

Medical Care Availability Task Force



Jon S. Corzine
Governor

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INTRODUCTION

In response to a growing concern over rising medical malpractice insurance rates and through the passage of Bill A50, the Medical Care Availability Task Force (“MCATF”) was formed.

The MCATF was charged with issuing a report to the Governor and the Legislature of its findings and recommendations on the following issues:

- 1) A: The advantages and disadvantages of establishing limitations on non-economic damages for medical malpractice judgments and B: on extending current limitations on liability that apply to nonprofit hospitals to employees, other than physicians, of those hospitals;
- 2) The impact of third party reimbursement policies by insurers and health maintenance organizations on access to health care services in the context of the current affordability crisis in the State affecting health care providers in the purchase of necessary liability coverage;
- 3) The advantages and disadvantages of adopting additional changes to the statute of limitations regarding medical malpractice actions;
- 4) A: The advantages and disadvantages of establishing additional procedures for mediation of actions alleging medical malpractice and B: for screening for frivolous medical malpractice lawsuits; and
- 5) The advantages and disadvantages of establishing a pre-suit procedure.

The MCATF organized on July 12, 2005 and held its first meeting on September 20, 2005, after which it met on seven occasions through June 26, 2007.

The MCATF formed three subcommittees as follows:

Subcommittee A to study items (1) and (3)

Subcommittee B to study item (2)

Subcommittee C to study items (4) and (5)

The three subcommittees met between quarterly task force sessions either by telephone conference or in person as determined within each independent subcommittee. Each determined the methods for collecting data relative to their respective charges. Due to budgetary restraints, it was agreed that there would be limited use of experts and if required, the experts would not receive compensation. The subcommittees reported to the MCATF at regularly scheduled quarterly meetings. Secretary Carol Miksad was apprised of all subcommittee meetings and arranged for teleconference calls, meeting space and the taking and publication of the minutes.

The following is a list of the members for each respective subcommittee:

Subcommittee A:

T. Ricker, *Chair*
J. Gonzalez-Gomez
P. Anzano
D. Britcher
J. Tricarico
E. Ryan
P. Hartt

Subcommittee B:

P. Amitrani, *Chair*
E. Ryan
S. Whitman
A. Talone
A. Clemency Kohler
G. Ciechanowski
D. Britcher

Subcommittee C:

J. McCormick, *Chair*
M. Perone
P. Hartt
C. Forte
R. Goldstein

FINDINGS AND RECOMMENDATIONS

Charge 1(a):

The advantages and disadvantages of establishing limitations on non-economic damages for medical malpractice judgments.

A plaintiff who is awarded a verdict is entitled to fair and reasonable compensation for any permanent or temporary injury resulting in disability to or impairment of his/her faculties, health, or ability to participate in activities, as a proximate result of the defendant's negligence (or other wrongdoing). Disability or impairment means worsening, weakening or loss of faculties, health or ability to participate in activities. It includes the inability to pursue one's normal pleasure and enjoyment. One must determine how the injury has deprived plaintiff of his/her customary activities as a whole person. This measure of damages is what a reasonable person would consider to be adequate and just under all the circumstances of the case to compensate plaintiff for his/her injury and his/her consequent disability, impairment, and the loss of the enjoyment of life. The law also recognizes as proper items for recovery, the pain, physical and mental suffering, discomfort, and distress that a person may endure as a natural consequence of the injury.

Negligence is conduct which deviates from a standard of care required by law for the protection of persons from harm. Negligence may result from the performance of an act or the failure to act. The determination of whether a defendant was negligent requires a comparison of the defendant's conduct against a standard of care. If the defendant's conduct is found to have fallen below an accepted standard of care, then he or she was negligent. When determining the applicable standard of care, one must focus on accepted standards of practice in and not on the personal subjective belief or practice of the defendant doctor. The law recognizes that the practice of medicine is not an exact science. Therefore, the practice of medicine according to accepted medical standards may not prevent a poor or unanticipated result. Therefore, whether the defendant doctor was negligent depends not on the outcome, but on whether he/she adhered to or departed from the applicable standard of care.

The Subcommittee considered arguments both for and against imposing limits on non-economic damages in medical malpractice cases. The concepts discussed included, but were not limited to, whether such limits would lead to premium rate stabilization; whether limits would encourage settlements; whether limits would prevent some victims from receiving fair and reasonable compensation for their pain and suffering; and whether limits on recovery would make it difficult for victims to pursue a case given the high cost of doing so in the face of limited recovery.

The following report was issued on Feb. 27, 2006 by Americans for Insurance Reform:

“Americans for Insurance Reform (“AIR”) released a new study today confirming the wholesale decline of medical malpractice insurance rates nationwide. The AIR study also shows that this phenomenon is occurring whether or not states enacted restrictions on patients’ legal rights, such as “caps” on compensation. The medical malpractice insurance “crisis” is over, according to the study. AIR’s study is based on the most recent Council of Insurance Agents and Brokers survey of market conditions, showing that the average rate hike for doctors over the past six months has been 0 percent. This is following similar results for the last quarter of 2004, which saw rates rising only 3 percent at the end of that year. By comparison, rates jumped 63 percent during the same quarter of 2002. See chart below:

MEDICAL MALPRACTICE INSURANCE AVERAGE RATE HIKES PER QUARTER													
3Q 2002	4Q 2002	1Q 2003	2Q 2003	3Q 2003	4Q 2003	1Q 2004	2Q 2004	3Q 2004	4Q 2004	1Q 2005	2Q 2005	3Q 2005	4Q 2005
61%	63%	54%	48%	28%	34%	19%	9%	6%	3%	2%	2%	0%	0%

