PUBLIC HEARING

before

SENATE JUDICIARY COMMITTEE

on

MEDICAL MALPRACTICE REFORM

June 20, 1985
Room 400
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator John A. Lynch, Chairman
Senator John F. Russo, Vice Chairman
Senator Joseph A. Hirkala
Senator Edward T. O'Connor
Senator Carmen A. Orechio
Senator Donald T. DiFrancesco
Senator William L. Gormley
Senator Lee B. Laskin

ALSO PRESENT:

John J. Tumulty
Aide, Senate Judiciary Committee

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SENATOR JOHN A. LYNCH (Chairman): All right, we are going to get started on the hearing portion of the agenda today.

We have some nominations, and as soon as we have a quorum (greets Judge McElroy) we will take those up for a very brief period of time.

The agenda has been called a medical malpractice hearing, and there are several bills that have been listed. We are not limiting the discussion, however, to the bills that have been listed here today. If you want to discuss other bills or concepts, or other areas of concern in the medical malpractice area, we would be glad to hear those. What we are really doing is holding an informational session. We want to hear as much information as possible on both sides of the issue, or on all sides, whatever that happens to be; and to try to educate our committee as to the length and breadth of the problem that exists so we can make a legitimate determination, at some point in time, whether there should be a legislative response.

There will be no bills released today. Obviously, there are going to have to be several hearings conducted in this regard before we can get a decent handle on the nature and extent of the problem and whether or not there is a need or, indeed, an opportunity for legislative response. I suspect those will take place beginning in September. So why don't we get on with the witness list and get about the subject matter?

The first witness listed on our agenda is Howard Weiss, Vice-President of the New Jersey Medical Inter-Insurance Exchange (MIX). Mr. Weiss?

HOWARD P. WEISS: The impending crisis in the professional liability insurance market here in New Jersey is applicable to the physicians, but it is also applicable to a lot of other professions in New Jersey. We read about the dentists who are having 400% increases in their malpractice insurance this year. We read about attorneys having anywhere between 120% and 450% rate increases. But the real problems, I believe, start with physicians. They are the ones who are in the forefront. They are the ones that have seen their premiums go up over the years, starting in the mid 1970s when the initial crisis took place.

In response to this crisis, the physicians in New Jersey formed their own insurance company in 1977, the Medical Inter-Insurance Exchange of New Jersey, which took a unique approach to the administration of malpractice claims in New Jersey. It cut administrative costs in handling malpractice insurance from 35% to 8%. In addition, it cut the costs associated with defending claims from about $10,000 a case to about $3,500 a case.

Because of this, we were able to keep premiums stable from 1977 through 1981; and in effect, a physician in the State of New Jersey was paying only 98% in 1981 of what he was paying in 1977 for medical liability insurance, on average.

In addition, in our very first year -- 1977 -- we showed in 1981 a $10 million profit, of which we decided to give back $5.1 million to the physicians in the form of a 20% dividend. At the same time we were keeping rates stable, the physicians in New Jersey were getting money into the hands of the truly injured party three times faster than before our company was in existence. The average time it took to settle a claim with an indemnity payment was about 12 months, compared to the national average of somewhere between 30 and 36 months.

This was a pretty enviable record considering the environment in the 1970s. But since 1981, things have really deteriorated. Premiums in New Jersey have risen 62% in the last four years, and 41% in the past two years. This is despite the same dedication to keeping expenses low, and the same dedication to keeping the costs associated with defending cases at a minimum.

We have not been able to pay a dividend in any other year since the one we paid on 1977. And, the additional $5 million that we had kept in 1977 as a profit to permit us to pay another dividend when that year got more mature, has now all but disappeared. Sixty percent of that -- over 60% -- has disappeared.

The cause of these high premiums are basically two-fold. Number one, frequency, the number of claims is up; and number two, the average cost of settlements is up. In 1977, one out of every -- one claim for every five physicians in New Jersey could be expected. Now, that number is better than one for every three physicians.

The frequency and cost of claims rising is not an aberration. It's an underlying trend that we see year after year after year. Currently, physicians in New Jersey pay $9,000 a year for medical malpractice insurance, and the average surgeon in New Jersey pays $21,000, with some surgeons paying over $30,000. In neighboring New York State, two to three years ago, the average physician paid $9,000; the average surgeon $20,000. Now, the averages in New York are $21,000 for the average physician and $55,000 for the average surgeon, with some surgeons paying $85,000 to $101,000.

Rising premiums and frequency of claims has really affected every area of the physician's practice:

--higher fees, which get passed on to patients; more tests and treatments to protect themselves. Each contribute to the higher cost of health care in New Jersey, and higher health care premiums for everybody;

--a complete breakdown of the physician/patient relationship and mistrust between the patient and the physician in terms of how the patient is being treated and whether the doctor is going to be sued;

--retirement of part-time doctors who would like to remain in practice but cannot afford the premiums to remain in a part-time practice;

--doctors moving out of state;

--and abandonment of high-risk specialties and procedures.

In 1982, we were asked to create a category for obstetricians/gynecologists who wanted to abandon obstetrics and do gynecology only. We have now seen 28 physicians in our own state abandon the practice of obstetrics and do gynecology only.

We realize that the solutions to the medical malpractice problems in New Jersey encompass a number of areas; the policing of physicians who practice bad medicine; loss prevention programs that get information into the hands of our insured, informing them what kind of mistakes they are making and how to prevent them; and relief from the inequities of the tort system as it now stands.

We believe that the set of personal injury and malpractice bills that has now been proposed provides equitable solutions for all

involved. They will help reduce the frequency of non-meritorious cases while having virtually no effect on meritorious cases. In addition, they will reduce the per-claim costs without depriving any injured party of deserved damages.

The two out of every three--

SENATOR LYNCH: Would you be more specific on what bills you are talking about that are going to produce that--

MR. WEISS: Yes, absolutely...

SENATOR LYNCH: --and where you see the inequities in the tort system.

MR. WEISS: Two out of ever three claims that come to us are non-meritorious. Four out of five are found non-meritorious in court. Fifty-eight percent of our expense dollars are spent on cases that end up not being paid. Only 42% of our expense dollars get spent on getting money into the hands of the really injured parties. If we could just cut down on the number of non-meritorious cases, we could spend more time getting money into the hands of the truly injured. The certificate of merit bill will help us do that.

Right now, the plaintiffs' attorneys have far too long in which to find expert witnesses, and we drag cases on for two, three, even four years, with meters running on defense counsel and staff time spent; and the case ultimately gets dropped. We believe that having a set time period to produce an expert witness will help cut down on non-meritorious cases. In addition, better defining what an expert is will certainly help in getting rid of frivolous cases that are fraught with experts that are not really experts.

The statue of limitations bill, on which we support a three-year limit -- We have done studies that show that when claims are filed even as late as two years after the date of incident, they have a likelihood of 30% less chance of being a meritorious claim. In addition, physicians who are put under the pressure of defending actions years and years prior are under pressure of, number one, probably having insufficient limits for rewards that are going to be made in terms of today's economic standards versus insurance policies that were bought years ago; and in addition, being judged on standards

of today, rather than standards that existed when the incident happened.

Certainly, we support the collateral source, periodic payments bills and the capital and damages as methods for reducing the average cost of settlements. The collateral source bill would eliminate duplicate recovery of damages on the part of plaintiffs. The periodic bill would allow that future damages be paid for they are when incurred; and would allow the recovery of damages that are no longer necessary.

The cap bill would help protect against catastrophic loss and would help provide a much more stable reinsurance environment. The cap bill certainly has exceptions for willful misconduct, actual malice, and for commission of crime. We, in no way, shape or form, think there should be any protection for anybody under those circumstances.

We believe that, taken as a whole, these reforms to this tort system are equitable -- and we are looking forward to working with all interested parties, the Legislature, the attorneys, the midwives, the Governor's office, the insurance commissioner -- and coming up with a comprehensive, real solution to this problem. Thank you very much.

SENATOR LYNCH: Does anybody have any questions? You started out by trying to indicate that medical malpractice is different than other areas of concern we have in insurance cost increases today. How do you distinguish the concerns that you have from those that are existent with the lawyers, engineers, architects, dram shop keepers, local government units, all of whom are experiencing two, three, and four-fold increases in insurance over the last two years?

MR. WEISS: I don't think there is any difference. The only thing that I was suggesting was that the physicians are really in the forefront because they got hit earliest, and their premiums are highest--

SENATOR LYNCH: I was going to suggest that as a percentage of a health care dollar, that the malpractice insurance premiums are rather small when you compare those, for instance, to the dram shop keeper or the architect or even the lawyer.

MR. WEISS: Right. I don't think anybody can even suggest that when an average surgeon in New Jersey is paying over $20,000 a year for malpractice insurance, that that's an insignificant part of--

SENATOR LYNCH: Doesn't it depend on what the surgeon is making, and what that represents as a percentage of his business, or her business?

MR. WEISS: I don't believe the average surgeon in New Jersey is making a million dollars a year. I believe that paying $21,000, on its way to maybe $50,000, $60,000 or more, presents a real problem for the physician.

SENATOR LYNCH: Do you think you are going to have a problem finding obstetricians in New Jersey?

MR. WEISS: I think you will. I don't think you have today, but I think if the trend continues, and I think it will continue based on the underlying phenomenon, that you will have problems finding obstretricians, you will have problems finding neurosurgeons, and I think you'll have problems finding orthopedists. I think you'll see all of that right here in New Jersey.

SENATOR LYNCH: There is some information that has been submitted to this committee that would indicate that in 1983, the average American spent approximately $1,500 in health care costs. Of this, only $6.08 went to pay medical malpractice premiums. Do you have any statistical data on that?

MR. WEISS: I don't, personally, no--

SENATOR LYNCH: Does that sound familiar?

MR. WEISS: No, I have never heard that.

SENATOR LYNCH: If those were the facts, would that represent a rather insignificant portion of the health care dollar?

MR. WEISS: I would not say that, at the current time, medical malpractice premiums make up an overwhelming majority of the cost of health care. I think it contributed to it. I think it is the fastest-growing contributor.

If you compare the rise in malpractice premiums to the rise in the cost of health care, you'll find out that it is rising at 22%, I believe, faster than the cost of health care, and it is becoming a

larger and larger percentage of the cost of health care in this country.

And that is not even counting what the AMA points to as somewhere between $15 billion and $40 billion spent on extra tests and treatments that physicians feel obligated to do to protect themselves against the threat of suit.

SENATOR LYNCH: I am sure that a lot of us sympathize with the physicians and the problems that they are having. I think one of the questions that's ultimately going to have to be answered is whether or not there are to be adjustments and reform or reaction, whatever you want to call it, by way of legislation, and whether or not that can be translated into a savings on the health care dollar.

MR. WEISS: Agreed.

SENATOR LYNCH: Do you project that would happen if some of these bills were passed?

MR. WEISS: All I can say as a representative of the Medical Intra-Insurance Exchange--

SENATOR LYNCH: If you do, then how would you guarantee that that would happen? How would it be structured so that the consumer, the public taxpayer, the rate payer, the insurance premium payer, whatever, is benefitted by the adjustments that were made in the health practices insurance law?

MR. WEISS: I can't speak for the physicians. I can speak for the insurance company, and certainly the insurance company will take anything, any changes in the tort system into account when we make our premiums. When we pass--

SENATOR LYNCH: Usually, it is the other way. That is the case of the general liability law for local governments, when they just raised them 400, 500, 600 percent this year on the basis of one case, without any risk experience to demonstrate the need for it.

MR. WEISS: All our rates are made, basically, on real experience. We certainly would take into account whatever changes in the tort system happen into our rate making calculations, and pass the rate savings, if there are any, on to the physicians. I can't tell you right now -- I'm not a representative of a medical society or organized

medicine -- so I can't tell you what the physicians would then do. I assume that the physicians would be willing to show some good faith, but I can't say that for sure.

SENATOR LYNCH: Any questions? Senator Gormley?

SENATOR WILLIAM L. GORMLEY: Has there been any discussion of what mechanism would be able to indicate that good faith?

In other words, the primary public concern, as indicated by Senator Lynch, is the health care dollar. And that is obviously the motivating factor behind these bills, I assume, because of the cost of the insurance rates. Our question is, what vehicle has been discussed? Has there been a vehicle discussed without the need for good faith, so that while we are going through this agenda, concurrently with that, there would be something to protect the health dollar?
Has there been any discussion about that at all?

MR. WEISS: I am not aware of any of it. Certainly we would undertake to assure this committee that there was some legitimate mechanism for making sure that the health care dollar was protected.

SENATOR GORMLEY: You have the one bill that specifically addresses the question of structured settlements.

MR. WEISS: Correct.

SENATOR GORMLEY: It is my feeling that when somebody wins an award, one way or the other, that person is entitled to that money at that time. What is the basis for saying that you have to require a structured settlement, that they have to accept it in a structured manner? Why would you say that?

MR. WEISS: The basis of the argument is that when an award consists of a large amount of damages that are going to occur in the future, that an estimate is made of those damages in terms of a number of things: the lost wages, the medical bills that are going to be necessary, the pain and suffering that will occur in the future. What we are saying is, if we can pay for those damages when they occur in the future, by a structure, then when certain damages are no longer necessary -- like maybe there is no longer a need for medical treatment -- then that money would not become -- would revert back to the insurance company. Right now, if we are forced to settle future damages, even if they are discounted--

SENATOR GORMLEY: They are discounted.

MR. WEISS: But that it still includes maybe 20 or 30 year's worth of medical treatment that may not be necessary.

SENATOR GORMLEY: So you are saying, the person would be awarded a certain amount but they would have to prove every year after that that they could keep their award.

