is perfectly appropriate.

SENATOR CODEY: But he can then practice at any hospital other than at that hospital, and he is still impaired, and he is still incompetent. No one has reported him. Those patients are still at his mercy.

DR. KINSEY: Any time it requires-- Basically, when it requires a Board action to sanction a person, it is reported. But, short of that, is is probably not.

MR. BECKER: I think that the--

SENATOR McMANIMON: I have a question.

SENATOR CODEY: Senator McManimon?

SENATOR McMANIMON: Is there a level that you classify as a stopgap measure before reporting to the Board?

DR. KINSEY: Pardon me?

SENATOR McMANIMON: Is there a level which you classify as a stopgap measure before it gets to the Board?

DR. KINSEY: We have instituted sanctions for physicians who we felt were not practicing up to standard. We have restricted their level of privileges, or, in some surgical cases, we have required an additional physician to be in the operating room to assist, or we have limited their privileges in terms of the type of privileges that can be performed. We

have picked these things up in our quality assurance process where we have seen a deviation from the standard of care. We initially try to educate, but then sanction.

SENATOR McMANIMON: Once you reach the Board, they are notified then, and they must notify the Medical Board, correct?

DR. KINSEY: That is correct.

SENATOR McMANIMON: That is why I say, is it a standard procedure to have a stopgap measure in order that it doesn't reach your Board?

DR. KINSEY: Yes. There are various levels. We institute actions to control behavior before it ever reaches the Board. Our feeling is that we can assure a certain standard of care in our hospital by instituting action at our level.

SENATOR CODEY: But your action sometimes has the action of protecting the physician and harming the public.

DR. KINSEY: No. In no case is it to protect the physician. It is to assure that the physician--

SENATOR CODEY: Well, if the Board is not informed, then the public cannot be informed. That doctor may be subject to those sanctions within your particular hospital, but not in the other hospitals where he may be on the staff. Nor is he under any sanctions in his office with his patients.

MR. BECKER: That brings us to the problem of reporting among hospitals. This is one problem we would like to see addressed. We have hospitals which, on occasion, have reported to other hospitals that a physician has been sanctioned, and they have been taken into court and subjected to legal harassment. So, we think there needs to be, certainly, something in the legislation that will prevent that.

SENATOR McMANIMON: Have there been cases where doctors have left the hospital because of the fact that there is a possibility the report may have gone to the Board?

DR. KINSEY: It may have occurred. I don't know of any specific case at our hospital.

SENATOR McMANIMON: See, what we are trying to determine here is, are we being subjected to a situation where you have a stopgap measure, and the report doesn't go to the Board? You apply certain disciplinary actions and they, in turn, leave the hospital and go elsewhere, and nobody is even cognizant of the bad report they ordinarily would have if it is allowed to go to the Board.

DR. KINSEY: We are frequently asked about just those circumstances you are describing. Any time a physician applies for staff privileges at a hospital, there is a request for information from any previous hospital with regard to previous sanctions or disciplinary actions, and that information is given in a report to the requesting hospital.

SENATOR McMANIMON: No report of it goes into the private practice, though?

DR. KINSEY: If he goes into private practice and doesn't practice in a hospital, then, no.

SENATOR CODEY: But, once he is on staff, there is no requirement that one hospital which takes sanctions against him informs the other hospitals where he is on staff of this action on some form of incompetency or impairment?

DR. KINSEY: Again, it goes back to the fact that I think we need a uniform standard of quality assurance throughout the State, that would assure that my hospital practices quality assurance the same as any other hospital in the State.

MR. BECKER: And that also this information can be shared with the other hospitals.

SENATOR CODEY: But the sad thing here, is that the hospitals don't feel any moral obligation to inform the other hospitals of a problem with a particular doctor. He is free to practice at other hospitals and, of course, with his patients. Okay. Thank you, gentlemen.

Our next witness will be Mr. Peter Sweetland, President, Medical Inter-Insurance Exchange of New Jersey.

P E T E R S W E E T L A N D: Thank you, Mr. Chairman and Senator McManimon.

As has been stated so far today, the Medical Inter-Insurance Exchange has supported the need for the study which was done, and has cooperated fully with the State Commission of Investigation in their examination of our records. The report is extensive in its scope, but we do believe there are occasional abbreviations of detail, which leave the information subject to misinterpretation. This is much in line with what has been said earlier, but I feel it needs restating. Leaving out some particular facts -- particularly follow-up information -- might water down a particular point the Commission was seeking to make. I would like to refer to a few facts that are of interest, relative to items in the report.