According to Joanne Doroshow, AIR spokesperson and Executive Director of the Center for Justice & Democracy, “Consumer rights organizations have long maintained that the ‘crisis’ of skyrocketing insurance rates for doctors and other policyholders would end when the insurance investment cycle stabilized, and that this would occur whether or not so-called tort ‘reform’ laws were enacted. Insurance industry data now unmistakably confirms this prediction.” “We are now witnessing the wholesale collapse of insurance rates, including medical malpractice rates,” said J. Robert Hunter, AIR spokesperson, Director of Insurance for the Consumer Federation of America, former Federal Insurance Administrator and Texas Insurance Commissioner. “The end of the ‘hard market’ of sharp rate increases, less competition and cutbacks in coverage has occurred and a ‘soft market’ is now fully in place.” A “hard” insurance market is characterized by higher rates, less competition and limited coverage. This is the result of the cyclical nature of the insurance business. Prior to the “hard market” of the last few years, the last such “hard market” occurred in the mid-1980s. But like today, the insurance cycle turned after a few years and prices began to fall. This had nothing to do with tort law restrictions enacted in particular states, but rather to modulations in the insurance cycle everywhere. “The hard phase of the insurance cycle clobbers American businesses and professions every ten to fifteen years,” said Hunter. “Although these hard markets last only about two to three years, they can no longer be tolerated. State regulators must enforce the rating laws in order to end the boom and bust swing from illegal overpricing, such as the rates some policyholders have been asked to pay today, to illegal and inadequate under pricing, which will be seen when the market softens too much later in the cycle. Fortunately, the hard market price jump is behind us and we

are now entering the softer market so legislators have a decade or so to grapple with how best to do this before the next hard market hits the nation. And there is now clearly no need to rush into quick legislative fixes, such as legal limits on patients' rights."

The MCATF finds that there is insufficient evidence to warrant a change in the current system.

Charge 1(b):

The advantages and disadvantages on extending current limitations on liability that apply to nonprofit hospitals to employees, other than physicians, of those hospitals.

At present, all but one of the 83 acute care hospitals in the State of New Jersey has not-for-profit status. N.J.S.A. 2A:53A-8 provides that damages payable by hospitals for negligence caused by the hospital or its agents or employees are limited to \$250,000. Although this serves as a “cap” on the hospital’s liability, it is not an effective “cap” because of another statutory provision pertaining to the liability of employees and agents of the hospital. That statute, N.J.S.A. 2A:53A-7(b), provides that although hospitals may have “limited” liability nothing in the statute shall be deemed to exempt the employee or agent individually for their liability for any negligence.

Discussion of the advantages centered on rate stabilization and lower rates for non-physician employees. Limiting liability exposure of certain non-physician hospital employees should result in fewer large, unanticipated losses paid by such employees’ insurers. As a result, insurers will be better able to predict their maximum claim exposures which, in turn, should result in a decline in the instances in which rate increases are necessary to offset unanticipated loss exposure. In addition, rates are calculated, in part, to offset anticipated losses. Since insurer claim losses will be reduced through the imposition of caps, rates should eventually lower as premiums necessary to compensate for losses paid by the insurer are reduced. Discussion of the disadvantages focused upon the current statutes above, increased physician exposure, increased medical malpractice rates and decreased plaintiff recovery. Because the funds which can be recovered from a hospital and its non-physician employees by a plaintiff in a medical malpractice action will decline, a plaintiff may be more inclined to seek funds from a source with higher limits, like a physician’s medical malpractice policy. Because settlements with or verdicts against physicians may increase in dollar amounts because a plaintiff’s avenue for recovery is capped against non-physicians, physician medical malpractice rates could increase to cover medical malpractice insurers’ additional paid losses. A plaintiff whose claim against a non-physician is capped may be unable to compensate for that cap by recovering funds from physicians or other entities. As a result, that plaintiff may not be appropriately compensated for his/her loss.

The MCATF does not recommend extending current limitations on liability that apply to nonprofit hospitals to employees, other than physicians, of those hospitals.

Charge 2:

The impact of third party reimbursement policies by insurers and health maintenance organizations on access to health care services in the context of the current affordability crisis in the State affecting health care providers in the purchase of necessary liability coverage.

As a preliminary matter, the Subcommittee found that to provide a responsible and meaningful study of the charge noted above would require the gathering of appropriate data, the expertise of a health care economist to analyze that data, and significant financial resources to accomplish that task, none of which was available to this Subcommittee.

Adequate “access to health care” depends upon a number of factors that affect whether and how many health care providers choose to practice in New Jersey and to which specialties such providers gravitate. These factors likely include, among other things, New Jersey’s economic environment, payer reimbursement rates, medical equipment costs, inflation, tax rates, litigation risk, medical malpractice insurance rates, the regulatory environment, student loan debt and forgiveness, real estate costs and employment costs.

The complex interaction of these and other factors in determining whether access to health care is impacted by reimbursement policies alone is a complex task. Therefore, these findings include some anecdotal accounts of availability that has been suggested to correlate with reimbursement rates. We do not believe that this is a reliable measure of the “impact” of any particular policy on access to health care services.

Additionally, it should be noted at the outset that the charge to the Subcommittee was to measure the impact of “third party reimbursement policies by insurers and health maintenance organizations” (“health plans”). This definition of this request posed an independent challenge. We took that to include payment policies by the State’s only health service corporation, Horizon Blue Cross Blue Shield of New Jersey, which technically is neither an insurer nor an HMO. However, we recognized that this appeared to exclude some of the largest payers in the State, employer self-funded health plans. Many large employers self-fund their benefits, and while they may contract with an insurer, health plan or other carrier to administer benefits, the applicable reimbursement policies for providers are ultimately determined by the employer. Concern exists over the degree to which these self-funded plans are subject to State regulation. The New Jersey Department of Banking and Insurance (“DOBI”) has estimated, based on filings required for insured business, that only 25 percent of New Jersey residents are covered under State-regulated, commercial health insurance plans, and another 9 percent under Medicaid coverage through a health plan.¹ If one accepts this

¹ New Jersey Department of Banking and Insurance, Source of Coverage analysis at: <http://www.state.nj.us/dobi/lhactuar.htm>.

definition, a vast majority of payers are outside the charge of the statute and beyond the scope of this committee's charge. This exclusion complicates this analysis even further since only a segment of the market would be analyzed by this Subcommittee, skewing any results. Should a comprehensive study be commissioned to properly analyze the impact of reimbursement policies on availability, it is recommended that self-funded plans and Medicaid coverage be included in that analysis.