MR. WEISS: No, they wouldn't have to go through--

SENATOR GORMLEY: Because that would allow a challenge every year after that.

MR. WEISS: We're not saying there should be the right of challenge. What we're saying is that we would structure future awards so that we would pay so much a month for this, so much a month for this, so much a month for this; and then when something was no longer necessary, we wouldn't have to pay for it anymore.

SENATOR GORMLEY: Has a tax counsel reviewed this mandatory requirement? Has a tax attorney or specialist in tax reviewed the tax ramifications on requiring all settlements to be structured?

MR. WEISS: I can't answer that. I don't know.

SENATOR GORMLEY: I think that would be something that you would want to look into, because it significantly changes the impact on the recipient of the award; and one of the things that have been very delicately handled when structured settlements are set up are tax ramifications; and that's a question that would have to be looked at.

MR. WEISS: Sure.

SENATOR LYNCH: Any other questions? Thank you very much.

MR. WEISS: Thank you.

SENATOR LYNCH: We will have a quorum in about five minutes, so we can get on with the interviews of our nominees.

Second on this list is Thomas Vesper, Esquire, from LEGAL. Good morning.

THOMAS VESPER: Good morning, Mr. Chairman and Senators, members of this committee.

If I may, I would like to stand and address this committee as I would a court; and the oath that I would give is that if I fulfill this representation that I will make to the court, do not violate it,

may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; or if I transgress it and swear falsely, may the opposite of this be true. That's a sixth century oath; I think it's familiar to the doctors.

This is not a fight between lawyers and doctors. My name is Tom Vesper; I'm a trial lawyer from Atlantic County. I represent LEGAL, Lawyers Encouraging Government And Legislation. But I'm speaking here not only on behalf of lawyers, I'm speaking on behalf of some people who I want to introduce you to.

In one case, the young boy who could not be here today-- He is 16 years old, and three or four times a year for the rest of his life, he must have this 22-gauge sound placed in his urethra, and he must be dilated, or dilatated, as the doctors say, for the rest of his life because of a urethral stricture. And the judge in that case very fairly estimated, along with a settlement panel, that not the economic loss,

but the real effect -- psychological and emotional on a young boy who is going through maturity, puberty -- is $600,000, not $100,000.

There is a woman in Lake Shore Convalescent Home. This woman is in her 50s. She never married; she cared for her mother. Her mother is in another nursing institution. This woman was struck down from behind as a pedestrian, and since 1981, has been in a semi-comatose state, in and out. All she can do is open her eyes -- open and close. And she can listen to things.

Now, the therapy that is given to her is reasonable and necessary, and it is minimal. And it is provided with the empty spoon that we have given to claimants under the No-Fault Act. She gets all her medical expenses paid, and the therapy that is given to her every morning is, she listens to music and a seashell similar to this (gestures) is held to her ear so that she can listen to the sound of the ocean. That woman, thanks to the efforts of my partner and our firm, has recovered a half a million dollars and is now, thanks to the efforts of her legal guardian, able to go to the seashore, to a specially-equipped home, so that she can not only listen to it, but so that she can see, and perhaps feel on her face, the ocean.

In Cumberland County, and I see my friend from Cumberland County, Mr. Hurley, there is a man who had an accident, and because there was a $100,000 policy limit, only recovered $100,000. That man is 21 years old; he is in a wheelchair for the rest of his life. I don't know of too many people, including Senator Hurley, that would say to him, that the non-economic loss he has suffered, the loss of his dream to become a motorcycle cross-country racer, is only worth $100,000.

And there are two other examples of people, and I will be very brief; and I make that representation because I know there are other matters that this committee has.

I will only address two bills. LEGAL's position is that we oppose all bills, but to avoid repetition, and in order not to burden this committee, because you have other matters and other people to hear, I'm only going to address two of the bills: the expert bill and the statute of limitations.

But let me give you two other examples of people who are so seriously injured, and the effect on their lives which is euphemistically called non-economic, was this: One young man in the Coast Guard, 19 years old, because the driver of his vehicle was served and the driver was underage, was paralyzed from the neck down. I told that young man a year ago what he could expect to recover in this case was the limit, the policy limit for that dram shop, which was $500,000 plus the $15,000 for the vehicle. So that young man knew that he had all this money coming to him, and a month ago, he shot himself.

There is another example, and it involves Social Security and worker's comp, of a man who worked all his life with his hand. It was taken off. He developed a condition called cholecystalgia -- very, very painful. When this man used to come to my office, I used to watch him cry. He also killed himself.

These people of whom I speak could not be here today. I would not embarrass them by naming them. But these are the people that we see every day.

I think Jerry Spence put it best when I heard him speak in Wyoming. There is a crisis going on in Wyoming. Jerry Spence said he was reminded of a picture that was in his grandmother's home, of two

dogs chained together at the neck. He always wondered, and he asked his grandmother one day, "Why are these two beautiful dogs chained together?" And his grandmother explained that these dogs tend to bite, and when someone jabs these dogs or steps on their tails or taunts them, the dogs do not attack the intruder, exposing the owner to liability; the dogs attack one another. And the bottom-line people, the insurance industry, have the attorneys and the doctors chained together.

I am not attacking the doctors, and I don't attack MIX because I respect the good-faith that efforts MIX makes in all of its claims. And that's a sincere representation by me to Mr. Weiss. His company is one of the few in the state that actually makes diligent, good-faith efforts to evaluate cases quickly and settle them fairly. That's not the majority rule, however. The tort system that Mr. Weiss says should be changed -- Before I say this, Al Medvin and my brother, George Duffy, were going to speak as attorneys representing the trial lawyers of the State bar. They have, together and separately, more experience and more statistics as to the $100,000 cap bill and also the collateral source rule.

But what Mr. -- and also about this alleged crisis-- What Mr. Weiss testified to as a problem. There is no -- and he said all professionals are affected by this problem -- There isn't a problem. There is a cost of practicing our profession. We are professionals. We have undertaken the schooling and the training, and then we have taken on the responsibility of representing the public. And for this trust, we must pay. We must pay in the form not only of the federal and state taxes, but our malpractice insurance.

So my firm's rates have gone up, but not unreasonably so. Not to the point where I perceive that there is a professional malpractice crisis in the state of New Jersey. Nor did Mr. Spence, the cowboy lawyer from Wyoming, see one in Wyoming. And the inequities of the system that Mr. Weiss talks about -- Let me talk about the fact that our system, the tort system, grew up on the basis of equities. It grew up and -- Law is not logical. As Oliver Wendell Holmes said, it is based on experience. Case by case by case, laws are not passed, or the

law is not decided by the judge based upon someone coming in and saying, "We've got an emergency here. You've got to make a decision right away. Do we get more money?", or wait a minute -- let's hear it from both sides, which a judge does. He hears from the attorneys, he weighs the proof, or the jury does, and they decide that case. That case then becomes a precedent. And before we change the precedents that have grown up over 200 years, and in New Jersey since 1947, we should look at very carefully at whether there is a need to change our tort system. There is no need, because the tort system is no longer medieval. In medieval times, if I went to the dukedom of Atlantic County and I attacked Sir William Gormley, whether I attacked him deliberately, negligently, or whether somebody else moved my hand -- I'm sorry for that example.

SENATOR DONALD T. DIFRANCESCO: That is not illegal, by the way.

MR. VESPER: But he doesn't refer to himself today as Sir William.

SENATOR LYNCH: Not yet.

MR. VESPER: When he was in the Marine Corps, he was referred to as "sir", before and after every question.

SENATOR LEE B. LASKIN: Get back to the malpractice.

MR. VESPER: Yes sir. If that offense occurred, what was looked to then was simply the result. Was someone injured? If they were, then the other person lost their hand, their arm, their sword, whatever. We improved that system, thanks to our British forefathers and our common-law system. Now we look for blameworthiness. There is an ethic in our tort system. We look for who is at fault if someone is at fault. If no one is at fault, no one recovers and no one has to pay. And that system is not only a good system because it works based on experience, it is a good system because of the ethic involved. No one should have to pay more or less for something that they did not cause. Blameworthiness.

I said I would restrict myself to two bills, and I will do that. The expert bill, S1140, is objected to on the basis that it does not accomplish its objective. The statement on p. 2 is that "the objective is to discourage the filing of false, frivolous or uncertain

claims in medical malpractice." We do not want false, frivolous or baseless claims filed in any form against any person, including doctors, lawyers, accountants, professionals, or farm workers. It's not fair to the system. And we trial lawyers try to weed through and investigate properly all claims. This bill does not assist us at all. This bill puts an unreasonable restraint on investigations. Rather than address the real problem, which is, did you want to know where the baseless claims are coming from? Those that are coming -- and I totally disagree with Mr. Weiss' statistics and I'd like to see the basis for them. I question the statistics of two out of three claims being baseless, when the American Medical Society found that just in the hospital's own peer review, only one out of 10 legitimate claims were made to anyone's insurance company. One out of 10 legitimate claims--

But the real problem, if there is one that is causing rates to go up, and I doubt that seriously -- there is, from time to time, a claim that is brought by an inexperience attorney. There is, from time to time, a claim brought by an attorney who has not fully investigated, or, has made another common, young mistake that I am sure happens to many attorneys: believes 100% of what his client tells him. He is sworn to represent his client and sometimes believes too much. Skepticism has been called by one poet--

SENATOR LYNCH: How do you address that problem? If you have a lot of attorneys our there doing that, and obviously we have an inordinate amount of attorneys per capita in New Jersey, probably more than any other state in the union...

MR. VESPER: Senator Lynch, I want to be very, very specific about this. There are not a lot of attorneys out there doing this. There are some. I recognize that that causes real problems, unnecessary problems for the insurance company. The path to go, I think, is to follow the Governor's Task Force recommendation that before a lawsuit could be filed, the attorney -- either the attorney filing that lawsuit or the attorney who signs the pleadings because he represents that he's going to co-counsel the case -- that attorney be certified as either an expert in medical malpractice or whatever other expertise has to be established. But some experience has to be brought to bear and an

attorney who knows the good case versus the bad case, that even with the horrendous result, was not the cause of the doctor's negligence.

There are bad results that even though there was some mistake by the doctor, it was not causally related to that mistake. And those cases have to be identified. Sometimes they cannot be, unless thorough investigation is done by an experienced attorney.

SENATOR LYNCH: Do you think that type of an approach is the answer to a lot of our areas with such a litigious society that we have here, and the overabundance of attorneys that we have?

MR. VESPER: No, sir, I believe--

SENATOR LYNCH: Do you think you are going to have to have trial specialization for all forms of tort litigation?

MR. VESPER: Not for all forms of tort litigation. If there were, I would have never stepped into the courtroom. Young attorneys have to have some experience in some form. My only suggestion is that in the professional malpractice area -- this includes all professions, doctors, lawyers, perhaps anyone that is licensed by the state of New Jersey, as a professional -- before a lawsuit can be filed against that professional, an attorney certified as either a certified trial attorney or as a certified malpractice specialist should review the case, should review the facts and yes, indeed, should file certification.

This bill, 1140, introduced by Senator Matthew Feldman, seems to overlook the fact that in New Jersey now, when an attorney files a pleading, he is certifying that there is a good-faith belief in its accuracy and probable cause for recovery.

But what is happening, and I can see it happening--

SENATOR LYNCH: Do you believe that? That an attorney who files the average complaint in the state makes a true certification?

MR. VESPER: Yes, sir, for the average complaint, I do. I believe that any attorney that files a complaint--

SENATOR LYNCH: How many complaints do you think are filed in civil litigation before there is even a completion of an investigation? I know we are getting far afield from where we are supposed to be.

MR. VESPER: I'll answer your question. From my own experience, I would say, if a case comes in and there is very little time to investigate it -- I'm not talking about medical malpractice cases; we try not to take those that come in on the eve of the statute -- but those cases that come in and there is little time to investigate, and we do file a complaint, we always "allege", "it is believed and therefore we allege", and that might constitute 15%, no more than 20% of the complaints that we file; I think less than 15%.

SENATOR LYNCH: Senator Russo?

SENATOR JOHN F. RUSSO: Just on that point, Mr. Chairman. It always struck me about the attorney who files the complaint without the investigation, assuming he has time, and it turns out he really never had a case -- That has got to be the most counter-productive thing to a law as I can imagine. You go through a case with investigations and interrogatories, but you never had a case in the first place, so you end up making nothing, anyway.

MR. VESPER: Senator Russo, that is why I indicated to Senator Lynch, the chairman, that I believe that is done in even a substantial amount at a time. It is not done 20% at a time, because if you did it that often, you would go bankrupt. The young associate would no longer be with that firm; or the attorney that thought he could practice alone would not be practicing law, he would be selling other services.

But this particular bill--

SENATOR LYNCH: You would not do it, and your firm would not do it, but you have such an overabundance of attorneys out there today who are not associated with large firms or middle-sized firms or who may be coming fresh out of law school, and are taking a lot of cases that probably should never be filed. That is a product of an overabundance of attorneys in this state. I think you have one attorney for ever 350 people. In Japan, you may have one attorney for every 40,000 people.

SENATOR RUSSO: They're smaller.

SENATOR LYNCH: They're smaller, right.

MR. VESPER: But not as productive as New Jersey.

I want to indicate, Senator, and I don't say this facetiously, that the committee is concerned about what you perceive to be a large number of young lawyers coming out of law school, glutting the market and taking anything that walks through the door and filing lawsuits--

SENATOR LYNCH: We're concerned about the overall picture. We don't know that that is a fact; we don't know that that is a significant factor. It may very well be, and we could come to the conclusion, that what we are dealing with here in the medical malpractice area is simply a symptom that prevails in a lot of areas; and maybe if there is any addressing to be done, that it has to be done in the big picture, not isolated in this area. And that is something that we are going to be looking to you folks for, as we move along.