In a number of instances, the horror story, as you described it, was the first example of a problem dealing with a particular physician, and action was taken as soon as those facts were known. The continual reference to settlements of $24,999-- Actually, over our 10-year span, we have averaged less than five of these a year. There are many more at exactly $25,000. We have an obligation to attempt to settle a case for a reasonable, but minimal amount, and in a certain number of cases, that is how it came out. But, this information was brought to the Commission's attention by me. I cited it as an example that whatever dollar value might be placed on a reporting requirement, you are going to have instances where things will come in just underneath.

I do, however, agree with Mr. Maressa's comment that a case of an egregious error would seldom, if ever, settle at this level; that virtually all of the cases warranting concern about incompetence are paid amounts far in excess of this, and have been referred to the Board of Medical Examiners.

In one other example in the report, there is a citation of a particular physician with 194 suits. Now, that is horrifying. The fact of the matter is, virtually all of those cases were presented as a result of one situation. The physician, some dozen years ago, prescribed a particular antibiotic that yellowed children's teeth, and an individual lawyer accumulated a great number of these cases and presented them. But they are all over a dozen years old. That particular physician is still insured by us, and does not present an abnormal suit picture at all.

Now, don't get me wrong. We certainly agree that there are incompetent doctors who deserve restrictive attention, and we want to cooperate in singling them out. We strongly support the recommendation in the report that we be obliged to report all cancellations and surcharge qualifications to the Board of Medical Examiners. This actually is a recommendation that our company made over three years ago, when we participated in the Insurance Commissioner's Task Force on Malpractice. We need immunity from civil action in making that report. We need a legislative requirement. That is why when you undoubtedly ask us, how many times have we reported a case directly to the Board of Medical Examiners? -- we will tell you there were few, if any. But, given immunity, we are quite interested in doing it; quite interested in cooperating in a better coordination of the information that is available.

As far as individual loss reporting -- I made reference to the size of loss requirement -- starting at the end of this year, the previously referenced Federal Health Care Quality Improvement Act of 1986 will require all malpractice insurers to report every paid loss to a Federal clearing house. We recommend that the State require that the same information be reported to the Board of Medical Examiners -- all paid losses.

The reporting of open cases -- as the SCI Report suggests -- presents a different problem. The significant majority of the cases presented are without merit. If the Board of Medical Examiners starts adding and reviewing all allegations of professional liability, I think it will produce a confused and incorrect view of given physicians' actual backgrounds.

Now, the final thing I have to say is by far the most important point I want to make. We are really alarmed to see that the report has led a large number of people and, apparently, based on your prior statements, including yourselves, to believe that the small number of identifiable impaired or incompetent physicians are the major cause of New Jersey's malpractice insurance problem. That is not so. I am not just talking about a personal opinion. The facts bear out that, for example, impaired physicians present a less-than-average exposure to malpractice actions. The report itself cites that only 2% of the physicians involved in the Impaired Physician Program had significant lawsuit involvement. This is borne out by an outside study -- several outside studies -- the most recent of which is being completed now by a researcher at the Rand Corporation, using New Jersey data. He also states that the incidence of malpractice actions against impaired physicians is less than average.

Now, incompetent physicians. We can spend a lot of time trying to define and compare incompetence versus negligence. We find that repeaters, in terms of payment of loss, are a small portion of the total losses paid out by our company. Believe me, if we could identify a small number of doctors to get rid of, and solve the malpractice problem, we would have done it years ago. I have been at this 27 years. It comes up constantly. Let's zero in on the repeaters, get rid of them, and we will solve it. That is not the case. The bulk of the losses are against good doctors who are definitely

having problems which, in many cases, can be prevented. But they are not the same person every time. They are not people you would categorize as incompetent.

Now, we are working hard to prevent the losses of the average physician, and not just zeroing in on those who you may be categorizing as incompetent, and we think we are having an impact. Actually, over the last several years, the incidence of suits against physicians -- per physician insured -- has gone down. We are making progress in preventing loss. We want to cooperate in this particular area of eliminating those most severe examples from the practice of medicine.