Finally, the way the charge was written, it seemed as if the Subcommittee was mandated to find that the relationship between reimbursement policies, presumably low, and medical malpractice insurance rates, presumably high, was causing lack of access to medical care. Based on both the anecdotal information gathered by the Subcommittee, and the May 2007 Rutgers Health Policy Center Study of Physician Availability, we did not find this premise to be accurate. Rather, the Subcommittee found that there were many factors that contributed to a perceived and, in limited cases, an actual lack of providers. Some of the factors were economic and others were more societal/political.

ACCESS TO CARE

Analysis of access to care is essentially a measurement of whether the supply of providers is sufficient to accommodate the demand of consumers. The Subcommittee was greatly aided by the comprehensive analysis of the Rutgers Center for State Health Policy which did a report entitled, "Availability of Physician Services in New Jersey: 2001-2006."² That report, commissioned by DOBI, calculated the physician-to-population ratios by specialty. The study found that the total supply of patient care physicians in New Jersey increased over the five-year study period by 1388 physicians, and that the ratio of patient care physicians per 100,000 persons in New Jersey increased by 0.8 percent during the study period. Additionally, the study found that the New Jersey supply is comparable to physician supply levels nationally. The study reflects that New Jersey is not an outlier and that physician supply is generally stable, but it did find that the supply of some specialties were below national levels.

One of the first decisions that the Subcommittee was required to address was how to decide which medical specialties it would look at. As a practical matter it would have been impossible to study every one of them. We initially decided to study the specialties enumerated in the Medical Malpractice Liability Insurance Premium Assistance Fund, which had the benefit of the Rutgers study noted

² Rutgers Center for State Health Policy, Availability of Physician Services in New Jersey: 2001-2006 at:
<http://www.cshp.rutgers.edu/Downloads/7410.pdf>

above. These specialties were:

1. Obstetrics / gynecology;
2. Neurosurgery; and,
3. Diagnostic Radiology involving mammograms

At the suggestion of the member doctors on the MCATF, we also added

4. Family Practice Physicians

A major problem in researching this issue was the difficulty of finding empirical data. There was no centralized source of information, or information that was specific to New Jersey. Although we requested data from carriers, it was not provided because the information was claimed to be proprietary in nature. As an example, while we found hard data about the cost of performing a mammography, it was on a national level. And while certain large-group practices could give us specifics that pertained to their practice group, there was no centralized source of information for their specialty statewide.

Generally speaking, it appears that the cost of providing care has increased while the rate of reimbursement for those services has decreased, remained the same or increased modestly. As a result, if a physician wants to maintain his level of income, he must see more patients. This may mean less time with each patient which, in turn, may mean less time for his personal and family life, a factor that may translate into whether or not a physician wants to stay in practice, or practice in New Jersey at all.

According to the CENTER for STUDYING HEALTH SYSTEM CHANGE (HSC) Tracking Report, June 2006, p. 3, the average physician net income from the practice of Medicine, and after adjusting for inflation, declined 7 percent between 1995 and 2003. This was according to their 2004-2005 Community Tracking Study Physician Survey. Primary care physicians fared the worst with their decline being 10.2 percent.

HSC goes on to say that:

“Flat or declining fees from both public and private payers appear to be a major factor underlying declining or stagnating real incomes for physicians. Medicare payment rate increases for physician services amounted to 13 percent from 1995-2003, lagging substantially behind inflation, which totaled 21 percent during this eight-year period.

While Medicare fees have declined in real terms since the mid-1990s, the trend for private insurer payments to physicians has lagged even more: in 1995, commercial fees were 1.43 times Medicare fees on average; by 2003 this fee ratio had fallen to 1.23.”

In terms of directly affecting access to care, HSC opines that “The downward trend in real incomes since the mid-1990s is likely an important factor underlying

reduced physician willingness to undertake *pro bono* work, whether providing charity care to patients who can't afford to pay or volunteering for other medically related activities, such as serving on hospital committees.”

While it should be noted that this report did not analyze New Jersey data exclusively, but based its conclusion on data gathered nationwide, the information that the Subcommittee gathered on its own coincides with that of HSC. One of the largest Radiology groups in New Jersey gave us information on their three largest commercial payers without naming the payer. The information was the historical reimbursement rates for 5 representative procedure codes. For the first payer, the reimbursement rate has declined from 2002 to the present. For the other two, since 2004, the rate of reimbursement has increased only slightly. In terms of the largest percentage increase, it was 32 percent which amounted to a \$12.00 increase to \$49.40 for a 2 View Chest X-ray. The largest dollar increase was \$47.00 which amounted to a 3 percent increase for an MRI Brain Scan. The reimbursement went from \$1,289.58 in 2004 to \$1,336.24 in 2006, an increase of \$46.66. It should be noted, however, that while reimbursement rates for specific services may have been stagnant, overall reimbursement from payers for radiological services may not be stagnant if the overall volume of radiological services has increased.

The Subcommittee obtained some additional information supporting the relatively flat increase in reimbursement fees from the New Jersey Medical Society. It came from a large Obstetrics practice in Mercer County. It was in a much different form than that of the Radiology group. This just highlights the difficulty, as initially stated, in researching this matter.

The group, through the Medical Society, was able to provide us with what six major payers paid for deliveries from 1991 to the present. The payers were Oxford, United Health Care, NJ Plus, Medigroup, Aetna, and Cigna. Since some of the payers have several plans, they only gave us averages. Our Subcommittee then further averaged the highs and the lows. While this may be less than totally scientific, it still shows a trend.