MR. VESPER: My brother, George Duffy, is the president of the Plaintiffs' Trial Academy sponsored by ATLA, our New Jersey branch of trial lawyers. We continuously try, diligently, to teach young lawyers how to litigate properly and ethically. That is done on a continuing basis, and I think we spend more than the 1.2% of our gross income in educating ourselves.

But that speaks to another matter. This bill, Senate Bill 1140: If you want-- and I say this not facetiously-- if you want to look at the bad man in the practice, and Holmes said, when you look at the law, you read the law as if you were a bad man; if you do that with this law, it is easy to circumvent. Easy. Because all the attorney that doesn't know what he's doing has to do is say in an affidavit, "I don't have all the records of the defendant doctor; I need all these records from the defendant doctor to get an opinion from an expert", and he doesn't have to file the affidavit that's necessary. If you want to look at this from a very skeptical point of view, that there are bad men out there, the bad man can easily circumvent this. Whereas, if the bad man has to go to an attorney and say, "Look at my file now; look at my preparation, look at the complaint--do you think I should file this?" and there is no certified attorney who is going to risk his professional reputation in authorizing that, I think you are really going to stop the problem of the bad man filing the bad suit.

This act has a very large gap in it. And, it does not address the real problem, which is the bad man. I can live with this. There is no problem with this act as far as the good practitioner is concerned. But it does not address the problem which is stated in the objective, which is to discourage the bad man from filing the bad case.

Finally, if I may, because I see that you do have the quorum, Senate Bill No. 1079. Mr. Weiss addressed the inequities of our system. The statutue of limitations, and what is called the New Jersey exception to the statute of limitations -- the discovery rule -- is based upon equity. Equity means nothing more than being fair to one another. The test is this: In New Jersey, the law is this -- Two years, within which to file a lawsuit, unless, and I'm reading from Lopez vs. Swyer, 1973 Supreme Court case, "the issue will be whether or not the injured party is equitable in title to the benefit of the discovery rule, and the burden of proof rests on that party to establish from the relevant facts and circumstances that the following factors" -- and the following factors are included: the nature of the injury; the availability of the witnesses and written evidence; the length of time that has elapsed since the alleged wrongdoing; whether the delay has been to any extent deliberate or intentional -- that would be either by the doctor or the plaintiff -- and whether the delay may have been said to have peculiarly or unusually prejudiced the defendant.

That is the law as it is now. That did not grow up from someone saying, "We have got to -- This is an emergency; we need help." This grew up after hundreds of years of cases being brought by people such as the DES [diethylstilbestrol] daughter who was afflicted by an estrogen pill taken by her mother 20 years before. You are going to have -- and let's be very careful about what we are calling this -- this statute proposed in Senate Bill 1135, this is not-- excuse me, 1079-- 1079 is not a statute of limitations. That would be like calling a banana an elongated yellow fruit. This is a statute of repose. This statue means you have two years within which to file the lawsuit. Or, even if you do not know you were injured, which makes a lot of sense -- you do not even know that you were injured, and even if you do not know

you were injured, you only have three years; and if you are the baby that does not find out until she is 20 that she was deformed by a pill, you are out of luck. And that is so that the bottom-line boys, see, can make a profit and can accurately depict how they are going to invest their dividends or reinvest their things.

Members of the committee, there may be a problem with infants, and I frankly admit that there should be something done to assist the insurance industry in not having to spread out their claims over great periods of time. But to change the discovery rule, does exactly the opposite of what Mr. Weiss asked you for. It does not do equity; it does inequity. As Judge Franks said, in the Alice in Wonderland world, the effect of eliminating an innocent victim's tort action before the wrongdoing could even have been discovered, is like the topsy-turvy land in Alice in Wonderland. You cannot die before you are conceived; you cannot be divorced before you are married, or harvest a crop never planted, or burn down a house never built, or miss a train on a non-existent railroad. For substantially similar reasons, it has always heretofore been accepted as a sort of logical axiom that a statute of limitations does not begin to run against a cause of action before that cause of action even exists. This does. Three years from the time the doctor did anything wrong, whether or not you discover it, is all the injured victim gets, or the injured victim's offspring.

There was a call for equity, and I call for that too. And I say finally that this was done or attempted in New Hampshire, Alabama, Florida and North Carolina, and I will not bore the committee with reciting what the justices of those Supreme Courts said about not only the illogic, but the affront to the experience of the common law of doing such a thing to innocent victims.

SENATOR DiFRANCESCO: What was done in those states? I'm not sure.

MR. VESPER: They tried to pass a statute of repose--

SENATOR DiFRANCESCO: Aren't there a lot of states that have statute of limitations on medical malpractice?

MR. VESPER: Not a lot; no, Senator.

SENATOR DiFRANCESCO: What is Pennsylvania's rule?

MR. VESPER: Pennsylvania's rule, I believe, is two years. But I am not certain--

SENATOR DiFRANCESCO: What does this bill say?

MR. VESPER: This bill says there is a two-year statute of limitations, but a three-year statute of repose. There is a difference between the statute of limitations and the statute of repose. A statute of limitations is two years from the date of the offense, all right? Two years from the date of the offense, or when you discovered the offense was committed. A statute of repose means, if I do something to this nice lady that is sitting next to me, and she does not know about it for three years, and then she finds out about it; or if I do something that does not take legal effect upon her for three years, that is too bad.

SENATOR DiFRANCESCO: In Pennsylvania, it is two years, isn't it?

MR. VESPER: No, it is a statute of limitations. I don't believe that Pennsylvania has a statute of repose. I do not want to make that representation because I have not really researched it.

SENATOR DiFRANCESCO: I am only asking because I know you do a lot of work in this area, and I do not, so I--

MR. VESPER: Yes, sir.

SENATOR DiFRANCESCO: -- was just asking you because I do not know the answer.

MR. VESPER: I do not know the law in Pennsylvania. I know the law in New Jersey, in this area. And I think that the law as it exists now, after experience, after people have come to court with their problems and defense attorneys representing the insurance industry came up with their defenses, and what was fought out in the courtroom over those years is the common law. The common law should remain untouched.

SENATOR DiFRANCESCO: According to my note here, 18 states have enacted some form of special statute of limitations for medical malpractice. Are you aware of that?

MR. VESPER: It may be a statute of limitations, Senator, but it may not necessarily be a statute of repose. A statute of repose is

an absolute bar, even though you do not know there was a cause of action, even though the cause of action may not have affected the individual.

In other words, if I give you a pill that does not take effect for three years, and that pill then affects you or your offspring, 20 years from now there is no cause of action because it is beyond three years from the date that doctor did whatever he did.

SENATOR DiFRANCESCO: Would you be surprised if I told you that in Pennsylvania, it was two years?

MR. VESPER: No, I would not. I said that there may have been a statute of limitations act passed in Pennsylvania, of two years. If it is a statute of repose, and I do not know whether it has been challenged constitutionally, as the statutes of repose and limitations were in New Hampshire, Alabama, Florida and North Carolina. But when they were, the justices of those Supreme Courts in those states saw not only the illogic, but the horror of saying to people, that "We're just going for the interest of making more profits for the insurance industry, so that some people do not have to be bothered working out calculations. We do not think that you have any cause of action, even thought it may have been legitimate, after two years or four years or five years."

I am going to sit down now. But the fight, as I said, is not between lawyers and doctors. You are going to hear -- This is how I perceive these two acts, and how I perceive--

SENATOR LYNCH: Tom, you will have another chance to summarize at a later date, I am sure.

MR. VESPER: Yes, sir.

SENATOR LYNCH: We have had a lot of people that are here to speak; we do not have a lot of time and we have to do these nominations. I appreciate your coming out--

MR. VESPER: I thank you for listening to me.

SENATOR LYNCH: --and for giving us a little education.

SENATOR GORMLEY: Senator Lynch, Tom mentioned the Governor's Commission. When is the report going to be made public?

MR. VESPER: The report is supposed to be released, I believe, sometime in July. There are seven recommendations; one of them is what I told the chairman.

SENATOR GORMLEY: About the specialists?

MR. VESPER: Yes, that addresses the frivolous lawsuits and the bad man practice.

SENATOR LYNCH: Thank you very much.

MR. VESPER: Thank you.

SENATOR LYNCH: We will take the nominees at this point, now that we have a quorum.

Continuation of hearing

SENATOR LYNCH: Our dual witness is Dr. Daniel Reider, and Dr. Hillel Ben-Asher, both of the New Jersey Medical Inter-Insurance Exchange. Good morning.

DR. DANIEL REIDER: Good morning. With your permission, I will start.

Thank you for the opportunity, I think. As a physician, I am out of my environment. I am sure that my anxiety and nervousness will become quite apparent to you as this goes on. I think I accepted it because when I do have to appear as a defendant in a malpractice suit, it will be good training.

I am an osteopathic physician. I have been in family practice in Fort Lee, in Bergen County, since 1956. I am certified in family practice by the American College of General Practitioners. I was president of the New Jersey Association of Osteopathic Physicians in '75. At present, I am a clinical assistant professor in the Department of Family Practice at the University of Medicine and Dentistry of New Jersey, and the New Jersey School of Osteopathic Physicians. And I am a member of the Board of Governors of the Medical Inter-Insurance Exchange of New Jersey.

Before this issue is settled, you are undoubtedly going to hear a great many statistics. On the one hand, as Senator Lynch has stated, the trial lawyers will tell you that a very small percentage of the health care dollar that goes for malpractice insurance costs -- I would just like to point out, Senator Lynch, that on that particular

statistic, when you are talking about health care costs, you are also including pharmaceutical costs, nursing care costs, hospital costs, and to get an accurate reflection, I think you have to calculate the percentage that goes for malpractice insurance of a physician's income, rather than total health care cost.

SENATOR LYNCH: Doctor, I raised the question first of all, because I was not sure that that was an accurate statistic.

DR. REIDER: I am not sure--

SENATOR LYNCH: Secondly, it ties to the fact that one of the issues that this Committee is obviously going to be concerned with before we are done with our deliberations is, what is going to be the impact of all of this upon the public? Are they going to be looking at lower rates? Are they going to be looking at lower fees? Are we really satisfying a true public purpose?

So, that all ties to that. You are saying that, if we are saying that less than $7, or whatever it is, of a $1,500 expenditure per year goes to the payment of the malpractice insurance of all forms, then obviously, that is something that has to be taken into consideration when analyzing whether or not there is a public need to address this problem, and whether it is going to have an impact upon the cost.

DR. REIDER: I will try -- I did not come prepared to debate that particular point. I just hope to clarify that one issue. My intent is not to come here and talk statistics, but rather, to tell you how the changing face of professional liability has changed my own practice and my relationship with my patients. I will try to show you how the escalating threat of malpractice has affected costs and availability of medical care.

Let me first address the availability issue. Over the course of my medical career, I have given up many medical procedures that I used to perform routinely, and I might add, performed well. These included uncomplicated obstetrical procedures, orthopedic, and some surgical procedures.

I gave up doing these procedures to avoid the large-premium surcharge that I faced by working within each of these categories. This

caused some disappointment to my patients, but in physician-rich Bergen County, there was not a problem in securing these services, although perhaps at a greater financial cost. However, if the same procedure holds true for rural doctors, if you find rural doctors giving up certain procedures because they cannot be covered for malpractice, then I think you will have a definite problem in availability.

And this problem of availability of medical care in rural areas is also adversely affected when a high-risk specialist, who may be thinking of practicing and opening up in a rural area, cannot afford the premium of his malpractice insurance and must join a large group in an urban area during his formative years.

Now, the Federal government has stated that there is no shortage of physicians, but that there is a maldistribution. The medical malpractice problem is contributing to that maldistribution; in addition, if you question many doctors who have left private practice to join the military or public health service, they will cite the escalating fear of malpractice as their prime motivating factor.

SENATOR LYNCH: We obviously have a maldistribution nationally. Are you saying that we have a maldistribution in New Jersey?

DR. REIDER: If you look on July 1st, the Public Health Service issues a bulletin every year as to areas that are medically under-served. I'm sure that you will find many areas in New Jersey that are medically under-served, when that issue comes out this July 1st.

Also, in the area of availability -- Up until very recently, I accepted Medicaid patients freely. Despite the fact that I was reimbursed perhaps 30 to 35% of my usual fee, the welfare office would refer cases to me because they knew I had accepted them and treated them well; and they would come from miles around. Now, I will treat a patient on Medicaid only if they or their family were prior patients of mine. I came to this decision because there is evidence -- and I cannot quote you an exact reference -- that welfare patients are more likely to initiate a malpractice suit than non-welfare patients. Perhaps it is the million-dollar lottery type of psychology that is responsible, but if this trend continues, there will be a problem with indigent patients getting care in a private doctor's office.

I would like to come to how the threat of suit has affected the cost of medical care that my patients must bear. The direct cost per patient, per office visit, is not very great, especially in my office, because I am in primary family practice. Therefore, my premium per year is not very high. The indirect cost is very high, and I'm not talking about just good, careful medicine. I'm talking about what is labeled defensive medicine. I'm talking about the doctor's fear of going into an alien courtroom environment and having his professional ability denigrated. I'm talking about the long, drawn-out process, often lasting years, of depositions, testimony and uncertainty. This is the great trauma that physicians fear, and to avoid this type of confrontation and psychic trauma, physicians will do a few more blood tests to be absolutely certain. They will order x-rays on the slightest indication. They will ask for consultations, perhaps more readily than may be really necessary, and frequently, multiple consultations to uncover possible hidden disease that is most likely not even there.