Thank you for having me here.

SENATOR CODEY: Senator McManimon?

SENATOR McMANIMON: On that last remark of yours, you said suits have gone down over the last several years. Why have insurance rates increased so drastically?

MR. SWEETLAND: Because the average size of the loss is going up at a much more rapid rate. There were no million-dollar jury verdicts in New Jersey until 1984. In the last two years, there has been one a month. That is what is driving the rates.

SENATOR McMANIMON: One a month.

SENATOR CODEY: Thank you very much, Mr. Sweetland.

SENATOR McMANIMON: Very good.

SENATOR CODEY: Our next witness will be Dr. Lomazow, of MEDICAL.

D R. S T E P H E N L O M A Z O W: Mr. Chairman, Senator McManimon, thank you for permitting me to testify. My name is Dr. Stephen Lomazow. I have been practicing neurology in New Jersey for the last seven years. Some of you know me as cochairman and founder of an organization called MEDICAL, an organization of health care providers concerned with the rights of physicians and their ability to deliver quality health care.

I testify today as both a practicing physician and an advocate speaking in the public interest. With respect to the findings of the SCI, it is evident, first of all, that there should be mechanisms for the reporting of impaired health care providers to the appropriate authorities. The identity of those providing information to those authorities should be protected with the utmost confidentiality, and they should be protected from civil liability. Without being extremely specific, I can tell you from personal experience, that there is potential for great financial and emotional stress here. I will speak to my particular case, and if you have any specific questions--

There is some talk about whistle-blowers. Well, it is an ugly term, but I guess you could characterize me in the past as being a whistle blower. I can also cite the case of a surgeon in Newark, who was held personally liable for over $500,000 for reporting the supposed, or alleged malpractice of an anaesthesiologist he worked with. This received tremendous publicity. While I am not entirely aware of the total outcome of the case, you can clearly see how this had a tremendous effect upon this man's personal and professional life.

Also, the ability of the authorities to determine the veracity and the sincerity of any allegation should be expanded, and any subsequent hearings need likewise to be conducted confidentially to protect the rights of all concerned. Previously, Senator, you asked whether any investigation should be made public. I can only cite an analogy to a legislator who was investigated for certain improprieties, who was subsequently found to be quite innocent of those charges. He suffered tremendous personal and professional hardship in that regard, to the point where I believe the Senate walked out the other day in his support. So, there is a potential there for problems. I would respect the confidentiality of all investigations.

While it is clear that the aforementioned mechanisms need to be in place, I must caution that the degree of public attention given to the SCI findings and, indeed, these proceedings, is potentially quite harmful, in that, first of all, there will be an erosion -- and there is an erosion -- of the overall public confidence in the medical profession. A strong doctor-patient relationship needs to be maintained, in order to deliver quality health care. If a health care provider does not have the respect of his patients, his medical advice will not be followed. Now, perhaps there is only a small incidence of impaired physicians, but this carries through to the medical profession in general.

Secondly, I am concerned about the quality of medicine in New Jersey itself. I would not like New Jersey to be labeled as a State in which it is undesirable to practice medicine. Recently, the Massachusetts State Medical Society, for reasons, some allied to this, and some not allied to this, passed a resolution stating that Massachusetts is an unfavorable place to practice medicine. Doctors are leaving that state in droves. I would hate that to happen to New Jersey as an upshot of any particular investigation here.

We live within the shadows of New York and Pennsylvania in this State, and many patients go "across the river" for their medical care. We need to promote pride and confidence in the quality of New Jersey medicine, and attract more quality physicians to this State. So far, the publicity surrounding this report and investigation has not fostered this. The medical profession is one of high intellect, high visibility, high intensity, and high stress. Doctors, though, are subject to the same ethical and moral indiscretions which face any group of individuals. All in all, as has been testified many times, the vast majority have, in the past, functioned, and continue to function, competently and ethically, despite an increasingly restrictive and stressful professional environment.

While I am generally in agreement with the thrust of the SCI Report, I hope that any reforms can be legislated without further sacrifice to the public image and good will of an honorable profession.

Thank you.

SENATOR CODEY: Thank you, Doctor. Any questions? (no response) Thank you very much, Doctor.

Our next witness will be Nancy Becker, representing the Association of Trial Lawyers of America, New Jersey Chapter. By the way, Trial Lawyers of America-- Does that mean you represent Mr. Stern?

