
Public Hearing

before

ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE
and
ASSEMBLY BANKING AND INSURANCE COMMITTEE

*“Testimony concerning issues and recommendations relating to health-care quality issues,
the enhancement of patient safety, and medical error reduction”*

LOCATION: Committee Room 4
State House Annex
Trenton, New Jersey

DATE: August 1, 2002
10:00 a.m.

MEMBERS OF COMMITTEES PRESENT:

Assemblywoman Loretta Weinberg, Chairwoman
Assemblyman Herb Conaway, Vice-Chairman
Assemblyman Matt Ahearn
Assemblyman Willis Edwards III
Assemblyman Jerry Green
Assemblywoman Joan M. Quigley
Assemblyman Samuel D. Thompson

Assemblyman Neil M. Cohen, Chairman
Assemblyman Paul R. D’Amato
Assemblyman Robert J. Smith II



ALSO PRESENT:

David Price
Mary C. Beaumont
*Office of Legislative Services
Committee Aides*

Wali Abdul-Salaam
Sheila Kenny
*Assembly Majority
Committee Aides*

Tasha M. Kersey
Victoria R. Brogan
*Assembly Republican
Committee Aides*

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ASSEMBLYWOMAN LORETTA WEINBERG (Chairwoman):

Good morning, everyone. On behalf of the Joint Committees, the Health and Human Services Committee and the Insurance and Banking Committee, under the Chairmanship of my colleague, Assemblyman Neil Cohen, welcome. And I guess, by the size of the crowd in the hot August month, we know how important this issue is to a variety of all of you and all the residents of the State of New Jersey.

This is the second in a series of hearings on medical malpractice that we have held as joint committees. I believe that the members of both of these Committees are quite convinced of the seriousness of the problem to physicians, to their patients, and therefore to all of the residents of New Jersey. I for one believe that this is a medical problem, as well as an insurance problem. We do know that there are success stories out there, whether from the Veterans Administration, the anesthesiologists, and other groups that I hope to hear from today. Some of those groups who are not able to be in attendance -- and we expect to hear from them in writing over the next couple of weeks. Today we hope to hear ideas on how the improvement of medical care can be encouraged without jeopardizing physicians and hospitals. I thank all of you for coming, but here's my colleague, he has a few introductory remarks.

ASSEMBLYMAN NEIL M. COHEN (Chairman): Just that I want to welcome all the attendees today who will be testifying, as we work our way through this complicated process that impacts on physicians, our justice system, and on the consumers of health, as well as victims. Today's testimony, as Co-Chair, I will call some of the witnesses. We're going to strictly abide by

the policy of summarizing your testimony. If you have written testimony, you can submit it to the Committee. But the rule on nonreading of the statement will be enforced, and maybe we can begin testimony now because there's so many people.

ASSEMBLYWOMAN WEINBERG: The first witness is Gary Carter, President and CEO of the New Jersey Hospital Association -- is going to be joined by Dennis Miller, from Somerset Medical Center, and Dr. William Cors, from Somerset. Welcome.

GARY CARTER: Good morning. My name is Gary Carter, and I'm the President of the 105-member New Jersey Hospital Association. In addition, I serve on the Joint Commission of the Accreditation of Healthcare Organizations', commonly referred to as the Joint Commissions, National Committee of health-care executives examining ways to collect quality statistics from hospitals and other health-care facilities and use the data to improve performance. I'm also on a second committee of the Joint Commission to identify indicators of quality and measure those from hospital to hospital.

First I would like to thank the Chairs and the Committee members for giving me the opportunity to testify on the continued efforts of the health-care providers to make enhanced and improved patient safety through prevention of medical errors.

I have testimony that I've handed in. I'm just going to read a few comments from that testimony to speed this process up and be respectful of your time. Although it may be tempting to draw a direct connection between current medical malpractice crisis and medical errors, I believe that despite the obvious relationship of particular medical errors and the cases that result from

them that the two are not directly correlated. The current insurance crisis is a result of many factors. This Committee addressed most of those issues at your June 3 meeting, and so I'm here today to focus on the issue of improving patient safety.

What is a medical error? Dr. Dennis O'Leary, M.D., President of the Joint Commission, testified before Congress in May and described medical errors in this way: "The risk of errors in health care is high, an inevitable correlate of the intense human effort involved in patient care; the complexity of services provided; the expectations as a matter of public policy that care be provided with fewer resources; and the progressive introduction of new procedures, new technologies, and powerful new drugs, each with their potential great benefit and their potential for leading to harm to patient care."

Others define medical errors as complex interplay of multiple factors which result in a sequence of failures in mental or physical activities resulting in an unintended outcome. Rarely is a bad outcome due to the carelessness or misconduct of a single individual, but rather through a system process breakdown.

Regardless of how we define medical errors, the health-care delivery system is constantly striving to achieve a culture of safety and improving the care that we provide. Part of this process is reacting to and dealing with errors when they occur. The Joint Commission has a sentinel event policy for hospitals to report unexpected incidents that are directly responsible for patient injury or death. In this type of situation, the providers complete a root cause analysis, which is a process for identifying the factors that occurred in the delivery of care resulting in unanticipated outcomes. The

focus is on the systems and processes, not individual performance, and the end product is intended to provide recommendations on how to avoid future outcomes. Unfortunately, New Jersey lacks the necessary legal protections regarding the discovery of root cause analysis information, which prevents our facilities from taking full advantage of the benefits this process has to offer.

NJHA urges this Legislature to enact the necessary statutory protections to allow our hospitals to take full advantage of this review process and improve patient safety.

Additionally, the health-care system is following the advice of the United States Department of Veterans Affairs and National Center for Patient Safety, which developed the Healthcare Failure Mode and Effect Analysis process, borrowing concepts already implemented in other industries including aviation and engineering. It looks at a process, in this case, any aspect of delivery of care, identifies where errors may occur, and takes steps to eliminate or minimize future occurrences.

The Board of the New Jersey Hospital Association has made a commitment to being a leader in the field of health-care quality and safety by establishing the Quality Institute. The mission of the Quality Institute is to gather the various quality efforts under way in New Jersey's hospitals and spread those works across the state.

The ability to collect valuable data relating to adverse events and near misses relies on a culture that encourages and rewards reporting, rather than a punitive system, which inherently contains disincentives.

In conclusion, I want to leave you with these three points. A medical error is most often a complex interplay of multiple factors resulting in

an unintended outcome, rarely due to the carelessness or misconduct of a single individual, but rather a result of a system process breakdown.

In health-care quality, there is no such thing as good enough. There is always room to improve, and the health-care community is constantly striving to achieve this moving target. In order to succeed, hospitals, patients, and caregivers need to work together. Risk management and quality assurance practices are in place and are continuing to be upgraded in every hospital statewide.

And finally, the professionals who deliver care know the systems and the processes the best, both the strengths and the weaknesses. We as health-care providers and government officials have a societal and ethical obligation to work together to create a culture of safety, including protections for caregivers, so that we can proactively assess the risks inherent within the delivery of health care, inform our patients, and work together towards the elimination of errors. One proactive step you can take is to support statutory protections for the root cause analysis performed by caregivers.

Thank you for giving me the opportunity to testify.

ASSEMBLYWOMAN WEINBERG: Thank you.

Mr. Miller.

DENNIS MILLER: Thank you, Madam Chairperson, and thank you, Chairperson Cohen, and thank you to the Committee for allowing me to testify this morning. My name is Dennis Miller. I'm the President and Chief Executive Officer of Somerset Medical Center. Our facility is a 355-bed teaching hospital based in Somerville, in Somerset County, servicing the

growing residents of central New Jersey. We are fully accredited by the Joint Commission and a member of the New Jersey Hospital Association.

In April, the Hospital Association's Board of Trustees established and asked me to chair the Medical Malpractice Insurance Task Force. I believe the reason for that was prior to my joining Somerset Medical Center three years ago, I was their health-care executive in charge of Aon Corporation's health-care professional liability practice throughout the northeast and greater New York region, and Aon Corporation's predecessor, Alton-Alexander. We had the world's largest health-care insurance practice where I worked for more than 500 clients dealing with issues of professional liability.

The mission of the task force of the malpractice crisis was to attempt to understand the cause of the current malpractice crisis, identify potential solutions that the hospital association can pursue to provide relief to both physicians and hospitals in the state. Issues that deal with tort reform will be presented at a much later hearing.

As you heard from Gary, and as you will hear from Dr. Cors, our Senior Vice-President of Medical Affairs, there are many proactive initiatives occurring in hospitals statewide that enhance and improve patient safety. Rather than repeat many of the issues that Gary has touched upon, I'd like to share with you briefly the perspective of Somerset Medical Center to give you an example of how our facility has and is implementing numerous quality improvement issues. Yet despite that, the cost of malpractice insurance has gone skyrocketing.

The Medical Center has become a leader in medical quality through a series of statewide conferences for the early identification of trends

in medical quality and established the Quality Performance Improvement Committee of the Board of Directors, chaired by Dr. Ron Nahass, Chief of Infectious Diseases. The Board is committed to medical quality as a top priority and reflected in our mission statement of that commitment. Proactive risk management programs have been characterized by education, root cause analysis, and proactive claims management. Yet despite flat or decreasing trends in the number of claims, our liability insurance premiums have skyrocketed. Less than one-hundredth of 1 percent of the patient encounters, and I want to repeat that. There are approximately over 100,000 patient encounters a year at Somerset Medical Center. Less than one-hundredth of 1 percent result in a claim. Half of those claims are dismissed.

In spite of that low percentage, in spite of the fact that claims have been flat or decreasing, we had a 63 percent increase in insurance premiums for professional liability, from 1.1 million to 1.8 million, in one year or a 63 percent increase, which was half of the hospital's entire operating margin. Something is wrong with this system. The Medical Center has made a \$10 million investment in a state-of-the-art clinical information system that will not only make us more efficient in terms of having our clinical systems report to each other, but prevent a physician from manually writing an order and have all orders electronically submitted to reduce medication errors. Dr. Cors will briefly talk about that. But when the Medical Center has implemented all these statewide quality initiatives, proactive, and risk management, minimized claims, our malpractice premiums have prevented us from supporting other initiatives in our community because we just don't have the money because we're spending that kind of money.

At this time, I'd like to introduce Dr. William Cors, who is our Senior Vice-President of Medical Affairs to discuss more about our quality and improvement initiatives.

Bill.

ASSEMBLYMAN COHEN: Before you get to that, over the last couple of years, what have your premiums been?

MR. MILLER: The last three years, Assemblyman Cohen, they have gone up 40 percent, 45 percent, and this year 63 percent.

ASSEMBLYMAN COHEN: And that's with less claims made?

MR. MILLER: Yes. Less claims or flat claims. Yes.

ASSEMBLYMAN COHEN: Thank you.

MR. MILLER: So our operating budget is \$150 million. We are one of the few hospitals in New Jersey that have an operating profit. I'm proud to say that's because we have the lowest expense per admission in New Jersey based upon Hospital Association data. We also have the highest patient satisfaction scores. In the emergency room in the United States, we rank in the 99 percentile, and the rest of the hospital, in terms of one of the highest patient-satisfaction scores in the United States throughout the hospital, plus we have a very aggressive guest services and patient satisfaction program. Despite all these initiatives that the board has implemented, that I as the Chief Executive Officer have implemented, that the medical staff has implemented, we are experiencing skyrocketing claims that are just preventing us from doing all things we need to do. It's impossible. Premiums are going up.

ASSEMBLYMAN COHEN: That's what I wanted to say. Who is your carrier?

MR. MILLER: Princeton Insurance Company.

ASSEMBLYMAN COHEN: They're still writing?

MR. MILLER: Yes, they are.

ASSEMBLYMAN COHEN: Thank you.

ASSEMBLYWOMAN WEINBERG: Dr. Cors.

WILLIAM CORS, M.D.: Thank you, Madam Chair, and other members of the Committee. My name is William Cors. I am a native of New Jersey. I received my medical degree at UMDNJ, New Jersey Medical School of Newark. I did my residency there under Stu Cook, who is now the president of the university. I practiced neurology for 15 years, and since July of 1999 have served as Senior Vice-President of Medical Affairs at Somerset Medical Center.

In that position, I have the responsibility to Dennis Miller and ultimately to the Board of Trustees, who represent our community, for the quality of care and patient safety in our institution. I'm going to outline some very specific initiatives the Medical Center has undertaken, but first I want to speak as a physician and say that I have been extremely concerned with the medical malpractice insurance crisis and how it's affecting practitioners on our staff. We have had at least three young OBs, not people ready to retire -- three young obstetricians -- who have given up the delivery of babies because of rising risk and malpractice premiums.

I have had rumblings of difficulties arising in the area of orthopedics and neurosurgery to provide that kind of coverage. I will be the first to admit that we need a system that effectively deals with and prevents incompetence and wanton medical errors which is an extreme minority of

cases, but we are needing to avoid an environment of fear where physicians become unwilling and unable to deliver high-risk care. Because if I don't have the physicians to provide that kind of care, I have the patient safety issue over which I have no control.

Now getting to the patient safety issues where we do have control. Somerset Medical Center has taken a number of initiatives to ensure patient safety and medical quality for the residents of our region. The first is that it is our intention to become a Leapfrog certified hospital within the next 12 months. Two aspects of that include the installation of a physician order-entry system, which Mr. Miller alluded to, in which all orders for medication and treatments are entered by a computer hooked to prescribing software that's designed to pick up any drug interactions, errors in dosages, and requiring a manual override on the part of the ordering physician.

The second is to staff the intensive care unit at our hospital with specialists in critical care medicine on a 24/7 basis. These are physicians who would be in-house, whose obligations would be solely to our intensive care unit for the coordination and care of the critically ill patients in that unit. That initiative alone will cost in excess of \$1 million per year to initiate.

Beyond the Leapfrog initiative, we have made a major investment in an installation of a QuadraMed data system for an analysis of practice variation and identification of best practice among our physicians so that we can identify those physicians who are practicing in an optimal fashion, obtaining good clinical outcomes, and we can spread this information to the remainder of our staff as the model and standard of care in our institution.

In addition to that, we have an adult hospitalist program.

Hospitalists are, for a lack of a better explanation, inpatient physicians. All they do is take care of adult medical patients inside the hospital. They are there night and day. They are available when things change with the patient. They are in-house. They can respond in a timely fashion. They can shepherd the patients through the system in a very efficient manner and provide an increased safety and outcomes improvement in medical quality. We have had that program for four to five years, and we have been talking with other hospitals in New Jersey who are looking to institute these programs on how to successfully do that.

In addition to that, we are expanding the same type of coverage now to our pediatric service. As of today, we have instituted a 24/7 in-house pediatric neonatology coverage for coverage of all children under the age of 18 admitted to our hospital, all children born at the hospital, all children in the newborn nursery, all children arriving in our emergency room to be seen and cared for by board certified pediatricians and board certified neonatologists. This represents an investment of roughly \$500,000 to \$750,000 per year.

Further, we have 24/7 in-house obstetrical coverage. We have board certified obstetricians that are physically present on the labor and deliver unit to care for any patient in an emergency situation. If a patient comes in and requires an emergency C-section, this can be accomplished in our Medical Center within 15 to 20 minutes because of the presence of the in-house physicians.

In addition to that, we have participated in the National Nosocomial Infection Surveillance Survey. Nosocomial infection refers to an infection that's acquired in the hospital. This is a program that is offered

through the Centers for Disease Control and deals primarily with high-risk infections in the critical care unit. We've made a significant commitment to that effort and have had marked improvement as a result of our participation in that.

I'm just giving you a broad sense of what we are trying to accomplish at significant investment to ensure an environment of safety and quality in our institution. There is always room for improvement. We are looking for an environment where we can move forward and feel safely that we can deal with root cause analyses without fear of retribution, and that we can continue to upgrade the services and quality provided at our Medical Center.

I thank you for giving us the opportunity to testify. We'd be happy to answer any questions.

ASSEMBLYWOMAN WEINBERG: Thank you very much, gentlemen.

I am going to ask you to just step aside for a few moments to hold questions for you because I want to call Peter Guzzo up, from Consumers for Civil Justice, because he has somebody with him who cannot stay too long. So I would appreciate your forbearance and just to hang in there for a few moments for questions.

MR. CARTER: Thank you.

MR. MILLER: Thank you.

DR. CORS: Thank you.

ASSEMBLYWOMAN WEINBERG: Peter.

PETER GUZZO: Madam Chair and Assemblyman Cohen, members of the Committee, thank you for the courtesy. I'm going to just turn it over

right now on behalf of Consumers for Civil Justice to Dennis Donnelly, and with us also is Carmen Rivera and her son Alex.

D E N N I S D O N N E L L Y, ESQ.: Assemblymen, thank you for allowing us, and briefly, I think to make a couple of key points.

I listened to the three previous physicians, all of whom are making excellent efforts. I think if those efforts had been in place, then Carmen Rivera and Alex would be worrying about school supplies instead of medical supplies, but they weren't. So I think that the efforts now are fine, but I do direct all of you to the New Jersey State Medical Society Webpage with their press releases and a press release in February of 2002 this year, which I would be happy to supply to all of you, which indicated that the U.S. health-care system does not -- and I repeat -- does not contain many incentives for physicians to monitor and improve quality.

Before we had an insurance crisis, which is real and which was created by a lot of other things that happened in this culture, the same way some people don't have pensions because Enron had problems, before we had that, there really wasn't enough approach to preventing medical errors. The approach is being made now and to the extent that this Assembly assists that approach and monitors that approach and pushes that approach it will reduce situations like what Alex and Carmen have to deal with today. So I think it's important for you to know that.

The second thing I didn't hear in the excellent presentation by Dennis Miller, and all three physicians, is why isn't Princeton Insurance encouraging those hospitals, which are initiating patient injury reduction methods, and why isn't there a criteria and a system in place by which

insurance carriers are motivating them to make those efforts by giving them decreased rates and, in turn, increasing the rates of those hospitals that don't care to make the initiative and won't make the investment. Why don't we have any qualitative interest in the insurance industry, in rewarding those who do it well, and, in, instead, distributing the cost of taking care of the errors to the people who continue to make them and who decline to put into place systems to stop them.

Before allowing Carmen to speak -- and Carmen is Alex's mom and does put a human face on this -- I would just add the following. We all need to step back, and politics in particular has always been a war of competing interest. You're being attacked, and you're on the battle line. Lawyers are on one end and physicians are on the other. You are constantly being given, perhaps, over-easy fixes, and one of them, in particular, as well, if we only had caps.

Let me just give you this analogy. All of you are public servants, all of you work very hard. All of you were voted in by constituents in the State of New Jersey. However, there's a serious budget crisis at present. If someone proposed to you that we're going to put a cap on legislators who can actually sit -- we're going to say after the election, after the people have voted, we're only going to let 25 percent of you sit, because that will save a lot of money and cost, you would say, "It's ridiculous, it's repugnant, and it's just adverse to what our system is all about."

ASSEMBLYMAN COHEN: Unless I'm part of the 25 percent.

MR. DONNELLY: Every day, in New Jersey, your constituents serve on juries. They give up time. They give up their work. They sit and

they listen to individual cases. They work hard. They try to do what's right. In up to 70 percent of malpractice cases, because many of the worst cases are settled, they decide in favor of physicians. But when they decide for a patient, they have listened to the case for weeks, and they vote. They vote the same way they vote in an election. And for someone to come along and say, "We don't care about your vote. We know you saw the real pain and the real suffering and the real 'non-economic damages' here, but we know better, and we're going to limit it to 250 or 500 or 750 or 1 million or whatever the limit is, is wrong the same way it would be wrong to limit what you do."

So let me ask Carmen, briefly, to tell you what happens when New Jersey juries analyze and when the system itself analyzes a medical error, which in her case happened at the delivery of Alex when forceps and a vacuum extraction essentially crushed his skull.

C A R M E N R I V E R A: Good morning.

ASSEMBLYMAN COHEN: Good morning.

MS. RIVERA: My name is Carmen Rivera. I'm speaking on behalf of my son Alexander. Five and a half years ago our lives changed completely. The day that was supposed to bring so much joy to my husband and my oldest son, as well as myself, turned into a tragic day, a day of mourning. What perfection to others was seen -- a change in our lives. And Alexander came to us with problems, with issues. At one point in time, we didn't know what it was. Everybody addressed it as a stress from delivery. Little did I know, we learned later on that it was a case of malpractice. The doctor used bad judgment, made wrong decisions, and Alexander's life changed forever.

Our lives have never been the same. Alexander has medical issues. I'm very grateful that we live in New Jersey where he has so much good health care. His pediatrician is his best advocate. The hospital that we go -- every time he goes into intensive care -- we have been over 20 times this past five and a half years -- they have taken excellent care of him. But the reason why we can keep Alexander home is because we have that window open to go to court to prove our case, the same way that medical malpractice insurance increases so to care for children or for anyone who has a medical need.

Alexander's life changed completely. He will never be able to sit at a restaurant and order a meal, but probably his feedings are more expensive than any meal in any restaurant. The reason why we're able to have Alexander home sharing everyday life with us is because we have that window open to present our case, to show what happens when wrong choices are made. I would like to have that window open for anyone who actually is in need to keep their family together even though the cost of insurance has increased.

Alexander might never be able to walk or talk, but he is a key part of our lives. We want to extend his life as much as we can. We want to keep him healthy, but on our own we cannot do that. We need the help of the insurance companies. We need the help of the doctors. It's an issue that involves everybody. The same way I don't want to pay high insurance in the car, but I have to. There are certain things we have to cut. I don't feel that this should be one of them. We have to leave that window open for those cases in which it can be proved that an error was made, and families need that help for after.

Everybody left and everybody forgot what happened that day. Alexander will live with this for the rest of his life. If it would have been my choice, I would like to be right now by the beach rather than sitting here presenting his case, but that might never happen. I want to leave that window open for anyone else who is in need of assistance, that it is not closed and the caps are not mandated.

Thank you.

MR. DONNELLY: With more clients like Carmen, it would be not only easier to be an attorney, but it would all remind us that we do get to help people. I wanted you to see the human face of medical errors, and I wanted you to see what happens when juries properly account for families that have to live their lives and deal with it.

Thank you very much.

MS. RIVERA: Thank you.

ASSEMBLYMAN COHEN: Counsel, the case went to a jury?

MR. DONNELLY: This case did not go to a jury because at a certain point in time it became clear to both the carrier and to us-- The carrier by the way, Zurich Insurance -- now they have some trouble and maybe they're out of the state -- but this was certainly a case they needed to resolve fairly. And they did, because the system allowed them to.

ASSEMBLYMAN COHEN: How close did it get to a jury?

MR. DONNELLY: Right up to the usual--

ASSEMBLYMAN COHEN: To the courthouse steps.

MR. DONNELLY: Because we know in practice -- all the way to the courthouse, yes.

ASSEMBLYMAN COHEN: Let me just ask you, how much was-- What's not discussed-- I'm against caps, number one. What's not discussed is what the cost to litigate is one of these cases, especially where there is multiple defendants.

MR. DONNELLY: Okay.

ASSEMBLYMAN COHEN: You may get some idea as to the type of expense that's involved if it had gone through a jury, if you could elaborate.

MR. DONNELLY: I understand.

Assemblyman Cohen, let me address that in two ways and let me give you another analogy.

ASSEMBLYWOMAN WEINBERG: Excuse me. But do it briefly please.

MR. DONNELLY: Yes.

ASSEMBLYWOMAN WEINBERG: We have a lot of people here to testify, and we want to hear how we can improve this system, not what's existing right now.

And thank you, Mrs. Rivera for coming forth and telling us your story.

MR. DONNELLY: Bringing a case like this to court often exceeds \$100,000 in cost. Therefore, any attorney who knows what they're doing carefully evaluates that it is a meritorious case. What you ultimately do, by the way, is instead of investing your time and money and effort for a couple of years on the price of soybeans on the commodities market or on stocks -- and you wouldn't be doing very well if you were doing that now -- you invest in

people like Carmen and Alexander Rivera and you prove their case. I hope to be able to continue to do that.

ASSEMBLYMAN COHEN: Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you very much, Mrs. Rivera. Thank you and thank you for bringing Alexander.

Oh, I'm sorry.

Matt.

ASSEMBLYMAN AHEARN: One brief question.

In this case, if there had been an effective privilege of self-critical analysis for the defendants in the case, would it have prevented you from obtaining, through discovery, the information you would have needed to obtain that settlement?

MR. DONNELLY: In this case, because of the fairly egregious nature of what occurred, using instruments in a delivery where the prior delivery required a caesarean section and it was contra-indicated, I didn't need any fascinating documents. In many cases, to be truthful with you, in many cases you could and some cases you couldn't. I think if you're going to address that, you should address it in a comprehensive way, and you should address it. If you're going to allow privileges, then there's no free lunch, and they come at the cost of state reporting and oversight on the state level and the improvement of delivery of care, and maybe we'll all be better off.

ASSEMBLYMAN AHEARN: Thank you.

ASSEMBLYWOMAN WEINBERG: Dr. Conaway.

ASSEMBLYMAN CONAWAY: I just have to comment on the analogy about juries and legislators.

