CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

of the

COMMITTEE ON HEALTH AND WOMEN'S ISSUES

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January 31, 2012
Start: 1:18 pm
Recess: 5:50 pm

HELD AT: 250 Broadway
Committee Rm, 14th Fl.

B E F O R E:
JOEL RIVERA
JULISSA FERRERAS
Chairperson

COUNCIL MEMBERS:
Inez E. Dickens
Peter F. Vallone, Jr.
Elizabeth Crowley
Mathieu Eugene
Rosie Mendez
Helen D. Foster
Albert Vann
James G. Van Bramer
Ruben Wills
Gale A. Brewer

A P P E A R A N C E S (CONTINUED)

Suzanne Blundi
Deputy Counsel
New York City Health and Hospital Corporation

Susan Waltman
Executive Vice President and General Counsel
Greater New York Hospital Association

Leslie Kelmachter
President
New York State Trial Lawyers Association

Christie Rich

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Elizabeth Colin

Dr. Iffath Abbasi Hoskins
American Congress of Obstetricians and Gynecologists

Dr. Milton Haynes
Chairman, Committee to Eliminate Health Care
Disparities
New York County Medical Society

Ross Frommer
Associate Dean
Columbia University Medical Center

Ann Pfau
Judge

Douglas McKeon
Administrative Judge
Supreme Court, Bronx

A P P E A R A N C E S (CONTINUED)

Joanne Doroshow
Executive Director, Center for Justice & Democracy
New York Law School

Sam Senders
National Structured Settlement Trade Association

Jesse Laymon
Citizen Action of New York

Patrick Krug
Rebecca Weber
New York Public Interest Research Group

Dr. David Friedman

Kraig Cook
Deborah Axt
Deputy Director
Make the Road New York

Dr. Jay Tartell
President
Queens County Medical Society

Patricia Burkhardt
President
New York State Association of Licensed Midwives

Ebony Constant
Organizer
Bertha Lewis
Founder
Black Institute

2 SERGEANT-AT-ARMS: Quiet, please.

3 CHAIRPERSON RIVERA: Good

4 afternoon, ladies and gentlemen, my name is Joel

5 Rivera, I am filling in for Council Member Maria

6 Carmen Arroyo, who is the Chair of the Health

7 Committee. Today is a busy day at the City

8 Council and we will keep our remarks short.

9 First let me--we will be conducting

10 a vote on two pieces of legislation. We will be

11 voting on Intro 751-A, sponsored by Council Member

12 Maria del Carmen Arroyo, which would reauthorize

13 the Child Fatality Review Advisory Team. We will

14 also be voting on Intro 753-A, sponsored by

15 Council Member Annabel Palma, which will

16 reauthorize the Homeless Death Reporting Law. I

17 would like to thank and acknowledge the Council

18 Members Arroyo and Palma for their leadership on

19 these issues.

20 On January 24th, the Committees on

21 Health and General Welfare conducted a joint

22 hearing where we considered both of these bills.

23 We heard from the Administration and advocates on

24 these important issues. These bills were set to

25 expire at the end of January 2012, however, with

2 today's vote in anticipation--anticipated action
3 by the entire Council, we will reauthorize these
4 laws. We will continue to use the Child Fatality
5 Review and Homeless Death Reports to inform our
6 policies and improve the quality of life for our
7 most vulnerable residents.
8 I would like to thank the staff of
9 the committees for their hard work. I would also
10 like to recognize my colleagues from the Health
11 Committee who are here with us today. We have, to
12 my left, we have Council Member Inez Dickens,
13 Council Member Peter Vallone, Council Member
14 Elizabeth Crowley, Council Member Mathieu Eugene,
15 Council Member Julissa Ferreras. To my right, we
16 have Council Member Rosie Mendez, Council Member
17 Helen Foster, Council Member Al Vann, and Council
18 Member Van Bramer. And we are also joined by
19 Lacey Clarke, the counsel to the committee, Joseph
20 Mancino, and Pamela Corbett as well.
21 At this point in time, can the
22 clerk please call the roll on both of these pieces
23 of legislation?
24 MR. KEVIN PIN: Kevin Pin,
25 Committee Clerk, roll call on the Committee on

2 Health, Intro 751-A and 753-A. Council Member
3 Rivera.
4 CHAIRPERSON RIVERA: I vote Aye.
5 MR. PIN: Foster.
6 COUNCIL MEMBER FOSTER: Aye.
7 MR. PIN: Vallone.
8 COUNCIL MEMBER VALLONE: Aye.
9 MR. PIN: Vann.
10 COUNCIL MEMBER VANN: Aye.
11 MR. PIN: Dickens.
12 COUNCIL MEMBER DICKENS: Aye.
13 MR. PIN: Mendez.
14 COUNCIL MEMBER MENDEZ: Aye.
15 MR. PIN: Eugene.
16 COUNCIL MEMBER EUGENE: Aye.
17 MR. PIN: Ferreras.
18 COUNCIL MEMBER FERRERAS: Aye.
19 MR. PIN: Van Bramer.
20 COUNCIL MEMBER VAN BRAMER: Aye.
21 MR. PIN: By a vote of nine in the
22 affirmative, zero in the negative, no abstentions,
23 both items have been adopted. Members, please
24 sign the committee reports.
25 CHAIRPERSON RIVERA: Thank you very