N A N C Y B E C K E R: I don't know if he is a member of ATLA, but--

Good afternoon, Mr. Chairman, Senator McManimon. Alan Medvin, who is the past President of the Association of Trial Lawyers, prepared this testimony. He expected to be here today but, unfortunately, his court appearance which was supposed to have occurred yesterday, was postponed until today.

"The New Jersey affiliate of the Association of Trial Lawyers of America totally concurs in the conclusions, and enthusiastically supports, the recommendations of the SCI with respect to impaired and incompetent physicians. The conclusions of the SCI did not come as a surprise to any attorney who regularly engages in representing victims of alleged medical negligence. In our practices, we have seen flagrant examples of both incompetent and impaired physicians. On the other hand, we readily acknowledge the fact that even the finest physician may, at any given instant, deviate from accepted standards of medical care with respect to his treatment of a particular patient.

"As has been stated on numerous occasions by New Jersey Insurance Commissioner, Ken Merin, the primary problem with respect to the rising cost of medical malpractice insurance is medical malpractice itself. Because the

conclusions and recommendations of the SCI are ultimately directed to the improvement of patient care, we would enthusiastically support any legislation which attempts to implement those recommendations. We agree that significant steps should be undertaken to help improve identification of problem professionals. Thus, we agree with the recommendations concerning the amendment of various provisions of Title 45 of the New Jersey Statutes.

"In addition, steps must be taken to encourage both physicians and attorneys to report to the BME, physicians who apparently have acted in an incompetent or an impaired manner, as reflected in information discovered during the pendency of a medical negligence case. Most attorneys regularly involved in representing patients in medical negligence actions, can determine which doctors may have been merely negligent, as opposed to those defendant physicians who appear to be incompetent. Thus, attorneys should be encouraged to report to the BME cases in which evidence of incompetency exist, along with all supporting documentary materials.

"We strongly agree with the conclusion of the SCI, that hospitals must take a much more active role in dealing with imparied and incompetent physicians. The law as proposed by the SCI to encourage hospitals to take this action should be enacted as soon as possible. In addition, we propose that a statute be enacted that would mandate that the name of each and every physician who renders any medical service to a patient during a hospital confinement be identified in a clearly legible form, on a separate record to be contained in the patient's hospital chart. In addition to the names of these physicians, they should be identified as to whether they are attending physicians, residents, or interns.

"It is obvious that for any of the proposals as recommended to be effective, the BME must be strengthened with significant additional funding, so as to allow the Board to

expand its staff and to improve its technology. All of the Commission recommendations would be for naught if, because of inadequate resources, the Board of Medical Examiners could not achieve its mandate.

"Perhaps most importantly, however, is that significant steps must be undertaken to break through the conspiracy of silence that now exists with respect to policing of the medical profession by its own members. There is no doubt that this conspiracy is as strong as it ever was, perhaps due to the feeling of, 'There but for the grace of God go I,' or because of a fear of ostracism by one's colleagues. Perhaps it is simply feelings of collegiality that have prevented doctors from adequately policing their own. Whatever the reason is, it is up to the New Jersey Medical Society, county medical societies, hospitals, and insurance carriers to encourage physicians to take a greater role in the reporting of impaired and incompetent physicians.

"Doctors must be educated that they have a financial interest in cleansing the profession of these practitioners, to say nothing of both a moral and professional obligation to do so. A significant reduction in, and eventual elimination of, incompetent and impaired physicians, would have a tremendous impact on the quality of medical care available in this State. As a result of this improvement, the frequency of medical negligent cases would certainly decrease, leading to an eventual decrease in medical negligence insurance premiums. This would be accomplished without any legislation that would have an adverse impact on the rights of the injured patients. Until such steps are taken, and are evaluated, it is clear that the tort system, which continues to be the single greatest deterrent to bad medicine, be left intact."

SENATOR CODEY: Thank you very much. Our next witness will be Dr. Ira Sweet.

D R. I R A S W E E T: My name is Dr. Ira Sweet. I am a school psychologist. I probably would not be here today if I were not on medical leave, and I would probably not be here today if I didn't receive proper and decent care from my physicians. I would like to thank you for allowing me to speak on behalf of the consumers of medical services. I appreciate the fact that you called for these hearings.