MR. DONNELLY: I didn't mean to insult any--

ASSEMBLYMAN CONAWAY: Let me finish my comments. I appreciate mother and son for taking the time to contribute to this discussion today. One of the differences, of course, between the action of juries and legislators is that we have to take account of all of the costs in the system. We have to try to assess what the costs are with a particular action because we have to look globally. Juries, as I understand it, really -- and they ought to, I guess -- really focus on what, on the individual at hand and their particular problem without regard -- and indeed, some of these things that I understand, you are not allowed to take into account other impacts on a system.

But let me move on from that just to say on the question of discovery. Again, looking all sides of the issue and whether or not there are going to be privileges. I think your response was that we ought to bring in some kind of (indiscernible) system as a response to that. But what would be, in my view, and I support these privileges by the way -- in fact, I have legislation on it -- I think that on the long run you're going to see that you'll have improved-- You'll be able to drive the ball down the field in terms of improving outcomes and bringing in the kinds of changes that can be made that you cannot get now. And if you start to do the balancing test of whether or not you're going to get better outcomes, better procedures versus not, than I think having those kinds of privileges in place is better than not having them in place.

MR. DONNELLY: I'm not going to disagree with you -- surprise, surprise. I'm just going to say that, number one, tie it back into insurance rates and reward those-- And somehow get insurance carriers interested in

something that seems to have eluded them, which is that you want to encourage the people who are doing the good job and discourage the people who are doing the bad job. And secondarily, I'm not a big fan of bureaucracy either, but I think that whether it's in a combination of the Health Department or the medical society, there has to be a little bit more oversight into how that calculating of medical errors is done, how medical improvement is done, and how well you're doing if you get the privilege in return. Everything in life is a balancing process, Assemblyman.

ASSEMBLYMAN CONAWAY: Just one last one. I would say again and I would ask, and I'll put it in the form of a question. I'm not aware now of whether you talk about auto insurance, and perhaps you can educate me, that we now as a government, as a regulatory body, incur into the marketplace and require insurance companies to give one discount or another. Aren't those kinds of procedures and marketing measures taken by insurance companies in a competitive market-- That is, if I'm insurance company A and want to bring on good risks, it might be to my advantage to give discounts to those players, actors who are taking on these important error-reduction measures, and the company that doesn't make lose that business. Doesn't the market work along those lines, and often, when you let it do that?

MR. DONNELLY: These days saying the market works is a dangerous statement, but the answer is it should work that way, but many times it doesn't.

ASSEMBLYWOMAN WEINBERG: Thank you very much.

Assemblyman Thompson, questions for this group?

ASSEMBLYMAN THOMPSON: Thank you.

ASSEMBLYWOMAN WEINBERG: Is your question for this group?

ASSEMBLYMAN THOMPSON: Yes.

ASSEMBLYWOMAN WEINBERG: Yes.

ASSEMBLYMAN THOMPSON: I also want to take an issue with your analogy that you've utilized. You suggested comparing placing limitations on the award with whether or not you can serve. Actually, that comparison would be better if whether or not you get an award versus whether you serve. The true analogy should be if you're considering whether or not there should be limitations and comparing it to elections, we do have limitations in elections. Thus, the decisions are made on how long you can serve. If you're elected, you're not elected for life. You're elected for two years or four years. So to say placing limits on how much you can receive to compare to placing limits on how long you can serve when you're elected.

MR. DONNELLY: Sometimes analogies have a life of their own, and I really didn't mean anyone to take that one too much to heart. I just wanted to put a little different perspective on it, but thank you, Assemblyman.

ASSEMBLYWOMAN WEINBERG: Don't get up yet.

ASSEMBLYMAN COHEN: Oh, one second.

Assemblyman D'Amato.

ASSEMBLYMAN D'AMATO: Thank you.

Some of the physicians, who have spoken to us informally and who have testified here before, complained about the fact that they are dragged through litigation that can last two to three years, and at the end of that litigation, the case is dismissed against them. Do you have any thoughts about

instituting a procedure here in New Jersey whereby, before a lawsuit is filed, an attorney such as yourself could take the deposition of a physician to determine whether he or she deviated from a standard of care?

MR. DONNELLY: It's a complex question, and part of the problem is that there is natural and sometimes unnatural distrust on both sides of the fence, and I mean physicians and attorneys. Many times there isn't. Four months ago, I gave a grand rounds lecture at Robert Wood Johnson Hospital because a doctor there was interested in hearing where can we do better. I think the issue addressed here goes as follows. There is a pressure on an attorney sometimes to say, "Okay, how come you didn't name the right party," and maybe too many people are named. Good attorneys try to avoid that because more parties cost more money and have more attorneys attached to them.

But presuit discovery would be one way of sorting things out. A second approach would be the allowance of permitting voluntary dismissal of the defendants so as to avoid costs, but to allow the statute to be suspended so that in the event at the end of the case new discovery came out. You understand that privilege is a good idea but sometimes it runs counter to reducing the lawsuit. Because if you can't get at the truth, and I understand in some cases it's obvious, but if you can't get at it, you maybe do have five parties when you really only need one. I think the system itself certainly could work on that. I think that physicians and lawyers, were they willing to get together and try to address that, could maybe make some headway, but it's one way to go.

ASSEMBLYWOMAN WEINBERG: Assemblyman D'Amato, we have had discussions with both the medical society and the trial lawyers about this idea of presuit discovery, and I think there is some willingness on both sides to address that issue.

ASSEMBLYMAN D'AMATO: Madam Chairman, the only reason I bring this up is, in my conversations back in my district, physicians and insurance representatives have explained to me that oftentimes the cost of litigation -- paying attorneys fees and expert witnesses -- sometimes will exceed the amount of the premium. So I'm pleased to see that this dialogue is taking place, because it seems to me that if you do a one-shot deposition, there perhaps is a probability that particular doctor won't be dragged through the litigation.

Thank you for allowing me to ask the question. I appreciate it.

MR. DONNELLY: Thank you.

Am I safe to get up -- and really this time?

ASSEMBLYWOMAN WEINBERG: Part of your morning exercise.

Okay. Can we ask if anybody has any questions for the New Jersey Hospital-- Then, please come back.

Assemblyman Green.

ASSEMBLYMAN GREEN: Thank you, Madam Chair.

I have a question for Mr. Miller. I was hoping today to come here to be able to get a better handle on how we can deal with this particular issue. I sat through the last hearing, and I was witnessing a lot of pointing of the finger. The reason why I'm asking Mr. Miller -- I happen to have been a

patient at your hospital, and I'd like to feel -- not only the doctors but the facility itself is a first-class facility. From the outside, I guess you're about the best person that I can ask the question pertaining to -- no one is more closer to the patient than an individual like you. No one is more closer to a doctor than an individual like you. So somewhere along the line I'm trying to get a feel of who is really responsible for the problems we're having today with malpractice.

Because at the last hearing, Madam Chair, if I listened to correctly, everyone was saying that what happened to this young man earlier, those things happen. We hope it never happens to another child, but yet still we have a process in place where the family can get rewarded. So I feel that no one wants to stop that. I'm concerned about the lawsuits, the amount of money that is spent on lawsuits. That's one question I want to ask you in terms of do you think this system has gone too far, or vice versa. At the last hearing I listened to-- We have a small handful of doctors who basically fall into the category of not doing the job they need to be doing, and I'm pretty sure we should be able to find ways of eliminating that.

But so far this morning, nobody has talked to me about insurance companies who have made huge mistakes outside of the State of New Jersey in terms of their creative ways of making more money. We should be able to put into different categories exactly where the problem happens to be. Again, I like to feel the individual who deals with all these particular levels of involvement, like you do, we can get a picture of it, and someone coming up blaming you. Then when you sit down, someone blames someone else. Let's get passed the blaming. Let's talk about where problems exist and how we can

root it out and how we can move it on, so this way we can enjoy the services like you or any particular hospital.

Again, we don't get anyone pointing the finger or making this Committee feel that an individual will not get the right type of reward, God forbid, if there is an accident. I don't think those are the problems that we're trying to address in this Committee. I'd like to get some feel for the question I just asked from you. Thank you.

MR. MILLER: Assemblyman Green, I would answer that as brief as I can with the following. I think we're all responsible. I don't think anybody, per se, is, but we as a society, we as hospital administrators, you as legislators, my colleague, Dr. Cors, as a physician, have responsibility to make sure that we're providing and doing everything we can to provide the highest quality of care to people we can. I think around this world, America is probably known for providing the best health care, period.

Second of all, no one-- I mean, I'm a father of two teenage boys. No one would obviously deny that family their right to pursue the ability to have funds to take care of that child for the rest of his life. Actually, no one is even thinking about that. No one is even talking about closing the window of suing.

I do think we have a couple of issues, though: (a) I think there is a situation, whether it's been with Enron or WorldCom or dot com or-- I think we have found ourselves in a situation of a lottery system. I think many times a bad outcome is not necessarily malpractice. I think there's been a correlation in our society that automatically a bad outcome means a malpractice and someone needs to pay. It's an opportunity for some people, whether with one

profession or another, to try to find an opportunity to make money out of it, and I'm not sure that's always right.

Second of all, we have certain situations where insurance companies themselves-- I would love the opportunity to have my insurance company give us credits and discounts for the millions of dollars of (indiscernible) we make, but the reality is there is only one carrier right now who is even writing hospital insurance. There's not an opportunity to have five companies compete for the business, just this one. So they need to spread the loss amongst everybody.

Second of all, most insurance companies make their money not on premiums collected. They make their money on investment income. When the market goes down, their investment income is going to go with them. I also think, though, that there is a cap today on hospitals. Years ago, it was a \$10,000 cap. There's a cap today that a hospital cannot be sued for more than a quarter million dollars. The problem is they got around it by suing the employers. The problem that we need to have is that the employers who are so hard to get to begin with should be subjected to the same cap that the hospitals, would be one thing to helping here. But I think we have a responsibility, all of us, to find the middle ground. How do you do the following. How do you make sure that we can continue providing the best health care we can so physicians can practice medicine, as we want them to do, and yet the consumer and the patients and the parents have a right to financial remedies when something does go wrong, God forbid, and a child like that, which is a tragedy, has to be taken care of? We need to fix that. We can do that collectively by making sure that we're going to have all the critical

information systems necessary, documentation, be able to do due diligent reporting within, without having to have discoverability. There's a lot of efforts we can -- and I think you're going to hear more about it down the road.

ASSEMBLYMAN GREEN: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman Conaway.

ASSEMBLYMAN CONAWAY: Let Willis go first.

ASSEMBLYWOMAN WEINBERG: Who are you pointing at?

ASSEMBLYMAN CONAWAY: Willis. I think Willis was supposed to go first.

ASSEMBLYWOMAN WEINBERG: Oh, Assemblyman Edwards. I'm sorry. You were out of my eyesight there.

ASSEMBLYMAN EDWARDS: Good morning. First of all, let me just say good morning.

My question is sort of directed towards Dr. Cors. You mentioned in your opening statement with respect to three of your OB/GYNs who had decided not to go into the practice of delivering children. In my office, I've received numerous calls from various residents from the community, as well as physicians, dealing with the concern of finding adequate physicians who could deliver children.

About a week ago, my wife and I gave birth to a new daughter, and the physician, while we were discussing various different issues, said, "If you hadn't come in August, I wouldn't have been able to deliver your child, because my premium has escalated to a proportion which is out of norm with the amount of income that our office is taking in."

Is there some sort of solution that we can come towards our high incident rates? Because what we hear a lot of is good -- those doctors doing a good job and those doctors who are doing a bad job, but I think there has been little dialogue with respect to the professions of physicians who are dealing in high-incident areas. How would you like to address that particular area?

DR. CORS: I've gone back and read the Book of Solomon several times. I don't have an easy solution. I think that, in essence, there has to be some way to sort out the cases that truly need to be compensated -- I think everybody in this room would agree that an Alexander Rivera falls into that category -- from the numerous other cases that have little to no merit, because they still need to be defended, they still need to be prepared, they still need to have some conclusion brought to it. The way it works with a lot of the insurance companies is even if you're named in a suit, regardless of what the outcome is four or five years down the road, your premium goes up. It just keeps escalating.

I guess what I'm saying is where do we get to a point as a society where we don't have access to high-risk services and we wake up one morning and say, "There's nobody to deliver our babies. There's no trauma team in Las Vegas, Nevada. There's no neurosurgeon who is going to take an emergency room call when you have a car accident and have a blood clot on your brain." I don't have the answers to those questions, but I think that there needs to be some compromise to walk through this whole area of litigation and error and separate out, as I've said in my testimony, the true cases of incompetence and wanton error from episodes of maloccurrence on a very personal level.

My father currently is a patient in a hospital. He went in for a cardiac cath, and during that procedure, suffered a stroke. It was an untoward event. Was it malpractice on the part of the doctor? How do you answer that question? My dad was a smoker, a hypertensive, a person who neglected his health. It was a bad outcome, but it wasn't malpractice. I think that we need some way to kind of walk through this as a society, because it is going to affect us all. I have two young daughters in their twenties. I hope there's somebody to deliver their babies when the time comes.

ASSEMBLYMAN COHEN: I'll try to limit it, because there are a lot of things raised in a lot of the comments. Number one, in the case of Alex's situation, it wasn't resolved in 30 days. Somebody didn't agree to resolve it until they hit the courthouse steps -- three and a half years, over a hundred grand in out-of-pocket expenses before you got to that justice. So it wasn't settled within 60 days, where somebody said, "Oh, yes, it's a problem. We ought to resolve it." It took them a long time, and they were about to try the case.

We need to -- and this is an extremely complicated, a whole complicated issue, a societal issue, business plan issue. I mean Connecticut has its own physician plan for insurance coverage. They've managed to survive even during bad economic times because the physician insurance system is self-contained to the state of Connecticut.

My brother is a doctor and self-contained because Connecticut decided they were not going to go to Texas and Mississippi and California and try to make a lot of money amongst directors and officers and capture the entire national market. We need to try to address something immediately,

which is why some of us have been considering freezes on last year's rates, why we're considering renewals. All this for the course of 12 months at least. Because of Assemblyman Edwards remarks that the physician that delivered he and his wife's child may not be practicing in OB/GYN come August.

So we have to come up with something at least temporarily. It's going to be an affirmative obligation on us to come up with something immediately, because capping is ludicrous, but capping involves eight, nine, ten years down the road in terms of the effect of capping. So we need to come up with something-- This is becoming a health-care emergency. We may need to resolve something no later than the end of September, which may get into certain controls that the insurance industry may not like.

What I'm also saying is that there was a reference to physicians who may not be working in the hospitals because they're not going to want to be in OB/GYN or other high-risk or neurosurgery areas because of the cost of premiums. I'm wondering whether the hospitals are then going to have to start hiring in-house physicians and set them up in practices and provide the insurance malpractice coverage to those physicians so that the hospital and patients are going to have OBs available and neurosurgeons available. That may be the new wave until this economy changes, until business plans change with regard to insurance companies, that maybe that's going to be the way so that women, and, obviously, men whose spouses or nonspouses are giving birth, that they're going to have physicians available.

I'd just like to know, maybe just in a brief snapshot, that if this does keep up because they can't make money on their reserves because the economy is bad and every two or three years or every ten years we seem to go

through this crisis that seems to ebb and flow and whether or not you're going to need to purchase or set up physicians, young physicians and those who are already experienced, in their practices and bear the cost of the premiums just so that you have access to that availability.

ASSEMBLYMAN CONAWAY: Can I ask a question?

MR. MILLER: We actually have already begun looking at that issue about hiring people just to do OB in the hospital. Now we have today, at Somerset Medical Center, 24-hours, seven-days-a-week -- we have a board certified obstetrician in-house which provides assistance to the voluntary obstetrician who is in the office, who may not get there at 2:00 in the morning, 2:00 at night. We thought about the possibility of talking to him about actually having to hire people and employ them and then provide the malpractice with them. But that's only going to push their cost problems onto us, that we may have to do that as part of our mission but it will add millions of dollars of expenses to us with no supporting revenue. It's not really, maybe, an immediate answer to have someone to deliver Assemblyman Edwards baby, but it's not certainly an answer for the long term, because where am I going to get the money from to--

ASSEMBLYMAN COHEN: No. I mean, the revenue comes from if-- Let's say you had an outside physician, who did OB, but had privileges at your hospital. Well, you charge for whatever is given on behalf of that doctor, part of the operating room, that's your charge. The doctor is getting the revenue by virtue of the procedure from health insurance.

MR. MILLER: What managed care pays for delivery, most physicians don't want to do it.

ASSEMBLYWOMAN WEINBERG: I was about to say, and I think we have this pretty much substantiated, that the third party payment to OB/GYNs is lower than it was 10 years ago.

MR. MILLER: Right.

ASSEMBLYWOMAN WEINBERG: So that's what has created this crisis, particularly in the area of OB/GYN, because the reimbursements have gone down and the insurance has gone up. So there's something left unpaid in that equation, and I know we are all worried -- particularly the impact that this has on womens' health in the State of New Jersey.

Mr. Carter, and then the Assemblyman.

MR. CARTER: Somerset is blessed in that they have a bottom line, but an inner city hospital losing money every year can't necessarily go out and hire physicians to bring them in to deliver the babies. These babies can be very high-risk babies, so this just can't be thrown to the hospitals expecting that they can solve it.

ASSEMBLYWOMAN WEINBERG: Assemblyman.

ASSEMBLYMAN CONAWAY: I think that's right. One of the things, I mean, just reflecting on this statement about the hospital sort of being able to hire the needed physician supply for obstetrics is not a very practical way to go. I mean, you have hospital practices, folks who practice there, those who practice outside the hospital. They do so for the various reasons, but certainly they are all needed in order to provide the services that are there, and if the predictions of the loss of obstetricians come to bear, particularly if no action is taken by the government, we could lose, I understand, 20 percent of the people who are practicing. That represents -- I don't know if disaster is the

right word -- but a very serious patient-access risk to women in the State of New Jersey.

You mentioned the problems of access to high-risk specialty care in the hospitals. I was listening to this. I'm saying welcome to Philadelphia. If we don't act, that's what we're going to have. One of the people in this audience, just down in Philadelphia at a hospital there, signs all over the physician's offices, "We are done. We cannot continue to practice because of what's happening with medical malpractice insurance." Now we have a choice here in the State of New Jersey to allow this situation to go unabated, unchecked and end up like Philadelphia or to take decisive actions to make sure that patient access is maintained, that physicians are able to continue in practice.

And before I get to my questions, also the comment about appropriate reimbursement for what's being done. We are all being underreimbursed for what's being done, part of the reason why hospitals are on the edge now. You are lucky in Somerset, I think, because of where you are and have a lot of employed folks there. You have, I think, compared to a lot of other people, a very favorable patient mix, and I'm glad for you.

One of the questions I had -- well, looking at yourself, why do you suppose -- and I understand you're not the only one doing this, having been and talked to folks at Robert Wood who are doing these kinds of internal reviews in bringing these kinds of things -- what is it about Somerset and Robert Wood, that you're able to do this? Is it just a question of leadership? How costly is this if you're an inner city hospital or you're currently operating in the red, bringing on these kinds of changes doing this kind of internal-- I

mean, you can afford that, I presume. Do you think that that is something that is broadly affordable in the hospital system or is there something unique about the leadership at Somerset and Robert Wood? And I have a couple of questions beyond that, please.

MR. MILLER: We did it because, when we had our board retreat and strategic planner, we felt it was absolutely essential that we do it for our own survival, that we felt that the consumer would demand nothing but the best in terms of quality. Therefore, it was one of the highest initiatives that we had. We felt we had to come up with the money to do it. There was no other choice. We wanted to do it. We weren't mandated to do it. We certainly are clearly different than a hospital in an urban area with a 40 percent self-pay proportion and a 40 percent Medicaid population and having absolutely no bottom line. We have certainly a relatively decent pair mix certainly in the Somerset, Hunterdon County area. So we're able to-- We actually borrowed the money to make the investment in the critical information system, and not everybody probably has that ability to do it. We did it because of the board leadership and our medical staff leadership. We're very unique. We have a great working relationship.

MR. CARTER: I think every hospital would like to do this, but it's a matter of economics. If you don't have a bottom line, if you don't have reserves, how can you do this? And the hospitals are feeling consistently under stress. Charity care, which is obligated by this state -- 624 million. The State pays 381 million. Medicaid rates are at 75 percent of cost. It's just an ongoing vicious cycle, and just throwing it to us doesn't solve the problem. But I think every hospital would do these things if we had the resources to do them.

ASSEMBLYMAN CONAWAY: You mentioned some of the impacts of this crisis. Of course, you've seen the loss of physicians who are practicing obstetrics. My own neighbor has had her baby this year, lucky, because her obstetrician won't be there for the next child. What are you finding in terms of your ability to recruit good physicians to your facility in this malpractice environment? Is it difficult to get people to come to your facility and/or to your part of New Jersey because of this problem that we're as yet unable to solve?

MR. MILLER: Because of the growth of our population and the favorable demographics, we are able to recruit and retain people to practice. I can tell you, though, in addition to Dr. Cors indicating three young people who dropped off, we've had people who have said, "I can't even do GYN surgery because not only-- People think if I drop out of OB and my malpractice rates come down, I can still do GYN." I said, I can't afford. There's not enough surgeries like in the GYN to -- that malpractice just for GYN, that if I just focus on GYN in my office, it's not enough. So it's really a tough economic issue for some of these people here, but overall we are able to, because of the phenomenal growth in the population base, able to recruit physicians when they see the ability to earn a living. We are able to do that.

ASSEMBLYMAN CONAWAY: Gary, any comment?

MR. CARTER: Again, it's the same thing. The demographics are great where he is. They're not great in inner cities. And if, you know, most of your patients are going to be Medicaid, which already reimburses the physicians at obscenely low levels, it's difficult to recruit.

ASSEMBLYMAN CONAWAY: And one last question, Madam Chairman, if I may.

This question of trying to use some other model to bring insurance to physicians. Now I understand that Robert Wood is going offshore, as to leave the country, in order to set up one of these -- what are they called -- the--

MR. CARTER: Captive.

MR. MILLER: Captive.

ASSEMBLYMAN CONAWAY: --captive insurance companies, and are bringing their employed physicians into that. Is there some mechanism, some way to help either -- that you can see to bring, allow physicians to do that, or maybe extend this kind of coverage to those physicians who are affiliated with these particular hospitals that could be done in a cost-effective basis and also in terms of technology? What do you see as the barriers to having hospitals extend with technology in-- Because your physicians that are working there that are doing order entry, that's great. But a lot of the care that's being delivered is not being delivered through the hospital system. It's being delivered in primary care offices just like mine, as a matter of fact. And so one of the questions I have is, is it possible to use hospitals as a node, if you will, to extend technology out of the primary care office to bring this kind of medical error reduction there? Are there (indiscernible) of costs that can do that?

ASSEMBLYWOMAN WEINBERG: We really have to move this along. There are a lot of speakers there waiting to get to the microphones, so let's ask brief questions and give brief answers. You can see I'm surrounded on one side by a physician and on the other by a lawyer. (laughter)

MR. CARTER: There are ways that we can do this. We are also looking at captives. We are looking at different insurance vehicles. I think we can try to extend the technology into the doctors' offices. This is all a part of the process that everybody is looking at to try to solve the problem long term.

MR. MILLER: I would just like to add, very briefly, I do not think coming up with new vehicles to finance insurance is solving the problem. I do not think forming a captive insurance company or going self-insurance or what the mechanism is-- The financing of the premium ain't the problem. It's the magnitude of the intensity of the losses that are being required to be paid out. That's the problem.

Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman Ahearn.

ASSEMBLYMAN AHEARN: Yes, through the Chair. Whatever we end up doing, I agree with Assemblyman Cohen, that this Legislature is going to have to do something soon, but it's all going to revolve around the battle of words. The term that I keep hearing coming up is high risk, and I hear it high-risk baby. I hear high-risk procedures. I hear high-risk practice areas. What I'm wondering is, is there anything within the medical profession -- I mean, I'm an attorney, but I've never done malpractice or personal injuries -- is high risk a term of art where there is some agreement that a legislative definition could be created, or are we dealing with a fog of words that we get bogged down in and never be able to define what high risk is?

DR. CORS: I think that you probably can. I'm not sure it would be so simple, but I think one can intuitively understand that removing a mole under local anesthesia in a dermatologist's office is not the same as operating

on somebody's head with an operating microscope. I think that traditionally, even if you looked at the type of cases that generate claims, is one way of--

It's not working. (referring to PA microphone)

ASSEMBLYWOMAN WEINBERG: That was my fault.

DR. CORS: It's one way of determining what high-risk cases are. I think there probably would be a broad understanding of what kind of falls into category *A* and category *C*, and there might be some argument about some cases in between, which are category *B*, but I think cases could be stratified.

ASSEMBLYMAN AHEARN: If anyone has any suggested structure or classification system, I would certainly love to see it.

DR. CORS: Well, the malpractice companies do, just by virtue of premium differentials. As a neurologist, I pay one premium. My neurosurgical colleagues pay a premium that's 10 times mine. So the malpractice insurance companies already determine that what a neurosurgeon does is approximately 10 times riskier than what I do. So there is that built in.