In 1991 the above payers were paying an average of \$1,985 for a delivery. In 2005 the average reimbursement rate was \$2,577; an increase of \$592 or 30 percent in 15 years. That amounts to an average yearly increase of 2 percent. At the same time, inflation increased by an average 2.6 percent per year, or 39 percent overall.

Medical malpractice rates also appear to have increased over recent years. DOBI was able to provide us with base rates for coverage limits of \$1,000,000 (per incident) / \$3,000,000 (annual aggregate) for most of the medical malpractice insurers for the years from 2000 to 2004. The manner in which we have incorporated this information into this report is admittedly less than totally

scientific. In essence we have averaged the averages. However, once again, it shows a trend. See the following table:

	Family/Gen	Neurosurgical	Ob/Gyn	Radiology
2000 rates	\$ 6,514	\$ 53,948	\$47,836	\$13,927
2004 rates	\$14,028	\$103,467	\$93,208	\$30,562
Total % increase	115 %	91 %	95 %	119 %
Annual % increase	23 %	18 %	19 %	23 %

What the above table does not show, but what was relayed anecdotally, is that while the rates have gone up, the amount of coverage appears to have declined. One provider told us he was once able to get coverage of \$10,000,000 / \$12,000,000 in 2000. Since then it has been decreased to \$3,000,000 / \$5,000,000 in 2006. Some physicians are only able to get coverage in the amount of \$1,000,000 / \$3,000,000. However, it is not entirely clear whether other factors may have affected these provider rates, such as litigation or other changed risk factors.

Apprehension by providers of possible litigation against them in their professional capacity appears to have increased nationally. According to the American College of Radiology, nationally, 15 percent of medical students expressed fear of being sued in 2001. By 2003 that number had increased to 60 percent. It is difficult to discern to what extent New Jersey medical students express similar fears and whether such fears affect a student's choice of specialty.

Each of the four specialties that we studied also had their own particular issues which we will now detail.

RADIOLOGY

Radiology seems to be the one specialty where the evidence is quite strong that economic factors may be causing access problems to health care.

We interviewed the managing partner of one of the largest Radiology groups in the State located in northern New Jersey. He told us that the wait times in their busiest office is eight - ten months for a screening³, and two months in the slowest office. It should be cautioned that this single practice may not be reflective of wait times throughout the State. In this practice, wait times may be a bit longer than other offices because they have two Radiologists read every mammogram. These findings coincide with national averages. In Florida the wait time for an initial mammogram is five months; in New York, forty days; and in Washington, D.C., four – six weeks.

³ A "screening" is procedure used for a person who is asymptomatic. The statement does not reflect wait times on a person with symptoms, who would be classified as a "diagnostic" procedure.

We indicated above that the Radiology group that we interviewed has two Radiologists read each mammogram. While use of one Radiologist could shorten the wait time, this practice believed that the extra caution is warranted because of the potential for a law suit based on a misread mammogram and the obvious importance of catching breast cancer at its earliest stage, when treatment is most successful.

Radiologists appear to be at greater risk of being sued. According to the Physicians Insurers Association of America "...Breast cancer is the No.1 condition for which patients file medical malpractice claims." (The Breast Cancer Crisis, by Leslie Laurence, Ladies Home Journal, October 2004). There are many reasons for this. The first is that they may have double or triple the number of patient contacts per day than the other specialties. Because they do not have to necessarily see the patient, only the X-ray, they can interpret a hundred examinations per day. Add to the sheer number of patient contacts the claim of 15 percent - 30 percent false negatives. That is why Radiologists estimate they will be sued every 3 – 4 years. According to a survey of 800 Radiologists by the Radiological Society of New Jersey, 31 percent acknowledged getting sued within the last five years.

Radiologists also appear to have the greatest chance of getting an adverse judgment. In 2005, the ProMutual Group did a risk management report entitled Failure to Diagnose Putting the Pieces Together. It was a review of closed claims in selected specialties from 2002 – 2004. They paid a total of \$8,360,000 for 20 claims for failure to diagnose cancer of the breast, lung, colon or brain. The average payout was \$418,000.

Compounding this risk is the feeling that the reimbursement is not adequate to justify the risk. According to the American College of Radiology, the average cost of doing a screening mammogram on a national level is \$105.57. Reimbursement is often below cost.

We asked this large Radiology group to provide us with historical reimbursement information. They sent us the reimbursement rates from the four top commercial payers for six representative CPT (current procedural terminology) codes for 2004 to the present. This report selected one of the CPT codes, 76092, 2 View Mammography as representative of a trend for the other codes:

	2004	2005	2006
Carrier 1	\$ 71.00	\$ 99.34	\$ 99.34
Carrier 2	\$ 90.00	\$117.67	\$117.67
Carrier 3	\$ 77.00	\$ 84.00	\$100.00
Carrier 4	\$105.14	\$122.41	\$122.41

As we can see, Carriers 1 and 3 are paying below the national average cost of doing mammography screening. Carriers 2 and 4 are paying 11 percent and 15 percent above the national average cost for mammography screening.

While the exact cost of performing a mammogram specifically in New Jersey is not readily known, it is likely higher than the national average, due to New Jersey's tax on Radiology outpatient facilities, technologist salaries and liability premium costs. Mammography becomes even less profitable when practices, such as this large Radiology group, have two Radiologists read every film in order to be more accurate. This financial reality, coupled with the liability exposure and shortage of mammographers, creates a strong economic disincentive to do mammography. This situation has also spurred the growth of "boutique" women's imaging practices which do not participate with insurance plans. These practices collect higher fees or out of network fees for providing women's imaging. These centers only address the imaging needs of that small segment of the population who can afford to avail themselves of these services.

We also interviewed the head of a large Radiology practice in South Jersey which has 30 Radiologists on staff and does 30,000 mammograms per year. He essentially confirmed the information his colleague in the North had given us. However, he was also able to give us some concrete data on wait times as well as cost versus reimbursement based upon 30,000 mammograms per year.