Unlike our state lottery, which is paid for by the participants, we are all paying for that fearfulness in increased premiums for health insurance, or in increased taxes for government programs. Calculating the exact monetary cost of defensive medicine is very difficult, but I dare say that in every major illness it could amount to hundreds of dollars.

Every patient injured by a physician's error should be compensated, and he should be compensated fairly and above all, quickly. His compensation must not be delayed by long legal proceedings and the injured patient must get the major share of the compensation distribution. The medical profession has come a long way in recent years in cleaning its own house, through combined efforts of the Board of Medical Examiners, professional societies, hospital peer review, physician-sponsored impaired physician programs, and educational programs sponsored by the Medical Inter-Insurance Exchange designed to make physicians more aware of the pitfalls awaiting them, so they can avoid errors in diagnosis and treatment.

I say that we have gone a long way towards cleaning our house. We must strive to take malpractice compensation out of the

category of windfall profits, for a few lucky individuals, at the expense of the general public. When the average citizen realizes his cost in this present inefficient system, you the Legislature will not be able to resist his clamor for reform. Why not take the lead in a statesmanlike manner and create a sane, sensitive and intelligent approach to this problem, and protect all the citizens of New Jersey, in whose name you are empowered to act?

Thank you.

SENATOR LYNCH: Any questions? Senator Laskin?

SENATOR LASKIN: I'll ask my question, so I guess at the beginning, if anybody else following me wants to comment on my comments, it would be worthwhile.

Let me explain a couple of things. One, I'm a lawyer; secondly, I have never filed a medical malpractice claim; and thirdly, I have virtually no personal injury work -- a few cases every once in a while. I am not a member of the American Trial Lawyers, and I rarely have anything to do with these kinds of lawsuits.

Here's the problem that I have. The lawyers are absolutely regulated by the Supreme Court. If a lawyer breathes the wrong way, the Supreme Court may disbar the lawyer, or suspend the lawyer, and frequently does. I think that the lawyers of New Jersey, compared to other jurisdictions, are probably the most regulated -- and I agree with it, by the way -- the most regulated and disciplined professional association in the United States. Our Supreme Court has supreme authority. There is virtually no appeal from Supreme Court regulations on lawyers. It is not the same thing with the medical profession.

You made one comment that you had spent a lot of time cleaning up your own house. I think you have got a long way to go, a long way to go. I will tell you personally, most of my social acquaintances are doctors, not lawyers; and I hear these kinds of comments and stories and they scare me half to death, some of the stories I hear about the medical profession: the drunken doctors in the hospitals, emergency wards, and the operating tables, and the fact that doctors really do not do too much to clean up their own houses. Would you be opposed to a board, similar in power to the Supreme Court, which

would have absolutely the same power over the medical profession that the Supreme Court has over the legal profession? I would feel a lot better, and I do not think the malpractice issue would be as big a deal as it is today, and it is, on both sides. Would you be opposed to that kind of a supreme regulator to the medical profession? Don't tell me that the state Medical Board has those powers, because they really do not, and you would be talking to the wrong guy.

DR. REIDER: Dr. Ben-Asher tells me that this is an issue he is going to address. Briefly, however, I think that if you look at the action of the State Board of Medical Examiners, which has come under the Department of Consumer Affairs now and is very consumer- oriented--

SENATOR LASKIN: I understand what you are saying--

DR. REIDER: --and compare the number of disbarments and suspensions that they have done in the last two years--

SENATOR LASKIN: --I do not agree that they have done enough. I am asking you would you be agreeable to a supreme board--

DR. REIDER: I would be agreeable to anything that improves the quality of medical care.

SENATOR LASKIN: --that has the same kinds of powers and authority with doctors as the Supreme Court has with lawyers.

DR. REIDER: Fine. I have no personal problem with that.

SENATOR LYNCH: Any other questions? Members of the Committee? Doctor, thank you very much then.

Doctor Ben-Asher, Vice-Chairman of the Board of Governors of the New Jersey Medical Inter-Insurance Exchange.

DR. HILLEL BEN-ASHER: Thank you, Senators.

I am a board certified internist, I have been practicing medicine full-time in Morristown, New Jersey for 23 years. I have been on the Board of Governors of the Inter-Insurance Exchange since its inception.

I have also had well over 15 years' experience as a medical witness in medical malpractice cases. Initially, I was asked to review cases by defense attorneys, and for over 10 years now, by plaintiffs' attorneys as well. I reviewed cases regularly for both plaintiffs and defense attorneys; I have testified in court for both plaintiffs and

for the defense, and I have testified in court against defendants who were insured by the Medical Inter-Insurance Exchange of New Jersey. This is discussed with them, and they understand this.

Approximately 50% of the cases referred to me at present are referred by defense attorneys and approximately 40% by plaintiff attorneys. There are several malpractice plaintiff firms in this area who tell me that they refer all their cases involving internal medicine to me for review prior to instigating suit. I think there are about a half-dozen such firms that do so.

In reviewing the cases for both the plaintiffs and the defense, I would estimate that between 80% and 85% are non-meritorious. I find that the percentage is approximately the same, both in cases sent to me by plaintiffs' attorneys and by defense attorneys.

There have been a number of situations now where cases have been referred to me by plaintiffs' attorneys, which I found were non-meritorious, and subsequently, are sent to me by a defense attorney for review -- a case being filed by a different plaintiff's attorney. On a number of these, there is no plaintiff's expert witness listed, and no plaintiff's expert witness ever comes forward, indicating to me, at least, that my initial review was probably accurate and there is no legitimate case.

On a number of cases I have gotten, subsequent to my review there is an expert witness from an out-of-state doctor frequently who is not in the same specialty at all, or from an out-of-state doctor who has never practiced medicine and therefore would not be familiar with the usual and customary standards of care. This is one of the issues that we would like to see addressed.

It is important that experts for the plaintiff, and experts for the defense, be familiar with what is the appropriate quality of care and be familiar with what is the reasonable, usual and customary standards of practice. Only that way can we eliminate frivolous claims. It is important that plaintiffs' attorneys recognize that not all people who come before them with a question have a valid case.

It is interesting that I feel that the majority of plaintiffs who come to an attorney with a question of malpractice have a valid question. And it is very unusual when I review a case for the plaintiff or for the defense, and find that, in my opinion, it is totally frivolous from the plaintiff's point of view. I don't think that plaintiffs bring many frivolous cases to attorneys. I think that plaintiffs occasionally, actually frequently, are misguided; and are misinterpreting an adverse result, a bad result, for malpractice.

I think it is important that we establish firm criteria to separate out what is just a bad result, and perhaps I should not say just a bad result, because the patient suffers just as much if it is a bad result due to malpractice or not due to malpractice -- But I think it is important that the law establish firm criteria, on the basis of which a plaintiff's attorney can file a suit.

The next subject that I wanted to address was exactly what Senator Laskin was bringing about, and that is what we are doing, what we can do, what we should do, and perhaps what we are not doing, in handling this problem. Part of this problem arises, Senator Laskin, out of the decisions by the state Supreme Court. It was -- I don't know the exact time -- maybe about 20 or 25 years ago, that the state Supreme Court told us that we may not demand membership in the Medical Society for membership on the staff of a hospital. Consequently, at the present time, a significant percentage of doctors practicing medicine in New Jersey do not belong to the Medical Society. The Medical Society has lost significant control, therefore, over quality.

The Medical Society does have an active peer review/judicial mechanism to review its members, and to punish and discipline its members. The problem is, what else is necessary, since the state Supreme Court has said that we can not demand membership in the Medical Society, of all doctors in New Jersey? I don't quarrel with the Supreme Court's decision, I am just saying that this has created a problem and therefore, there is at present no single body that can control the quality of medical care.

SENATOR LASKIN: But there could be.

DR. BEN-ASHER: Yes, sir, there could be.

SENATOR LASKIN: The state Medical Board could do that.

DR. BEN-ASHER: Yes sir, it could. I believe that is a part of the answer.

Let me address some of the things that are being done; specifically, by the Medical Inter-Insurance Exchange of New Jersey because I represent them as well. We recognize first that malpractice does occur. I would not be accepting cases on behalf of plaintiffs' attorneys if I did not personally recognize that malpractice does occur. And when malpractice does occur, the patient, the injured party, should be compensated.

The most important thing that we can do, which goes beyond legislation, is try and decrease the incidence of malpratice. Part of that is pressure upon the doctor, part of that is education of the doctor, and part of it is control. In terms of pressure on the doctor, the Medical Inter-Insurance Exchange of New Jersey has refused to renew policies on 44 doctors since its existence, because of their adverse experience. Over the past two years, 11% of new applications for insurance from doctors already practicing in New Jersey who want to change to our insurance company, have been rejected because of their bad experience. Now, this does not eliminate them from the practice of medicine, but it does exert significant financial and personal pressure on the doctor who is not practicing good medicine.

Over 300 doctors who we insure have been surcharged additional premiums above the regular premium because their experience is so poor -- not poor enough to refuse to reinsure them, but poor enough to feel that they require additional pressure to upgrade the quality of care.

The law is now that any settlement or verdict over $25,000 must be referred to the State Board of Medical Examiners, and the State Board of Medical Examiners is in the process of gearing up to review these cases. I think this will resolve that aspect of the problem after it occurs. The important thing, of course, is before it occurs.

The Medical Inter-Insurance Exchange of New Jersey has a risk-prevention program. It has a department of risk prevention which has hired five full-time personnel to deal with risk prevention. That is, to cut them off at the pass -- to prevent malpractice from

occurring and to prevent claims. It is financially worthwhile, of course, to the insurance company; if you prevent claims, you are going to lose less money, but it helps resolve this issue.

The risk prevention program has been evaluating various hospitals, reviewing the experience of various hospitals, and it picks out various problem areas where there seems to be the greatest potential for malpratice. We have devised a medical-legal correspondence course, in which, so far 3,357 physicians have enrolled. This is a correspondence course, a booklet with information which is provided to the doctor who then takes an examination in this. He is offered credits for educational experience, since we are all required to fulfill a certain amount of time in post-graduate education, if he passes the course. Every doctor who is on the surcharge program with our insurance company, that is; every doctor who has been charged an extra premium because of his bad experience, is required to take this medical-legal correspondence course. And, every new physician applying to us for insurance is required to take this medical-legal correspondence course.

We conduct what we call loss avoidance workshops and seminars; we have had 46 so far in the past 18 months, and over 1,300 doctors have attended, approximately one per week. These are what we call specialty-specific, where the risk prevention personnel from the insurance company go out to specialty societies and to groups to try and work out the problems that tend to lead to claims. This is the same thing as preventing malpractice. We have a practice evaluation program where risk prevention people will come into the doctor's office and review office procedures to try and prevent risk, to prevent claims. An example would be that patients are advised of what problems they have, to insure that adequate medical records are kept, both in terms of doctor's notes and records of follow-up; to insure that patients who have an abnormal finding or have a problem that needs follow-up are getting it, rather than to leave it to chance.

A newsletter, which is again specialty-specific, is sent out to doctors four to six times a year -- hopefully, it is read -- educating doctors on situations which tend to lead to malpractice;

situations that could be helped, which are not the best possible medical care of the individual. The Medical Inter-Insurance Exchange has had risk-prevention programs with several of the societies; specifically, anesthesia, plastic surgery, radiology, ear, nose and throat, and urology. Already, this has shown some improvement; specifically, with regard to anesthesia, following these workshops our actual experience in losses dropped so significantly, that the insurance premium rate for anesthesiologists last year was reduced.

SENATOR LASKIN: I don't want to interrupt, but doesn't that answer the reason why we are all hear?

DR. BEN-ASHER: Absolutely.

SENATOR LASKIN: Is it a malpractice premium problem, or is it a better education, doing a better job within the profession problem?

Now, you talked about anesthesiology, which is a part of the specialty that gets hit, almost as much as, we will say, the Ob/Gyn people. They get hit a lot; when I say hit, I mean with lawsuits. But you have done something to lower premiums in the field of anesthesiology, which says to me, it is really self-improvement and better education which is the answer to this mess.

DR. BEN-ASHER: Absolutely; I could not agree more. I think this is a big part of the answer to this mess. We have to eliminate, if possible, malpractice; and anybody who tries to come before you and say that there is no malpractice has his head in the sand, or is being unrealistic. There is malpractice; that is a big part of the problem, and we have to eliminate the malpractice.

If you remember, however, I started by saying that, in between 80% and 85% of the files sent to me, both by plaintiffs' attorneys and by defense attorneys, I find no evidence of malpractice. This must be handled together. There are two hands, and we have to put gloves on both of them. One, we must eliminate the malpractice that does occur. There are bad apples in every barrel, whether it is the legal profession or the medical profession; or whether it be bartenders who give alcohol where it should not be given, or shop owners who sell defective products. There are bad apples, and this has to be

addressed. And we are trying to address that. I think it is important that we address that, and that is the type of problem that can be handled, to a certain extent, by what we are doing and by what the State Board of Medical Examiners is doing.

But there is also the extremely important problem of what the doctors review as frivolous claims; and as I said, I don't personally believe that the patient has a frivolous claim. He may have an unrealistic claim. The awards sometimes are out of proportion to what is a realistic claim. To me, the biggest problem that I see and one of the most important problems that I see, is that many plaintiffs' lawyers do not have the ability to evaluate what is a legitimate claim. Or they are willing to take a flyer on a frivolous claim, hoping that we, the doctors, will be frightened into settlement or what have you. Something must be done to handle the situation. A stop has to be put on the extra

burden that occurs to the doctor that is faced, psychologically, with the claim that has no merit; to the insurance company that has to investigate and defend the case that has no merit; and to society, that has to pay for the investigation of the case that has no merit.