ASSEMBLYMAN AHEARN: Just a quick follow-up question. Is there any already established procedure where either your insurance company or someone requires that before you do a procedure on a patient, if it's considered high risk with that insurance company, do you have to disclose that to the patient? Yes, before whatever a high-risk surgery is, are you telling a patient, "Hey, this procedure--"

DR. CORS: Well, we inform consent for the procedure, sure.

MR. CARTER: Every time you meet with the patient you explain to them the risk associated with and the benefits every time.

DR. CORS: Every single time. Yes, every time.

MR. MILLER: That is required.

ASSEMBLYMAN AHEARN: And in that process -- I know about there's informed consent -- but is there any distinction in what you do with informed consent between what you would consider a low-risk procedure and a high-risk procedure, or is it the same briefing, same discussion, same paperwork?

DR. CORS: No. It's the same process. It is a totally different discussion. If I'm signing a consent for an appendectomy, it's one set of information. If I'm signing a consent for an operation on a spinal cord, it's the same process. It may be the same form. It's an entirely different discussion.

ASSEMBLYMAN AHEARN: Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you very much, gentlemen.

MR. MILLER: Thank you.

MR. CARTER: Thank you.

DR. CORS: Thank you.

ASSEMBLYWOMAN WEINBERG: I'm going to call Dr. Susan Mettlen, Vice-President of Information Services at UMDNJ.

S U S A N M E T T L E N, Ph.D.: Good morning. Thank you for allowing us the opportunity--

ASSEMBLYWOMAN WEINBERG: The red light has to be on.
(referring to PA microphone)

DR. METTLEN: Good morning. Thank you for the opportunity to present this morning. My name is Dr. Susan Mettlen. I'm Vice-President for Information Services at the University of Medicine and Dentistry of New

Jersey. Dr. Cook has asked us today to come and give a presentation of our comprehensive electronic medical records system, which we believe is very important in promoting patient safety and reducing medical errors.

During the last four years under his leadership, we built a comprehensive system that has electronic laboratory, electronic pharmacy, electronic radiology, and then coupled with our electronic medical record in the out-patient setting promotes an integrated system for information.

ASSEMBLYWOMAN WEINBERG: Dr. Mettlen, let me ask--

DR. METTLEN: Yes.

ASSEMBLYWOMAN WEINBERG: Since you've developed this system, what have you seen in your malpractice rates?

DR. METTLEN: We're self-insured so there isn't that issue. But we can speak in a few moments to perhaps experience in incidences of errors. During the next year we will be implementing the final stages of our inpatient system. When we're complete, we're going to have a completely integrated system, which does what was mentioned a moment ago, take from the hospital and bring out to the physician offices and the clinics a system that has the alerts, the drug interactions, the information at the point of care for physicians, which we believe is critical in promoting patient safety.

In order to do a demonstration, we have brought a sample system. This is not a real patient, but it gives you the idea of how the record works and how it's used in everyday practice. This is for an outpatient setting. And to do the demonstration, I brought Dr. Jack Norris, who is our Director of Health Informatics at the New Jersey Medical School, and he's also a practicing physician. He is going to just take you through this and give you an idea of

how the alerts work, how this interacts, and how it provides information to the physician. Okay.

ASSEMBLYWOMAN WEINBERG: Again, very briefly, please. Skip over some of the slides if you can.

JOHN W. NORRIS III, M.D.: Okay.

ASSEMBLYWOMAN WEINBERG: Go ahead.

DR. NORRIS: Good morning. What I'll do is, with the permission of the Committee, I'll turn on the projector.

The University Hospital is the safety net hospital, in the Newark region, for patients who are indigent, patients who are high risk by whatever definition you make that. The practice that I work in -- I was the Medical Director of -- is the General Medicine practice down the hallway from the Emergency Room at the University Hospital. You might say it's a safety net hospital. It's a safety net practice of a safety net hospital.

The system that I'm going to demonstrate, very briefly for you, is an electronic medical record with decision support features. That's the key aspect of it. It ties in some physician order entry, but is not a true physician order entry system. (demonstration begins)

The first thing that I wanted to show you is a typical examination room. And a typical examination room, you can see, has the patient's chair, the table, the doctor's chair, a telephone, and a computer screen. The system itself makes it much easier for physicians to keep in contact with the staff and the staff to keep in contact with the patient. Messages, instead of little bits of paper like what I have here -- instead of getting messages from my patient's like this at one single source, they can be put on a screen that I can pick up

any place in the medical center, and by double-clicking, drop into a patient's chart. In this case, abnormal labs with Mr. Walter Cauldwell.

Now again, as Dr. Mettlen stated, this is a fictional patient. This is not a real patient. We are not on a live system. We are on a programmer's version of the system. The key to it is the aspects that, when you open the chart to see the patient, you have a problem list, medications, allergies, advanced directives, registration notes -- like this particular individual wants to be called Wally -- the picture of the individual, the notes, and also a flow sheet. If an issue comes up with a medication, you can just double-click on the section, highlight the medication such as Monopril that you wish to see, double-click on that and instantly be in the know. So if you adapt anything having to do with medications, problems, or specific medical indicators, the system will not only assist the physician, bring that information quickly to them, but also allow the physician, with the design of the room you saw, to show it to the patient at the same time.

To show you briefly, just starting with health care -- is a systematic process. Starting with a medical health technician, a med tech, doing vital signs with the patient, the med tech gets the patient, brings him into the room, does blood pressure, knows their problems, meds, allergies, knows the last thing that the physician wanted at the last visit to make certain it's present, knows, in our multiphysician practice, who actually is the primary for the patient, has the ability to enter vital signs. If they enter in a vital sign such as 210 systolic blood pressure, which is a very high reading, the system kicks out to them that you'd better tell the physician now, as an alert.

The system also knows that this patient happens to be an asthmatic. You can see, in yellow and red, we're using it as an indicator, stating to the staff member, "The patient is short of breath, do a peak flow." Once this information is garnered by the technician, they sign off on the note. The physician gets the -- walks into the room and sees the patient, what the physician gets. Now this is where I see health care going as far as electronic systems and decision support.

Notice, we didn't say why Walter came in. Let's say -- primary care practice -- Walter came in because he has a cold. Well, when Walter came in with his cold, I notice immediately that he has a greater than 30 percent chance of having an MI in the next 10 years -- having a myocardial infarction, having a heart attack. That according to Adult Treatment Panel III by the NIH, the latest cholesterol guidelines that about May of 2001, were widely publicized and stated to be very aggressive guidelines that many Americans would end up on cholesterol-lowering medications, and we prevent many heart attacks. They came out with a way that I can assess an individual patient's risk instantaneously just having the system present the data in a certain format. The system easily goes ahead and carries out that format in a way that the patient can also see. Now this again is talking patient safety. I'm not wasting an opportunity to care for a patient.

The system knows the patient's age. It knows the good cholesterol, the total cholesterol, the blood pressure, and the smoking status. According to this guideline, each of these gets weighted, and that comes to a total. Once you have the total, that's converted to a percentage risk. Anyone who is 20 percent or more is associated with having coronary artery disease

and being in risk of having a heart attack now. So you have to be aggressive with the therapy.

But that's the stuff that's coming in the near future to assist us. This is costly equipment. This is things that have to be developed. You need consensus panels. You need guidelines translated into practical software that works efficiently at the point of care.

If we go into the physician's note, one of the things important whenever anyone does any job, especially a physician, is they have to have access to information instantly. First of all, I know what I wanted to do with the patient from the previous visit. I also know, by hitting the problem list, what the problems are and can assess them. I also know that the last time the patient came in this was the history of that illness. This is the HPI. As well as, if I decide while talking to the gentleman, that I want to start him on a lipid-lowering agent, I hit medications, no. Reference list, I'll start him on Lipitor.

The computer shows me the different dosings that the medication comes in, the relative cost on average that the medication costs -- I can double-click on the one that I want. It drops in. The system right now has a yellow light. That means for this patient's HMO, this is a high-cost medication. They will provide it, but they don't necessarily support its-- I'm going to be talking utilization and will allow me to print out not just the prescription on a piece of paper printed for the patients, but will also allow me to print out the pharmacy-type handout that explains in lay terms what the side effects and possible complications are of that medication.

Now once I entered that into the list before I printed, and since I don't have a printer, I'm just going to hit the button that says, "Check interactions." The system checked the interactions. And on this patient's list, notice how many things interact with food, interact with other medications such as Monopril interacting with Ecotrin, alcohol interacting with the Cimetidine, which he takes for his upset stomach. And if I want to look closer, I highlight -- they said Cimetidine. They report, it not only tells me the effect, but tells me the mechanism of action. So I'm referenced. That's an example of true decision support technology, a system that just doesn't tell me, "Doc, are you sure you want to do this," but explains to the doc or reminds the doc on what it is that they're concerned about doing.

So okay. So what happens is, rather than go through each of the different things it does, one of the most important things is the system also allows me to quickly structure patient education. The key to patient safety is cultural competency and a patient understanding what's going on. As you can see from the list, and I won't go through it, this allows us not only to document and act as a checklist as the patient is about to leave the door, what it is to make certain that the patient understood, but also allows us to document that the patient preferred Spanish, and we used a translator from AT&T whose number was such and such.

So now, to close, I'd like to show just one more demonstration, and that's this. As the patient is leaving the general medicine practice of the University Hospital in Newark -- and this system is also available throughout the state through other UMDNJ sites -- as I'm entering that I want the patient to follow up with a 20-minute visit in two weeks with me, the system is also

reminding me that this patient needs to be screened for colon cancer, don't forget it. It's showing me any past history the patient has with colon endoscopy, PSA screen. Notice this person's allergic to flu shot and has refused it in the past. Underneath Pneumovax, which they had, and notice I have no consider light, no alert, I could go ahead and I could drop in an order to go ahead and give them a Pneumovax if I so chose. The bottom line is allergic, you don't get it; not allergic, the doc has the option to give; patient has the option to refuse, but we've documented the refusal. Something in my experience not -- has been challenged in many practices.

The final thing that I'm going to show you has to do with PPDs. Everyone who is involved in public service gets tested in their physical exam when they start to make certain they have not been exposed and are not carriers of tuberculosis. They get a little skin test. Well, if that skin test is positive, you should never have it again. It's chest X-rays. Well, in this case, the system does not know that this person is PPD positive and gives me the option of doing it. If I state that the person is known PPD positive, notice it gives me a chest X-ray result and it gives me an ability to do X-rays instead.

And that's the end of my presentation. (end of presentation)

ASSEMBLYMAN CONAWAY: Thank you very much for that.

Any questions from the Committee about what was said? (no response)

I'll just ask one or two. Is this particular software program, is this owned by the University or is this a private vendor who is--

DR. METTLEN: This is actually an example of Logition, which is commercially available through Medscape. We have done extensive

modification in building information within the system. The alerts that Dr. Norris showed are ones that were developed at the University.

ASSEMBLYMAN CONAWAY: What do you think the cost-- Like I said, I have an idea of that, but just for everyone else -- so I've been researching these things for myself -- what's the cost of something like that? How do you see the University being involved with its physicians, either who are on staff or even those physicians who are affiliated and bringing this kind of technology to the typical outpatient office? What kind of barriers, costs, logistics, do you think are involved in that kind of a process?

DR. METTLEN: The cost for a user license is approximately \$2000 per physician. The most expensive cost obviously is the maintenance of the big system that maintains all of the system. We do that internally. We've probably spent \$3 million over the last four years developing the alerts, the knowledge base, the information supports. We currently have this available to 3500 physicians, nurses, med techs, etc., throughout the state. It's our goal to bring this to the rest of our affiliates to allow them to use it also.

ASSEMBLYMAN CONAWAY: Assemblyman Ahearn.

ASSEMBLYMAN AHEARN: Are there any studies or any empirical data that shows that use of an automated system like this reduces errors over a properly established paper file in the doctor's office? What's the cost-benefit analysis here? What the bang for the buck in terms of error reduction?

DR. NORRIS: If you go to the agency for health care quality and research that used to be called health care quality -- let's just pass on what it used to be called. What happens is they have a very detailed Website that

includes many examples. A lot of work has been done at Mass General by a Dr. Bates. There's Dr. Whachter (phonetic spelling) from the University of Southern California. They've seen in studies where they attempted to look for specific errors. I mean, as much as an 87 percent reduction in the type of error they were looking for based on the introduction of these systematic systems.

ASSEMBLYMAN AHEARN: Are you undertaking any kind of data gathering at the University now presently in New Jersey?

DR. NORRIS: Yes, we are.

ASSEMBLYMAN AHEARN: Any kind of indication so far?

DR. NORRIS: It's difficult. It depends. If I paint it with a broad brush, I could do the example of driving down here. How many accidents did I avoid? It's very difficult sometimes to go ahead and do a comparison on how much we actually reduced considering that our volume has been influxed to do organizational changes within the system.

ASSEMBLYMAN AHEARN: I understand that, and I understand all the footnotes and caveats to any statistical analysis, but it seems to me that over a five-year period, if you had X number of a particular type of error, and then, following the year after this you saw an 80 percent reduction, I mean, is there anything dramatic that should attract my attention as to why? We're already in a very expensive profession with costs rising all of the time, and I get the feeling that this is being presented as some sort of error reduction, but I mean the costs are staggering, as you said. I've been involved in similar tools for litigation support in some of the big pharmaceutical companies, and the biggest problem is people don't use it.

So I'm just curious as to where the real analysis is and who's going to do it as to whether or not all of this development and doing this really solved any problems, or is it just part of something that's being done as a general trend to automate and reduce paper? Does it really improve practice, or is it just a different filing system?

DR. NORRIS: Let me give you an example of tobacco. Tobacco -- one in three Americans become ill or die from tobacco-related illnesses. We have studied tobacco and-- In the past, we were very challenged in our documentation of tobacco status of our patients and our ability to gauge, to scale, to state how well we were doing in assisting our patients of quitting. We've done that. What we've been able to do is find that patients coming through this safety net practice -- 5.6 percent of our patients who come through in the initial studies, 5.6 percent of patients who come through who are current smokers actually end up as a net quit, which we consider a success.

Now that also led us to go ahead and decide on a business plan on a hospital wide basis that we wanted to open a smoking cessation center at the University, and what we're doing is using it as evidence to go ahead and move forward with that. So, to answer your question as I can, I would state to you I would take tobacco as one of the largest risks we have. That now we know where we stand with it. We've used the information to change our business plan. And that as it stands right now, we see ourselves as making a difference, and this system is absolutely to be given great credit for us being able to do this.

ASSEMBLYMAN AHEARN: Well, I again -- I use your example of smoking. In my mind, you have to develop these systems, poured my years

and lives and things into them, so I understand how you can become attached to a system. But for a smoker, what's the advantage of a \$3 million system versus putting a red tab on the patient's file in the cabinet that says, "This is a smoker?"

DR. NORRIS: The advantage is twofold. One, instead of looking to subset of our-- When you walk into the office, your physician is not just-- When they see a dot on a chart, that's a dot on a chart. Then I have to go through each and every one of the visits, or I have to find a particular sheet on that particular issue, which literally I'm digging through paper instead of staring at you and talking to you. So, when a physician is in a room with a patient, this system brings that information to him very expeditiously in a systematic way.

DR. METTLEN: Well, we found previously when we had the dot on the chart or the note in it -- in the paper world very rarely, probably less than 10 percent, did the physician ever discuss smoking cessation with patients. Now we know it's over 90 percent. Now we are just at the point where we are establishing base lines for all of these, because just coming from the paper world we really didn't know. We never knew how many physicians counseled patients, for instance, to quit smoking. Now we know and we're working on using those as targets to improve.

In our OB/GYN practices, for instance, the chair in meeting weekly with the faculty has the top 10 procedures that they believe are important, and they give each physician a rating on the percentages of patients that were offered those treatments or were screened. This is moving toward the 100 percent goal. What we know is that we started out with, in some cases, 14

percent of women were being counseled to get mammography, and now it's over 85 percent. So we are in the process of establishing those base lines, setting targets, and measuring the difference.

You asked why physicians would use this. One of the areas that we've found that has been very motivational is financial, because of all of the pressures that you've heard mentioned today. One of the things that we know when we use an electronic system, we capture every procedure. We capture everything that's done, and everything is billed appropriately. In the paper world, that didn't always happen.

ASSEMBLYMAN AHEARN: One, I guess, two more questions. On the technical end of this database, I know it's a proprietary front end. Is the database that's behind this a national ANSE-approved database structure, or is the structure itself proprietary too?

DR. METTLEN: It is not proprietary. We use an oracle database. We're using it for data mining, for research, and for other.

ASSEMBLYMAN AHEARN: Thank you.

DR. METTLEN: Yes.

ASSEMBLYMAN CONAWAY: I would just comment that I believe that this technology is absolutely -- in making this technology ubiquitous, our health-care system, in fact nationwide, is absolutely critical to bringing out in the primary care offices where most of the care is being done to raising the level of care and quality care to helping quit smoking, to make sure women get the mammograms and their Pap smears and all the preventative medicine things that need to be done. It would be a wise

expenditure of national and State dollars to make sure that kind of technology acquisition can take place.

Thank you.

DR. NORRIS: Thank you.

DR. METTLEN: Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you.

I'm going to call up Bruce Stern, who is President of the Trial Lawyers of America. Following that, Dr. Robert Rigolosi, who is President of the New Jersey Medical Society.

Mr. Stern, again we are anxious to hear how we can improve this system.

B R U C E H. S T E R N, ESQ.: Thank you, Madam Chair, Mr. Chairman.

Unfortunately, medical errors happen. They're expensive, they're tragic, and they affect and devastate families and individuals. We're here this morning to help you appreciate and understand and to personalize. We talk about statistics, and we see charts, but we need to put a human face on the tragedy that occurs all too often.

You know, this weekend we all sat transfixed in front of our TV screens watching what was going on to nine miners buried beneath the earth in Pennsylvania. They spent millions of dollars to get those nine Pennsylvania coal miners out of the ground. People stayed up all night waiting until the last miner was pulled from the earth.

Last summer, as a result of 100 deaths due to faulty tires, Ford Motor Company and Firestone severed a century-old relationship, all because

100 people died. There were congressional hearings and media blitzes. When we opened the newspapers yesterday morning, all across the country we saw the plight of 56 pilot whales and the efforts of all of the volunteers that worked to try to save them.

Madam Chairwoman, 98,000 people a year die as a result of medical errors. Over 2500 infants, our babies, are killed each year due to hospital-acquired infections. Many of these deaths are preventable if only hospital employees would do what our parents have taught us ever since we were so small and we could climb up on the step and reach the faucet -- wash our hands. According to the Centers for Disease Control, hospital-acquired infections are the fourth leading cause of death in the United States behind cancer, heart disease, and stroke. More people die in the United States from medical errors than from highway accidents, breast cancer, or AIDS.

We remain frustrated that the medical industry is seeking immunity from responsibility and accountability for its medical errors. Instead of crying for legislation to limit its responsibility, accountability, and liability, its time would be better served and spent seeking a solution to prevent death and harm than from shielding itself from personal responsibility.

I'm Bruce Stern, the President of the Association of Trial Lawyers of New Jersey. I want to thank this Committee for allowing me to speak today and applaud your efforts to focus on patient safety for all of New Jersey's residents. I speak not for my 2400-member attorneys, but for all the citizens of the State of New Jersey.

I would like to introduce to you Sandra Egbert sitting behind me. Sandra is here today because her life was forever changed as a result of a

medical error. Sandra was a teacher's aide in Morris County, and she had a small little rash on her cheek. She went to her doctor, who diagnosed that she had dermatitis and prescribed a corticosteroid cream. He told her to come back in a month after using it. Over the next day or two, her face began to swell. She developed fevers. Her husband called the family doctor and told him what was going on. Her husband asked, "Should she be given an antibiotic," and the doctor said, "Trust me, I know what I'm doing," and he simply changed the medication from one steroid to another.

The next day she was taken to Morristown Memorial Hospital, her face swollen, where she was ended up being hospitalized for over a month and underwent the first of 27 operations and surgeries. Sandra has stopped working. She's in constant pain, and she's become a virtual recluse because of her facial disfigurement. According to her medical expert, the Chairman of the Department of Family Medicine at Thomas Jefferson Medical College, the administration of steroids was like throwing gasoline on a fire. Had she been given antibiotics within the first two days, she would have-- What was a minor infection turned into what the doctors call a flesh-eating disease. After a lawsuit was filed, the case was settled in private mediation. Sandra is proof that medical errors happen.

We talked about and have discussions about caps and tort reform. The insurance industry itself has said that limiting patients' rights will not reduce malpractice premiums. The CEOs of New Jersey's two largest medical malpractice carriers -- MIIX and Princeton -- have both admitted that caps and tort reform will not result in lower medical malpractice premiums.

Even the American Insurance Association has said that lawmakers who enact tort reform should not expect insurance premiums to drop. Since March, this legislative body has been seeking a legislative solution to the malpractice insurance problem. We remain convinced that your focus needs to be on the business practices of the malpractice insurance carriers. However, patient safety and medical errors are important issues for this Committee to address.

Consider this: Medical errors produce more permanent disabilities than do workplace accidents. The agency for health care, research, and quality found that the number of adverse affects from medical treatment has more than doubled in recent years, rising from 300,000 in 1993 to 700,000 in the year 2000. Two recent studies found that 70 percent of adverse events and 50 percent of surgical errors are preventable.

In New Jersey, doctors disciplined for gross negligence receive, on average, a three-month suspension. New Jersey ranks 26th in a state-by-state study in the number of serious disciplinary actions meted out by the medical board. These are statistics that point to the reality of medical errors. However, when I think of medical errors, I don't think of statistics and charts. I think of people.

I think of Wanda Presley of Trenton. Wanda went in in the spring of 1998 with low back pain.

ASSEMBLYMAN CONAWAY: Just one second before you go. As you go and talk about the cases, and I appreciate the folks coming, would you, when you get to the resolution, talk about what amount of money these clients actually received and how the award was meted out in terms of

noneconomic damages and other compensation? If you could just break those down for us, I'd appreciate it.

MR. STERN: If I'm able to, I will be happy to do so.

Wanda Presley, in the spring of 1998, developed severe low back pain. She saw six separate physicians. She was in the emergency room. Despite positive X-rays and positive bone scans, not one of those physicians ever ordered an MRI. By the time the MRI was finally done two months later, which revealed a bone infection, osteomyelitis, it was too late. She had developed an epidural abscess. The two-month delay by these six physicians have left her virtually confined to a wheelchair. She'll need care for the rest of her life. Ms. Presley's case was settled just prior to jury selection.

Wanda, and other family members affected by medical errors who are seated with me today, are here because they want you to understand that medical errors can and do happen. They affect real people. They are not just statistics. They're our mothers, our fathers, our brothers, our sisters, our aunts and uncles. They are our children. When I think of medical errors, I think of Maria Siemers, sitting to my right.

I sat here with all of you last month at the first of these hearings. I sat back there, and I listened to one of the obstetricians talk about a bad baby. Have you ever heard a more repugnant term in your life? But that's what the obstetrician called it, as if an infant is at fault for a birth injury. Ms. Siemers was having a normal pregnancy, when, according to her fetal monitor tapes, the baby went into distress. The doctor did nothing, did not read the fetal monitor tapes. By the time they tried to deliver the baby, it was too late and her baby daughter was born stillborn. No one ever told Mr. and Mrs.

Siemers that her obstetrician had been in a confidential alcohol rehabilitation program. They never knew and were never given that information.

As we all work to gather information about the bad business decisions and the problems caused by the medical malpractice insurers, when it's all remembered what this is really all about, doctors who came to Trenton last month by the busloads to cry in the streets for tort reform never mentioned patient safety, not once. Hospitals are sending all of you, all of you, laundry lists of every restrictive tort reform measure possible as a way of addressing this problem. They need to concentrate their efforts on error elimination as a way of eliminating lawsuits.

This problem is really all about Wandra Presley, Sandra Egbert, Maria Siemers, and their families, and all the many others who suffer as a result of errors and medical negligence.

Madam Chairwoman, Mr. Chairman, members of this Committee, I pledge to you our sincere willingness to work with you to identify the real problems of the medical malpractice problem. We want to help you tackle this insurance industry problem, but I also pledge that we will fight any attempts to restrict the legal rights of those who are harmed by medical errors.

Thank you.

ASSEMBLYWOMAN WEINBERG: Mr. Stern, I'm going to take issue with you on one point in your testimony. Since I am not associated with either the legal profession or the medical profession, I will tell you that the doctors with whom I have spoken do talk about patient safety, but it's very hard sometimes to provide good patient care if, in fact, what you realize from your medical practice goes to pay for your medical malpractice insurance. But

I can assure that the physicians in the State of New Jersey, by and large, are interested in their patient care.

ASSEMBLYMAN CONAWAY: You better believe it.

ASSEMBLYWOMAN WEINBERG: The unfortunate types of medical malpractice is -- that are represented by the people who have accompanied you today is one of the things that we are trying to hold down. We've got to find a common ground that is not quite as adversarial between the two groups.