His practice provides mammogram services to all regardless of the ability to pay. This includes Medicare and Medicaid clients which many practices no longer accept. Refreshingly they see this service as part of their social responsibility. Ironically, contrary to the experience of his colleague in the North, wait times for his practice are only a day or two. However, he did acknowledge that a neighboring practice has a two month wait. They have also performed mammograms for women from the Delaware Valley area who did not want to wait six months.

As to cost versus reimbursement, the average payment received for a screening mammogram is \$92.40. The average cost of the procedure is \$105.57. This includes obtaining the images, interpretation by a Board Certified Radiologist, and the Radiologist's medical malpractice insurance (10 percent of the cost). This is a net loss of \$13.17 or 12 percent. The percent of loss is even greater with Medicare and Medicaid where the loss is \$18.51 (18 percent) and \$70.15 (66 percent).

Presently, the revenue produced by their other imaging procedures is used to offset the loss of doing mammograms. But even this socially conscious practitioner admits that at some point he may be forced to explore ways to cut costs. One of those ways would be to stop doing mammograms for Medicare and Medicaid clients. Fortunately for the women in his area, he has not had to make that decision – yet.

The current trend is that while the needs and benefits of mammography will increase as the population in New Jersey ages, the State Radiology community may have a decreasing ability and incentive to meet those needs.

Recently, the Radiology Society of New Jersey did a survey of 800 Radiologists. Within the past year 21 percent have increased services and 38 percent have decreased services. 89 percent said they intend to decrease services in the near future. 89 percent also said that new recruits are unwilling to perform mammography or have asked for limited exposure to it.

FAMILY / GENERAL PRACTICE

We found no empirical data to show that Family / General Practice physicians are leaving the practice or are reducing services in New Jersey. What we did find is data showing that medical school residents may be entering the Family Practice in declining numbers. The reasons for this may be economic as well as social.

Medical malpractice insurance rates, in absolute dollars, are the least expensive for Family / General Practice physicians than for the other specialties. However, they are the highest in terms of percent of income. According to DOBI, from 2001 to 2004 the med-mal rates for Family / General Practice increased an average of 23 percent annually.

Again we find that reimbursements did not keep pace with the increased cost of doing business. A large Family Practice group gave us the reimbursement rates for three representative CPT codes for Family Practice. The rates covered the years from 2003 to 2006 and were from seven payers whose identities were not disclosed. (This again illustrates the difficulty in getting hard data for this report.) When we take the average increase in all three CPT codes over the four years, it amounted to 2.6 percent. As we indicated earlier, according to DOBI the average yearly increase in medical malpractice insurance rates for Family Practice were 23 percent for the years 2000 – 2004. (The CPT codes used are designated as “Evaluation and Management” and included 99212, 99213, and 99214. They pertain to office visits of increasing complexity).

But medical malpractice rates are not the only economic factor in a resident deciding not to enter Family Practice. Another reason is that upon finishing medical school a resident most likely has student loans of \$100,000 or more. It is much easier and quicker to pay off these loans at a specialist’s salary than at a salary which a Family Physician makes.

Additionally, specialists may be held in higher professional esteem than Family Practitioners, which could affect the number of providers entering this field. This is unfortunate since statistics show that New Jersey, which has one of the highest per capita specialist ratios, conversely has one of the lowest outcome

ratios. Medicare Spending, The Physician Workforce, And Beneficiaries' Quality of Care, by Katherine Baicker and Amitabh Chandra, Health Affairs, April 7, 2004.

According to the doctors we interviewed, the solution to the shortage in Family Practice is not to go for a grand slam but a series of base hits. One thing would be to work out some type of loan forgiveness program for doctors that stay in Family Practice for a specified number of years. The intent would be that in those years they would build up a profitable practice, which might deter their pursuit of another field. Another way to improve the lot of Family Practice physicians would be to get rid of the "hassle factor" as one physician described it. He was referring to the referral process. That physician believed that most of the specialists are already in the payer's network. According to one provider, referrals are granted 90 percent of the time, and thus the physician felt it was a waste of the physician's time, time that he could be spending with a patient that actually needs his services, to see a patient that he is just going to refer to a specialist. It should be noted that insurers and health plans do sell coverage without the need for referrals, but are estimated to cost about 6 percent more than coverage with referrals.

Streamlining the claims submission process would be helpful. One doctor told us that he has had to hire a nurse full-time to just process claims. Obviously, if he did not have to hire the nurse, or if he could use the nurse to help with patients, it would be an improvement in his financial status.

NEUROSURGICAL

Our anecdotal information for this specialty came mostly from the managing partner of the largest Neurosurgical practice in the State. According to the managing partner, in 2002 there were 92 Neurosurgeons in the State. According to the most recent Rutgers study on availability of physician services, there are 101 licensed Neurosurgeons in New Jersey. The committee notes that all "101" may not be practicing in New Jersey. However, DOBI reports that 74 New Jersey insured and practicing Neurosurgeons received premium subsidies for 2005. In 2006 there were, in his words "70 plus." While one could think that the decrease in Neurosurgeons corresponds to decrease in access, we were not able to substantiate that with any hard data. One suggested reason for the lessened number of new surgeons, without a seeming impact of access is the rising number of Fellowship Trained Orthopedic Spinal Specialists.

Neurosurgeons are faced with increasing medical malpractice rates. On average, their rates appear to be the highest of the four specialties under consideration. Averaging the information we received from the DOBI, average premiums have increased from \$53,948 per year in 2000 to \$103,467 in 2004. This is an increase of 91 percent or 18 percent annually. This particular practice reports that they are paying over \$170,000 per doctor.