The very best in plaintiffs' attorneys investigates these cases very quickly and eliminates them. But from what I see, many plaintiffs' attorneys do not investigate them adequately and will pursue them, and the end result is that 80% of the cases go to court.

SENATOR LASKIN: I don't want to interrupt, because this is important to all of us, but I can not wait until the end because there is one of the bills that does make a lot of sense to me on this point: Feldman S1140, which, when the lawsuit is filed, would require some kind of certification by a doctor such as yourself who evaluates a claim, saying that in his opinion, it is a reasonable claim and has some merit. Wouldn't that, in itself, really go a long way towards solving the problem that you are now addressing? I don't mean the whole problem, but the issue we are talking about.

DR. BEN-ASHER: Yes, sir, I was addressing exactly that bill. I think this is one of the more important bills that will hopefully help eliminate or at least decrease the frequency of frivolous claims.

SENATOR LASKIN: See, I don't have a problem --

SENATOR LYNCH: Isn't it the same thing, however, Senator Laskin, that -- playing devil's advocate -- that Mr. Vesper pointed out with regard to a program enunciating the need for certified medical malpractice attorneys as a legitimate specialty, before they could file medical malpractice actions?

SENATOR LASKIN: I don't think it is completely the same thing, because if a lawyer --

SENATOR LYNCH: It is a question of where the source -- whether you are talking about which end of it --

SENATOR LASKIN: If a lawyer is certified or not certified, as a doctor who is a certified person because he has got the credentials to be a physician; if a physician will say in an affidavit, knowing that he is subject to scrutiny, discipline or whatever can befall him, whether the lawyer is a big-deal lawyer or not -- pardon the vernacular -- but if a physician will say, "I think it is a legitimate, responsible claim," I think that really has some merit. That does not bother me like some of these other bills that I see about limitation of damage and all, because then you are trifling with the jurors and how they resolve damages not only in malpractice cases but in any kinds of cases. It is tough to figure out what a personal injury is worth.

But, in line towards tightening up this situation so that at least we are reasonably certain that legitimate claims are being processed, conceptually I can see nothing wrong with a law that would require some kind of a certification process at the time a suit is filed. I don't think lawyers or doctors would really disagree too much with that requirement, because it would benefit the legal profession, where the lawyer is not the so-called expert -- and the so-called experts, I think, don't give the problem, because they study and they know what it costs to litigate this kind of case -- is not going to generally take a frivolous case. It's the non-expert lawyer who more frequently takes the frivolous case, either because he does not know or because he figures he will take a shot at it and try to make a lot of money.

So I think that if the certification process was in effect, lawyers or doctors would not have a problem with that. That makes sense to me.

DR. BEN-ASHER: Senator Laskin is absolutely right. A certified trial lawyer is certified to try cases. He does not have a medical education. I don't believe that the certified trial lawyer is certified or is an expert in deciding what the medical issues are.

SENATOR LYNCH: The point that I think Mr. Vesper was trying to make was, if you have a certified medical malpractice attorney -- if you had that type of procedure, those attorneys are not likely to be filing specious actions that do not have any reasonable prospects for success.

I think other witnesses have testified, and some of the reports here would demonstrate, that a great deal of frivolous claims are being filed by those who may not have any idea of what they are doing. And that may be a source of a lot of the litigation that we are talking about.

The second point on that subject matter -- I am not sure how you would address this, Senator Laskin -- is, if you require that pre-certification, you are frustrating any discovery that may be necessary to elicit all of the facts that could be needed by an examining review physician to determine whether or not there is malpractice; and that they may be limited to those reports and documents that are a matter of record. I don't know how you would get around that.

SENATOR GORMLEY: If I may interject -- I don't think you are talking a circumstance where you would have a complete discovery. Obviously, that would be impossible. I think you are talking a stage, even preliminary to summary judgement, if you will, where you at least can put your foot in the door, the affidavit would be based on reasonable knowledge and belief.

Bill 1140, if it eventually, after we spend much more time on it, comes to the point where we feel there should be a certification, then we have to be very careful with how we deal with two, because a good attorney could manipulate paragraph 2 so that the first paragraph is meaningless.

I would think that you would have to be specific as to what would have to be provided on the immediate basis for the purpose of that affidavit. Also, something else we might consider is not upon the filing of the complaint, but upon the filing of the answer. I think that might coincide a little bit better, because you are talking about a limited amount of discovery. But I see paragraph 2; if it is our intent to have some form of certification, there be some form of claim that is a loophole; and we might want to be more specific as to the type of discovery.

SENATOR LASKIN: I am not talking about the specifics, I am just talking theory. Now, I would not have a problem with some kind of a certification process where a licensed New Jersey physician must put his name on an affidavit and say, very generally -- I don't even want to get too specific, because that really gets into the litigated issues; but just something that would say, "My opinion based upon reasonable medical probability, I think there is a reasonable grounds for cause of action," or some words to that effect. I don't want to get into too much detail.

But theroretically, or conceptually, I have no problem with that.

SENATOR GORMLEY: Also, on the certified trial lawyer, if in fact you have something like this, the emphasis on the certified trial lawyer is totally diminished because you are placing the threshold question on someone who is licensed, not really certified.

Also, with certain members of the bar who want this certified provision, maybe they would waive that portion of the rule providing the only exception to referral fees as it applies to certified trial lawyers. I find this a loophole in the rules that we now have for the Supreme Court allowing for referral fees from certified trial attorneys. I find that to be a problem or casting a shade on the need for certified trial attorneys.

DR. BEN-ASHER: May I suggest, gentleman, that when you do get to your deliberation, and if you agree that it a certification is needed, that an insurance be included that the certification be from a doctor who is qualified in the specialty involved. Now as I say, I have

many situations where a surgeon or a urologist would criticize a pediatrician or an internist, or an internist would criticize a surgical technique -- I personally would never make a judgment on surgical technique; I am not competent to do so. But I have read many reports from plaintiffs' experts rendering an opinion totally foreign to their own field; and this is what we are interested in, that there be a certification of expertise in the field.

SENATOR LYNCH: Thank you very much, Doctor.

We are going to have to terminate this hearing. I apologize to those who have been on the list and have been waiting here; I think it is obvious there is a need for a non-session day hearing at which time we can continue these discussions.

I think it is also clear that this is not going to be concluded in a matter of one or two sessions, so that there is an awful lot of details that are going to have to come out. We will continue on a date to be selected, with proper announcements, which will be a non-session date so that we could spend a good six hours in hearing testimony and the first witness will be Allan Medvin from ATLA, or his designee.

There were an awful lot of people who did not sign up today because they knew that they would never be reached. I am sure that we are going to have another 20-30 witnesses before we have concluded. We will be making an announcement over the course of the next four weeks as to when we will continue this hearing.

Thank you all very much.

(HEARING CONCLUDED)

APPENDIX

NEW JERSEY
STATE BAR ASSOCIATION *Headquarters* 172 WEST STATE STREET, TRENTON, N. J. 08608
609-394-1101

Position Statement
S-1140
Requires a Plaintiff in a Medical Malpractice Case to File An Expert Affidavit within 60 Days of Filing the Complaint and Establishes Standards for the Use of Experts in Medical Malpractice Cases

The New Jersey State Bar Association strongly opposes S-1140, which requires the plaintiff in a medical malpractice case to provide to the defendant, within 60 days of filing the complaint, an affidavit of a practicing physician stating that there is a reasonable probability that the care exercised by the defendant fell below acceptable professional standards.

The bill also provides that the physician signing the affidavit meet certain standards. In order to participate in a medical malpractice case, the physician must be certified, have at least five years experience in the specialty, and must be actively engaged in the practice of medicine.

The bill also provides that an affidavit is not required if the plaintiff provides a sworn statement stating that the defendant failed to provide medical records or other information having a substantial bearing on the preparation of the affidavit. If the plaintiff fails to provide the affidavit or statement, the court shall dismiss the action.

The New Jersey State Bar Association believes that this legislation is ill-conceived and amounts to an unwarranted restriction on the use of the courts. The New Jersey State Bar Association believes that the production of an expert affidavit within such a short period of time following the complaint, sets up an extremely burdensome and unnecessary initial obstacle to utilizing the court system.

While the New Jersey State Bar Association is not opposed to action by the courts to speed up and resolve discovery problems in complex medical malpractice cases, it believes that the Supreme Court is the appropriate forum to determine the time limitations by which pleadings and affidavits must be sent and the qualification of experts. The Bar Association also believes that this bill may violate the court's constitutional powers to make rules for the practice and procedure utilized in the courts, as enunciated many years ago in Winberry v. Salisbury, 5 N.J. 240 (1950).

The New Jersey State Bar Association maintains that the time limitations set forth in this legislation may be too short in many cases. For example, if a defendant consumed the full 45 days to produce the relevant information, the plaintiff would have only 15 days to gather an expert affidavit. This is impractical. Medical malpractice cases are often extremely

complex and the ultimate conclusion that negligence occurred is often possible only after examination of all of the circumstances and the exchange of interrogatories and depositions. Moreover, the information necessary is not always solely within the control of the defendant, but is often in the control of third parties. Certainly, then, the 60 day period of time for the filing of the expert affidavit is impractical because an expert often cannot know all of the facts surrounding the case within that short time span.

The New Jersey State Bar Association also notes that this bill will result in more litigation. If the plaintiff files a statement that the defendant has failed to provide the necessary medical records in order to obtain an expert witness, the defendant may challenge that statement in court. The resulting increased litigation will defeat the objective of this bill.

The New Jersey State Bar Association further believes that the standards set forth in this bill for the utilization of experts in medical malpractice cases is merely an attempt to limit the pool of available witnesses to testify in medical malpractice cases on behalf of plaintiffs.

This legislation increases the practical difficulties plaintiffs face in obtaining physicians who are willing to testify against their peers. The standards adopted in this legislation limit the availability of esteemed retired physicians who are less susceptible to peer pressure. By removing the retired physician from the pool of available witnesses in medical malpractice cases, this legislation unduly restricts the availability of expert witnesses and particularly those who have had years of expertise in medicine. In addition, the Bar Association further believes that this legislation will operate to limit the use of young practitioners and those engaged in general practice as opposed to a specialty.

The New Jersey State Bar Association views this bill as an unjustified attempt by the medical profession to determine which experts the plaintiff shall utilize in medical malpractice actions. The Bar Association objects to this bill because it believes that the plaintiff should be able to choose the experts that he or she believes are most appropriate.

Proposals which limit the pool of available expert witnesses are unnecessary because judges already determine the qualifications of experts. In each case the judge determines whether the witness has sufficient qualifications to entitle him to testify as an expert witness. Once a witness has testified as an expert, it is up to the judge or jury to determine the credibility and weight of the expert's testimony. Thus, the trier of fact is the ultimate judge of both the qualifications and credibility of the expert.

The requirement that a witness have particular expertise in the general area or specialty involved in the litigation, unduly limits the possibility of securing evidence from members of the profession who, although perhaps not practicing in the particular area involved in the litigation, have sufficient expertise to make a judgment based upon the evidence. For example, under this legislation a general practitioner who treats many orthopedic injuries would be barred from testifying as an expert in an orthopedic malpractice case. This result is unduly restrictive given the fact that general practitioners often treat patients for orthopedic injuries, particularly for soft tissue injuries.

The New Jersey State Bar Association therefore objects to this legislation and urges you to do so also.

6/14/85

NEW JERSEY
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609-394-1101

Position Statement
S-1079
Abolishes the "Discovery Rule" in Medical Malpractice Cases and Substitutes a Three Year Statute of Limitations

The New Jersey State Bar Association vigorously opposes S-1079, which abolishes the present "discovery rule" in medical malpractice cases, whereby an individual has two years from the time he discovered or should have discovered a negligent act to file suit, and substitutes a three year statute of limitations, regardless of whether the negligence was known. By abolishing the "discovery rule" in medical malpractice cases, and substituting in its place a three year statute of limitations, this bill profoundly alters existing state law.

The statute of limitations would also apply to children and to persons under other legal disabilities. A minor under the age of eight would have until his 11th birthday to file suit, based on a cause of action which accrued prior to his 8th birthday. Currently, under existing state law, the statute of limitations is tolled until a minor reaches the age of eighteen.

The New Jersey State Bar Association does not believe that medical malpractice defendants should be singled out for special treatment immunizing them from liability. Limiting the civil liability of an irresponsible physician runs counter to the legal system's efforts to compensate the injured victim. The Bar Association feels that abolition of the discovery rule for medical malpractice defendants would seriously jeopardize patients rights and would constitute an undue advantage to medical malpractice defendants.

The object of the statute of limitations is to place a person on notice that legal rights have accrued and to set a time limit for the assertion of those rights. However, in order to assert those rights, one must have discovered that an injury has occurred. The New Jersey State Bar Association believes that the discovery rule is equitable because the statute of limitations does not begin to run until a person discovers or should have discovered the injury he seeks to complain about. The discovery rule is particularly equitable in those cases where an injury does not manifest itself within the time span proposed in this legislation. The equitable nature of the discovery rule is particularly beneficial in cases where there has been a misdiagnosis or in situations involving children.

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This legislation has the unfair effect of negating an injured person's right to seek compensation even before the patient knows that he has sustained an injury caused by medical negligence. Such a strict time limitation upon the rights of patients is totally inequitable.

Abolition of the discovery rule, and the resulting extinguishment of the right to seek compensation before there is an effective opportunity to exercise it is especially unjust to minors and persons who are under other legal disability, such as the mentally handicapped. Many times children are injured and their parents do not assert their rights. It is only when they reach the age of majority that these children are able to bring suit on their own behalf. This bill severely limits the ability of minors to bring suit and it is often in the case of minors where there is a lack of discovery of the injury. Certainly, as the injured party, the minor should have control over whether or not a lawsuit should be filed.