Thank you.

MR. STERN: If you'd like me to comment, I appreciate--

ASSEMBLYWOMAN WEINBERG: Not particularly.

ASSEMBLYMAN CONAWAY: No. Mr. Stern, I notice and perhaps I still haven't heard the breakdown of any of these and how this -- again, what happened in noneconomic damages, how much did the families actually receive at the end of the process? I hesitate to ask the folks who come, but perhaps, through you, those questions could be answered for me, please.

MR. STERN: I'd be happy to supply you with that. I thought you had asked me to finish my statement, and then I was going to provide you with the information. My understanding is -- and I didn't represent any of these three families that are here. My understanding is that Ms. Egbert's case was settled for \$2 million. Now, it's interesting, at the time that this occurred, Ms. Egbert was working as a teacher's aide making \$150 per week. As a result of what occurred to her, she is now permanently disabled. So, if we just look at the problem and look at what the hospital administration and the doctor's have asked for -- and we will get the bills on caps -- had there been caps in place, all

Ms. Egbert would have recovered as a result of the 27 surgeries in the medical negligence that occurred was about \$400,000 or \$500,000 for all that she's gone through.

With regard to Mr. and Mrs. Siemers--

ASSEMBLYMAN D'AMATO: Madam Chairman, Mr. Chairman, before we proceed, I just have a note of caution. I don't know if any of these settlements were a sealed settlement precluding a disclosure of the information that Dr. Conaway wants. I just -- it's a note of caution, because Mr. Stern wasn't their attorney, perhaps there should be some exploration of that.

ASSEMBLYMAN COHEN: Well, Counsel-- Mr. Stern, if you can just check with the witnesses as to whether or not anything has been sealed, or whether any of the settlements are confidential.

MR. STERN: I believe that Mr. and Mrs. Siemers case was settled for \$500,000. I'm sorry, it was a verdict of \$500,000.

And Ms. Presley's case, I understood, settled just prior to jury selection for \$2.34 million.

You were talking about costs before--

ASSEMBLYMAN CONAWAY: I wondered how much that you received of those settlements.

MR. STERN: The settlement was \$2.34 million. I know the costs were \$66,000, in response to one of your earlier questions to Mr. Donnolly.

ASSEMBLYMAN CONAWAY: All right. Well, after that question is just go unanswered.

MR. STERN: I don't know if there's something else I'm missing.

ASSEMBLYMAN CONAWAY: Just moving on, one of the things, that you said, that you would like to offer suggestions about what we can do. I haven't heard any yet. What do you think we ought to do? What are your specific suggestions. I can write them down here, and we can go over them, as regards the question of medical error reduction. What is your contribution to the process at the end of the day -- we can achieve the kind of system that you think we ought to have here in the State of New Jersey?

MR. STERN: Well, I think we can have full and prompt disclosure of medical errors -- should be required. We've heard discussions about the VA experience, and we are in support of that. We think that the Board of Medical Examiners should create a better system for review with physician actions where malpractice is found. We think the New Jersey Division of Consumer Affairs should permit members of the public who have filed a complaint against a physician with the Board to learn the status of their complaint. We think physicians in addiction problems must have restrictions upon their privilege to practice until they have demonstrated recovery from their addiction.

We need to improve the accuracy of patient identification, use at least two patient identifiers whenever taking blood samples or administering medications or blood pressure and improve the effectiveness of communication among caregivers; improve the safety of using high alert medications; eliminate wrong site, wrong patient, and wrong procedure surgery; improve the safety of infusion pumps; improve the effectiveness of clinical alarm systems to name just a few. We can provide you with our list.

ASSEMBLYMAN CONAWAY: Now you mentioned -- all of those things have costs. Have you thought about costs of implementation and how some of these are going to have to be born, I guess, by the physician, about the tax incentives that you might suggest. How is this-- A physician -- certainly reimbursement is capped flat, we can't negotiate with our payers. We can't raise our salaries to take on these extra costs. Any thought about how these costs are going to be born?

MR. STERN: Well, when you mentioned that your fees are capped with insurance--

ASSEMBLYMAN CONAWAY: That's right.

MR. STERN: --by private insurance, when they were sending mothers home, the Legislature stepped in and required longer stays and required the insurance carriers to pay for that stay. It's interesting that all of the doctors who are down here yelling for tort reform -- I always question when the issue was the HMOs coming in and cutting their rates, where were they then?

ASSEMBLYMAN CONAWAY: Where were you? Were you helping us trying to do something about preventing those cuts in fee reimbursements? Were you helping us then working as a team?

ASSEMBLYMAN COHEN: Let's be careful in terms of the question.

MR. STERN: I don't think--

ASSEMBLYMAN COHEN: Let's go back to civility in terms of tone, answers and questions.

MR. STERN: I don't believe, Assemblyman -- we certainly would always stand with you for that. The doctors were never organized. I've asked doctors why, when you used to get \$2500 to deliver a baby, and I remember when my daughters were born about what it cost for prenatal care in the delivery of my children, and now I understand what they recover is so much less. I asked why was it that you were willing to take so much less. You're walking out of hospitals today, leaving women without doctors to deliver babies because the cost is so high. Where were you walking out of hospitals when you weren't getting fairly paid? The answer I'm told is doctors came in and undercut each other on prices that they would work for. But, Assemblyman, we're certainly willing to work with you on that.

ASSEMBLYMAN CONAWAY: And one last question. You mentioned-- Oh, I'm sorry. You had focused, of course, on, and it's appropriate that changes need to be made to reduce the-- If there are bad physicians out there, in my view, they shouldn't be practicing. We need to do a better job of policing ourselves. We need to do all we can in medical error reduction.

I'm curious however, is there no impact-- You mentioned that I guess the tort reform or any kind of reform is a nonstart. I've heard things like it is ridiculous to think that caps could be involved in the process. Is it, and I might not be thinking about this appropriately and I want you to correct me if I'm wrong, if the amount that insurance companies have to pay for these awards goes up, isn't there some correlation between settlements that occur and the adjudications that occur through trial? If those figures are going up and they're coming with greater rapidity, are you stating that there is no

connection between that and the premiums that insureds have to charge their physicians and that we physicians have to pay?

MR. STERN: First of all, last month, during the hearing here on affordability and accessibility of medical malpractice insurance, we heard Ms. Costante from MIIX tell this Committee that there had been no increase in claims and settlements and verdicts over -- I don't know if it was a five- or a ten-year history. She then, in response to one of your questions, made the statement that they were now paying out a million dollar claim a week for the last 26 weeks.

Chairman Cohen requested Ms. Costante to please support that statement and to provide the Committee with that data. My understanding is, six or seven weeks later, that data has never been supplied. I have never seen any data to support the position that verdicts or settlements over the last year have increased. Now, in response to your second question with regard to a correlation between what is paid out in premiums, I, like you, sat here last month when Ms. Costante spoke. Assemblyman D'Amato asked her, and his question to her was, "If we enact caps and enact the tort reform that you have suggested, would that reduce premiums?" Her answer was, "No."

In Monmouth County, there was a town meeting of, I think, 175 doctors. The CEO of Princeton Insurance was there. He also reiterated that enactment of tort reform and caps would not reduce medical malpractice premiums. We heard it through the products liability debate that we went through in the mid-1990s. They are now saying they never told you that if you enacted tort reform it would reduce premiums. We see after the tort reform of the mid-'90s here in New Jersey, premiums to businesses for product

liability and premise liability is not changed. It's not me telling you, Assemblyman, that there's no correlation. We're getting that information from the insurance industry that sets the rates.

ASSEMBLYWOMAN WEINBERG: We have other people waiting, so-- If you would, Mr. Stern, would you provide us a copy of that list that you read off at the end of suggestions for improvement.

MR. STERN: I would be pleased to.

ASSEMBLYMAN COHEN: Just in terms of something I'd like the Bar to think about, and that is those procedures that we can maybe come up with presuit, prefiling procedures, where we can sort out so that we're not going to have to file 12 John Doe, Jane Doe nurses, and 12 John Doe and Jane Doe physicians, which you have to file just to protect your client and yourself. If there's anything in the Bar -- and I would ask the Bar to be creative, to come up with some prefiling procedures that can cut down on costs and try to bring cases to a quicker and earlier resolution. In the absence of that, we're still going to have a problem, because most cases aren't settled until you hit the courthouse door. And when you hit the courthouse door, you already invested \$100,000 in expenses, out of pocket, from the law firm, and that money is going to come off as a repayment from any award or a settlement or a jury verdict.

It would seem -- and a lot of what we've been saying is really a long-term solution. Because even if you do cut down on expenses and you cut down procedures and you resolve cases within the first six months, as opposed to going three years before trial and another two years before it hits the State Supreme Court, all of that may affect premiums three-, four-, five-, six-, eight-,

ten-years out. We need to try and deal with something that's more immediate. I'm talking within the next couple of months. I believe you're right, and that was the testimony. There was testimony by Ms. Constante to Mr. D'Amato's questions, to my questions, and a couple of other members that said, even if you do this, we can't tell you that your premiums are going to be reduced at all.

So, even if you put into place things that would reduce, systematically, costs that are involved, they can't even guarantee that you're going to have any reduction at all. They can't even guarantee that you're going to have any increased stability. So you have 5 percent increases, 8 percent increases, not 3 percent to 45 percent. So, even if you go through all this, none of us have a commitment from the insurance industry that if everything was put into place that someone is going to see a reduction in premiums within 12 months or within two years. Right now, there is no promise that will ever be reduced.

I'm glad you went through the history of products liability litigation, the promises that were made, but no concomitant reduction in premiums at any point later on. The promises we get from the insurance industry are cap, limit, restrict, but we can't guarantee you a reduction. And every time we've gone through that process, no one has ever seen a reduction at all. And if it does exist, I offer it to the industry to show us exactly what has been reduced, where steps were taken.

But the Bar needs to work out some kind of procedure that's going to cut down on the expense and time for resolution. I mean, maybe that will help to some extent.

ASSEMBLYWOMAN WEINBERG: Okay. Now for the--
Oh, I'm sorry. Assemblyman Thompson.

ASSEMBLYMAN THOMPSON: Thank you, Madam Chair.

Mr. Stern, by far the majority of your testimony seemed designed to convince us that medical errors occur. Well, actually, we didn't need convincing of that. We know medical errors occur. There is a great deal of effort going on within the medical community today to reduce the rate of errors. However, as long as humans are involved, I have to be pessimistic and feel medical errors will continue. Every effort will be made to minimize medical errors I'm sure, but they will still occur periodically no matter how much effort is put into it.

The reality of the situation that we're facing today is that, as a consequence of the cost of medical malpractice insurance, many physicians feel they cannot afford to practice medicine, and, therefore, the medical services needed will not be available to our citizens. But what we have to come up with is a solution to somehow or other make this an affordable proposition so physicians can stay in practice and to be available when people need them. That, of course, is the goal that we're working towards here.

Yes, we will do everything we can to encourage the elimination or reduction of medical errors, but they're going to be there. But the bottom line is we have to come up with a system to make it affordable, whether we're speaking in terms of caps or whether we're speaking in terms of other procedures that were spoken of there. That's why we're looking for your help, the medical community's help, everybody working together to, bottom line,

come up with a system that is affordable so that the health care needed by our citizens will be available.

MR. STERN: I think you're absolutely right.

ASSEMBLYWOMAN WEINBERG: Sam, turn off your microphone so his goes on.

MR. STERN: I apologize.

I think you're absolutely right. We heard the testimony this morning of the strides taken by the medical community. Medical malpractice and medical errors isn't something that just started in the last year. They continue to work to try to improve the system. We know and heard stories about what the anesthesiologists have done to better their profession and reduce medical errors. And at the last hearing, we heard further testimony about that. And that's what gets us to the fact that medical errors and reduction is not going to solve the short-term problem that Chairman Cohen and Chairwoman Weinberg discussed.

The problem is not the tort system, the civil justice system in the problem that you're addressing just now. The problem is with the medical malpractice insurance carriers. Why have they artificially increased their rates in the last year. We can look at states that have no caps, and there are a number of them that have no caps and no premium increases. Their tort systems run just like our tort systems. Many of those states permit a greater recovery for wrongful death than our states do. So the issue isn't the civil justice system, nor is the issue medical errors to address the problem that this Joint Committee has come together to address, which is why have the insurance carriers arbitrarily and capriciously just raised their rates.

And that's where I think the focus of these Joint Committees need to be. It would have been helpful had they supplied the information that was requested by this Committee six weeks ago.

ASSEMBLYMAN THOMPSON: I'm not sure we're at the point yet where we can necessarily say that's the sole problem there, but, of course, you're looking at all areas, and we'll try to find them.

ASSEMBLYWOMAN WEINBERG: Assemblyman D'Amato.

ASSEMBLYMAN D'AMATO: Thank you, Madam Chairwoman.

A thought to my colleagues who are here today and also for you, Mr. Stern, as a follow-up to what Chairman Cohen was saying. When I was a much, much younger attorney, we had in New Jersey a medical malpractice mediation panel. It was one judge, one physician, one lawyer. I think we might want to look at that. Because as soon as an answer was filed to a complaint, I think they had limited discovery and there was this mediation. This might be a way of reducing protracted litigation and all the expenses that come for both sides, not only the plaintiffs but the defense attorney. Defense costs can be 60,000, 75,000. Expert costs can be 50,000. So it is something that I would invite the Bar, the physicians, and all of us to, perhaps, look at it.

Thank you.

ASSEMBLYWOMAN WEINBERG: Go ahead.

ASSEMBLYMAN CONAWAY: Thank you.

You mentioned-- The one thing that I hear-- Well, let me ask this question first. California -- the AMA just sent out something. They were looking at the nationwide -- the landscape in terms of medical malpractice and premiums. California was one of the states that was not listed as being in crisis

or having a problem. I note that they have pretty stringent caps out there. Now, do you believe that California is not in crisis because-- Is there some other reason that they're doing so much better than we are with -- given the fact that they have a different law as regards caps? To answer that question, I'll just make this comment and close.

What I seem to be hearing is that the physicians are going to have to do a better job policing itself, and that's true, we do. Hospitals need to do a better job at medical error reduction. It's true, they do. That the insurance are at fault and we've got to do something about them, I wonder if you think we ought to regulate medical malpractice insurance companies, like auto insurance -- I didn't ask that question -- but maybe that's something you can chew on. All I hear is that everybody else needs to do something, but not tort reform, and that the trial lawyers, who I think arguably contribute to this problem, don't have to bring anything to the table to bring a solution to this problem. Am I wrong in making that statement?

MR. STERN: Well, let me answer it this way. In 1995, we had tort reform in New Jersey. We didn't address the medical insurance issue in the mid-1990s. We didn't address medical negligence and medical errors in the mid-'90s, but we did address tort reform. We enacted the affidavit of merit statute, which saw a reduction of 25 percent in the number of medical malpractice claims in the State of New Jersey. I believe it went from 2500 down to 1600. We put in joint and several laws that changed the law that we had for centuries here in New Jersey. So there has been tort reform in New Jersey that applies to medical malpractice cases.

To answer your question about California, which has a \$250,000 cap, number one, the premiums--

ASSEMBLYMAN CONAWAY: Cap on which -- just on economic damages?

MR. STERN: I'm sorry. They have caps on noneconomic damage.

ASSEMBLYMAN CONAWAY: Only?

MR. STERN: Only, in California. The premiums in California are 20 percent higher than the average in the United States.

I also recently heard a story about a corporate attorney whose wife was pregnant-- I'm sorry, there was a child. The child was killed. So there was no economic losses due to the tragic death of the child due to medical negligence. This corporate attorney had -- therefore the most that they could ever recover was \$250,000. They tell me he was appalled because he couldn't find an attorney in the state of California to take his case for the wrongful death of his child as a result of medical errors because the recovery was limited to \$250,000.

Now when you look at states like Arizona, Maine, Minnesota, Mississippi, North Carolina, Oklahoma, Vermont, and Wyoming, as well as our sister state of New York, none of which those states have caps, none of them have a malpractice insurance crisis. You look at West Virginia which has caps. They saw a 30 percent increase in their insurance premiums over the last year. So we look at other states that are having no problems and have no caps, we ask what is different about New York, what is different about Oklahoma, North Carolina, Mississippi?

ASSEMBLYMAN CONAWAY: Answer the question. What is it?

MR. STERN: There is no difference.

ASSEMBLYMAN CONAWAY: Oh, there must be. There has to be a difference.

ASSEMBLYWOMAN WEINBERG: I'm going to exercise the prerogative of the Chair now, because this hearing was not intended to be about noneconomic damages or about tort reform. We have other issues. I would like the list that you've prepared on suggestions. I would like to know the list of states that you refer to in which you said there are no caps and medical malpractice insurance has remained at a fairly good level. So I'd like to get that list from you, if I may.

MR. STERN: We'd be happy to supply that.

ASSEMBLYWOMAN WEINBERG: Excuse me?

MR. STERN: We would be happy to supply that to you.

ASSEMBLYWOMAN WEINBERG: Thank you very much, and I appreciate all of those of you who came down and accompanied Mr. Stern. I want you to know that we are well aware that there is medical malpractice all over the country. And what we're trying to find out here is ways to avoid these kinds of future mistakes on your behalf and on behalf of the future generations here. So thank you for coming.

MR. STERN: Thank you, Madam Chairman.

ASSEMBLYWOMAN WEINBERG: I would like Dr. Robert Rigolosi and members of the Medical Society come forward.

ROBERT RIGOLOSI, M.D.: Thank you, Madam Chairperson, and Mr. Chairman.

The Medical Society of New Jersey thanks you for the opportunity to testify today. My name is Dr. Robert Rigolosi, and I am the President of the Medical Society of New Jersey. And with me today are two members of the Medical Society, Dr. Fred Jacobs and Dr. Bernard Saccaro, on my far right.

Dr. Jacobs is a pulmonary specialist and is a former Director of the Intensive Care Unit at St. Barnabas Medical Center. He's also a graduate of Rutgers Law School and is admitted to the New Jersey Bar. He's past President of the New Jersey State Board of Medical Examiners, and currently, Dr. Jacobs is the Executive Vice-President for Medical Affairs in the St. Barnabas health-care system.

Now Dr. Saccaro is a board certified internist and rheumatologist from Bergen County. He's the Chairman of the Medical Society's Medical Liability Task Force. He's our expert on malpractice issues, and you've heard from Dr. Saccaro before at your first public hearing.

At the outset, let me say that we are willing to discuss patient safety and medical error issues with you and the trial bar, but we want to do this along with and not in lieu of tort reform. We are convinced. The American Medical Association, our AMA, is convinced. Other state medical societies are convinced. The federal government is convinced, and polls show that the American public is convinced that only tort reform will ease the medical malpractice insurance crisis. Specifically, we're looking for a cap on awards for noneconomic damages and a real statute of limitations.

We're encouraged by two recent developments. First is President Bush's call last week for the Congress to limit noneconomic damage awards in medical malpractice cases to no more than \$250,000. Second is Nevada's

Legislature's convening of a special session this week, specifically to enact such a cap. Nevada, as you probably know, is one of twelve states considered to have a medical malpractice insurance crisis.

New Jersey, to our concern, is also on that list. So while we discuss public safety and medical errors, let's not lose sight of the fact that only tort reform will ease this crisis and prevent future such events. Otherwise, we're going to lose physicians to other more friendly states or premature retirement.

I would now like to introduce Dr. Fred Jacobs.

F R E D J A C O B S, M.D.: Is the microphone on? (referring to PA microphone) How's that?

Thank you. Thank you very much, Dr. Rigolosi.

Good afternoon. I thank you for allowing us to appear today before this particular Joint Committee hearing and reminding everyone that providing quality care and protecting public health is of vital importance to the citizens of New Jersey. We welcome the opportunity to have this particular public discussion.

From medicine's inception thousands of years ago, physicians have, on the whole, provided their services to healing patients, instructing others to carry on the medical arts tradition. With very few exceptions, no other profession has patient care as its primary goal. We do.

The Medical Society of New Jersey is the longest established medical society in the United States of America and, having been founded in the year 1766, has advocated for quality in patient care since 10 years before the Declaration of Independence. Over the years, the Medical Society has

worked with state government and private entities to advocate for patients and their right to quality, accessible, affordable health care. Other states, and even the U.S. Government have emulated our propatient legislation, regulation, and initiatives.

As Dr. Rigolosi mentioned, we cannot address patient safety and medical errors without discussing the worst malpractice crisis to ever hit our physicians. This crisis also affects the people of our state, our patients, your constituents. In a few minutes, I'll discuss the Medical Society of New Jersey's proposal for quality of care initiatives. These sensible ideas are the right thing to do for our patients. On July 24 of this year, the United States Department of Health and Human Service's Secretary, Tommy Thompson, released a policy report entitled, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System." This is the report I'm holding. (indicating report) You will have it later.

This report lead to President Bush's call for new federal legislation to expand Americans access to care, improve quality of care, and squeeze the excesses and abuses out of the malpractice litigation system. This HHS report should be required reading for anyone involved in a malpractice crisis in New Jersey and throughout the country. And yes, we are in a crisis, and the cause is clear. Numerous studies point to excessive jury settlements and awards, particularly through unfettered noneconomic damage awards. We all pay the cost of these awards through higher health-care costs, higher health insurance premiums, higher taxes, reduced access to quality care, and threats to quality of care. The relatively few plaintiffs receiving multimillion dollar awards in the

litigation lottery create a tax endangering the future health care for New Jersey residents.

Malpractice premiums have skyrocketed, forcing us to lose many of our brightest physicians. Others must decide between paying premiums and hiring enough staff or buying necessary equipment. To make the money to pay their premiums and run their practices, physicians are forced to curtail their time with each patient. Invariably, this could lead to missed diagnoses or other potential mistakes that endanger patients, but create a windfall for personal injury lawyers.

Along with malpractice reform, the road to patient safety is to monitor trends, work collegially to identify problems and solutions, and attempt innovations. It does not happen through a strategy of punishment, intimidation, and fear. I'll be blunt. Absolutely no positive relationship exists between continuous quality improvement and today's escalating tort system. In fact, the opposite is true. The current tort system actually hinders quality of care and accessibility to the health system.

The National Institute of Medicine is a defining voice on quality of care. The IOM is very clear that most preventable incidents result from systems errors, not individual errors or bad physicians. Rather than blaming individuals, we should focus on preventing future errors by designing safety into the delivery system. Yet, this system, hampered by cost containment, struggles to keep up with these advancing technologies. The IOM concludes that the fear of creating new avenues of liability is by far the number one barrier to physicians and hospitals seeking to improve health-care systems. Given the opportunity, we could create better patient health outcomes and

reduce medical costs by perhaps as much as 20 percent. Those savings could be further invested in health care and provide more benefits to your constituents.

The President of the United States noted how the practice of defensive medicine to reduce the liability risks adds tremendously to the costs of health care. Physicians order more tests, refer to more specialists, conduct more invasive procedures, and prescribe more medications than what they feel to be medically necessary. As the HHS report says, “Every test and every treatment poses a risk to the patient and takes away funds that could better be used to provide health care to those who need it.”

Now I’d like to summarize the Medical Society’s proposal of quality of care initiatives. A more thorough description will be distributed for your review. Our first suggestion involves quality of care indicators. The Center for Medicare and Medicare Services, known as the CMS, had initiated monitoring a set of nearly 35 indicators in the inpatient care of elderly patients. These have quickly become the gold standard in quality improvement and reflect evidence based medicine.

New Jersey has fallen short in its performance against these indicators, ranking 48th out of 51 jurisdictions in the baseline study. Since then, voluntary efforts have been only marginally successful. We propose that the Legislature authorize the Commissioner of the Department of Health and Senior Services to collect and publicly release hospital-specific data on quality of care measures used by CMS.

Our second suggestion involves mandatory reporting. For a decade, New Jersey hospital licensure regulations have required mandatory

reporting of anesthesia related incidents. We propose extending these reporting mechanisms to all patient care incidents that hospitals or other health facilities report, or are required to report, to various other commissions, government agencies, and malpractice insurance carriers. Physicians would likewise have to report incidences in their practice offices, such as deaths and unanticipated injuries requiring additional medical care.

But like the anesthesia reports, these new reports would also be confidential and nondiscoverable. Public access would impair reporting, reduce the value and validity of the data in identifying trends, and generally impede quality improvement efforts. It would also encourage needless exploration by the plaintiff bar and drive up malpractice claims and costs exponentially.

Our third suggestion involves legislation recently passed by the Senate of the State. S-571 requires the posting of physician-specific information on the Internet, including certain aspects of malpractice history. We suggest that it also allow physicians to report enrollment in organized quality improvement programs and be expanded to cover all licensed health professionals. A disclaimer similar to the one used in Massachusetts should be included to put the concept of malpractice in its proper context.

Physician quality improvement efforts are next. All physicians providing any care to patients should be involved in systemic efforts to improve quality of care. We suggest that the Legislature consider requiring the State Board of Medical Examiners to compile a listing of recommended quality programs. Physicians may be required to participate in at least one recommended program as a condition of licensure.