OBSTETRICS/GYNECOLOGY

Obstetricians presented a unique and more difficult specialty to analyze. While “hard data” continued to be a problem to obtain, one large Obstetrics practice in South Jersey provided reimbursement information that showed that the range paid by various carriers was wide and that when averaged the reimbursement level was not significantly higher than it was two decades or much earlier. In the intervening time, the cost of running such a practice, particularly with the increased number of visits for many pregnant women and testing that is expected during pregnancy, as the prenatal evaluation technology has increased, has led to a significantly narrowed margin, even before one considers the rise in malpractice premiums of the last decade. Obstetricians reported that their income stream is more modest than, for example, Neurosurgeons, and the resulting net income they can achieve makes this an uninviting specialty for many. As a result, some hospitals in this State have reported a decrease in the applicants for a “match” in Obstetrics and fewer and fewer U. S. – based graduates filling those residencies.

The MCATF has found, based on some anecdotal and limited available empirical information, that there may be problems of access to medical care in the four specialties that were selected. Depending on the specialty, economic factors play a greater or lesser part in determining access. These factors include inflation, taxes, rising health care costs, fear of being sued, need to pay off student loans, etc. The Rutgers study on physician availability found there are specialties and regions where access may be of significant concern. The New Jersey physician population has grown, but in 2005 to 2006 declines in two-thirds of the specialties studied was noted. Commercial payer reimbursement, public programs, medical malpractice rates and New Jersey’s economic environment may, individually or as a whole affect access to care. Patients insured by government payers (Medicaid, Medicare and Charity Care) anecdotally have access issues resulting from lower reimbursement rates. The impact and significance of each relevant factor cannot adequately be determined without a more comprehensive analysis. We strongly recommend that the Legislature fund an independent analysis conducted by a qualified neutral and impartial entity. In short, without significant expertise and funding, isolating the specific impact of reimbursement policies by insurers and health plans on access to health care services is not possible. In addition, the MCATF notes that failure to extend the Medical Malpractice Liability Insurance Premium Assistance Fund program, particularly to Obstetricians and other specialties determined by DOBI, could have untoward consequences for patient access.

Charge 3:

The advantages and disadvantages of adopting additional changes to the statute of limitations regarding medical malpractice actions.

Every action at law for an injury to the person caused by the wrongful act, neglect or default of any person within this State shall be commenced within two years next after the cause of any such action shall have accrued; except that an action by or on behalf of a minor that has accrued for medical malpractice for injuries sustained at birth shall be commenced prior to the minor's 13th birthday.

The most significant advantage to shortening the statute of limitations is to the benefit of the insurance companies in that predictability of future losses can be more accurately assessed. The obvious disadvantage is that this increases the number of people unable to seek just compensation for harm due to negligent acts because the fact of negligence wasn't known until after the window closed.

The MCATF does not recommend adopting additional changes to the statute of limitations regarding medical malpractice actions since this compromise was reached following extensive debate during the crafting of Bill A50.

Charge 4(a):

The advantages and disadvantages of establishing additional procedures for mediation of actions alleging medical malpractice.

In an effort to settle rather than have trials of medical malpractice cases, the Bergen, Middlesex and Passaic vicinages volunteered to undertake an initiative using mediation for medical malpractice cases. Cases suitable for referral to mediation are those in which the defendant, physician, or healthcare provider has consented to explore a possible settlement of their case and the insurance carrier has not taken a “no pay” position.

The initiative was developed by the Judiciary and members of the medical malpractice bar representing both plaintiffs and defendants and insurance carrier representatives. The initiative worked as discussed below.

1. Screening and Referral to Mediation

At the close of discovery, including all extensions of the discovery end date, or prior as agreed by counsel, the court in the initiative counties referred all medical malpractice cases to mediation to trained, court-approved mediators having specialized expertise in handling medical malpractice cases. At 60 days prior to that time, the court sent a letter to counsel in these cases advising that the case will be referred to this initiative at the close of discovery and advising concerning the applicable procedures. Cases were permitted to be removed upon certification indicating: (1) that the case was a “no pay” case; (2) that the healthcare provider did not consent to settlement; or (3) demonstrating other “good cause” why the case should not go to mediation. Mediation was generally to be completed within 60 days of the date of the Order, unless the court for “good cause” extended the time. Within 14 days of the Order referring the case to mediation, the parties by a stipulation filed within the court within said time, were permitted to substitute a different mediator (who may be on the court-approved roster of civil mediators, but did not have to be) or could opt out of mediation and into a special settlement program. Participation in the settlement program had to be on consent of all parties and the process had to be completed within 60 days of the date of the Order of Referral of the case to mediation.

2. Selection of Neutrals

The mediators that served in the program and who were assigned cases by the court consisted of trained individuals who were credible with the bar. Parties could, within 14 days of the date of the Order of Referral to Mediation, file a stipulation with the Civil CDR Point Persons in the participating counties substituting a different mediator. The substitute

mediator could be an individual currently on the roster of court-approved mediators or can be anyone else agreed to by all parties. A list of court-approved mediators appears on the Judiciary's Internet website at www.judiciary.state.nj.us.

Mediation conducted in this initiative conformed to the current procedures set forth in R. 1:40 et seq., including those relating to the payment of mediators. However, no *ex parte* submissions to the mediator were permitted unless otherwise agreed by the parties. If the parties opted into a settlement program, this prohibition on *ex parte* submissions to the settler without the consent of all parties similarly applied.

If the parties timely opted out of the mediation by consenting to participate in the settlement program, the settlement process was to be conducted by two panelists, one representing plaintiffs in the handling of medical malpractice cases and the other representing defendants. In the alternative, the parties had the option to request that the settlement process be conducted by a single individual, who could be a retired judge. In the event that the parties agreed to refer the matter to the settlement process, the parties and settlers were to work out all compensation issues.

3. Evaluation Results

Passaic ultimately opted out of the program. The pilot in the remaining counties began on January 1, 2005.

In Bergen County, notices were sent to 167 medical malpractice cases; 23 of these (14%) were eligible for referral to mediation. Seven of these opted out as "no pay" cases. The remaining 16 were mediated; none was resolved.