Therefore, the New Jersey State Bar Association strongly encourages you to oppose S-1079. The policy of this State should be to continue to allow injured patients who did not know, or by the exercise of reasonable diligence could not have known that their injury was related to the fault of another, to be allowed to have their legitimate grievances aggressively advocated. The abolishment of the discovery rule in medical malpractice cases constitutes an unwarranted infringement upon the rights of the patient to legal redress and amounts to undeserved special interest legislation.

Thank you for considering the views of the New Jersey State Bar Association.

6/14/85

NEW JERSEY
STATE BAR ASSOCIATION *Headquarters* 172 WEST STATE STREET, TRENTON, N. J. 08608
609-394-1101

Position Statement
S-1135
Requires a Victim's Award to be Reduced by the Amount of Health and Disability Benefits Received by the Victim

The New Jersey State Bar Association strongly opposes S-1135, which has two major components. First, the bill reduces the personal injury award of the victim because of the negligence of the defendant by the amount of any health insurance, disability income or government entitlement benefits received by the victim. This applies to all personal injury cases, not just medical malpractice.

The New Jersey State Bar Association believes that this provision lets the wrongdoer, such as the negligent doctor or driver, escape or limit the consequences of his conduct, because of the fortunate circumstances that the plaintiff has insured himself for certain injuries. To point out the inequity of the bill, it would require that the award against a negligent doctor be reduced by the amount of social security disability payments that the plaintiff receives because of his disability. We do not believe that the liability of the wrongdoer should be reduced because of social security disability payments for which the injured party has paid taxes.

Furthermore, in those instances where people have purchased disability income protection or other types of disability coverage, it is inequitable to reduce the liability of the negligent defendant because of this. The plaintiff in such cases has paid hefty premiums for many years to obtain this benefit. It would be a windfall to the negligent doctor to reduce his liability because of the foresight of the victim in protecting himself by buying a disability policy. Such payments, therefore, are not windfall benefits but are benefits earned and paid for by the victim and/or his employer.

Furthermore, most personal injury awards are generally for pain and suffering damages, not medical payments. Therefore, health insurance payments should not be deducted from the pain and suffering award. What this bill actually does is shift the burden for wrongful conduct from the negligent doctor to the victim or another insurer who has done nothing wrong. We do not believe that the Legislature should relieve the negligent doctor from the consequences of his negligence.

The second major provision requires all awards of $100,000 or more in all personal injury cases to be paid in periodic payments rather than in a lump sum payment. The bill requires the periodic payments to be stopped, except for wage loss benefits, if the victim dies during the course of the periodic payment.

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This provision also is another attempt by negligent doctors and others to arbitrarily limit their liability.

The bill does not state that the periodic payment shall include the payment of interest in future years to compensate for inflation. The bill is therefore actually a large reduction of the award. The bill takes custody of the principal and any future interest earnings out of the hands of the injured party and puts them in the hands of the person who caused the damage. Again, this provision hurts those that are most seriously injured and who may be in most need of having large sums of money initially available for future investment and medical care.

The State Bar Association views as outrageous the section of the bill that would terminate all portions of the personal injury award in the future, except for income loss, if the victim dies during the course of the periodic payment. This has the effect of limiting the liability of the negligent doctor because of the death of the person whom he injured. Indeed, in many cases, the death may have been as a result of the negligence committed by the defendant.

The State Bar Association does not believe that the death of the plaintiff should in any way diminish the liability of the defendant. We note that there is no corresponding provision in the bill that should the victim outlive the life expectancy on which the periodic payment is based, that the payments would be extended.

Mandatory periodic payments may also fail to insure the necessary flexibility to permit the plaintiff to meet the future costs of medical expenses. The plaintiff, better than the person who harmed him, knows when he will need medical care, particularly in the early years following his injury, and how best to provide for himself.

This bill also would increase litigation to enforce periodic payments. The trials themselves would be extended because economic experts would have to be presented to the judge to determine the amount of future periodic payments, thus increasing the length and complexity of the litigation.

The State Bar Association points out that in some instances structured settlements, which of course include interest, have been negotiated voluntarily between the injured party and the negligent doctor. In appropriate cases a structured settlement might benefit a client, but it certainly is not the rule in each and every case. Cases involving the elderly or terminally ill patients, or people with special economic circumstances may not be appropriate candidates for periodic payments. The best result can be achieved by negotiation between the victim and the insurance company to achieve an equitable structured settlement.

We should also point out that structured settlements are positively based in that they avoid the need for trial. This is far different, however, than the mandatory inequitable periodic payment provisions in this legislation, which imposes a periodic payment on an unwilling victim after trial.

For the reasons above, the New Jersey State Bar Association urges you to reject this bill.

6/14/85

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NEW JERSEY
STATE BAR ASSOCIATION *Headquarters* 172 WEST STATE STREET, TRENTON, N. J. 08608
609-394-1101

Position Statement
S-1112
Places a Cap on Damages of $100,000 for Pain and Suffering in All Personal Injury Cases

The New Jersey State Bar Association vigorously opposes S-1112, which limits damages for pain, suffering and loss of quality of life to $100,000 in all personal injury and wrongful death actions. It should be noted that this legislation applies to all personal injury actions, not just medical malpractice cases. It applies to the drunk driver and negligent doctor, as well as all other kinds of personal injury cases.

The New Jersey State Bar Association opposes the legislation because it places the rights of negligent doctors and other defendants over the rights of innocent victims. This legislation is arbitrary and unreasonable. A cap of $100,000 hurts those that have been most severely injured. Those suffering catastrophic injury or death because of the negligence of another will arbitrarily have their awards reduced. This is inequitable and unjust.

It is important to note that a judgment against the defendant doctor only comes after a judge or jury has determined that the victim has proven that the doctor or other defendant was negligent and did not adhere to the standard of care necessary. The State Bar Association believes that once negligence is proven, the victim should be made as whole as possible. In many cases, the innocent victim's life will never be the same. The victim should at least be able to recover all of the damages that a judge or jury says is owed to the victim and not have the award arbitrarily reduced to $100,000. Limiting the liability to $100,000 is not just unjust, but cruel.

The legislation also has the perverse affect of rewarding those that cause the greatest harm by limiting their liability. It is arbitrary in that the cap of $100,000 has no relation whatsoever to the nature and severity of the injuries, but merely seeks to limit the liability by placing an arbitrary cap on damages.

The bill, furthermore, seriously undermines the jury system by requiring that the jury's judgment, to the extent that it exceeds the cap in this legislation, shall be disregarded.

The State Bar Association believes that it is unreasonable to limit an injured person's lifetime pain and suffering damages to $100,000 to benefit a doctor who makes more than that in a single year. This onerous provision clearly revictimizes the victim once again by reducing the amount of the award.

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The legislation also decreases the deterrent affect of litigation on malpractice. If doctors or drunk drivers or other defendants know that, at most, they could be liable for $100,000, there is no incentive for safety. The more damage the defendant does, the greater the immunity this bill gives him.

We should also point out that in the rare case of a truly excessive verdict, remittitur by the court is available, which reduces the amount of the jury award. This can be done both at the trial and appellate levels and a clearly excessive verdict may be reduced under our current law.

Instead of seeking to limit the rights of innocent victims, the defendants and particularly doctors, should examine the practices of the insurance industry with respect to the amount of payments to victims verses the amount of premium dollars received, the amount of investment income, the level of reserves and the like. A strong financial disclosure bill similar to the one enacted for auto insurance is necessary to gain all of the facts on medical malpractice insurance. This could clearly show that the amount of payments to victims does not approach the amount of premium dollars taken in.

Furthermore, the Legislature should critically examine the alleged "crisis" in malpractice insurance. According to the medical profession's own surveys, the average New Jersey doctor paid $6700 for malpractice insurance in 1983. This was approximately 4% of their gross income. It was also approximately the same amount of money that doctors spent on professional car upkeep. (See Chart Attached)

It should also be noted that the entire cost of medical malpractice insurance amounts to one-half of one percent of the health care dollar. The facts surrounding medical malpractice certainly do not justify such measures as limiting damages to $100,000.

This bill is designed to enhance the immunities of a privileged profession. The medical profession should increase its own disciplinary enforcement mechanisms instead of limiting victim's rights. The American Medical Association estimates that at least 10% of its members are "impaired" due to alcohol, drugs, or medical disabilities which render their fitness to practice their profession into question. Tougher disciplinary proceedings and a crackdown on the incidence of malpractice are remedies that the medical profession should devote their attention to, in cutting its exposure to malpractice litigation.

Taking away the rights of malpractice victims may be easier for doctors to attempt than critically examining one's profession, but it is not the right thing to do.

The New Jersey State Bar Association urges you to reject this legislation.

6/14/85

1984 Report on physician/owned medical society created liability insurance companies

Company	Insureds	Limits	Coverage	Premium range	Average premium
Alabama	2,850	$1M/1M; 5M/5M	CM*/O	$1,159-13,555/466-3,080/ 1,237-14,729	$ 4,900
Arizona	3,010	1M/1M; 5M/5M	CM*	3,064-22,252/1,308-8,328	8,500
NEC, CA	2,900	1M/3M	CM*	4,996-31,648/994-6,294	6,500
NORCAL, CA	5,600	1M/3M; 2M/4M	CM*	2,604-28,520/872-7,116	NA
SCPIE, CA	7,331	1M/3M; 5M/5M	CM*	3,404-29,184;1,288-10,496	6,700
Colorado	2,200	1M/1M; 5M/5M	O	1,200-14,000	5,000
D.C.	1,100	1M/3M; 10M/10M	CM*/O	1,563-26,185/513-11,385/ 1,666-26,382	7,300
Florida	4,360	500/1M; 1.5M	CM*	4,363-42,348/781-7,582	7,700
Georgia	2,400	1M 1M; 5M/5M	CM*	1,147-25,307/380-9,895	5,800
Illinois	7,986	1M/3M; 5M/5M	O	3,944-42,700	9,400
Indiana	430	100/300	O	630-5,046	1,200
Kentucky	1,723	1M/1M; 5.2M/5.6M	CM*/O	1,592-12,196/533-3,631/ 1,691-12,982	3,300
Louisiana	2,000	1M/1M; 5M/5M	O	1,841-15,284	4,500
Maine	895	1M/3M; 5M/7M	CM*	2,858-25,305/752-6,659	5,600
Maryland	2,900	1M/3M; 5M/7M	CM* O	656-12,400/200-6,200 1,562-19,690	6,000
Michigan	4,585	1M/1M	O	3,935-44,669	5,100
Minnesota	2,203	1M/3M; 4M/7M	CM*	939-13,688/311-4,013	4,700
Mississippi	2,050	1M/1M; 5M/5M	CM*/O	1,501-17,011/461-5,222/ 2,011-22,795	5,000
Missouri	1,254	1M/2M; 2M/3M	O	2,153-21,535	4,291
New Jersey	6,850	1M/3M; 5M/7M	O	3,373-24,272	6,700
New Mexico	1,500	100/300	O	956-6,197	3,250
New York	15,830	1M/3M	O	4,541-63,311	12,500
N. Carolina	3,805	1M/1M; 5M/5M	CM*	1,600-17,129/556-7,330	2,600
Ohio	4,541	1.1M/1.3M 5M excess	O	2,047-17,944	4,080
Oklahoma	3,603	1M/1M; 5M/5M	O	922-5,234	2,903
Pennsylvania	6,200	200/600	CM*/O	2,304-19,351/648-5,443/ 2,400-20,158	4,700
Tennessee	4,830	1M/3M; 10M/12M	CM*	1,933-16,436/649-4,456	4,740
Texas	3,200	1M/2M; 2M/3M	O	1,200-16,500	4,000
Utah	1,325	1M/3M; 5M/7M	O	910-13,674	3,600
Washington	1,803	1M/3M; 5M/7M	RO**	1st 891-7,148 2nd 2,005-16,083 3rd 2,785-22,339	2,800

CM—Claims Made O—Occurrence
*First year claims made range
**Report occurrence

Premium range based on $1 million coverage except when maximum available is less. Maximum limits available are indicated also. Average premiums are estimated. Financial data based on 1983 year end statements.

Data source: AMACO

1050 31st Street, N.W., Washington, D.C. 20007 (202) 965-3500

MEDIAN EXPENDITURES FOR MAJOR ITEMS IN 13 STATES

Florida doctors, who have the highest total expenses, also lay out the most dollars for office space, malpractice insurance, and depreciation on medical equipment, but not for the other items listed here. Texans spend the most on office payroll, New Yorkers the least. Expenditures for office rent or mortgage payments are lowest in North Carolina. Drugs and medical supplies cost Georgia doctors the

	Office payroll[1]		Office space[2]		Drugs and medical supplies[3]	
	In $	As % of gross	In $	As % of gross	In $	As % of gross
Florida	$30,420	11.8%	$11,700	4.8%	$5,080	3.4%
Texas	32,000	11.3	10,830	4.6	4,130	3.1
California	24,330	12.5	10,590	5.8	4,250	3.5
Ohio	24,290	12.1	7,880	4.5	3,800	3.5
North Carolina	31,360	16.7	7,000	4.8	4,630	3.8
[illegible]	23,930	12.3	10,000	5.3	4,100	3.4
Georgia	26,250	10.8	10,000	6.1	8,750	3.8
Pennsylvania	25,360	12.1	7,170	4.1	3,400	3.6
[illegible]	26,070	12.7	9,630	5.7	4,500	3.2
New Jersey	21,670	12.5	9,250	5.0	3,500	3.6
New York	20,750	13.5	9,570	5.8	3,570	3.3
[illegible]	23,060	13.9	7,500	5.7	2,560	3.2
Virginia	27,220	13.5	8,380	4.8	3,170	3.3
All U.S.	26,410	12.6	9,520	5.0	4,260	3.5

[illegible] salaries, bonuses, and retirement plan contributions. If any, for [illegible] fees, cost of materials and laundry, meals and lodging for doctor and nonphysician employees only. [illegible] of mortgage payments. [illegible] equity. All figures are medians per physician, based on only those M.D.s who [illegible] non-depreciable small instruments. [illegible] depreciation. [illegible] recorded some 1982 expense of the type indicated.