This fits in with the Medical Society's commitment to quality. We have led several groundbreaking efforts and recently announced our Alpha Physicians Excellence Project, which helps physicians identify practice needs and matches them with continuing medical education.

The final suggestion centers on computerized physician order entry, which may be the best available means for reducing medication errors. This is accomplished through the use of a handheld computer, such as a Palm Pilot, or through a desktop computer to enter a prescription. The prescription is compared to the patient information and provides a warning if the medication is contraindicated or likely to contain a mistake in the dose or the product. The authorities in the state could facilitate the use of computer order entry to answer administrative concerns about the need for paper orders.

Earlier I referenced HHS Secretary Thompson and his recent report. Secretary Thompson said, "California led the way for the nation by establishing statewide limits on malpractice claims 25 years ago with bipartisan support. We should learn from the success of California and other states that have successfully reformed their malpractice systems."

The ultimate goal of tort reform is to improve the delivery of health care while saving money. Think of what this money could provide in New Jersey -- health-care coverage to the uninsured; vaccinations for children and the vulnerable; enhanced prescription drug benefits; new diagnostic and treatment equipment. In the greater scheme of things, isn't this the true patient safety and health-care quality we all want?

We look forward to working with your Committee in the effort to improve health-care quality and are prepared to respond to any questions you may have.

Thank you.

ASSEMBLYWOMAN WEINBERG: Dr. Jacobs, thank you, and thank you for the very clear suggestions that you offered here, but I understand that you were President to the Board of Medical Examiners.

DR. JACOBS: Yes, I was.

ASSEMBLYWOMAN WEINBERG: Well, I don't want to put you on the spot, but I will. (laughter) Could you comment on whether you think they have the staffing, the funds, whatever might be needed, to actually carry out the couple of suggestions that you have here that would fall under the Board of Medical Examiners?

DR. JACOBS: Thank you, Madam Chairperson, for giving me that opportunity. Actually, the Board is chronically understaffed and underfunded, as you may know, and does the best it can. Naturally, adding new programs to the Board's agenda would require additional funding. That, I think, would be the responsibility of this body, the Legislature. The Board deals with the discipline of physicians in many different ways, some of which are related to quality issues and some of which are not.

On the quality agenda, it's unusual in my experience, even rare, to find a doctor who's truly a bad doctor. Usually there are gaps in education or gaps in experience, and those gaps need to be identified by a focused evaluation and corrected, if possible, by a program of active remediation. And now, I believe, the Board at the present time is working in that arena. This

had been done in other states in the country and has been very successful. So I would think that the Board would need some additional support if it's going to achieve some of these objectives, but it's a goal worth achieving.

ASSEMBLYWOMAN WEINBERG: Any other questions here?

Yes, go ahead.

ASSEMBLYMAN D'AMATO: Thank you, Madam Chairwoman.

Dr. Jacobs, as our Chairwoman Weinberg just noted a couple of minutes ago, the stated purpose of this hearing is to take testimony on how we can improve patient safety, reduce medical errors, and improve the quality of patient care. How does tort reform, as you have addressed it -- how does that make a physician want to improve patient safety, reduce medical errors? There's a disconnect, or I just don't see it. Because I would think that I'm a physician and I'm concerned about being sued, well, I'm going to be very concerned about patient safety. I'm going to really work hard to reduce medical errors, not only in the hospital, but in my medical office, and I'm going to be deeply concerned about the quality of patient care. Would you please address that?

DR. JACOBS: Sure. I'd be happy to. I think that the question assumes that the major driver in physician activity is fear of litigation. I think that that's fundamentally false. The major driver in the activities of physicians is to provide quality care for their patients, with or without the risk of lawsuits. The problem with lawsuits is it creates an incentive for physicians to do more than they need to do to protect themselves, they think, from these kinds of aggressions by the plaintiff's bar. In order to protect themselves, they engage in efforts of defensive medicine.

I've been around a while, and I'll tell you, I have never met a doctor -- I've never met a doctor who didn't get up in the morning and want to do the best thing for the patients he was caring for, regardless of whether he was being sued or not. I've never met a doctor like that. Now, some doctors get up in the morning and they forgot how to do it, because it's been a long time since they've been reading a journal, or they forgot how to do it because they've been impaired because of some reason. But I've never met one who got up in the morning and said, "I'm going to be a little lax because I'm not worried about being sued." I think that doesn't exist.

ASSEMBLYMAN D'AMATO: Thank you.

DR. RIGOLOSI: You know, if I might comment on that, the quality of care is going to suffer, because if we continue the way we're going and doctors leave the state because of the crisis that we're in now with malpractice and you're going to have less physicians performing the same amount of work to the same population. So you're not going to have the coverage that you had before, and the quality of care will suffer. The quality of care will suffer because the Assemblyman tells us about his obstetrician who will not be available in August, and that, in a way, is going to affect the quality of care across the state.

ASSEMBLYWOMAN WEINBERG: Go ahead.

ASSEMBLYMAN CONAWAY: I just wanted to put a finer point on, if I may, Assemblyman D'Amato's question. I thought, Fred, that he was asking a question in response to your comment about the need for the physician community and the hospital community to do the kind of self-exploration that, if undertaken, would lead to reduction in errors. But that

kind of self-exploration is not going to take place if the hospitals or the physicians are, by doing that, are going to put their neck in a noose. Like my bill to protect hospitals -- I'll look at this other one -- for their self-exploratory efforts at debriefing and finding out what went wrong with the situation so you can put in corrective measures. That kind of process can't take place in the current environment because people simply are not going to -- have to face a situation where we're going to have to fold up and expose themselves to some tragic suit. I think that was why the question came.

DR. JACOBS: Thank you for that clarification. Let me answer that particular aspect, because I think that hits it perhaps clearer than I had understood. Today in the hospitals that I'm involved with, which are nine acute care hospitals, we have a very active quality improvement program, as you may know. One of the principle barriers we have to getting the information and the doctors involved in the quality improvement program, the discovery of the errors, and the exploration of the reasons for the errors in the hospitals is fear that the information derived from those efforts will be discoverable and lead to further jeopardy of the doctors and the hospital in a court of law, which is one of the reasons why we said the reporting of these mistakes, when they occur, should be nondiscoverable and confidential. Because there is a barrier.

Doctors are concerned, and hospitals are concerned, about developing a case, so to speak, and handing it to a plaintiff's attorney on a silver platter. It's not that they don't want to do it. They're concerned about doing it might expose them to a greater risk.

At my job -- in my real job, day job -- is to convince doctors that we have to do it anyway. Now that is somewhat of an uphill fight because after all, I mean, if I'm going to come into a Committee hearing and tell you that my colleague did X, Y, Z procedure, and I wouldn't have done it, and I wouldn't have done it because of these reasons, and I think this particular evaluation and this judgment may have been something that wasn't what I considered to be appropriate to the standard of care, and those minutes are discoverable, I think that that particular doctor has a problem. It's a credit to them that they do it anyway. They do it anyway, but it's an environment which is very hostile to their best intentions.

ASSEMBLYWOMAN WEINBERG: Could I just interrupt here for a moment, because, again, that's come up many times in my discussions with the various groups that we've had, as background to these hearings. On the other side, I mean, the possible plaintiff or possible injured patient still has discovery through the medical chart. I mean, I'm correct about that.

DR. JACOBS: That's right. I think that's fair. Here's the chart. The chart is what the chart is. An expert reviews the chart and comes to a conclusion about the chart. But I think it's not a level playing field if the expert or the plaintiff's bar has the advantage of a full-scale investigation done by the hospital in an effort to improve the quality for other patients. That's why what was referred to in the Supreme Court as the so-called privilege of self-critical analysis was knocked down. I thought that was a tragedy because the confidentiality of self-critical analysis is what drives, to a large extent, the ability of companies, not just hospitals, to improve themselves. If they're going to be in an environment where every time they investigate something which is

suboptimal in their operation, they're going to be looking at a lawsuit, there's going to be very little incentive for them to continue doing it, and I don't think that's in the public interest.

ASSEMBLYWOMAN WEINBERG: Assemblywoman Quigley, you've been very quiet, so you're entitled.

ASSEMBLYWOMAN QUIGLEY: Well, I've been saving it up, Madam Chair.

No, thank you very much. I just wanted to comment on this and to amplify the doctor's remark, perhaps a little bit from the hospital's perspective. As the attorney said to us earlier, often the problem is not with the individual, it's with the system. When a hospital is having a quality review committee, they may be looking at one specific instance where something might have gone wrong. All right. If that becomes discoverable, everybody involved in that committee is going to be very careful about what they say. If it's not discoverable, they can be a little bit more frank, and they may say to each other, "Yes, this time it went wrong, but it happens three times a week, and we ought to fix that." It's not the kind of thing that they would say if it was discoverable, because then you've got the other attorney sayings, "Gee, let's go find us some more clients."

What we need to do is to be able to allow that kind of candor where people can say, "Where there were not problems there could have been." Let's fix it so there never will be.

ASSEMBLYWOMAN WEINBERG: And that again is one of those solutions that we are trying to look at.

If I could just ask you one more question. Assemblyman Cohen said that tort reform would not affect medical malpractice insurance rates for 10 years down the road. Can you comment on that?

B E R N A R D S A C C A R O, M.D.: That question was brought up, and I talked to Pat Constante about that very question. She's the CEO of MIIX. She said that, in the short term, they probably would have been effective, but over the long term they would stabilize or even drop down.

DR. RIGOLOSI: If I could make one comment that has to be clarified. During Mr. Stern's testimony, he stated that there are several states that do not have malpractice crisis. He mentioned Mississippi. Mississippi has the worst malpractice crisis in the United States. In the state of Mississippi, there is a big sign on one of their major highways that states, "Drive slowly, because the nearest trauma center is in the next state." The problem in Mississippi is they have three neurosurgeons to cover the whole state. So I don't know where he got his data from, but he was definitely wrong.

The other thing that he said was what is the medical society doing to improve insurance rates and reimbursement. Well, we're doing a lot, and I don't know how he missed the fact that on May 8 we sued five HMOs. It received media attention on TV, radio, and in the newspapers. We sued them for down coding, for mishandling claims. We sued them for rejection of medical necessity when it was obvious that it was medically necessary. So we are doing a lot. I just want to clarify that.

ASSEMBLYWOMAN WEINBERG: Thank you.

Dr. Saccaro, do you have anything to add to this?

DR. SACCARO: Well, just briefly, I just wanted to-- Along the patient safety lines in the northern part of the state where I come from, for example, at Hackensack Medical Center, safety is the number one issue. This has jumped to the forefront, and along with medication safety, patient safety issues are on the front burner. I think that this is true around the state.

The other thing I think is that we have some common ground with the trial attorneys. Number one, we want victims of medical malpractice to have full economic compensation. If a patient can't work because of an injury, that's actuarially calculable, and it can be awarded. We also with them want to have patient safety issues number one.

Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you very much. Thank you for your patience, and thank you for your testimony.

I would like to call David Knowlton, from the Health Care Payers Coalition, followed by Michele Guhl, if she is still here, so we can hear from somebody who is kind of on the insurance side.

DAVID KNOWLTON: Thank you. My name is Dave Knowlton. I'm the founder and a board member of the Payers Coalition of the New Jersey Health Care Payers Coalition. I'm the Chair of their affiliated foundation, which is the Health Care Quality Institute.

First off, I wanted to congratulate you, Assemblywoman, for convening hearings that are not only on the malpractice issue, but on the causes of the problem. It's our hope that we're going to get somewhere where we can start to, instead of constantly trying to rescue people, we can start shooting the people who are throwing them off the bridge. We have an

enormous problem here. I'm not going to reiterate. A lot of what I was going to say has been covered by other speakers. The study that talked about the 48 -- actually it's 48 out of 52 states, including Washington, D.C. and Puerto Rico. The Payers Coalition has done a number of studies that found quality issues.

But the biggest issue for us is the Institute of Medicine report that you've heard about. I don't think people fully appreciate the magnitude of this. It's 230 preventable medical deaths every single day. We had 206 people killed when TWA Flight 108, I guess it was, went down in Long Island. It's one of those airline crashes every single day. If we take the Vietnam Memorial in Washington, D.C. and we did it for people who died from preventable medical errors, we'd have to have two of them, because there would be twice as many names, and we'd have to build one every year. This is an enormous problem.

We think that if you turn it personal -- in our Payers Coalition Purchasing Cooperative, 150,000 lives, we lose one person a week to a preventable medical error, 52 a year.

ASSEMBLYWOMAN WEINBERG: Mr. Knowlton, just for the record or for anybody that might not understand, would you just quickly explain what the New Jersey Payers Coalition is?

MR. KNOWLTON: I'm sorry. I was trying to be brief. You've heard a lot of testimony today. The Healthcare Payers Coalition is a not-for-profit coalition of business and labor that a lot of businesses belong to. We were founded for quality. We're 10 years old. We were the first group to evaluate hospitals and report it publicly to the press and to the New Jersey

public. I Chair what used to be their Quality and Data Committee, which has now been formed into a separate foundation to look at quality issues.

I wanted to take a minute to help people understand medical errors, so out of just commonsense wise. Medical errors are not a function of person, they're a function of process. Everything that you read in the literature, the Harvard study, all say the same thing. Ninety-nine percent of medical errors occur because the system fails because of what they call a toxic cascade, which is a whole series of events take place that cause the system to fail.

We need to address those types of systems. Errors will happen, we're human beings. Since they can be expected and even predicted, we need to put systems in place to address them. I can't lock my keys in my car because the car manufacturer knows I'm human, and I'll make a stupid mistake and leave my key in the car, but a physician can leave an instrument in a patient. That's not -- the physician's error is because they're human. We need to put systems in place to prevent this from happening.

If, for example, the recent study that was just out -- the California HealthCare Foundation is actually taking an in-depth look of what happens when errors occur. They're doing this the way you would look at an airline crash, looking in some depth, how is this happening, and what order. One of the things that they've found is some 50 occurrences-- The first case was the wrong patient. The patient got the wrong procedure done to them. They looked at it, and they found almost 50 events that took place in order for that error to occur. The doctor is the one who is liable because he ultimately did the procedure. But the error is a sequence of events.

We can identify people who we don't want to get into buildings where we have security systems. Why can't we use those systems to identify patients so we're sure the right patient gets the right procedure? This has been done before. Prior to getting to play around in the quality arena on the outside, I served as Deputy Commissioner of Health in the Department of Health in New Jersey from 1987 to 1990. During that time, we added a rule, with the cooperation of the Medical Society, and I was chatting with Vince Maressa about it earlier, that required pulse oximetry on all patients that received anesthesia. This just allows you to record how much oxygen is going into the blood.

As a result, medical malpractice dropped radically for anesthesiologists. When, in 1940, anesthesia had one preventable death per 2500 people, in 1970, it was one preventable death per 7500. It currently is one preventable death per 200,000.

ASSEMBLYWOMAN WEINBERG: And what happened to the medical malpractice premiums?

MR. KNOWLTON: It's one of the lowest of all of the specialties. It used to be one of the highest. But you used to be able to go into a hospital OR, and there were three suites. In Suite 1, you turned the gas down clockwise. In Suite 2, you turned the gas down counterclockwise. That's stupid. We need to put error checking in place. What have we done? The Quality Institute-- We spun off the Quality Institute for two purposes: to start to look systematically at medical errors and to engage purchasers in making quality improvement an absolute obsession.

The second thing we did is we bid for and became the people-- You've heard The Leapfrog Group talked about here. Well, I'm the chief frog. The Quality Institute has been asked to roll out the Leapfrog initiative in New Jersey. I like the name Leapfrog Group because it gets its name from people saying we cannot have an incremental improvement in health-care quality. We've got to leap forward. We can't say it's acceptable to lose the equivalent of a major commercial jet crash every day in health care in this country.

ASSEMBLYWOMAN WEINBERG: Are you saying those statistics -- the 200-and-some-odd are right here in New Jersey?

MR. KNOWLTON: No, they're nationwide.

ASSEMBLYWOMAN WEINBERG: That's nationwide.

MR. KNOWLTON: The Leapfrog Group you've heard people talk about -- computerized physician order entry, evidence-based referral, and the use of intensiveness of a seatbelt, antilock brakes, and air bags of health care. I had a hospital executive say to me, "Well, maybe some of our poor hospitals can't afford it." I said, "Maybe they can't afford to be in the health care business." I don't mean that to sound harsh, but what would your reaction be to putting your family in a car without seatbelts or without an air bag? You wouldn't consider it now. We need to be aggressive in moving some of this material forward.

What can you do? What the Legislative can do? You can empower an informed consumer. The consumer has a right to know. We support it. Indeed, we said we'd carry the information for free. The Codey-Vitale bill, Senate Bill No. 571, that was discussed here, I heard Dr. Jacobs make a suggestion, a disclaimer in that, which sounded fine to me. But

consumers do have a right to know. There is a tension between what Dr. Jacobs talked about saying we ought to be able to freely talk about health care quality and not have a consequence, and the right of you to know that the doctor you are going to is a good doctor. How do you balance those two things I think is going to be a difficult challenge for your Committee.

We have been advocates for reporting errors, also reporting near misses. How we improve our aviation system in this country is because we report the near misses and they're evaluated. What happens when they almost collide. Unfortunately, in the health care system, we only report it when they do collide. We need to start to track health-care quality. Some of the initiatives that the Medical Society recommended I applaud. Where we disagree is we think that when there is a pattern-- I don't want to advocate what that threshold should be, but where there is a pattern of error, the public has a right to know. We advocate that they have a medical right to know what's happening.

Example, a physician may just not be a good doctor in a particular way, and he keeps on having case after case after case that indicates that he's not a good doctor. At what point do you say enough already? At what point do you the consumer have a right to know that that doctor isn't practicing optimally? We think that you do have that right to know. We understand this attention between what people will disclose and won't disclose and mortality and morbidity hearings at hospitals. We think that there has to be a total preoccupation with error reduction throughout New Jersey, and I think that's going to begin with folks like you, with the hearings that were held by Senator Matheussen and Senator Vitale in the Senate.

I heard Assemblywoman Weinberg comment on the Board of Medical Examiners or asked Dr. Jacobs. We cannot improve medical error tracking in this state without doing something about the Board of Medical Examiners and giving them some resources. Maybe we can surcharge some malpractice awards or some other alternative means to start to improve the quality of the Board of Medical Examiners level. But we need to remediate doctors who have a history of not being able to perform well, and we need to restrict their licenses if they cannot be remediated. That has to happen.

Finally, I think that we need sort of what the Malcolm Baldrige awards did for quality in general. It needs to be applied to health-care quality. We do need to recognize, as you suggested Assemblywoman, that we recognize quality of care, not just the problems of care. There needs to be a structured way to do that and to recognize that people like Somerset Medical Center that you heard from this morning -- Dr. Cors is a member of my Board -- has been aggressive in quality, and we need to recognize that in a big way and communicate that to the public, which is part of what the Leapfrog Group is intending to do.

I'm passionate about this and can go on and on, but I'll shut up because you have a lot of people waiting to speak.

ASSEMBLYWOMAN WEINBERG: Well, I appreciate your coming, because this is what we hope to address -- what the short-term solutions are, if there are short-term solutions. What I am hoping we do is address solutions which will stand us in good stead for years to come.

If you have any written materials, Mr. Knowlton, we'd appreciate having them.

MR. KNOWLTON: I don't have them with me, but I'll get them to David.

ASSEMBLYWOMAN WEINBERG: Okay.

MR. KNOWLTON: I will get you written material.

ASSEMBLYWOMAN WEINBERG: Any other questions for Mr. Knowlton.

Assemblyman.

ASSEMBLYMAN CONAWAY: You mentioned -- only because it's some meetings I've attended on this problem -- that there needs to be something done to address the ability-- If the rates aren't going to come down, if you can't do anything about that, there must be some way of addressing the physicians' ability to pay these rates. Now, it's been mentioned, I think it's documented that obstetricians are now being reimbursed less today for delivering a child. That's nine months of care and getting less for that. Whatever happens, how many times the patient needs to come in, it's a set fee for that. It's actually less than it used to be.

Now you mentioned putting a surcharge on awards. I can't imagine that there are enough awards out there and it certainly impacts the individuals who, of course, many of them are going to depend on those awards to maintain their life and maintain their health and whatever care they need that that is going to be sufficient to remediate this problem.

Now you're involved with payers. One suggestion has been that we need to put some kind of a surcharge on covered lives in order to deal with this issue. Your thoughts about that I'd appreciate, or setting up some kind of pass through system, or if we're not willing to-- Somehow this cost is going to

have to be born. Because right now what it is is that physicians' fees are flat, coming down in many cases. We've got to hire a lot of people just to manage the relationship between payers. You used to be able to run your office, get a nurse, maybe a second, and that's all you needed. Now you need an army of people to get back and forth on the phone for all the things that are not paying and all the down coding and all the other things that they do. You have to have an army of people. That, of course, comes out of your salary, out of your fees. You collect fees, and you have to pay expenses.

Now all of those things are flat. You've got all these employees that you shouldn't have to have, but you have to have just in order to be able to get paid in the first place. Now your malpractice insurance goes up by 30 percent or 100 percent -- it's not uncommon now. How is that cost going to be born by the physician in this environment, where you can't see a patient a minute, and you can't negotiate to raise your fees, and you can't even actually negotiate with these folks to cut your costs, so how do you-- What's your suggestion on how we get-- There's some kind of a pass through or help physicians pay these outrageous increases in medical malpractice insurance rates?

MR. KNOWLTON: In 25 words or less, the issue is--

ASSEMBLYWOMAN WEINBERG: Only if the question is in 25 words or less. (laughter)

ASSEMBLYMAN CONAWAY: If you can get that to be. (laughter)

MR. KNOWLTON: This isn't a new problem. Up until 1993, hospitals' rates were set in the state. When I was at the Department of Health,

that was on my watch. Should the malpractice rates be passed through in the rates was a big issue. I'm arguing one thing, Assemblyman, and that is that you have to address this as a system problem. Just saying we've got to come up to throw more money into the sluice to pay more malpractice costs will just result in malpractice going up even further. It won't end. We've got to shoot the guy who's throwing them off the bridge.

The problem that you have -- I do advocate providing some revenue stream, be it 1 percent of awards or 2 percent of awards, that allows a pool of money that can start to systematically and systemically address these issues. You've got to start to put in place, like the anesthesiologists did, the types of systems that can arrest the maloccurrences that's driving up the cost.

ASSEMBLYMAN CONAWAY: Well, I don't argue with you that the system changes need to be. I'm a big advocate of that. There's no question that that needs to be done. And I think you'll probably agree with me when I say that that is something that's going to bring changes in the long term. People argue about the effects of caps or not caps. Certainly in the short term, they're not going to have any effect. Because what do insurance companies do? They've got the backup reserves to take care of the things that are coming in now. As long as these judgments continue to be -- come through at these lottery levels, insurance companies have to back up more and more reserves.

Now, as that comes down, as changes are made in the system -- it may be tort reform -- the reserves that insurance companies will have to put in the bank in order to take care of future liabilities comes down, and hopefully, the rates they have to charge will come down. But my question is, at the end of the year we could see obstetricians -- we could lose 20 percent of them. We

are losing physicians now every single day. My question-- I mean, systems-- We need to do it. Not going to help us prevent the loss of 20 percent of obstetricians. What do we do about the losses that are occurring now and the patient dislocations and the tragedy of someone who has trained their life to perform a service who now cannot do it. I mean, that's what we're talking about.

MR. KNOWLTON: You do not have a short-term solution, Assemblyman, in my opinion. You do not have a short-term solution, other than some sort of tort or award caps. You don't have one because you won't have a quick enough return in terms of money. In the short term, I would urge you, if you can contemplate that, not to do it unless it was tied to systemic change so that you don't continue to harm people. But I do not see -- I say that almost holding my nose -- because I'm also an advocate that you're capping awards that people have suffered from.

But the problem is, you're going to start losing obstetricians. You're going to start losing neurologists. You're going to start losing certain levels of physicians. How do you get to that point in 12 months? You can't, unless you have some cap and maybe sunset that cap once you can get some systemic things in place. But I don't see any other rational way to do it. That's my reaction.

ASSEMBLYMAN CONAWAY: Thank you.

ASSEMBLYWOMAN WEINBERG: I happen to agree with you. And although we are usually in the business of trying to find some quick magic fix, I would hope that there isn't going to be -- that we can come up with the

right set of answers so that 10 years from now there isn't somebody sitting in these seats addressing the same problem all over again.

MR. KNOWLTON: That is the issue.

ASSEMBLYWOMAN WEINBERG: Well, just in case there are different people, a few of you are young enough actually to be here in 10 years.

Yes.

ASSEMBLYMAN D'AMATO: Thank you.

I would encourage my colleagues -- for us to really look at this reimbursement issue. I spoke to two general surgeons, and I asked them how much does the insurance company generally pay for a hernia repair? We're talking in an operating room, so forth and so on. Do you know the answer to that?

MR. KNOWLTON: No, I don't.

ASSEMBLYMAN D'AMATO: One hundred and twenty-five dollars.