As an advocate for the consumers of medical services, I have been dealing with the Board of Medical Examiners for the past two years, as well as in 1977 and 1978. I must admit to you today, that this has been a most frustrating experience. I guess the good Lord was with me today, because in today's Asbury Park Press, which I gave to Ms. Seel (Committee Aide), there is a three-page article on my experiences with the medical profession. I think that would be enough for your records.

For eight months, I corresponded with the Board to be allowed to address them at a monthly public meeting. My requests were denied. Finally, on May 21, 1987, I went to a Board meeting with 13 senior citizens, and made an attempt to address the Board, without being invited. I was almost arrested.

At that time, I had prepared a three-page statement, and I would like just to read the closing paragraph to you: We are asking for humane medical care, in which the patient is able to maintain his own self-respect and dignity. I charge this Board with the responsibility of acting on the concerns I have presented. If you don't have the time, then I ask you to resign. If you don't have the legal authority, then I ask you to get it. If you don't have the moral and ethical courage, then I feel sorry for you, but more sorry for the consumers of medical services in New Jersey.

I know this Committee is mainly concerned with drug- and alcohol-impaired physicians, but I would sincerely hope

that this Committee would expand its horizons to include the incompetent physicians, who are being protected by a conspiracy of silence. I will document to you-- I will prove that to you today.

This was noted by your State Commission of Investigation. May I just refer you to an article in The New York Times a year and a half ago, in which they said 28,000 doctors are feared unfit. I will just read the first paragraph: "Across the United States, as many as 28,000 people may be practicing and treating tens of thousands of patients each year, each though they do not hold physicians' licenses and, in many cases, have little, or no, medical training, state licensing officials report." So when I hear today how wonderful the medical profession is, I refer you to this New York Times article.

Let me expand upon this situation to demonstrate how New Jersey itself, by its very laws, fosters this situation. In our State, as well as in other states, a physician can practice in any specialty he desires, which includes surgery, psychiatry, neurology, internal medicine, without the requirement of any postdoctoral training. This means that once they have finished their general internships, physicians can hang up their shingles and practice as specialists. They do not have to be either board certified or board eligible.

It should be noted that the Department of Hospitals (sic) has no regulations regarding this situation. Therefore, each hospital sets its own standard as to the credentials required for specialists. Because of this situation, the consumers of medical services might know more about what is going into a can of tomato soup than what goes on in the training of a specialist. Therefore, we have lots of so-called specialists practicing in New Jersey, with limited education and training. The Board of Medical Examiners knows of this situation, and refuses to take any action. Perhaps they are

protecting their own self-interest, as a number of Board members hold themselves out as being specialists, without being board certified.

I think of the song, "Where Have All the Flowers Gone?" which goes on to say that they are "blowing in the wind, my friend; they are blowing in the wind." I would just paraphrase this, and say, "Where have all the general practitioners gone?" I am afraid, my friend, they have changed their name to specialists.

Let me expand on this to demonstrate how the Board of Medical Examiners has been derelict in its responsibilities. About three years ago, I filed a complaint against a physician. Let me just state, when you file a complaint against a physician, you don't know where to go. Do you go to the hospital? Do you go to the local medical board? Do you go to the State Medical Board, or do you go to the Medical Society? The consumer really doesn't know where to go to file a complaint.

I went to the Medical Board of Examiners, and it was a big mistake. I must tell you, I felt like I was on trial, trying to find out what was happening. Finally, I wrote a letter to the Executive Director of the Medical Board. I would just like to read the last sentence. I asked him: "What is the complaint process? What do you do? What do you want? What do you do to file a complaint?" He said to me, "Please be advised that the Board does not have any rules addressed to its complaint handling process." This is from the Board of Medical Examiners.

Finally, the Attorney General got me to address the Board on April 17, 1987. I got a letter from Judith S. Bailey, Deputy Director of Consumer Affairs. Let me just read this letter briefly: "As of your meeting April 29 with the Executive Committee of the Medical Board, which I attended, you requested information on the guidelines for filing complaints." Gentlemen, she sent me a three-page guideline for

complaints, that was issued by the Director of the Division of Consumer Affairs, that all professional boards were supposed to follow, and the Medical Board told me they had no complaint process. They just throw this away, and do what they want.