10x

most and those in Massachusetts the least. New Jerseyites' car costs are the highest—largely because auto insurance is extremely expensive in their state—and North Carolinians' are the lowest. Expenditures for malpractice insurance, too, are lowest in North Carolina, and the figures on medical-equipment depreciation are lowest in Illinois.

Malpractice-insurance premiums		Professional-car upkeep[4]		Depreciation on medical equipment		Continuing education[5]	
In $	As % of gross	In $	As % of gross	In $	As % of gross	In $	As % of gross
$6,000	3.7%	$4,000	3.3%	$3,670	3.1%	$2,000	3.1%
2,800	3.1	3,950	3.3	3,000	3.3	1,750	3.0
5,660	3.8	4,090	3.4	2,550	3.2	1,670	3.1
4,300	3.4	3,000	3.1	2,900	3.2	1,500	3.1
1,400	3.2	2,250	3.2	2,880	3.2	1,500	3.1
3,430	3.4	3,460	3.2	1,500	3.0	2,000	3.0
3,500	3.4	3,250	3.4	3,000	3.3	1,500	3.0
3,830	3.5	3,390	3.3	2,300	3.6	1,630	3.1
2,630	3.5	3,000	3.2	2,060	3.0	2,060	3.2
N.J. 4,000	4.1	4,500	3.7	2,500	3.4	2,000	3.1
5,250	4.2	3,600	3.3	2,090	3.1	1,670	3.1
1,440	3.1	3,190	3.3	2,170	3.1	2,000	3.1
2,850	3.2	3,130	3.2	2,250	3.1	1,500	3.0
3,840	3.5	3,350	3.2	2,550	3.2	1,930	3.1

11x

ATLA NEW JERSEY

73 Main Street
Woodbridge, New Jersey 07095-2811
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June 20, 1985

My name is Alan Y. Medvin, and I am President of the New Jersey affiliate of the Association of Trial Lawyers of America. (ATLA-NJ). I would like to express our opposition to all of the bills now before the Senate Judiciary Committee that concern medical malpractice. Enactment of these bills will shift the burden of the cost of damages from the wrongdoers and their insurance companies to the victims who can least afford to bear this burden.

I will limit my remarks to bills which seek to place a monetary "cap" on damages awarded by a jury.

Article 1, Section 9, of the New Jersey Constitution states that "the right of trial by jury shall remain inviolate." That provision means that an individual has a fundamental right to have a jury, as triers of the facts, determine all issues properly placed before them pursuant to law, including amounts of compensation for non-economic losses suffered by the victims of negligence. Juries have been performing this function since the founding of our Republic.

12x

The American Medical Association, in a nationwide campaign, has offered up bills in thirty states that would seriously erode this function, by placing a legislative limitation on fair compensation. At the heart of this suggestion is a lack of respect for our nation's and our state's citizens that serve on juries and a belief that absent some legislative restriction, juries will be unable to determine what represents fair and adequate compensation for non-economic losses suffered by the victims of negligent physicians. Please also note that this proposed legislation not only applies to medical malpractice victims but to all other personal injury victims as well, although the support for this bill clearly comes from the American Medical Association and its affiliated medical societies and insurance carriers.

Where, we ask, has there been any demonstrated need for this type of radical legislation?

In New Jersey during 1984, there were only 5 jury verdicts in malpractice cases that exceeded the sum of $500,000.

It is true that on rare occasions, juries in personal injury cases render excessive verdicts. So too do they sometimes render inadequate compensation. In those rare cases, the trial judge has the power under existing law to either add to or subtract from, a jury's verdict that is rendered not in accordance with the evidence but in response to sympathy, passion, bias or prejudice. The legislation

sponsored by Senator Hurley, S-1112, and supported by the Medical Society seeks to limit damages where such damages are not the product of sympathy, passion, bias or prejudice but represent instead fair compensation for victims.

The perversity of such a bill limiting damages is obvious. It would affect only those most seriously injured and disabled. Verdicts for less serious injuries would fall within the "cap". Thus, those less seriously injured victims would not in any way be affected by the cap. However, those victims who have been grievously crippled, maimed or subjected to a life of pain and suffering, and whose economic losses as determined by a jury exceed the cap would be those victims who would suffer by virtue of this proposed legislation. It is their awards that would be reduced below what had been determined to be fair and reasonable compensation.

The rationale offered for providing less than fair compensation is that some societal benefit would accrue. The only benefit suggested seriously by the American Medical Association is that doctors' malpractice premiums would be reduced. They have not suggested that physicians in this state are not adequately compensated for their work or that some specific reduction in medical costs to patients would result from this legislation. They also have not suggested that doctors' incomes would be reduced. The simple truth is that medical doctors are among the highest paid group of workers in this state. Ironically, they are now asking this

legislature to approve a bill which would limit the compensation received by those who suffer as a result of their errors so that they may earn still more money.

What about the cost of insurance, particularly medical malpractice insurance? According to Dr. Robert Maurer, Chairman of the New Jersey Medical Society Legislation Committee, the average cost of medical malpractice insurance in New Jersey is between $5,000 and $6,000 for $1,000,000 coverage. He states: "The problem (in New Jersey) is not in the premium that the doctor pays." And, according to Medical Economics, the average American physician spends only 2.9% of his or her gross income on medical malpractice insurance, which is just slightly more than the 2.3% spent on "professional car upkeep.'

How then, has the medical profession carried its burden to demonstrate a compelling need for such radical legislative intrusion into the province of the jury?

In its editorial of April 22, 1985, entitled "Doctors Aren't Above the Law," Business Week, (by no stretch of the imagination the spokesman for trial lawyers) dealt with the issue we now discuss. They said:

> Legislated remedies generally lack the flexibility required to be fair to everybody - and often reflect the interests of the strongest lobbying group . California and several other states, for example, restrict awards that plaintiffs in malpractice suits can receive. This is unwise, since circumstances could easily arise where severely injured plaintiffs would be entitled to more than the law allows. (Emphasis added).

We agree. Bills that arbitrarily limit damage awards should be repudiated by this body.

EXECUTIVE DIRECTOR

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Lawyers Enco[illegible] Government and Law

preserving t[illegible]e of law for the public interest

Testimony before The

Senate Judiciary Committee

on

S-1112 S-1079
S-1135 S-1140

Appearing for LEGAL:

Thomas Vesper
June 20, 1985

17x

For the second time in less than a decade the cry has arisen that a "medical malpractice crisis" exists. The basis for this claim is the excessive cost of medical malpractice insurance, and its purported effect on health care costs.

The insurance companies and the doctors say the reason for this problem is the legal system. The cure they prescribe to the public is to reform the tort system.

That the cost of repairing the damage to the innocent victims of medical negligence is felt to substantially contribute to the high cost of health care in this nation is astounding.

Strong exception should be taken to the portrayal made by physicians and the insurance companies representing them that the high cost of health care is significantly attributable to malpractice premiums.

Every conceivable report or article disputes this fact.

Since 1976, the cost of malpractice insurance has actually been steadily declining as a percentage of total health care costs, until it now, at $1.5 billion in 1983[1], is less than one-half of one percent of total health care costs of $355.4 billion[2]. (See attachment A). The cost of medical malpractice insurance is not only low when compared to the cost of health care, it is low in absolute terms. In 1983 the average American spent $1,500 on health care. Of that amount, only $6.08, or 11¢ per week went to malpractice insurance premiums.[3] If we were to abolish the rights of those injured by medical negligence to sue for compensation we would realize very little savings in health care costs, and would visit harsh results on innocent victims.

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1. A.M. Best's Casualty Loss Review Development, 1984.
2. Medical Benefits, The Medical Economic Digest, March, 1985.
3. A.M. Best's, supra fin[3]

Clearly, the cost of medical malpractice insurance is not a burden on the average citizen, particularly compared with total health care costs. But is that cost a burden on physicians? The answer is, by and large, no.

The average American physician spends approximately 3 to 4% of his gross income (currently estimated at around $200,000) on medical malpractice insurance.[4] While only 1.2% is spent on continuing education.[5]

The complaint of high premiums for doctors is not a new one. A quote from the Journal of the American Medical Association published in 1901, 84 years ago, lends a new perspective, "Suits against physicians and hospitals have become so frequent that the practice of medicine and more especially surgery has become so perilous to the pocket that some good operators have thought of giving up the practice."

The testimony of huge increases in premiums over the last several years has to be questioned when faced with some of the following data:

- An excerpt from the American Medical Association Special Task Force on Professional Liability (See Attachment B)

- A.M. Best's Casualty Report which indicates that physicians insured by the N.J. Medical Inter Insurance Exchange were rebated over $5 million in 1981 and over $30,000 in 1982. In 1983, over $20,000 was returned to policy holders in the form of dividends. (See Attachment C). This certainly seems to indicate that physicians were over-charged by the exchange during the period of the last "malpractice crisis".

- Comments contained in testimony before the Advisory Council on Medical Malpractice reform in Florida in 1982 are as follows:

> Probably the most successful medical malpractice insurance fund in the country is New Jersey's Medical Inter-Insurance Exchange. Surgeons pay 9.6% less in premiums than they did five years ago

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4. Medical Economics, Kirschner, Merian, "Is Your Practice Begging for More Money?", November 12, 1984, pgs. 214-230.

5. Ibid., pg 231.

> and family and general practitioners pay 24.5% less than five years ago. In testimony before the Advisory Council, Bernard H. Genest, administrator of the New Jersey program from 1977 to 1982, explained that their success was not the result of reducing judicial qualifications or limiting jury awards or attorney's fees, but of professional, good faith claims management. He attributed a large measure of that success to the willingness of its well-trained, well-paid adjusters to assess liability honestly and to make an early, good-faith settlement offer.

Has the financial situation of the Medical Inter Insurance Exchange changed so radically in the past couple of years to warrant the "cry" of crisis once again?

We often hear from the advocates of radical restrictions on the rights of health care consumers that the fear of malpractice suits forces doctors to practice "defensive medicine". What might appear to be defensive medical practice to one clinician may, to another, be quality medical care. Defensive medicine may be beneficial to the patient. One report states that: "X-rays taken after a fractured limb is casted, while defensive - to protect the doctor from legal action for failing to assure the final position of the bony fragments - also constitutes good medicine."[6]

Another report stated that while increased electronic fetal monitoring and cesarian sections probably were caused by the growing number of suits around fetal injuries, those procedures did increase the survival of newborn babies.[7]

A study was performed in California by a committee of the legislature of that state chaired by Assemblyman Henry Waxman, who is now in Congress. That study concludes that:

> "Perhaps the most significant affect of the rise in malpractice litigation upon consumers is in regard to the quality of medical care people receive.

---

6. Shore, S., Defensive Medicine is Good Practice, LAMP, May 1979, pg.22.
7. Troncedi and Barondess, M.D.'s, The Problem of Defensive Medicine, SCIENCE vol. 200, pg. 882, 1978.

By encouraging health care providers to adhere to standards, malpractice litigation may be fostering the practice of quality medicine."

These references strongly suggest that what is characterized as defensive medicine is actually - at least from the patient's point of view - good medicine.

The proposals of the medical industry to restrict the rights of health care consumers are nothing more than special interest legislation. That industry asks that a special niche in American law be carved out for doctors, while the rest of us are held responsible for our carelessness under time-tested rules of law. The "need" for this special protection from traditional American principles of responsibility does not even relate to the technical or scientific nature of the medical profession: the standard of care required of physicians is established by the medical profession itself. A doctor cannot be held negligent unless his conduct falls below the minimum level of care considered acceptable by other doctors in the same field of practice. Yet this standard is not reasonable enough for the medical community. They propose a wide variety of methods to prevent victims of medical carelessness from obtaining full compensation for their injuries.

A review of the four bills introduced on behalf of the medical community displays the attempt to protect the negligent doctor at the expense of the victims and the public.

S-1112 establishes a $100,000 cap on all pain and suffering awards. This proposal amounts to an effort to shift the costs of medical negligence to the very group of people who need compensation the most: the brain-damaged children, quadriplegics, and other acute victims of medical carelessness.

Take for example the incidence of malpractice in which Bob East, Miami Herald photographer, died after undergoing surgery when he was injected carelessly with a formaldehyde-like solution during surgery. Or the incident of a 20

month old boy in Philadelphia who died during a diagnostic study because he was given an intravenous saline solution more than five times stronger than was safe. And then there is the case of the pregnant woman in New York who is paralyzed from the neck down because a physician mistakenly injected an anti-cancer drug into her spinal column instead of into a vein. Would $100,000 compensate for the pain and suffering incurred by Mr. East's widow and children? Would it compensate for the pain and suffering the family must endure for the loss of their young child? Would $100,000 compensate for the pain and suffering that the paralyzed woman must endure for the rest of her life? The cap imposed by S-1112 strikes at the very essence of the jury system. Economic damages are determined by the facts of the case. But it should remain up to a jury to determine the price of "pain and suffering" to compensate a victim of medical malpractice.

S-1135 provides for periodic payments and abolishes the collateral source rule. This legislation would shift the costs of carelessness away from the careless to the innocent victim, who paid for his health insurance; the innocent employer of the victim, who paid for the victim's group insurance; or the innocent taxpayer, who paid for the government benefits. Only those victims who were responsible in protecting themselves by purchasing insurance or disability policies will be damaged. The injustice of this proposal is evident on its face.