ASSEMBLYMAN CONAWAY: Isn't that something?

ASSEMBLYMAN D'AMATO: And it's going down, down, down. If we want to improve the quality of patient care, we have to make it such that the doctor is willing to spend more time with the patient. I would encourage us to look at that particular issue.

ASSEMBLYMAN CONAWAY: There are actually disincentives in the pay scales for spending more time with the patient by the way.

ASSEMBLYWOMAN WEINBERG: The other thing to add to the OB/GYN issue, which I was really surprised about, is that the obstetrician doesn't get any reimbursement until three months after the baby is born,

which means that conceivably they are taking care of a patient for about 10 months, if you figure an OB patient shows up around her second month, without any reimbursement.

MR. KNOWLTON: Part of our--

ASSEMBLYWOMAN WEINBERG: There aren't many businesses that would be able to carry that kind of accounts receivable for 10 months.

MR. KNOWLTON: Part of our Payer Coalition -- we have a little different philosophy here, because our Payer Coalition is made up with people who cover whole generations, not just people that are in an insurance plan for a year or a year and a half. So our Coalition does not tend to reimburse that way because we think it's not -- it doesn't keep the doctors happy. It doesn't keep our members happy. But where union health and welfare funds, where if you provide inadequate care, you don't get elected as the administrator of the health and welfare fund the next year.

The other thing I wanted -- the last point, if I might just point out. On the Leapfrog Group, in order to participate with the Leapfrog Group as a purchaser, you must commit to put adequate funds and to reimburse adequately into increased reimbursement and to give recognition to the improvement of quality. We know that these things are going to cost money. You had to make a commitment that you were willing to fund them. The Payers Coalition's initiative with Leapfrog is going to cost the Payers Coalition almost a quarter of a million dollars this year in trying to see that these things get complied with systemically within New Jersey.

So I can't speak for business in general. I can speak for our members who have consistently said, as Assemblyman Cohen raises, if the physician needs additional revenue, I think we've been pretty reasonable about that. I don't think that is necessarily the rest of the health-care market, but I think it's the market of the qualified funds -- the health and welfare funds that we represent.

ASSEMBLYMAN CONAWAY: Well, I just have to ask a follow-up. I agree with Assemblyman D'Amato. This question of reimbursement needs to be addressed, and it's part of the issue. If physician incomes are going up to match these increases in cost, there wouldn't be a crisis. People wouldn't have to look at what they're bringing in in fees and what they're paying out and their cost. There would be some reasonable return to reflect the amount of time and experience and professionalism that go into what they do, but that's not happening.

You're involved with Payers. Now, do you negotiate with people who provide service to you over what those rates are going to be? What kind of interaction takes place along that issue? We have a joint negotiation, whether or not anybody is ever going to negotiate is a question. What happens on the negotiation end as far as you're concerned?

MR. KNOWLTON: Assemblyman, I don't personally do the negotiation. I work on the quality side. But the Coalition does negotiate with various medical groups and hospitals, yes. The only caution I've given here, and your point back to what Assemblywoman Weinberg said, is that be fearful, be cautious that in the rate issue -- and I learned this from setting hospital rates -- that the quantifiable, that is the price, the rate, doesn't squeeze out the

relevant, those issues you need to change systemically to stop medical errors. It's easy to say you could see, you could quantify the amount of money that's got to go in. It's easy to grab it and put something there. It's harder to address systemic problems that are going to improve quality. I think they need to be linked if you're going to put more money in.

ASSEMBLYWOMAN WEINBERG: Thank you.

And fortuitously, the next person -- was the next victim (laughter) -- Michele Guhl, who is President of the New Jersey Association of Health Plans that does some of this reimbursement. I didn't mean to set you up in exactly this way, but that's how it worked out.

MICHELE K. GUHL: Well, thank you, Assemblywoman. I come, I guess, with an apology at this point, because my testimony and my comments really are about improving quality and patient safety. So I did not come armed with data and statistics about what insurers are paying to their providers and the different counterarguments that could be made. I'm not really -- to be candid with you, and I know this is one of Assemblyman Conaway issues, it's an area worthy of debate. I don't demean it.

One can also, having been the Commissioner of Human Services, talk about the reimbursement to providers through our public paying system, which is woeful, frankly. I know you've all struggled with this. There was \$70 million, for example, put aside in this budget to increase physician rates through Medicaid, but because of the overall financial problems that the State is going through, that 70 million was cut to, I think, 17.5, or something like that.

I mean, there's a lot of blame, if that's where we want to go. My point is it's a valid discussion that I'd be happy to entertain, when prepared. It's a little bit off the point. I make the analogy that if, you know, we're grappling with auto insurance forever in this state -- no one thinks the fix is to pay car owners more. I don't mean that in a flip way, but I mean I'm just saying it's another issue. But the systemic things, and what I wanted to spend a couple of minutes, we did have some suggestions.

ASSEMBLYWOMAN WEINBERG: Well, just before you go on, you're right. That was not what we asked for you to come and testify about. But having heard what you did hear--

MS. GUHL: Yes.

ASSEMBLYWOMAN WEINBERG: --we would appreciate getting a follow-up from you--

MS. GUHL: I'd be -- yes.

ASSEMBLYWOMAN WEINBERG: --on terms of the reimbursement issues, particularly as it concerns the specialties that are having the larger problems.

MS. GUHL: Do you know what I did pull off the Net--
I'm sorry.

ASSEMBLYMAN CONAWAY: And one caveat on that, if I may, is that when you send the payer information make sure that it's for reimbursement and codes that people actually use. That would be helpful, as well.

MS. GUHL: Well, what I do have -- certainly -- that crossed my desk recently, and it's a national piece, but it's a simple one-page chart on

speciality groups reimbursement. I don't know if anyone has seen this. It does show an increase.

ASSEMBLYWOMAN WEINBERG: Could someone get that from her, perhaps--

MS. GUHL: It's oversimplistic. It's all I had with me when I heard this come up. I just wanted to show it to you.

ASSEMBLYWOMAN WEINBERG: Okay. And run some copies while you're speaking.

MS. GUHL: It's only a start. Thanks.

ASSEMBLYWOMAN WEINBERG: Okay. Thank you.

Go ahead, Michele.

MS. GUHL: Thanks. Okay, thanks.

Well, you know who I am, I think, at this point. Thanks for letting me speak. It's getting late in the day. I don't want to belabor this too much. No one is going to come up here and say they are opposed to quality, clearly. It's just a no-brainer to know that we all want, for all the right reasons, to enhance patients safety and improve quality. And yet, don't we all say we're in favor of it, and we're doing all kinds of things for it.

Of late, we've been inundated with horror story after horror story or some national reports that show that we're not doing very well in the arena of quality. Perhaps the appropriate focus should be what have you, as part of the larger health-care arena, done to improve quality and what more should we be doing.

So let me just, on behalf of the health insurance plans, because they do tend to be seen as less in that direct arena and are more in a supportive

role, but what our perspective on all of this is. For far too often, the health insurance industry, particularly as exemplified by managed care, is seen as the antithesis to quality -- as the green eyeshade machine unilaterally focused on controlling costs by limiting care, all in the pursuit of profit.

But I challenge you and would be happy to set it up -- this is serious -- to visit any managed care company. You'd be comforted and perhaps even a little surprised to see how much of their staff is comprised of doctors and nurses devoted to improving the quality of health care for their members, implementing program after program in disease management, in prevention, and in patient safety.

There's all kinds of examples. You have my testimony. I hope that you take a look at it so that you know that this industry is serious, for all the right reasons, in trying to control disease and enhance the quality of health for its members. So having said that, I won't read to you the details that I have here, but I will ask you this: Do you know that a woman covered by a health plan, meaning a managed care plan, is nearly 1.4 times as likely to undergo screening for cervical cancer as a woman covered under traditional fee for service; or that health plans provide screening for breast cancer at a rate nearly 1.5 times that of fee for service. This admittedly may sound a bit defensive, but I say it so you can look at this industry in full context and not just with a myopic view.

Asthma programs, diabetes prevention and control -- I'm looking at you with diabetes. I sent to each of your offices-- We did a marvelous diabetes clinical guideline this year that all the health insurers agreed on, signed off on. We had the physician groups at the table with us. Why did we

do that? Because in New Jersey diabetes is at close to epidemic proportions. There seems to be a lot of disparate or uneven treatment by primary care physicians for the disease for a lot of very understandable and complicated reasons.

It was the health insurance industry that thought that instead of each Aetna and Signa and United and this one, each putting out their own guideline, if we could come together with one guideline, there was a higher likelihood that that physician, generally the primary care doc, would read the guideline, use it, and it wouldn't end up in the circular file, when there are 20 guidelines. I say that again to let you know we are committed to doing things. We mailed out 7500 of these guidelines to doctors across New Jersey a few months ago, and I can't tell you how many have called me personally to tell me what an effective tool they thought it was. Okay. Enough about trying to level the playing field a little bit toward health plans.

Let me talk about what we think needs to get done. Some of it you've heard, but we do want to get a bit specific. We are currently an environment which prevents -- and this will speak, I hope, to Assemblyman D'Amato's questions among others -- but our current environment prevents the effective identification of medical errors. The environment is not conducive to reporting errors. There was a recent presidential commission report that noted -- I'm going to quote. "Perhaps the most significant deterrent to the identification and reduction of errors is the threat of costly adversarial malpractice litigation. We are living in a culture of blame, which has to be modified if we want to encourage reporting." And let us all remember that error reporting, as you've heard from many of the esteemed

members of the Medical Society here today, error reporting is critical to the improvement of quality and patient safety. Error reporting must be tied to malpractice reform.

I am not an attorney. There are a lot of different suggestions about how we do tort reform in New Jersey. We believe it is a key part of the solution, that we need to change this environment where reporting is done in an open, healthy scenario that encourages we all really try to fix the problem and not worry about what's discoverable down the road. You know the different types of components. We are happy to see that there's been a lot of litigation introduced to try to deal with tort reform, different levels. We're encouraged by it. We are particularly happy to see the kinds of things that weed out the wheat from the chaff in this thing because having been--

You know, when I see some of the individuals, who came up today and spoke, who have had been the horrible victims of error, particularly in my former role as a Commissioner of Human Services, where I saw that day in and day out, no one is trying to take away, or I don't think we should be, the right of an individual to sue for harm done. But what we have so typically in this country is a swing of the pendulum that's gone a bit too far. We've become too litigious, so we do believe that some elements of reform -- I'm not going to argue caps on noneconomic damages or not -- certainly things like screening worthy from unworthy cases ahead of time make a lot of sense to us. But suffice it to say, we'd very much support the tort reform as changing the environment so that reporting is done in a more open fashion.

The other thing that I just want to say is that we need to support efforts which enable the consumer to make informed decisions when shopping

for health care. To this end, we support efforts, whether they're legislated or voluntary, which result in more reporting on quality indicators and which provide the consumer easy access to quality information.

You've heard a little bit about Leapfrog. This is a national program that's just begun here in New Jersey. I hope you get more familiar with it as time goes on. It's a wonderful program. That's the type of thing we need to get real serious about, and we'd like to encourage all New Jersey's providers to participate in this voluntary program. We think it's a great quality enhancer.

We also strongly support the passage of the New Jersey Health Care Consumer Information Act, which has been referenced earlier, sponsored by Senators Codey and Vitale. I believe there may be an Assembly companion or a comparable, similar bill, A-915, sponsored by Assemblyman Edwards. Perhaps they're being combined. I don't know the details of that right now. But that provides public access to extensive profiles of physicians throughout the state.

Another great quality enhancer -- we would encourage other quality measures such as physician report cards and the development of a user-friendly procedure for consumer complaints and grievances against providers. The market -- when you have a well-armed consumer like a well-armed voter who is voting with his feet or is buying health care with his or her better knowledge, better armed with knowing what the history track -- the positive and the negatives of hospitals, of doctors, of all the different types of providers, that will sort, effectively, over time. People go to where the

quality is, and it becomes an overall pusher of quality for the entire system and, I think, raises the bar in time.

Let me just end by saying, before I entertain your comments and questions, which I expect, I'd suggest that we need a change in the culture from affixing the blame to fixing the problem. To do that, we need to decrease providers' fear of litigation. This, in turn, will require a supportive legislative environment for tort reform. I would respectfully urge the members of the New Jersey Legislature to have the wherewithal to get us some effective tort reform. We also need to support voluntary efforts, and in some cases, advocate for legislative remedies to enhance quality and provide our citizenry with much more information than they currently have on quality and indices.

With that, I'll conclude to let you know that the health insurance industry would like to be part of the solution. We think we play a supportive role currently with a lot of the programs in place, and we'd be happy to redouble our efforts in that regard.

Thanks.

ASSEMBLYWOMAN WEINBERG: Thank you, Michele.

MS. GUHL: You're welcome

ASSEMBLYWOMAN WEINBERG: Questions?

ASSEMBLYMAN CONAWAY: I guess one obvious question -- and thanks for your support on this tort reform question, because I think it's an important part of the solution, physicians' reform, hospitals' reform, tort reform. It's all got to be done together. I wonder though, and also certainly as part of what physicians need to do more reporting on physician profiles, and

things like that, I think that's appropriate. It occurs to me, however, in managed care plans, you might find that -- what if you were looking down your roster there, and you can't find, as happens now, particularly if you need mental health services, any physician to take care of you? I guess you would-- I guess the managed care plans, and you'll have to sort of look into the future, will work with folks to find people who are in their plan who meet their own quality standards and that the process for patients in order to do that would be one that can be accommodated by the payers.

ASSEMBLYWOMAN WEINBERG: The question?

ASSEMBLYMAN CONAWAY: Yes. Or are they willing to let people go to the physician that they find that they think is going to do the best for them. I mean, that's one of the questions, isn't it?

MS. GUHL: I'm not sure I understand your question, Assemblyman, about--

ASSEMBLYMAN CONAWAY: We empower consumers. They want to go to a physician that they think--

MS. GUHL: Yes. And then letting them go--

ASSEMBLYMAN CONAWAY: And then letting them get there.

MS. GUHL: You're talking about really what has been occurring in recent years, which is sort of the lightening or loosening up of managed care, frankly, for a lot of reasons. I hope we know why managed care started, but we all, I think, would say it may have been when it was designed and may have been designed too tightly. We've seen it, not just in New Jersey, but across the country, sort of lighten. I call it managed care light now, where you see a lot

of options to go out of network or do many other things that weren't in the original, I guess, design concept. So, yes, we can do that.

I just need to throw in a little bit of complication, because public policy making is very complicated, and I can certainly say that from some base of experience. Every time we do that type of thing, as noble and well-intended as it is, and we push up, necessarily, the cost of health insurance, we are all forced to grapple with the concomitant problem of the number of uninsured, which is not decreasing, notwithstanding a lot of new public moneys and public programs. So, I know all of you are really charged with how do I do the greatest good for the greatest number of people. You cannot be all things to all people.

So I suggest to you, and clearly it often gets rejected, but that the worst health insurance is no health insurance. As we keep mandating or whatever we're doing to give the consumer-- And I'm not saying the consumer shouldn't go for quality. We'd like to believe that our networks also go for quality and that the two-- You don't have to go out of network to find that. So they're not antithetical. But I simply say to you, the more we add to that product, the insurance product, and really start to go back to the days of more indemnity like, or fee for service looking like, we will absolutely increase the cost of health insurance.

Now you and I are often not directly feeling the cost of our health insurance, because most of us -- certainly I have been fortunate in my career that my employer is paying for the huge preponderance. So, as consumers, we're not real connected to the costs of our health insurance. So, yes, everyone says it's a problem. It's a problem. But the employers are real connected to

it, and they're starting to really scream, particularly in a down economy when their profits are low and they don't have -- the cost of providing health insurance to their employees has become a major concern.

Now what happens? They start to shift some of that cost to those employees in the form of higher deductibles and co-pays, and then what happens, some of those employees-- People like my two young male children who are in their early 20s and think they are immortal, say, "Well, excuse me, the hell with this. I'm not buying it. More cost is coming to me. I'm not going to take up health insurance."

I digress, and I apologize. I'm just simply saying it's all intertwined, and we have to be very cautious as we're trying to fix one thing we don't pump up another. I think the problem of the uninsured is one you, literally you, are going to feel more and more pressure on in your elected capacities to do something about. The State had to ratchet back--

ASSEMBLYWOMAN WEINBERG: But that is another hearing for another day. Yes, let's get back to our subject.

MS. GUHL: Yes, sorry.

ASSEMBLYMAN CONAWAY: It is another hearing. Giving the consumer an education, and having consumers shop around, necessarily bumps up against the concept of a network, and I just wanted to make sure that I understood what you said. If networks go away-- You see, I don't see the loss of a network as meaning you go back to indemnity, because you'll still have your cost controls in terms of fees, it seems to me, if they're covered under insurance. So I guess what I'm trying to understand and hope you can explain it to me is that the network itself-- You feel that the network itself is its own

cost-containment measure. Now, if somebody goes out for quality, are they going to go out to higher care when that person is still going--

MS. GUHL: Well, we think it's a quality measure also, Assemblyman, because health plans credential, as you well know, and recredential annually. And we'd like to think that the assurances of a network also are assurances of quality. So we don't think that the two are antithetical. Physicians who make errors and -- errors are human, you know, are natural -- but inordinate numbers of errors are not something -- costs that health plans are going to want to incur. For every error-- And the kinds of things that a health plan does, that they monitor, for example -- readmissions into OR -- different kinds of things they can look at from their systemic perspective to get a sense of is there potentially a quality issue with a particular provider or a particular hospital.

So I think the two goals, frankly, are oftentimes, more often than not, work in tandem, that controlling quality is a cost container, and they can move together.

ASSEMBLYMAN CONAWAY: Perhaps you can give -- because you raised that, you-- I hope it's a good question.

MS. GUHL: Yes.

ASSEMBLYMAN CONAWAY: Can you give us some or shed some light on the number of people that you have removed from your network because of problems. Is it 1 percent, 2 percent? Is it less than that, more than that? People that you've taken out of network because they have a lawsuit or had somehow fallen outside of some generally accepted parameter or parameter

that you're using in terms of your own policing of this? People tend not to go to physicians who don't have insurance or who don't accept their insurance.

MS. GUHL: I certainly do not, and I apologize, have that number. I can try to survey the membership. You're talking about the sort of ejection--

ASSEMBLYMAN CONAWAY: The actions that insurers take to remove people from network based on a fair -- to live up to quality standards, and particularly is driven by settlements in judgments and that process and how costly is it and what recourse -- have people been sued because you pulled somebody out of network? What costs might flow from adverse actions against physicians as regards moving them from networks? That would be very helpful.

MS. GUHL: I'll try.

ASSEMBLYWOMAN WEINBERG: We have about six or seven more speakers.

MS. GUHL: Okay.

ASSEMBLYWOMAN WEINBERG: We have about six or seven more speakers, if they're still in the room. A couple of you I do see in the room.

Any other questions from Michele?

Oh, yes. Joan.

ASSEMBLYWOMAN QUIGLEY: I'll make the question short. You mentioned before about the number of doctors who are employed by the health plans. If they are exclusively employed by the health plans, are they required to carry malpractice?

MS. GUHL: Exclusively. Well, most doctors are in the networks of multiple health plans. You go to your doctor, and he accepts or she accepts, you know.

ASSEMBLYWOMAN QUIGLEY: What I had in mind, and I'll try and explain.

MS. GUHL: Okay.

ASSEMBLYWOMAN QUIGLEY: What I had in mind, for instance, let's say a surgeon. He may work for a number of health plans, but he's not actively performing surgery in a hospital that would require him to have malpractice. Therefore, would he or she be required to have malpractice in order to render decisions for health -- or recommendations, whatever you call them -- for health plans?

MS. GUHL: Oh, for the plan? They work for-- I'm sorry, Assemblywoman, I was missing your question. I don't know. I haven't come across that.

ASSEMBLYWOMAN QUIGLEY: I don't know either. If you could find out.

MS. GUHL: I would assume to be a licensed physician in New Jersey, but you're saying they're not practicing in the way, the layman way we think of it.

ASSEMBLYWOMAN QUIGLEY: My understanding is that many of the physicians employed by health plans--

MS. GUHL: Yes.

ASSEMBLYWOMAN QUIGLEY: --no longer have active practices.

MS. GUHL: Right. That's correct.

ASSEMBLYWOMAN QUIGLEY: So, therefore, I wonder if they have malpractice insurance, and if so, who pays it?

MS. GUHL: They have to carry insurance. Okay.

ASSEMBLYWOMAN WEINBERG: Michele, thank you.

MS. GUHL: You're welcome.

ASSEMBLYWOMAN WEINBERG: Is Dr. Alfred Sacchetti from the American College of Emergency Physicians-- Please come forward. Our apologies for the fact that it's 2:00.

ASSEMBLYWOMAN QUIGLEY: Can we ask, Madam Chairman, if we would have to wait any longer to see him in an emergency service than he waited for us all day? (laughter)

ASSEMBLYWOMAN WEINBERG: Well, hopefully, he has a backup someplace back there.

ALFRED SACCHETTI, M.D.: Actually, you would wait a whole lot less in our department. (laughter)

I can do this in 90 seconds.

ASSEMBLYWOMAN WEINBERG: If I had known that, I would have called you much earlier. (laughter)

DR. SACCHETTI: I'm an emergency physician and the Research Director at Our Lady of Lourdes Medical Center. You've heard a lot of comments already today that have hinted to the problem. One of my research interests is actually error reduction. I can tell you that, along with two other emergency physicians from New Jersey, we wrote the first paper on error reduction in children with special health-care needs, and we presented the

session on errors at the National Congress on Childhood Emergencies. So there is, as in many other areas, New Jersey is kind of leading the way in error reduction.

I'm going to tell you that the -- real simple. To eliminate the errors, all the personnel involved in the delivery of health care must be empowered to report, to discuss any errors in a timely fashion. Unless you're willing to set up something that will do that, you're not going to reduce errors. The problem is that a free and open dialogue about errors is never going to occur in the present punitive system in which medicine is practiced. That's where it's going to fall back to the Legislature. You guys have my testimony. I'm not going to go through that. There's a lot of references at the back of that -- a lot of abstracts at the back of it.

One of the interesting things and one of the proposals that this Assembly needs to look at is the formation of a system that encourages pretty much an error reduction system that's around when an error occurs, to after the cause of the error, at the same time reimbursing or at least compensating the injured parties. Right now, everybody buries it under the carpet. And as you've heard earlier, most of the people involved went kicking and screaming to the court steps that they never made an error.

What I find fascinating about all the cases that were presented today, the people who were brought in as examples of error, was, there was absolutely no discussion that, as a result of that lawsuit there was anything that reduced the errors or prevented that error from occurring again at that institution.

ASSEMBLYWOMAN WEINBERG: Are you saying during the life of the lawsuit?

DR. SACCHETTI: I'm going to tell you that during the life of the lawsuit or at any part there was nothing in the process of bringing that suit to trial that in any way tied an error -- and I'm not even sure errors occurred in those cases -- that tied an error into any investigation that would reduce it or protect any other citizen from it happening again. What's interesting is, if you look at places where they put this system in, where they got completely rid of this adversarial role--

In Sweden, for example, if something occurs, the physician notifies the patient that an error may have occurred, helps them fill out the claim forms. They work with them to resolve it with various panels. The issue is resolved, and the patient compensated within six months. If you look at a system like that compared to what we heard today, where it was three to four years before anything was resolved, but the more important piece of it was you didn't have a bunch of health-care providers who were backed against the wall saying, "I didn't do anything wrong," protecting what they did. What they did, they said, "You know what? Maybe what happened to you was a result of an error. Let's investigate it. We'll sort the thing out. He's your compensation because we think you're owed it. There's nothing accusatory about it, and let's see what we can do to prevent it from happening again."

ASSEMBLYWOMAN WEINBERG: Is that the VA system now?

DR. SACCHETTI: You know what, I'm not familiar enough to say specifically what they do, but it's pretty similar to it where they have said, "We encourage the people--"

ASSEMBLYWOMAN WEINBERG: So then which system are you referring to then?

DR. SACCHETTI: This is actually in Sweden -- is where that system is in place.

ASSEMBLYWOMAN WEINBERG: Okay.

DR. SACCHETTI: In the VA system, what they found was if they went forward to the people and said, "You know what? We think we made an error in your care," a couple of things happen. One is the issues were resolved infinitely quicker, and more importantly, there wasn't an adversarial role where two people are pointing at each other and said, "You know what? It happened to you, Mr. Jones, let's see what we can do to make sure it doesn't happen to anybody else."

ASSEMBLYWOMAN WEINBERG: Any other questions?

Doctor.

ASSEMBLYMAN CONAWAY: I'm just--

ASSEMBLYWOMAN QUIGLEY: Field trip this week? (laughter)

ASSEMBLYWOMAN WEINBERG: Actually, it's not a bad idea, but David wants to go only in the summer months, so I'm sorry. (laughter)

ASSEMBLYMAN CONAWAY: You don't ski?

I'm interested how much -- without going too long, I guess because we are pressed for time -- but I'm curious about other aspects of the Swedish system. For instance, you mentioned that they get to resolution in six months. Do they have some kind of a scale that they use to determine what the compensation is?