I would like to give you another illustration as to what has taken place in this State. At the request of the Attorney General's office, the Executive Board of the Board of Medical Examiners requested to meet with me on April 29, 1987, to hear my concerns. On June 22, I received a two-page letter from the then President of the Board, stating how he would deal with my concerns. He said he would send some of my concerns to the Corporate Practice Committee of the Board of Medical Examiners, and some of my concerns to the Director of the Division of Consumer Affairs.

Subsequently, I contacted the Chairman of the Corporate Practice Committee, and I received a response on September 25. It is from Dr. Ambrose, and it reads: "Thank you for the copy of the June 22 letter from Dr. Wilford (phonetic spelling) to you. I have never seen this before, and I am quite frankly surprised over the matter of referrals to the Board's Corporate Practice Committee. I will clarify these references with Dr. Luca."

They lied to me. My concerns were never sent to the Corporate Practice Committee, and my concerns were never sent to the Director of the Division of Consumer Affairs. Subsequently, Mr. Chairman, I contacted-- I will be with you in one second, okay? (witness peruses his papers) It was my firm feeling that the Board of Medical Examiners was not cooperating with me in good faith. I wrote to the Director of the Division of Consumer Affairs -- five letters -- and I sat today and listened to Mr. Barry talk. I was going to explode. I sent him five letters over a six-month period, requesting an investigation of the Board of Medical Examiners. Each letter was sent registered mail, return receipt requested. I have yet

to receive any written correspondence from the Director, even after the Division of Citizen Complaints and Assemblyman Robert Singer specifically directed him to respond to me.

Out of sheer frustration, my friends, I sent the following letter to the editor of the Asbury Park Press, and I would like to read it to you. It says: "New Jersey Doctors Escape Scrutiny. It is with interest that I read that a State Commission has urged reform within the medical profession in New Jersey. I have been asking for these reforms for the past two years. Last year, I almost got arrested when I attempted to read a prepared statement before the Board of Medical Examiners. They refused to allow anyone to address them. Six months ago, I requested that Director of the Division of Consumer Affairs Barry investigate the practices of the Board of Medical Examiners. I have claimed that the Board is more interested in protecting the practices of physicians, than the consumer of medical services. I have yet to hear from Mr. Barry, even after calling him a number of times, having Assemblyman Singer contact him, as well as the Division of Citizen Complaints.

"It must be clear to the reader that there appears to be a fear on the part of State agencies to deal with the medical profession in New Jersey. Have no fear that I will end my crusade against the medical profession in New Jersey. I have discovered a vein of gold in these parts, at the expense of the consumers of medical services. They must also have friends in high places who will continue to protect their self-interest."

I would like to refer to a recent editorial in the Asbury Park Press, entitled: "Medical Examiners Need Tools to Do a Better Job." I would have preferred to have entitled that editorial, "Does the Board of Medical Examiners Have the Courage to Do a Better Job?" The last paragraph in that article refers to you gentlemen. It says: "In other words,

neither the medical examiners nor the SCI nor Codey's Commission were surprised by the latest findings. All have understood the state of things for some time. That leaves one question: Why is the Legislature waiting to ensure that the medical examiners have the authority, the staff, and the resources to do a better job of protecting patients? I hope Codey's hearings later this month can focus on acting on some solutions, instead of confining themselves to superfluous hand wringing."

Mr. Chairman, you and your Committee are entering a heavily laid minefield. The most powerful lobby in this country -- the medical profession -- will oppose you every step of the way. You are dealing with an illegal monopoly, which behaves no differently than a public utility. However, they are not seriously governed by State regulations. The public has nowhere else to go but to physicians when they are ill. The medical profession certainly doesn't operate on the law of supply and demand. In my opinion, they have engaged in a conspiracy to fix prices, and there is absolutely nothing anyone can do about it.

In closing, I would like to paraphrase remarks made by Dr. Albert Sabin. He said: "The medical profession today has lost the essential components of human compassion, and a new way of delivering health care is needed. Medical care must not become a business for profit, and I deplore the increased commercialization of health care."

I am reminded of the famous scene in the movie, "Executive Suite," when an employee said, "I'm mad, and I am going to do something about it." We, the consumers of medical services, are mad, and we are going to do something about it. This is only the beginning.

Thank you.

SENATOR CODEY: Thank you, Dr. Sweet. That concludes our hearing.

(HEARING CONCLUDED)