In Middlesex County, about 20 cases were eligible for mediation pursuant to the pilot's criteria; one settled.

4. Conclusion

The conclusion to be drawn reinforces the results of a previous pilot that used the Office of Dispute Settlement to mediate medical malpractice cases in a few counties — namely, the current medical, legal and insurance cultures do not support resolution of medical malpractice cases through mediation.

By the time a case has gotten to the point at which our current mediation system is available, there already exists an adversarial climate. At that point, it is usually too late for mediation to be viable. Additionally, mediation held too far in advance of the trial date is deemed too early by

insurers to pay on some cases that they in fact will pay on when the case actually gets called to trial. Many contend that business decisions influence the timing of insurer payments.

The MCATF recommends that all affected stakeholders look at some type of full-disclosure program. These programs work within an individual hospital, do not require legislation, and approach the issue at its inception before anger and defensiveness set in. The VA hospitals have been using it for many years and more recently, the University of Michigan Healthcare System has been using it to great success. Many other States across the country are currently using or looking at full-disclosure as an answer to medical malpractice concerns. The Task Force recognizes that New Jersey has adopted the Patient Safety Act, which seeks to reduce error through root cause analysis. However, a complete disclosure program also includes other key elements:

Full-disclosure programs create an atmosphere of healing for patients and physicians, offer expedient compensation only if warranted, and corrective procedural measures in cases where the system has failed.

A simple description of how such programs work following a bad medical outcome is as follows:

- **Root cause analysis show standard of care not met = error (s) or negligence**
- **Set meeting with patient/family and attorney**
- **Apologize and admit fault**
- **Explain what happened and fix**
- **Offer upfront compensation**

OR

- **Root cause analysis shows standard of care was met = no error (s) or negligence**
- **Still meet with patient/family and attorney**
- **Empathize, answer questions, open records - prove innocence**

The savings of such programs are:

- **Anger is reduced = fewer lawsuits, lower settlements**
- **Defense litigation costs go down; cases are closed in months instead of years**
- **Non-meritorious cases are reduced**
- **Medical errors are reduced**

- Patients and families become less likely to disparage medical providers⁴

The power of apology is in that it is the right thing to do ethically and it is the right thing to do medically. It heals the wound for the patient and for the caregiver. Framing apology as a liability issue sabotages the needs of both the patient and the doctor for healing. Withholding information and not apologizing for our mistakes makes a difficult situation infinitely worse. Key elements of full-disclosure programs include:

- Taking responsibility
- Showing remorse
- Making amends⁵

The MCATF further recommends that a NJ State presentation of this concept be held as soon as possible. Attendees should include hospital risk managers, physicians, plaintiff and defendant attorneys, patient advocates, insurance carriers, and any other interested parties and that the Governor and Legislature provide limited funding for a pilot program in this area.

⁴ The Sorry Works! Coalition - Power Point presentation to NJ Council of Teaching Hospitals 2006

⁵ "When Things go Wrong : Responding to Adverse Events, Lucian L. Leape, MD, presentation to NJ Council of Teaching Hospitals 2006

Charge 4(b):

The advantages and disadvantages of establishing additional screening for frivolous medical malpractice lawsuits.

A dictionary definition of the term “frivolous” is:

1. unworthy of serious attention; trivial
2. inappropriately silly
3. lacking in any arguable basis or merit in either law or fact.

The term “frivolous lawsuit” has become a buzz phrase in our society. It has been used to refer to lawsuits which the media headlines as audacious, ridiculous, and abusive. The MCATF began by looking at the legal definition of frivolous litigation in New Jersey:

The pertinent statute, N.J.S.A. 2A: 15-59.1(b), states:

“In order to find that a complaint, counterclaim, cross-claim or defense of the non-prevailing party (in a civil action) was frivolous, the judge shall find on the basis of the pleadings, discovery or the evidence presented that either: (1) the complaint, counterclaim, cross-claim or defense was commenced, used or continued in bad faith, solely for the purpose of harassment, delay or malicious injury; or (2) the non-prevailing party knew, or should have known, that the complaint, counterclaim, cross-claim or defense was without any reasonable basis in law or equity and could not be supported by a good faith argument for an extension, modification or reversal of existing law.”

The Affidavit of Merit statute, N.J.S.A. 2A:53A-27, was enacted in 1995. It reads as follows:

“In any action for damages for personal injuries, wrongful death or property damage resulting from an alleged act of malpractice or negligence by a licensed person in his profession or occupation, the plaintiff shall, within 60 days following the date of filing of the answer to the complaint by the defendant, provide each defendant with an affidavit of an appropriate licensed person that there exists a reasonable probability that the care skill or knowledge exercised or exhibited in the treatment, practice or work that is the subject of the complaint, fell outside acceptable professional or occupational standards or treatment practices. The court may grant no more than one additional period, not to exceed 60 days, to file the affidavit pursuant to this section, upon a finding of good cause.”

In the case of an action for medical malpractice, the person executing the affidavit shall meet the requirements of a person who provides expert testimony or executes an affidavit as set for in section 7 of P.L. 2004, c. 17 (C. 2A:53A-41). In all other cases, the person executing the affidavit shall be licensed in this or any other state; have particular expertise in the general area or specialty

involved in the action, as evidenced by board certification or by devotion of the person's practice substantially to the general area of specialty involved in the action for a period of at least five years. The person shall have no financial interest in the outcome of the case under review, but this prohibition shall not exclude the person from being an expert witness in the case.

The Legislature enacted the Affidavit of Merit statute as a way to curtail the filing of frivolous malpractice lawsuits. At the time of the enactment, the Office of the Governor referred to the Affidavit of Merit statute as a way to "strike a fair balance between preserving a person's right to sue and controlling nuisance suits". Thus, the primary purpose of the Affidavit of Merit statute was to ensure that lawsuits without merit would be identified in the early stage of litigation and dismissed.