DR. SACCHETTI: Yes, absolutely.

ASSEMBLYMAN CONAWAY: I mean, I'm just thinking of other things, because I can't imagine that you could have it in that quick a time.

DR. SACCHETTI: They're a bit ahead of the curve. In my testimony that you have, there's references in there. The article I think that references that I think is the first article at the end of the appendix. What they do is absolutely-- They've got a panel that sits down and says, "Do you know what? Did an error occur here? You're entitled to money. You're not entitled to money." It's similar to Workers' Comp. It is a fixed scale, what the compensation is. So there's not a whole lot of debate as to what someone -- what a particular injury is entitled to is. You kind of eliminate the problem that an injury that results in the loss of a hand in one county is worth a certain amount of money, but in another county, it's worth an entirely different amount of money. That was -- they pretty much sat down and said this is what different people will be entitled to. So it does go much more quickly.

ASSEMBLYMAN CONAWAY: We do have-- There actually has been legislation introduced that would set up that kind of system here in New Jersey. Now, I'm guessing that in Sweden it's a national system, and I guess physicians are employed by the state, I'm guessing, there.

DR. SACCHETTI: You know what? I'm not sure whether the physicians are employed by the state, but it is a national system. The one thing that they found is, and they modeled it, was once you got rid of the accusatory nature of errors, you got people to come forward and admit that they made a mistake and let's see if we can solve it and it not happen again. As long as you've got the punitive systems in place, two things are going to happen. One is, no physician, no nurse, no hospital is going to go to a patient

and say, "You know what? We screwed up. Let's see what we can do to help you out." And number two, nobody is going to go back and look at the system and say, "Let's see what we can do to prevent it from happening again."

ASSEMBLYMAN CONAWAY: The interesting thing -- and I'll end here -- is that they talk about the VA system and their ability to do that. But one of the interesting things, of course, is that you can't sue the federal government.

DR. SACCHETTI: Correct.

ASSEMBLYMAN CONAWAY: And so that's an interesting aspect of the VA's ability to do those sorts of things. There might be other hospitals that are doing it. I think it's a good idea, if you can do it and afford to do it.

DR. SACCHETTI: Well, I think that's where this Legislature comes in. If you can say it to the -- we're going to completely rewrite the tort system that, number one, guarantees you get compensated and you get compensated in a more timely fashion, then there's really not much of an objection to the system, and you now have a system where people say, "If you made a mistake, we're not going to come after you and prevent you from getting insurance. We're not going to come after you and publicize your name all over the state so that nobody ever goes to you." We're going to look at it, see where the system broke down because, as you guys have already heard, it's very rarely a bad nurse, a bad doctor. It's usually a system problem. We're going to look at the system and fix it, and in the end, you get the following results -- less errors occurring again, less chance for another citizen to be hurt

that way, a greater and more quick compensation to someone who was injured and overall things just improve across the board.

The problem is you've got to rewrite the whole legislative and tort system in order to do that, and I think that's where the challenge is going to be.

ASSEMBLYWOMAN WEINBERG: Thank you very much, Doctor.

DR. SACCHETTI: Thanks a lot.

ASSEMBLYWOMAN WEINBERG: I know I'm going to review your written testimony, and I appreciate it.

Is Dr. Van Kooy still in the room?

MARK VAN KOOY, M.D.: Yes.

ASSEMBLYWOMAN WEINBERG: Okay. And then Dr. Ronald Bochner.

I guess I've gotten even for all the years I've sat in waiting rooms by making all you doctors wait. (laughter)

I'm sorry. All the women, to my left, seemed to have enjoyed that by the way.

DR. VAN KOOY: My name is Dr. Mark Van Kooy. It's my first time doing this kind of thing. I've got to tell you I admire your perseverance and endurance. I'll do my best not to tax it too much further. Before I get to my comments, I want to say I'm really enthusiastic about being here because of the concerns that I've heard expressed and especially the need for mechanisms to look at processes rather than at individuals. It really energizes me to get back to work tomorrow, because that's what we're doing, and that's

what I'm going to describe to you is a solution. It's a way that we're working now that is focusing on processes and hopefully delivering better quality patient care, but also better business practices in health care, something that we are learning from industry how to try to step it up a little and make health care operate more the way businesses do, both in terms of quality and in terms of business performance.

My name is Dr. Mark Van Kooy. I'm a family physician, born and bred in New Jersey, trained at New Jersey Medical School, did my residency at Overlook. I work at Virtua Health, a four-hospital health-care system in southern New Jersey. We serve Burlington, Camden, and Gloucester counties. Virtua is the largest health-care provider in southern New Jersey, with over 900 acute-care beds, 55,000 admissions annually, and more than 7000 employees. We operate five campuses including acute facilities in Mount Holly, Marlton, Voorhees, Berlin, and an ambulatory campus in Camden.

I've been asked to speak about the use of Six Sigma as an approach to improving patient safety in health-care organizations. Six Sigma is a problem solving approach that focuses on process improvement. It can be applied to any process that has a measurable product. It's similar in many ways to process improvement methods that we've tried in health care in the past such as total quality management and continuous quality improvement. It does differ in several significant ways however.

First, customer expectations drive all improvement efforts, and that's the place that any Six Sigma project starts. Every project begins with a careful evaluation of who the customer of the process is and what their opinion and needs of the product of the process are.

Second, the Six Sigma approach recognizes that the process average performance, the mean performance, is only part of the story. That it's also very important to take into account variations around that average because, often, what our patients experience, especially in the area of quality and safety, are the variations from that mean. So knowing that the mean is good is not enough.

Third, long-term sustained results require planning, monitoring, and changes in system and structures to be sure the short-term gains last. And finally, Six Sigma is a tool kit and a timekeeper. Each project follows a tight series of prescribed milestones, each of which have very well-defined deliverables. So this works well in a complicated organization.

Those developing Six Sigma were not theoreticians but, rather, they were business leaders like Jack Welch at General Electric, who expected solid business results. The Six Sigma tools and structure organize problem solving efforts in a way that gets results. To paraphrase Mr. Welch in an often recounted discussion with a group of consultants, "Much of this is common sense, it just isn't common practice."

A little background, briefly, on Six Sigma. It was developed by Motorola in 1987. This was in response to stiff foreign competition in their market. This approach delivered remarkable results for Motorola, including a total cumulative savings directly attributable to Six Sigma projects of \$14 billion over the next decade. The CEO of General Electric, Jack Welch, learned of Six Sigma through a friend of his, the CEO of Allied Signal, Larry Bossidy. Jack Welch brought this into GE and it became a way of life for the employees. It's transformed the way they do business. The linkage to health

care is GE's broad array of health-care products and services. As a result of GE promoting this methodology with its customers, some of us in health care are learning to use this approach.

Six Sigma started in the manufacturing sector, and it has been widely adopted by industry. This is not something new. The corporations using Six Sigma include Motorola, General Electric, DuPont, Dow Chemical, and Glaxo Smith Kline, and many others listed in my written comments. Health care users are few at this point in time, but interest is rapidly growing. We at Virtua have been using Six Sigma since October of 2000.

Six Sigma companies report a very interesting and very consistent pattern during implementation of this methodology. At a meeting last year of Six Sigma companies -- not health care; health care was included, but it was predominantly non-health care -- including companies like Seagate and Caterpillar, presented their results and reported their initial experience. What they found was a very steep initial investment in the first year, but by the second year, the results of the projects were such that they were more than covering the total cost of implementations. These were with hard dollar savings. This was not with soft accounting practices.

Anecdotally, several of the health-care systems that--

ASSEMBLYWOMAN WEINBERG: Thank goodness.

DR. VAN KOOY: A timely comment. I thought you'd appreciate that.

ASSEMBLYWOMAN WEINBERG: We all puffed up at that.

DR. VAN KOOY: Several health-care systems that have implemented Six Sigma have had an identical experience. We at Virtua had

an identical experience. Even though -- and I will describe in a minute the resources required -- even though we've spent a lot of money getting this started, we've already paid for it. It is, at this point, free.

When introducing Six Sigma into health-care organizations, however, it is important that it be viewed as a tool set and not a philosophy or a new culture or an end in itself. At Virtua, Six Sigma was introduced to support the STAR initiative. The STAR initiative is a collection of priorities for action developed by our CEO, Richard Miller, to create a culture of excellence. At the center of the STAR is the creation of an outstanding patient experience. The priorities to achieve this result are highest clinical quality, excellent service, best people, caring culture, and resource stewardship. Six Sigma is a tool to get STAR results. It also reflects in a very tangible manner the deep commitment that Mr. Miller and the Board of Trustees have to getting results that matter to our patients.

Well, here's how it went. Planning for the introduction of Six Sigma began in July 2000 when Virtua contracted with General Electric Medical Systems to do the training. Training began in October of 2000, and our first projects began in January 2001. We are currently in our fifth wave of projects. To date, we've had 31 projects initiated in areas that range from chemotherapy medication error reduction to improved billing for home care services.

Six Sigma is remarkably resource intensive. We currently at Virtua have three full-time leaders or teachers like myself using standard Six Sigma terminology from GE and Allied. We're known as master black belts. There are seven full-time leaders known as black belts, and to date, 29 of our

managers and supervisors have been trained as project leaders, known as green belts. Eventually, the extent of this project is such that we expect to have 150 green belt managers doing projects in their areas of responsibility.

For the next couple of minutes, I'd like to describe one clinically related project, an anticoagulation project. This directly addressed patient safety. Heparin is a blood thinner that's given intravenously to treat conditions where excessive, inappropriate blood clotting is the problem. We measured the actual performance of the process at a level of detail not previously available and found that the average performance of the process steps was fine. They were very close to nominal performance. However, the variation in the process was substantial.

For example, this process requires that blood tests be drawn at a certain interval. These specimens were being drawn significantly earlier or significantly later than indicated. However, we also found that these minor variations in the process did not lead to the adverse events that we occasionally experienced related to Heparin.

By further reviewing this process, using standard Six Sigma methodology, we created a process map, and we found some very important information. It illustrated that there was misunderstanding and miscommunication among nurses, physicians, and lab staff, very much like what we heard earlier, no one person dropping the ball, but a system that didn't support excellent quality.

For example, we found that patients were not being weighed reliably, and the dosage of the medication relied on weights. Nurses were estimating weights and felt confident in their ability to do so. We

demonstrated to them by an experiment that they were not able to do so well, and through the project we moved from 48 percent weights being done of uncertain accuracy to now 94 percent of patients being weighed with documented accuracy.

Also, the process called for the medication to be held under certain circumstances where anticoagulation was excessive. However, we found that nurses varied in their interpretation of this six-hour time frame for holding the medication. Some thought that this was the time from when the drug was stopped, and others thought that it was the time from when the drug was restarted. It was necessary for us to look at the process in this level of detail to uncover that level of misunderstanding.

We also found that documentation was scattered all over the chart, and that was rationalized and codified in a much more easy to use document. When it came to looking at serious errors, however, we found that they were rare, but when they occurred over the last several years, they were related primarily to the complexity of the process. The process we use for delivering Heparin required 92 steps by individuals to get the drug through the first 18 hours of treatment.

Based on the recommendations from the project we did, we are switching about half of our patients to an alternate medication. It's going to cost us, for just one of our hospitals, an extra quarter of a million dollars in drug costs alone. However, only 21 processed steps are required to administer this drug and the productivity gains that we're going to accrue are going to be greater than the additional cost of the medication. So, as you've heard

theoretically in the past, we're going to deliver better quality at lower cost overall.

In the course of implementing Six Sigma, we've learned a number of important lessons. We found that Six Sigma created momentum that led to rapid change in quality and safety areas that previously had been stuck. They were known -- they were kind of flying under the radar, but they were stuck. CEO-level visible, passionate commitment and involvement are critical to the success of Six Sigma. This cannot be mandated. We strongly advise against starting this approach without that level of commitment in any organization

Six Sigma should be viewed as a tool and not a philosophy. Organizations that are considering using Six Sigma should have a clear goal of improvement in mind, such as the STAR initiative. It's not a program, and it shouldn't be viewed as a flavor of the month.

I also have concern about the future of Six Sigma as an important methodology in health care. I think it's critical that the use of Six Sigma remain voluntary. Regulators should mandate the results, but not the approach, since active support at the CEO level and through the organization is required, because this is a very stressful process. This requires people being confronted very directly with deficiencies in their performance in ways that an imposed method will just not allow to be successful. Six Sigma will lose credibility and it will become a flavor of the month if it's implemented without this deeply felt commitment by leadership.

In summary, Six Sigma is a structured proven methodology for process improvement. It builds on prior experience with quality improvement

in health care, but it has several characteristics that make it much more likely to be effective. When properly implemented, it offers an important alternative to improve hospital business practices, patient safety, and the quality of care we are able to deliver to members of our community.

Thank you for this opportunity to present my thoughts on Six Sigma.

ASSEMBLYWOMAN WEINBERG: Dr. Kooy, thank you very much and thanks for your patience.

I don't know what your malpractice experience is or how the Virtua Health System covers itself, but is this reflected in any way?

DR. VAN KOOY: This will not be reflected directly in our malpractice premiums in any way that I can understand. This is a quality improvement methodology. And as you heard from Somerset, that is not translating into alterations in malpractice premiums.

ASSEMBLYWOMAN WEINBERG: Assemblyman Thompson.

ASSEMBLYMAN THOMPSON: You mentioned in your testimony that it is a very resource-intensive procedure -- currently, three full-time master black belts, seven full-time project leaders or black belts and twenty-nine green belts, which ultimately will go to one hundred and fifty green belts. Now, are the green belts, full-time, devoted to this program, too?

DR. VAN KOOY: Green belts have 30 percent of their time allocated to this work, and their projects are identified in their operational areas of responsibility. The way we help them identify projects is to ask them, "What keeps them awake at 3:00 in the morning? What should they or are

they doing anyway, but where these strategies can allow them to obtain more powerful results and results that are more likely to be sustained.”

ASSEMBLYMAN THOMPSON: Would it be anticipated that this will be taking 30 percent of their time indefinitely or just during implementation stages and so on?

DR. VAN KOOY: It’s anticipated that this is the way we will do work, that this is how we do business.

ASSEMBLYMAN THOMPSON: Indefinitely?

DR. VAN KOOY: Forever. GE is the model here for us. This is the way they do work. I was trained up in Crotonville at their executive training center. I sat down to lunch, and one of their young executives sat down, and instead of having a leisurely conversation about how nice it was to be at this great facility, he grilled me on my control mechanisms for the last project I did, and it was very clear that he was very fluent and conversant on the intricacies of Six Sigma implementation and was going to make sure I was, too.

ASSEMBLYMAN THOMPSON: What, roughly, is the total staff of Virtua?

DR. VAN KOOY: Seven thousand employees.

ASSEMBLYMAN THOMPSON: Seven thousand. Okay. That’s to put it in perspective as to how many people you have.

DR. VAN KOOY: Yes.

ASSEMBLYMAN THOMPSON: Thank you.

DR. VAN KOOY: Thank you very much.

ASSEMBLYWOMAN QUIGLEY: Thank you very much, Doctor.

Is Dr. Ronald Bochner still here? Would you join us, please, and thank you for being so patient.

RONALD BOCHNER, M.D.: Good afternoon. I wanted to thank all of you, for convening this, on behalf of the New Jersey Citizens United for Health Care Access. We're the organizers of that Trenton rally, and I can tell you that we're pleased that government is very concerned about patients health care, so our commendations and gratitude for what you are doing.

Just a correction and clarification. The President of ATLA New Jersey indicated that at our recent rally we never once mentioned patient safety. He is correct. We never used the words patient safety. The synonym we coined was quality of care. So I just wanted to have that clarification placed in the record.

An informational piece for this Committee, since I testified before you last time: as of 12:01 a.m. this morning, St. Peters Hospital, the largest obstetrical hospital in the state of New Jersey, delivering 7500 babies per year has now lost 10 percent of its obstetrical providers. That's as of 12:01 a.m. this morning. That started on January 1 of this year and concluded with the time frame up to this morning. We anticipate, by year's end, another 10 percent will drop off, the largest obstetrical hospital in the state.

Having concluded the informational portion of this, I now wanted to speak about patient safety issues as I see them in my capacity as Chairman of Quality Assurance and Performance Improvement at Robert Wood Johnson University Hospital. I served on this committee for 10 years, and I've been its Chair for the last year and a half. I'm not going to repeat anything you've heard today. You've heard about computer systems. You've heard about all

sorts of things. I think those are wonderful tools that definitely lie in the future of health care in this country and certainly in our state.

But it boils down to one thing, and that is time: time a nurse spends with a patient, time a doctor spends with a patient. Time a consultant or a physician gets to think about a case. Time is a precious commodity. It's a very precious commodity when hospitals are reimbursed at an abominable, at an unbearably low rate for the care that they render. Nurses are forced to care for far more patients than they should have to care for.

I don't know if you've ever had the opportunity to drive four daughters to dance class in one day, but I have. I can tell you that the more kids I drive to dance class, the greater likelihood I'll forget to pick up that quart of milk my wife asked me to pick up. The more you do, the greater the chance for an error.

Why do nurses have so much responsibility for patients? Why does the system break down periodically? In fact, it's a miracle that it works as well as it does. You heard about medical errors, they definitely happen. But considering the volume of patients who pass through this health-care system, it's remarkable that we make so few errors. I can tell you that the number of people saved by our system and the number of people helped by our system far, far, far exceeds the number of people injured by it.

But why do people like myself serve on quality assurance committees? The answer is because we want to reduce that number of people injured on medical errors down to zero. We strive for the ideal. Again, it boils down to time. The one thing that disturbs me the most about what I see in hospitals and in physicians practices is how little time they get to spend with

patients. When a nurse is responsible for five or six critically ill patients, she will not do as good a job as if she is responsible for only one or two patients.

When a physician, in his practice, sees 50 patients in the time frame he should only see 25, he couldn't possibly do as good a job, and he's going to be more prone to errors. Why do hospitals assign so many patients to nurses? Why do physicians have to see so many patients in their practices? And the answer is reimbursement. It's embarrassingly low. One of the people you've heard testify before you today asked -- wondered why physicians accept such low reimbursement for the work they do given the risk they're exposed to. Why would anyone deliver a baby for \$2000 when they could face a multimillion dollar lawsuit for that? Why do radiologists in Florida read mammograms for \$34 when they're exposed to multimillion dollar lawsuits should they miss something? And the answer is because they're physicians. They were trained to care for people.

They're terrible businessmen. I will swear to you that we are terrible businessmen as a group, speaking on the whole. There are some of us who are rather brilliant in that regard, but they are in the minority. Physicians didn't organize. They didn't stand up for proper reimbursement. Hospitals didn't stand up for proper reimbursement. As a consequence to that, nurses are underpaid, overworked; physicians are underpaid, overworked. That's a cesspool for error. That's the issue as I see it.

Everything else you've heard before you is right on target. Computer systems make a difference. Compulsory lists make a difference. Performance improvement committees, they all make a difference. But it boils

down to time. The more time you spend on a case, the more time you spend thinking about a case, the less the likelihood of error.

You were presented with some patients today who were victims of medical error. They frankly deserve whatever reimbursement the system gives them. Anyone who is injured should get some compensation. Why were they injured in the first place? I remember a time when HMOs were insisting that physicians become primary care physicians, gatekeepers. This was forcing physicians who normally wouldn't take care of a certain pathological entity to take care of that pathological entity.

There's actually a discussion for some time amongst OB/GYNs how they would treat conditions, such as chronic hypertension and heart disease. We don't do that kind of work. But when HMOs came into our state, it took a stronghold somewhere around the mid-'90s. There was a great deal of discussion about us assuming those responsibilities, because we are the primary caregivers for many women. We are not qualified to do that kind of work, and I'm glad it never took place. But this was being propagated by the managed care industry as part of the way of containing costs, I suppose. Sometimes I feel like I'm a hamster running around one of those cages trying to catch myself.

The problem just gets worse and worse. They try to save money by cutting corners. As they cut corners, the ideals that we are held to in this state, in this country with regards to outcomes and medical care, can never be achieved. Fatigue is an issue. I remember when I had finished my residency in New York City. Five years later, they passed a law saying that residents like myself could no longer be awake for 36 hours at a stretch. I hadn't known any

other life for years. Now they can only be awake for 24 hours at a time. Why did they enact that? Because fatigued doctors make errors. Fatigued nurses make errors. Overworked nurses, overworked doctors, we make errors.

Do you want to see errors reduced? See reimbursements to hospitals increase. See reimbursements to physicians increase, so they don't feel obligated to see 50 patients in a time frame when they should only see 25 just to meet their expenses.

You've heard a great deal of things from people today. I can tell you at our Performance Improvement Committee at Robert Wood Hospital in New Brunswick, we spend a great deal of time dissecting the things that affect patient care. We have our quality indices that we look at. We call physicians on the carpet in front of us to explain why they did a certain thing or why a certain thing happened. We are free to do so. I must say I'm very pleased with the way our committee conducts itself and conducts business. But the thing I can't seem to fight is the system at large.

Nurses, they're our first line of defense in the hospital. They're the ones who will notice a patient isn't breathing or someone's blood pressure is low or someone is bleeding. But if they've got 10 patients they have to care for and then hours of paperwork to document the care that they've given, they can't possibly be on top of everything.

I'm just going to add to everything else you've heard today and say that I think that time spent with a patient is the number one way to reduce errors. If you have any questions, I'm free for them.

ASSEMBLYWOMAN WEINBERG: Any questions for Dr. Bochner? (no response)

DR. BOCHNER: I thank you very much.

ASSEMBLYWOMAN WEINBERG: Thank you for your patience, again, today.

DR. BOCHNER: And thanks for convening a Committee of this sort.

ASSEMBLYWOMAN WEINBERG: Thank you.

We just got some written testimony from Sharon Rainer, who is the Director of Legislative Affairs for the New Jersey State Nurses Association, which I think talks about some of the same things that Dr. Bochner just covered.

I see Bernie Gerard, Sharon-- Oh, Sharon, you're not here. I'm sorry. Nancy Pinkin, still here. Is Jean Pierce here from Patients First Coalition? (no response) Who am I missing that I haven't called? Oh, Eloise Smart-Loadholt. Is she here? Okay.

Sharon and Bernie, do you want to come up.

I'm sorry, Nancy. I don't know why I want to call you Sharon, Nancy. Nancy.

And Dr. Toliver is still here? All the way in the back. I'm sorry, Dr. Toliver will be next.

Nancy.

NANCY PINKIN: Good afternoon, and thank you for waiting with me to testify on the issue of medical errors and medical safety. I'm here on behalf of the Council of Teaching Hospitals. We do represent 12 of the State's major teaching hospitals, 4 hospital systems, and UMDNJ. You saw, this morning, there was a demonstration of the program that they're using for

medical errors and implementing computerized systems. Many of our hospitals are doing many of those things to try to reduce medical errors and patient safety.

Many of our hospitals have been named -- some of our hospitals have been named as top hospitals in the country. Many of our physicians have been listed in the top docs in the country. Our facilities have been the recipients of the National Merit Award for Nursing Excellence, and the Robert Wood Johnson Foundation just awarded one of our facilities with a perfection grant in recognition of their ability to deliver quality health care.

Our facilities are striving. We realize that medical errors are a problem, and we're taking every effort we can to try to reduce errors. There are many programs going on right now that they're involved in. They include everything from intensive initial and ongoing physician credentialing to contemporaneous quality assurance and quality control programs to monitor patient care. They're using programs to do benchmarking against national statistics to look at where they can improve on patient safety and quality. They're using an increased number of advanced practice pharmacists and pharmacy order systems to closely track all orders. Programs include particulars, which you saw some of them today, about the drug monitoring, about drug interactions, allergies, things of that nature. Also, supporting off-label use when that's appropriate.

They're doing reductions in verbal orders with emphasis on orders written on site or sent by Fax. They're training their staff to refuse orders that seems to be inappropriate or incorrect, or questioning dosages, such as the dosages used in chemotherapy. With chemotherapy, the drug itself is toxic, so

any change has a big implication, so they're looking at those types of issues. They're using more advanced practice nurses, especially in the areas of complex care, such as the ICUs, oncology, dialysis, cardiac care, transplant, open heart surgery, emergency services, and pediatrics.

There's a strong emphasis in our facilities on the nurse/physician communication, especially around lab results, changes in therapy, and any of the complex decision-making that goes on. They're focusing on morbidity and mortality conferences as an ongoing tool to educate and feed back information to the house staff and the physicians on standards of care.

We have also early compliance with the recommendations of the American College of Graduate Medical Education to reduce the number of house staff work hours that they have and to reduce errors by fatigue or being overwhelmed. They're also working on more on the basis of evidence-based medicine.