An enforced periodic payment fails to ensure the necessary flexibility to permit the victim to meet cost of future medical care as they occur. This bill would allow defendants to keep interest on future payments which would currently go to the victim. Payments would cease upon the plaintiff's death. This shifts a potential benefit from the victim's beneficiaries to those who are responsible for the injury and possibly death.

S-1079 limits the discovery rule in professional liability actions to three years after the date of the act or omission constituting the alleged professional liability. Presently, New Jersey has a two-year statute of limitations from the time the malpractice victim discovers an injury or could reasonably have been expected to discover an injury. In addition, minors have until two years after the time they turn 18 to file suit. This bill is limited to a particular vocation, health care providers. It negates an injured person's right to seek compensation if an injury is sustained but not realized within three years. This legislation could seriously jeopardize a patient's rights if legitimate injuries are not disclosed, advocated, and remedied.

S-1140 would impose more stringent qualifications on doctors who may testify in a malpractice action. This proposal would render incompetent as experts persons who are outside the particular school field of medicine or specialty to which the defendant belonged, even though a court was persuaded that the expert had ample knowledge of the particular medical issue involved.

It is difficult enough obtaining medical experts compared to the ease a defendant has of obtaining a physician to testify in his behalf. Such a proposal further extends the "conspiracy of silence".

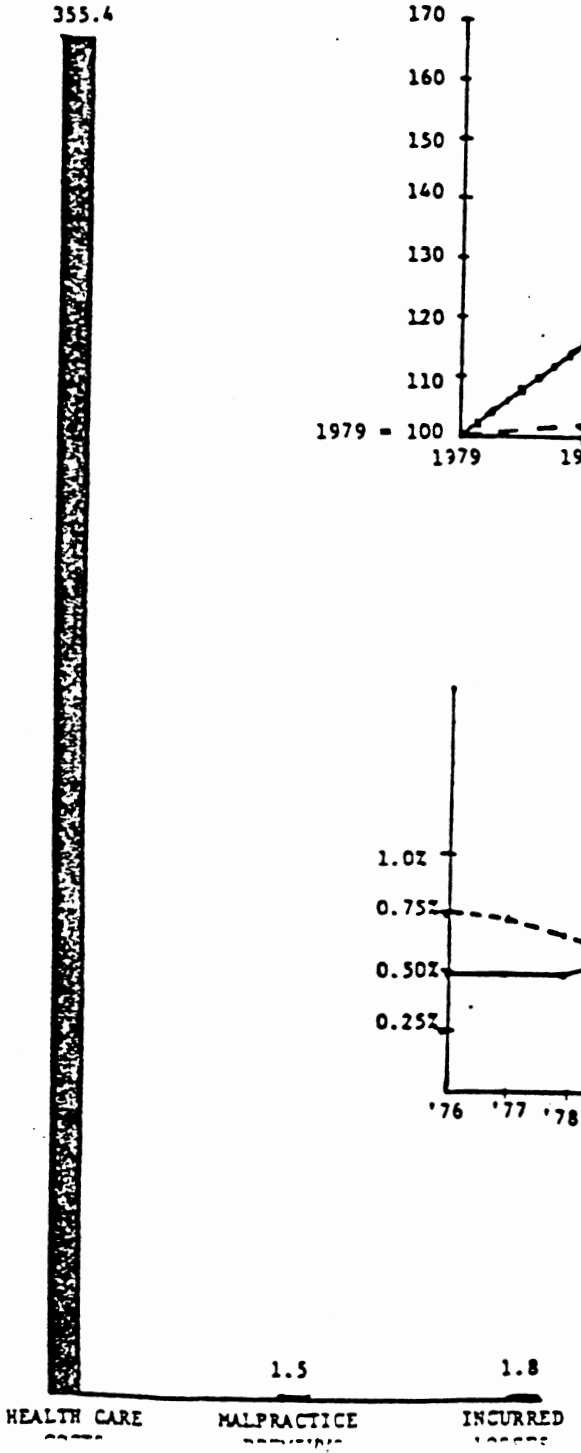
All of these legislative proposals are designed to protect the negligent doctor at the expense of the victims and the public.

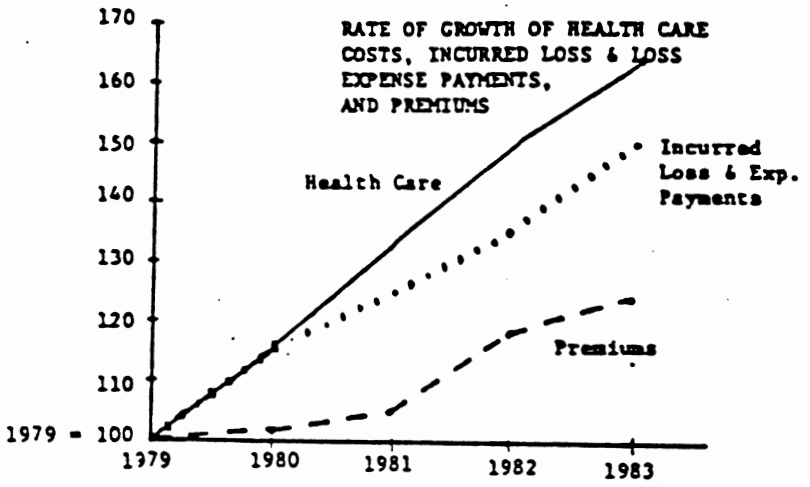
There is a medical malpractice problem. It is too much medical malpractice. As James S. Todd, M.D., Diplomat of the American Board of Surgery and a Trustee of the American Medical Association once said,

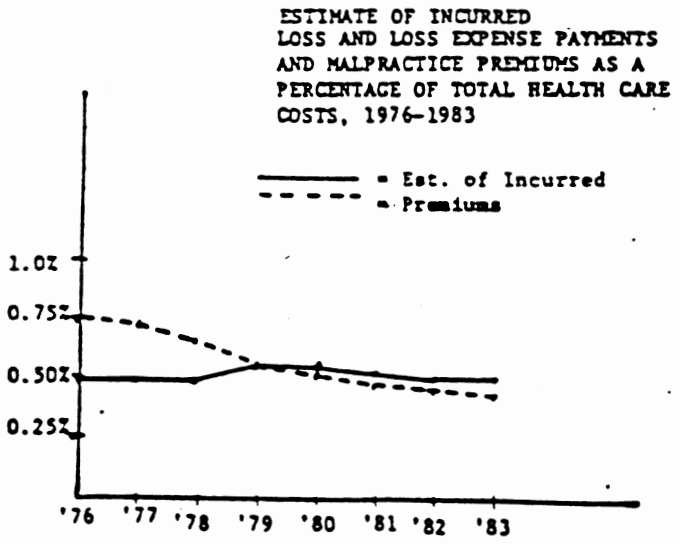
> " . . . Efforts directed toward tort reform and legislative relief must be reasonable and not self-serving. Malpractice is a medical problem, not a legal one, and those injured as a result of negligence are entitled to fair and prompt compensation."

ATTACHMENT A

MEDICAL MALPRACTICE INSURANCE: THE REAL STORY







Sources: U.S. Census Bureau
A.M. Best's Casualty Loss Reserve Dvlpmt.

3.4 X

ATTACHMENT B

Minn.	"In Minnesota we have had to increase our rates every year since the inception of our company in 1980. The average increase over the years is 22%. Hopefully, we won't have an increase in the future—it all depends on the projections. We're hoping to decrease premiums some day." —Robert S. Fiom, MD, Minn.
Miss.	"Mississippi has been faced with steadily escalating rates since 1977 when we started our company. There was no general rate increase in 1984. We did raise family practitioners who do OB one class and we also raised OB/GYN one class. However, we are faced with continuing losses with defense costs and anticipate a future increase." —C. G. Sutherland, MD, Miss.
N.J.	"In N.J. between 1977-1984 we had a 32% total rate increase with an average annual increase of 4% which we think is the effect of inflation. In 1980 we had our largest increase of about 15%. Some classes—OB/GYN and orthopedics—have been adjusted upward and others—ophthalmology, pediatrics and urology—have been adjusted downward. We will have to increase our rates (in the future)." —Vincent A. Maressa, N.J.
Okla.	"In Oklahoma we have some of the lowest premiums (in the nation) and can still sell an occurrence policy. In 1984 we had a 15% rate increase—the first in the five years of our existence. It's too early to predict for the future...(perhaps) small increases." —David Bickham, Okla.
Tenn.	"Tennessee has raised rates every year (because) it writes a modified claims made policy. We have rate increases projected for the future." —L. Hadley Williams, Jr., Tenn.

Data source:
AMACO

American Medical Association
Special Task Force
on Professional Liability
and Insurance
October, 1984

ATTACHMENT C

MEDICAL INTER-INSURANCE EXCHANGE OF NEW JERSEY

2 Princess Road
Lawrenceville, N.J. 08648
Tel: 609-896-2404 Data Bank No.: 03737

ADMITTED ASSETS

	Dec. 31, 1982	Dec. 31, 1981
Bonds: Amortized value	$160,612,906	$142,716,498
Stocks: Cost	(17,237,681)	(14,149,926)
Authorized value	19,402,645	13,042,779
Cash	85,463	302,631
Premium balances	266,756	43,752
Reinsurance recoverable	1,499,746	30,649
Accrued interest	3,956,593	3,358,574
Reinsurance balances	1,819,124	....
Other assets	....	995
Assets (statement)	$187,643,233	$159,495,878

BEST'S INSURANCE REPORTS—PROPERTY-CASUALTY

LIABILITIES

	Dec. 31, 1982	Dec. 31, 1981
Losses & loss adj. exp.	$153,383,733	$123,183,764
Expenses, taxes, etc.	263,161	158,866
Unearned premiums	2,958,719	2,233,998
Amount held for others	757,650	1,109,853
Loss drafts and balances	1,695,275	659,634
Savings to subscribers	31,977	5,104,183
Ceded reins. balances payable	10,064,032	8,751,372
†Unauthorized reinsurance	....	33,488
Total Liabilities	$169,154,547	$141,235,158
Subscribers' deposits	273,200	271,875
Surplus certificates	24,412,813	25,045,887
Net surplus	-6,197,327	-7,057,042
Total	$187,643,233	$159,495,878
Policyholders' surplus (stmt)	$18,488,686	$18,260,720

†Conditional Reserve Funds. See preface.

MEDICAL INTER-INSURANCE EXCHANGE OF NEW JERSEY

2 Princess Road
Lawrenceville, N.J. 08648
Tel: 609-896-2404 NAIC: 34398 AMB: 03737

ADMITTED ASSETS

	Avg. Yield	Dec. 31, 1983	'83%	'82%
Unaffiliated investments				
Cash & short-term invest.	0.0	$349,720	0.2	0.0
Bonds	12.2	190,066,703	85.9	85.7
Preferred stock	13.1	1,810,747	0.8	0.3
Common stock	2.1	24,348,750	11.0	10.1
Accrued interest		4,497,679	2.0	2.1
Total unaffil. invest.		221,073,599	99.9	98.2
Other assets		125,007	0.1	1.8
Total (statement)		$221,198,606	100.0	100.0

LIABILITIES, SURPLUS & OTHER FUNDS

	Dec. 31, 1983	'83%	'82%
Losses & adjustment exp.	$190,516,377	86.1	81.9
Unearned premiums	3,215,913	1.5	1.6
Reinsurance funds	11,859,653	5.4	0.0
Amount retained for others	1,260,667	0.6	0.4
Other liabilities	982,629	0.4	6.3
Total liabilities (stmt)	207,835,239	94.0	90.1
Assigned surplus	24,251,288	11.0	13.2
Unassigned surplus	-10,887,921	-4.9	-3.3
Policyhdrs' surp. (stmt)	13,363,367	6.0	9.9
Total	$221,198,606	100.0	100.0

SUMMARY OF OPERATIONS 1983

Statement of Income

Premiums earned	42,173,618
Losses incurred	63,841,117
Loss exp. incurred	10,213,874
Und. exp. incurred *	2,258,758
Other deduct. & inc.	-1,729,314
Div. to policyhldrs.	....
Net underwrtg. income	-32,410,817
Investment income	22,060,591
Investment expenses	624,967
Net operating income	-10,975,193

Change in Policyholders Surplus

Net operating income	-10,975,193
Realized cap. gains	7,204,369
Unrealized cap. gains	-783,062
Change in non-admit.	-136,708
Cap. & surp. paid in	-434,725
Change in cond. res.	....
Change in polhdr surp.	-5,125,319

*Underwriting Expenses Incurred:

Commissions:	
Salaries	890,717
Taxes, licenses, fees	240,186
All others	1,127,855
Total	2,258,758

Funds Provided from Operations

Premiums written #	42,586,022
Losses paid	29,689,886
Loss expenses paid	7,232,461
Underwr. exp. paid	3,213,403
Other deduct. & inc.	-5,834,148
Div. to policyhldrs.	[illegible]190
Funds from underwrtg.	8,264,230
Investment income	20,128,524
Investment expenses	657,915
Funds from operations	27,734,839

Change in Funds

Funds from operations	27,734,839
Realized cap. gains	7,204,369
Unrealized cap. gains	....
Change in non-admit.	-136,708
Cap. & surp. paid in	-434,725
Other changes	1,499,212
Change in funds	35,866,987

#Premiums Written:

Direct	50,241,154
Reinsurance ceded	7,810,342
Net	42,430,812

SOURCE: BEST'S INSURANCE REPORTS - PROPERTY-CASUALTY, 1983, 1984

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