The Affidavit of Merit statute was amended on June 7, 2004 to add a special requirement for medical malpractice cases which provides:

"In the case of an action for medical malpractice, the person executing the affidavit shall meet the requirements of a person who provides expert testimony or executes an affidavit as set forth in section 7 of P.L. 2004, c.17 (C.2A:53A-41)."

Simply put, an Affidavit of Merit is a document from a qualified person that basically says "there was probably malpractice committed". The affidavit must be provided either with the complaint or at the very beginning of the suit. The amendment in 2004 tightened up the requirements surrounding the qualifications of the person signing the affidavit. Because the affidavit requires that a stringently qualified physician has certified that the case has merit, by definition such a suit could not be deemed "frivolous".

It is interesting that the number of medical malpractice cases filed in the Superior Court of New Jersey began to decrease in 2004 and 2005, following the statutory amendment. Cases filed statewide in 2001, 2002 and 2003 were fairly stable (The filings were: 2001-1,613; 2002-1,656; 2003-1,673.) In 2004 and 2005, annual medical malpractice filings declined. They were 1,493 and 1,380 respectively. Whether or not the numbers are directly related to the amendment is unknown but certainly a compelling inference may be drawn.

The MCATF has determined that frivolous medical malpractice lawsuits are not an issue in New Jersey. The existing statutes and court rule have served to eliminate such cases and additional procedures are not necessary at this time.

Charge 5:

The advantages and disadvantages of establishing a pre-suit procedure.

Pre-suit procedures are used in order to get information from doctors and hospitals without having to file a lawsuit. The premise being that if sufficient procedures are in place to collect information ahead of time, a determination can be made as to the merit of a proposed claim. It should also enable possible defendants to be dropped from a potential claim prior to filing suit. Essentially, if we can know ahead of time what actually happened and who was involved, we can head off non-meritorious claims and we can include only those persons who are directly involved. The advantages are quite obvious: savings in overall cost and savings in time and aggravation to litigants and the system.

Currently there are two mechanisms available to a plaintiff for pre-suit discovery. One of these is the procedure whereby medical records can be obtained. Health care practitioners are obligated to turn over medical records. The State's Board of Medical Examiners requires that health care professionals provide a copy of a patient's treatment record no later than thirty days after it has been requested by the patient or an authorized representative such as the patient's attorney. This requirement remains true even in cases where the physician believes that the patient's condition would be affected once he or she is made aware of information contained in the record. The Board of Medical Examiners has the power to issue sanctions in the form of fines or license suspensions pursuant to N.J.S.A.45: 9-22.8 if physicians fail to comply with their mandates.

The second procedure is to petition the court in order to obtain a leave of court to conduct a pre-complaint deposition pursuant to Rule 4:11-1 (a). The petition allows the plaintiff to request not only a pre-complaint deposition for the purposes of preserving someone else's testimony or the testimony of the plaintiff himself (in cases where death is eminent), but it also allows the plaintiff to request an opportunity to inspect and copy designated documents pursuant to Rule 4:18-1(a).

Pre-suit discovery is rarely used and is only granted under very narrow circumstances where there is either a need to preserve the testimony of a party or a need for documents that have a substantial bearing on the preparation of the affidavit of merit. The requirements of the rule are there to ensure that pre-suit discovery is not used for the sole purpose of allowing a "prospective plaintiff to acquire the necessary facts to frame a complaint." In fact, the only exception to this policy rule is when the plaintiff is seeking information that would enable him to comply with the Affidavit of Merit Statute.

The MCATF finds that there is insufficient evidence to warrant a change in the current system.

EXECUTIVE SUMMARY OF FINDINGS AND RECOMMENDATIONS

The MCATF was charged with issuing a report to the Governor and the Legislature of its findings and recommendations on the following issues:

- 1) **A**: The advantages and disadvantages of establishing limitations on non-economic damages for medical malpractice judgments and **B**: on extending current limitations on liability that apply to nonprofit hospitals to employees, other than physicians, of those hospitals;
- 2) The impact of third party reimbursement policies by insurers and health maintenance organizations on access to health care services in the context of the current affordability crisis in the State affecting health care providers in the purchase of necessary liability coverage;
- 3) The advantages and disadvantages of adopting additional changes to the statute of limitations regarding medical malpractice actions;
- 4) **A**: The advantages and disadvantages of establishing additional procedures for mediation of actions alleging medical malpractice and **B**: for screening for frivolous medical malpractice lawsuits;
- 5) The advantages and disadvantages of establishing a pre-suit procedure.

Charge 1(a)

The MCATF finds that there is insufficient evidence to warrant a change in the current system.

Charge 1(b)

The MCATF does not recommend extending current limitations on liability that apply to nonprofit hospitals to employees, other than physicians, of those hospitals.

Charge 2

The MCATF has found, based on some anecdotal and limited available empirical information, that there may be problems of access to medical care in the four specialties that were selected. Depending on the specialty, economic factors play a greater or lesser part in determining access. These factors include inflation, taxes, rising health care costs, fear of being sued, need to pay off student loans, etc. The Rutgers study on physician availability found there are specialties and regions where access may be of significant concern. The New Jersey physician population has grown, but in 2005 to 2006 declines in two-thirds of the specialties studied was noted. Commercial payer reimbursement, public

programs, medical malpractice rates and New Jersey's economic environment may, individually or as a whole affect access to care. Patients insured by government payers (Medicaid, Medicare and Charity Care) anecdotally have access issues resulting from lower reimbursement rates. The impact and significance of each relevant factor cannot adequately be determined without a more comprehensive analysis. The MCATF strongly recommends that the Legislature fund an independent analysis conducted by a qualified neutral and impartial entity. In short, without significant expertise and funding, isolating the specific impact of reimbursement policies by insurers and health plans on access to health care services is not possible. In addition, the MCATF notes that failure to extend the Medical Malpractice Liability Insurance Premium Assistance Fund program, particularly to Obstetricians and other specialties determined by DOBI, could have untoward consequences for patient access.

Charge 3

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