Now, in addition to all of these ongoing programs, we're also participating in the Leapfrog program, which you heard Dave Knowlton talk about. Our facilities are doing both the physician order entry system at Leapfrog. They're using the evidence-based hospital referral. There are programs -- many of them are already centers of excellence with a wide range of complex medical and surgical procedures. But even with that, we're expanding our efforts to improve safety and try to evidence-based referral. It means that you send patients to the centers that have the biggest volume so that they can ensure quality by repetition and doing the same procedure over and over. And the last thing that they're doing for Leapfrog is the ICU position staffing by putting intensivists on call in the specialty ICUs 24 hours

a day so that they always have somebody there to take care of those high-tech needs.

Now, in addition to those efforts, also, the medical malpractice crisis impacts the teaching hospitals ability to deliver quality services. Efforts to review patient care systems and medical errors must be protected from inappropriate disclosure of discussions. We feel that that is key, and I think there was a lot of testimony to that today.

Tort reform is another aspect of medical malpractice crisis that we feel must be addressed. This crisis is nationwide. You heard the issue of the trauma hospital in Nevada, and we're very concerned about the trauma hospital system in New Jersey. This is our 20th anniversary of trauma. New Jersey has a very well-known trauma system. It's one of the best in the country, and we don't want to see that affected by the medical malpractice crisis. It's definitely a real threat.

All of these initiatives require dollars and that affects our bottom line. With the cutbacks in Medicare, managed care, and with New Jersey Medicaid paying less than the actual cost, the ability of teaching hospitals to purchase new technology and to pay for malpractice coverage is definitely impacted by that.

Now physicians just got an increase, as you heard Michele Guhl talk about, for the outpatient side of services. That's the first increase in 30 years, believe it or not. That number came from the Department of Human Services actually. And even with that increase, we are still ranked at the bottom of the nation in reimbursement for Medicaid services.

So we support all of the efforts that the Legislature is taking to help us with the malpractice crisis and to help us to be able to provide these services to patients. People are trying to do their best. We appreciate your listening to all this testimony today and all the other days.

Thank you. Do you have any questions?

ASSEMBLYWOMAN WEINBERG: Thank you, Nancy.

Any questions? (no response)

Dr. Clifford Toliver. You sat in that back row so patiently. Come forward, please.

CLIFFORD W. TOLIVER, M.D.: Thank you, Madam Chairman.

ASSEMBLYWOMAN WEINBERG: Push your button so that the red light is on. (referring to PA microphone) I have to turn mine off, okay.

DR. TOLIVER: Okay. Thank you, Madam Chairman and members of the Committee for hearing me. My name is Dr. Clifford Toliver, and I'm an obstetrician/gynecologist practicing in the area. I'm not here representing anyone other than the inner city residents and the physicians. I am a board certified obstetrician and gynecologist. I came to New Jersey in 1972. I graduated from the College of Medicine and Dentistry of New Jersey at that time. I did my residency in Newark. I stayed in the area and practiced. I taught at the Medical School for approximately a year and a half. I have remained in private practice in the Oranges.

Now the issue that I see in the Oranges that affects the public safety is when I first entered the practice in East Orange, there was approximately 10 obstetricians rendering service in the Oranges and East

Orange. Today, there are no obstetricians in Orange, and there are only two obstetricians delivering babies privately in East Orange, and that's myself and Dr. Brown (phonetic spelling). The physicians have decreased the obstetric service because of the increase in the malpractice insurance. Now, as Chairman of the Hospital Center in Orange, we no longer practice or deliver obstetrical services through that facility for the residents of Orange. That was done last year.

Now the issue becomes-- It's not necessarily medical errors, but there are medical errors, but the bad outcomes are different from medical errors. Let me give you an example of a sad situation that I see far too frequently. A parent brings an 11-year-old to your office to wonder why she no longer has her periods -- to discover that she is pregnant. Now you have to go through a high-risk situation of an 11-year-old, who will deliver at 12 years old, and who will have most of their major complications associated with an adult heaved upon her at the age of 12, including most likely and most probably caesarean section. She doesn't eat well. She's in a poor situation at home. There are at least seven or eight other kids there. Parents are either absent, don't work, or are on public assistance. She's malnourished, and she comes to you, usually, at 25 weeks pregnant, and you have to go back and try to catch up with all of the aspects of prenatal care.

Now the rising costs of malpractice -- and to give you a personal observation is that I was no longer in practice until yesterday when I finally received malpractice insurance. As of yesterday, my office, my employees, and my family were almost homeless. But finally achieving malpractice insurance at double the rate that I paid last year, fortunately, I am still in practice and

able to render care in the inner city or the urban areas to these types of patients. This is all I do. This is all I want to do. I'm not interested in anything else. I render care in the inner city. However, I'm faced with these cost savings measures that I will have to take.

I will no longer be able to accept Medicaid patients because they are the higher risks and the lowest paying. Those are the ones that I get sued for the most. Have I been sued? Yes. Legitimately, I don't think so, because the insurance companies force me to settle when there are times that I think I am in the right. So I have to settle because I'm told it's less money if you settle than if you go ahead and carry the case to court. Not knowing if you do that in either aspect, you're going to be hit for it in either way. Your malpractice will increase, and you will become what I was told, until yesterday, uninsurable.

ASSEMBLYWOMAN WEINBERG: Can I ask you with what company you got your insurance finally?

DR. TOLIVER: Zurich. Now the issues in the high risk areas that we're faced with -- substance abuse-- We're faced with HIV. No one wants to take care of these patients. Now you get a bad outcome. You've seen 40 patients a day. You neglect to write down that you asked a patient to present for ultrasound. The patient didn't go for ultrasound for whatever the reasons are. She had a bad outcome, and it's a medical error because you were overworked and you neglected to write just that one note, even though you know that you told the patient that. The patient knows that you told her that.

So the errors of commission, the errors of omission, I agree if anyone is injured, I think they should be compensated appropriately. Many

cases are won and lost on technicalities, and I've been involved in a few. I've been named in cases 19 years out for which I have no recollection of it in the medical record of what happened when I was a resident, was excused from the case, and you're still held for being involved in litigation.

I don't want to belabor the point of the malpractice crisis, because it's real. As being one of the doctors in the trenches, I can tell you it's real and it hurts. Now, what can we do? Everybody suffers in a malpractice case. My family suffers. I suffer. I'm being called a bad doctor. I'm being told that I should be stripped of my privileges. I'm being told that I am unfit to work. How do my kids go to college? How do I feed my family? I don't know anything else to do. I am a bad business person. I admit it.

Now what can we do? Well, I think one of the things that has to be done is I think there needs to be a freeze on premiums to last year's level. I think there have to be caps whether we like them or not. There should be periodic payments. We have to really adjust or think about the statute of limitations. I mean, 21 years out for a delivery that occurred 21 years ago is a bit much for a statute of limitation. We need review committees involving doctors, lawyers, maybe even some laypeople, nurses -- whoever -- to review claims to see if they are meritorious.

One of the other things that troubles me the most is that you get in a case, and then the expert witness has never practiced for five, ten, fifteen years, or he's from out of state or, one of the most distressing things, is that they're not of your specialty. They're of another specialty and they're rendering an opinion in your specialty.

ASSEMBLYWOMAN WEINBERG: That is another area that has come up in our discussions that I think we might be able to work a solution for.

DR. TOLIVER: I think standards for expert witnesses -- if they fail to review medical records properly or if they misrepresent the truth, I think there has to be something that has to be done in that regard. As a physician in the trenches, Orange and East Orange next year will probably have no physicians if something isn't done to address it, because the stress is too much for me to take or too much that I want to take. At this point, I honestly want to leave.

Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you, Dr. Toliver.

Any questions for the doctor? (no response)

I think you helped put a human face on the other side of this issue. I know certainly that the -- and we've heard about that in the past -- the kind of practice you are automatically dealing with a higher risk patient to begin with. So that that is reflective of other problems that could happen that are not necessarily the result of medical error.

But thank you for coming forth and for being so patient.

DR. TOLIVER: Thank you.

ASSEMBLYMAN THOMPSON: I have to say that one of the subjects you mentioned there is one that stirs me in this whole thing that -- exactly how we handle, I don't know -- but that is what you described as bad outcome cases. Clearly there are a number of cases that are bad outcomes, i.e., nothing wrong was done. But whether because of genetic problems or what,

a child was born disabled or whatever, but not due to neglect on the part of the physician, etc., a malpractice is filed and the jury looks there and they see the child and somebody has got to pay. And you end up with a label on you even though you did everything you could. You did it right. Now your malpractice prices go up, even though you did it right.

DR. TOLIVER: That's correct.

Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you.

Patricia Cavanaugh, Nursing Officer and VP at Capital Health Systems.

P A T R I C I A C A V A N A U G H, R.N.: Thank you for the opportunity to speak to the Committee today. My name is Patricia Cavanaugh. I'm the President of the Organization of Nurse Executives in the State of New Jersey and the Chief Nursing Officer of the Capital Health System, which is a merger of two hospitals in Mercer County and provides about 3400 births in a Level III regional perinatal center. So I would use that as a definition of high-risk OB.

If you were to ask a nurse executive in the state what keeps him or her up at night, it is patient safety and that we do no harm to our patients. The Organization of Nurse Execs represents about 700 nursing leaders, both in acute, long-term, and rehabilitation hospitals and health-care facilities. We are committed to patient safety and competent staff.

This morning, Gary Carter, from the New Jersey Hospital Association, provided a comprehensive overview of external regulations, joint commission standards, and quality improvement activities that our industry

must comply with in order to monitor patient outcomes. But in addition in the state, the Maternal Child Health Consortium, which represents regional hospitals, also monitors mother-child outcomes under the direction of the Department of Health. I'd like to continue the specific activities that nurses participate in to promote a culture of patient safety and quality outcomes, and I'll focus on obstetrical services, since that is really where the malpractice crisis is occurring.

The American College of Obstetrics and Gynecology, ACOG, has established well-defined indicators to measure quality. These indicators are the framework that nurses develop policies, perform their practice, their performance improvement activities, and provide outcome measures which are benchmarked against national standards. Obstetrical performance improvement activities are multidisciplinary and consist of physicians, nurses, and other members of the health-care team who perform that self-critical analysis that you heard of today for individual performance and for system improvement.

Registered nurses are an integral part of the care of the obstetrical patient and must be highly skilled and competent in order to practice in this very high-risk environment. The average training for a registered nurse within this speciality is no less than two years beyond their basic nursing education. In addition, most obstetrical nurses have high certifications from their professional organizations. This advance certification requires ongoing testing of competencies to assure continued knowledge in advanced technology and patient care.

In my testimony, I've attached for you a list of all of those things that we continue to monitor and to evaluate. It's truly only a sample of the things that we are involved in when we take care of the mother-child dyad. Patient safety and medical error reduction are priorities for health-care facilities. Education, performance improvement, and practice are focused on how we, as health-care providers, can assure the safest and most critical care to our patients. The culture of patient first starts with the governing board, hospital leadership, and ultimately to the direct care provider.

In conclusion, patient safety and quality patient outcomes and medical error reduction is a focus for all providers of health care. Hospitals throughout the State of New Jersey are well positioned among the finest hospitals in the nation, as evidenced by our high joint commission scores, the Magnet recognition of 12 of our major hospitals in the state, and the Governor's Award for Excellence. The public demands and expects quality, and it continues to drive hospitals to be competitive in how we provide advanced technology and sound clinical programs to our very small market share.

Again, thank you for the time to speak, and I will answer any questions about nursing.

ASSEMBLYWOMAN WEINBERG: Thank you.

Any questions? (no response)

Thank you again for your patience.

MS. CAVANAUGH: That's fine.

ASSEMBLYWOMAN WEINBERG: Bernie Gerard, are you still in the room, or are you hiding behind a pillar someplace? Oh, here you are. Do you want to add anything?

B E R N A R D W. G E R A R D J R.: No. I've submitted copies of written testimony. I'd ask you all to please review it.

Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you.

Is there anybody else around that I did not call upon?

Yes. Oh, I'm sorry. Come forward, the last speaker. We do have a legislative liaison from the Department of Insurance -- has been here practically the whole time, John Covello. And earlier Jay Jaimenez, from the Health Department, was here, and I think we had somebody, also, from the Board of Medical Examiners listening to all of the testimony, in addition to the Committee members.

The Health Committee gets the award as the longer lasting of the two Committees.

Go ahead.

E L O I S E S M A R T - L O A D H O L T: Hi. I'm Eloise Smart-Loadholt. I'm a real nurse. We're very few in number. When I say real nurse, I'm one of the nurses that is qualified clinically and administratively to do my job effectively. Basically, I would-- Being a veteran of the United States Army and UMDNJ, I would come prepared with a testimony, but I only learned about this meeting yesterday afternoon. So I had one of my associates who works with me, because we are legal consultants, draw up some examples and some recommendations for you. Normally, I would come with a stack this

big (indicating) because I believe in facts and backing up the facts. But what I want to say today has to do with the senior population.

In the last three months, I had the opportunity of visiting one of the biggest hospitals in Essex County, acute care, and one of the biggest trauma centers in Monmouth County, where I saw for myself, which I've been seeing for years -- I've been a nurse for 27 years -- that senior populations do not count. If you are 60 years or above, you are considered expendable, not cost effective, which means, if you do not have a family member there that cares about you, that knows medicine, that knows somebody that knows medicine, you will die. You will die early. If you do not die in the acute care center where they immediately diagnose you as dementia, you will die in long-term center. Now, within most of the cases we get, they die within three months of admission in a long-term care center, okay.

These people are treated like third-class citizens. These are your voters. I went into Beth Israel. The individual went there. She was complaining of chest pain. She had blood coming from the rectum, irregular heartbeats. She was supposed to go to ICU. She was in Beth Israel's ER for three days. This is what they do for senior citizens. They keep them in the ER. They maintain them in the ER until they stabilize them or until they die, then they transfer them to the floor. They don't make it to the ICU anymore.

Why do they do that? They say, "because Medicaid and Medicare are squeezing us." This is the doctors. "They are squeezing us." So the money is not there. We only can spend so much. I have gone in because I also work home care as a consultant. I work as a long-term care consultant. I do a lot of

things. My patients, they call me when they go into a hospital, because they know if they go in there alone, they won't get any care.

All right. Last year, alone, I had eight patients discharged from Beth Israel Hospital. Within 24 hours, they were dead. This is how they discharge them -- within 24 hours. Now, I doubt if Beth Israel shows this in their statistics, nor does UMDNJ. I have 14 years in UMDNJ. Who used to monitor UMDNJ's mortality rate? Me. I was the only nurse who did the mortality rate for the whole hospital. I was the critical care/nurse specialist for MICU, CCU, open heart, detox, and one medical floor, and there were 12 of us. Can you imagine what the rest of them did? But the seniors were treated the same.

I go to Neptune. The seniors are sitting there-- This poor lady, she was admitted for rehab, you know, your 21-day rehab that you send people to that these nursing homes gets all this money for for physical therapy. She was sent there just for a sprained leg -- sprained leg after she left Beth Israel because she fell. Within 10 days, they had drugged her up. She had developed an ulcer. The ulcer developed into gangrene, and she had a hospital acquired staff infection. That facility was told, document this. See that the doctor sees it. "Oh, yes, we're going to do it. We're going to do it." A facility that, mind you, your State survey team passed.

Now, I'm a long-term care. I've been one for eight years. All of their documentation, all their paperwork is typewriter written. Now you know how old that is. All of their standards of practice is outdated. But this place, this facility passed inspection by the State. They then, when this lady's time was up, they sent her home by wheelchair with gangrene and an infection.

Within 12 hours, she was readmitted to Neptune to your trauma center where she should have gotten the best of care, the best.

Okay. The first thing she saw was infectious disease -- a doctor who says, "Oh, do you want us to keep you alive?" She says, "Well, if I'm not brain dead, of course, I want you to keep me alive." So this doctor gets a piece of paper -- one little single piece of paper they have now -- and she checks off something and tells the aid to sign it. Do you know what she did? She made the woman a do-not-resuscitate.

They sent the lady up to the floor crying in pain, put her at the end of the hallway. I said, "Why don't you put her outside, put her on the staircase." All right. They sedated her with morphine with no monitoring. Blood pressing dropping -- I had to call her doctor. They take a temp and they estimate the temp. They put it under her arm. And I says, "She's hot." "Oh, her temp is 98, but we add on 2." I says, "Let me call the doctor again." We call the doctor. The doctor tells them, "monitor the patient."

Then all of a sudden you get your surgeon. The surgeon looks at the leg. "Oh, gangrene." He says, "We could try to save the leg, but Medicare is squeezing us so tightly and funding is so restricted." He says, "It's better that we amputate the leg." So they amputate the leg. This lady's leg is amputated. She bleeds for a week and a half. I said to them -- I looked at her chart, but I'm only a nurse practitioner. I said to them, "Based on her labs, she will not heal unless you give her the IV substance to build up her system. " She's not cost effective. The only thing we could do is put in a stomach-- So what happened to this lady? She breaks down.

ASSEMBLYWOMAN WEINBERG: Ms. Loadholt. You know, this has been a long day for us, and I know--

MS. SMART-LOADHOLT: Yes, I know, and I'm going to end it.

ASSEMBLYWOMAN WEINBERG: --you've been very patient by waiting but--

MS. SMART-LOADHOLT: Yes, I know. I'm going to end it. I'm getting done. Okay. What happens -- the end story is this lady was expendable. She was sent to another facility. She died. We have, like, over 2000 cases where this incidence has happened. You go in long-term care facilities -- they would rather take a hit from the State than correct the deficiencies. You have people functioning in long-term care facilities that are supposed to be licensed, and their licenses have been revoked for years. Where is the State survey team? Why aren't they picking up that? Why aren't they?

If I can go in there as a consultant, and I'm in there less than a week and I pick it up, why isn't your State survey teams picking it up? Why are these old people--

ASSEMBLYWOMAN WEINBERG: If you have any kind of evidence of unlicensed personnel working--

MS. SMART-LOADHOLT: We have plenty of evidence.

ASSEMBLYWOMAN WEINBERG: --we would greatly appreciate hearing about that. We will follow up ourselves of the institutions and/or names.

MS. SMART-LOADHOLT: But it starts from your acute care, because your acute care says that--

ASSEMBLYWOMAN WEINBERG: Right.

MS. SMART-LOADHOLT: --after 60 they're not expendable.

ASSEMBLYWOMAN WEINBERG: Well, since I might have reached that magic age, and this is something in which I am very interested.

MS. SMART-LOADHOLT: If no one goes with you, then they'll put you in a corner and you die too.

ASSEMBLYWOMAN WEINBERG: Notice I said might have.
(laughter)

MS. SMART-LOADHOLT: But these people deserve the care.

ASSEMBLYWOMAN WEINBERG: I agree.

MS. SMART-LOADHOLT: I've listened all day to doctors hollering they need more money. More money for what? They do nothing. They're there five minutes, ten minutes at the bedside. Nurses do the care. But then I said that Beth Israel -- Beth Israel had better staffing than anybody I've ever seen. The nurses never moved from the nurses station. So it's not staffing. It's not staffing.

ASSEMBLYWOMAN QUIGLEY: Madam Chairman, I have to tell you. I'm going to need a doctor myself soon because I'm getting real exhausted. I think it's about time we adjourn.

MS. SMART-LOADHOLT: No problem.

ASSEMBLYWOMAN WEINBERG: Okay. Thank you very much.

MS. SMART-LOADHOLT: Like I said, if you're over 60, think about it. Okay.

ASSEMBLYWOMAN WEINBERG: Thank you.

First of all, I thank all of you for staying so long. We began at 10:30 this morning, if you remember that far back. Just for a minute, I think we've heard some pretty good testimony today by and large. What kind of impresses me is the need to review the systems and not necessarily always the individual health practitioner or where the system breaks down, and how we're going to find that balance between being able to review that system in an appropriate manner and yet exposing those people who have patterns of bad practice.

So I think that's -- if I have to sum up five or six hours, that is certainly one of the areas in which we have to put our collective heads together to decide how we can approach this whole system so that we are not only holding down medical malpractice, but we're actually providing the best possible care to the residents.

So, if anybody has anything else to add, I'd be happy to hear it.

ASSEMBLYMAN D'AMATO: I just have one question.

ASSEMBLYWOMAN WEINBERG: Sure.

ASSEMBLYMAN D'AMATO: Is it agreed that we're going to meet again before September? Has there been any discussion about that?

ASSEMBLYWOMAN WEINBERG: No. I don't know that we're going to be able to meet again before September because of vacation schedules. This was hard enough to arrange, but certainly by early September we have to have whatever our suggestions are going to be in this area put together.

A moment, I want to thank the staff. First of all, those of you who make it possible for us to actually read all this afterwards where we have questions. David Price and the professional folks from OLS and certainly our

partisan staffs from both the Insurance Committee and the Health Committee for helping us put all of this together and keep this paperwork straight. So, from all of us, a great big thank you for all the work you've done.

ASSEMBLYMAN THOMPSON: The one thing I would add is, of course, we have a critical situation here that I think it's important that we get in a position to take some action in a relatively short term to deal with it early on. We can't let it go for a year or anything like that.

ASSEMBLYWOMAN WEINBERG: No. No. We wouldn't be meeting in August if we'd planned to let this go.

ASSEMBLYMAN THOMPSON: No. I'm just relating to our meeting. I mean, actually taking action--

ASSEMBLYWOMAN WEINBERG: One of the things I'd like to hear from the Insurance Department because there is this big discussion about freezing rates or requiring renewals at the same rates. I don't mean they have to do that right now, John, but in the very near time of -- what your views are on that, whether that will mean we will have less insurance companies writing insurance here or if, in fact, it will really be a short-term solution to a long-term problem.

ASSEMBLYMAN THOMPSON: That's one of the very unanswered questions that I see as what is the -- how are the insurance companies making out? What's their profit margins they're getting here? Is there excess profits or is it that they're really in a bind? Some real numbers on that.

ASSEMBLYWOMAN WEINBERG: John, is that something that the Insurance Department has looked into and has the ability to look into?

JOHN A. COVELLO: We could get the information since they are deregulated on their financials in terms of what they've filed. But for any coverages in excess of \$10,000, in terms of premiums, they don't have to file the rates with us. So that's a part of what's involved in the system is. It's been a deregulated line -- commercial insurance since 1982, but we could certainly see what information we have on those companies.

ASSEMBLYWOMAN WEINBERG: Since it was a difference of opinion on what the CEO from MIIX testified to, I know David said-- I think the transcript of the first hearing, you said, was ready. Yes, it's just been sent out. So all of us will be able to review her testimony as was transcribed to see who had the best recollection of that particular testimony.

Joan.

ASSEMBLYWOMAN QUIGLEY: I just wanted to encourage the Insurance Department to try and act as somewhat of a referee between the doctors and the lawyers. I'm getting an awful lot of mail on this. From what I'm hearing from the public, most people love their doctors. Most people love their lawyers. Nobody loves their insurance company. So both sides are now -- instead of blaming each other, turning around and saying, "Well, it's those bad insurance people." So just be careful.

ASSEMBLYWOMAN WEINBERG: Yes. And we have to be careful that we maintain some insurance companies here. That's the other thing I'm worried about.

ASSEMBLYWOMAN QUIGLEY: Yes.

ASSEMBLYWOMAN WEINBERG: Assemblyman D'Amato.

ASSEMBLYMAN D'AMATO: If I may, I think it was two weeks ago I had a very fortunate experience. Commissioner Holly Bakke was in Atlantic City, and we were waiting for Governor McGreevey to come down for an event. Assemblyman Frank Blee and I spoke to her for, I'll say, 25 to 30 minutes. She is one of the most informed individuals on this issue. I learned so much in that half hour of conversation. I would just recommend to the Chair that perhaps, and I know she's very, very busy, but perhaps she could be one of the witnesses that come here.

ASSEMBLYWOMAN QUIGLEY: If we don't have time to do that, she'd been interviewed by the New Jersey Medical Society. There's a very interesting article authored by her in this month's edition of the *Medical Society Magazine*. I believe that comes to all our offices.

ASSEMBLYWOMAN WEINBERG: It does.

ASSEMBLYWOMAN QUIGLEY: So it's a good thing to look at and you'll learn almost as much right away.

ASSEMBLYWOMAN WEINBERG: I did have the opportunity of meeting with her in my office down here. You are right, she is well informed.

I think one of the reasons for this hearing today is that we wanted to emphasize that this has to do with delivery of medical services as well as insurance, i.e., for this side of the members of the Committee of the Task Force.

But I'm glad you mentioned that. I'll look for the article this month.

ASSEMBLYWOMAN QUIGLEY: Yes, good.

ASSEMBLYWOMAN WEINBERG: Joan, when did the recent one come in? Do you know?

ASSEMBLYWOMAN QUIGLEY: I think it was within the last 10 days, because I read it recently.

ASSEMBLYWOMAN WEINBERG: Okay. Maybe you can get us reprints of the article and send them out to the Committee members.

MR. COVELLO: I'll try and get it and provide it to the members. Yes, I will do that.

ASSEMBLYWOMAN WEINBERG: Thank you.

Okay, anything else? (no response)

Sam, you're the only one who stayed with me.

Oh, no, no. Assemblyman D'Amato. (laughter)

If there's a reward in heaven, you're in line.

ASSEMBLYMAN THOMPSON: But you were sitting here even longer.

(HEARING CONCLUDED)