2 much. Next we will move on to the second portion
3 of today's hearing.
4 [Off mic]
5 CHAIRPERSON RIVERA: Okay. We will
6 take a brief moment to pause.
7 [Pause]
8 [Off mic]
9 CHAIRPERSON RIVERA: Again, we'll
10 reopen the hearing, no need for new introductions,
11 I believe. We're joined by Council Member Ruben
12 Wills as well.
13 Today we will be conducting a joint
14 hearing with the Women's Issues Committee, chaired
15 by Council Member Julissa Ferreras, on
16 professional and financial barriers facing women's
17 health care providers. We will also be hearing
18 Proposed Resolution 84-A, sponsored by Council
19 Member Elizabeth Crowley, which calls upon the New
20 York State Department of Financial Services and
21 the New York State Department of Health to devise
22 a comprehensive solution to address the financial
23 and professional barriers to women's access to
24 obstetric care.
25 Before I begin, I would like to

2 thank my co-chair today, Council Member Ferreras,
3 and particularly Council Member Crowley for her
4 leadership on this issue. As former chair of the
5 Council's Health Committee, health care access
6 issues were one of my highest priorities.
7 There are many considerations that
8 physicians make when starting to practice in New
9 York State. There are also many factors that may
10 lead physicians to practice outside of New York.
11 A recent study by the Center for Health Workforce
12 Studies revealed that less than half of all new
13 physicians remain in New York state after
14 completing training or a fellowship program.
15 Some of the significant reasons why
16 doctors reported leaving included being closer to
17 their family, better job located outside of the
18 state, and seeking higher salaries outside of New
19 York. Nearly one-fifth reported that one of the
20 reasons why they left the state was the cost of
21 malpractice insurance. This is especially true
22 among obstetricians and other women's health care
23 providers who pay significantly high malpractice
24 rates, particularly in the New York City region.
25 For example, an ob-gyn in the Bronx can pay

2 approximately $176,000 on medical malpractice
3 insurance, while an ob-gyn in Rochester pays about
4 $38,000. Recently, this issue received attention
5 by Governor Cuomo's Medicaid Redesign Team. The
6 team's mission was, and continues to be, to reduce
7 state--if we can get order on the Committee.
8 SERGEANT-AT-ARMS: Keep it down,
9 please.
10 CHAIRPERSON RIVERA: Thank you.
11 The team's mission was, and continues to be, to
12 reduce state Medicaid costs and improve quality of
13 care. One working group was convened and
14 discussed medical malpractice insurance. The work
15 group was tasked with reviewing the cost of
16 medical malpractice coverage, analyzing and
17 scrutinizing cost drivers, and make
18 recommendations to reduce the cost to providers,
19 improve patient safety and health care quality,
20 and control cost.
21 Several medical malpractice reforms
22 were enacted as part of the budget, these include
23 Medical Indemnity Fund, hospital quality
24 initiative, and settlement conferences for medical
25 malpractice cases. We will hear more about these

2 initiatives and other strategies to control
3 malpractice costs.
4 Today we will hear from the
5 hospitals, physicians, attorneys, public health
6 organizations, and other concerned members of the
7 community about access to women's health care
8 providers. We must remember that we all share the
9 same goal, and that is ensuring that women have
10 adequate access to high quality health care.
11 While we may differ in how we achieve this goal,
12 this hearing will bring together all stakeholders
13 and provide every party the opportunity to discuss
14 their recommendations.
15 I will like to thank the staff of
16 both committees for their hard work. I also want
17 to recognize my colleagues from the Health
18 Committee who were with us [off mic] reintroduce
19 them or…?
20 [Off mic]
21 CHAIRPERSON RIVERA: Okay. No need
22 to reintroduce them, they're still here. As a
23 reminder, if you are here to give testimony,
24 please make sure that you see the Sergeant-of-Arms
25 and fill out a witness card so that we know you

2 are here and that we can call you to testify.
3 Before we open up from the first panel, at this
4 point in time, I'd like to call on my colleague,
5 Councilwoman Julissa Ferreras, who would like to
6 give an opening statement.
7 CHAIRPERSON FERRERAS: Thank you,
8 Co-chair. Good afternoon, I'd like to thank
9 everyone for coming to today's hearing, my name is
10 Council Member Julissa Ferreras, I am the Chair of
11 the Women's Issues Committee. I'd like to thank
12 my co-chair fill-in, Council Member Rivera, but
13 also Council Member Maria Carmen Arroyo of the
14 Health Committee, as well as Council Member
15 Elizabeth Crowley for bringing this issue forward.
16 Women's health care needs vary
17 throughout their life cycles. Although some women
18 rely on primary care providers to fulfill their
19 basic health needs, there are certain times women
20 need specialists. Today we are focusing on the
21 availability of such specialists and the
22 importance of the services they provide for women.
23 Included in this group are obstetricians,
24 gynecologists, or ob-gyns, as we commonly refer to
25 them. Ob-gyns provide a range of health care

2 services to women, including preventative
3 gynecological, family planning--sorry,
4 preventative gynecology, family planning, prenatal
5 care, and delivery of children. Additionally,
6 they often are the main screeners of several types
7 of cancers that affect women, including cervical
8 and breast cancer. Unfortunately, we are hearing
9 that certain circumstances are leading to
10 decreased numbers of those who provide such
11 services in New York, thereby creating delays in
12 access to service and increases in practices that
13 are putting women's health at risk. Of particular
14 concern is the lack of access to specialized care
15 for low income women who often have multiple
16 health risk and too few options.
17 According to a report by the
18 American College of Obstetricians and
19 Gynecologists, many ob-gyns have made changes to
20 their practices that include increasing the number
21 of cesarean deliveries, or C-sections, decreasing
22 the number of high-risk obstetric patients, no
23 longer preferring vaginal births after C-sections,
24 decreasing the total number of deliveries, and no
25 longer offering obstetric services altogether. It

2 has been confirmed by various government health
3 agencies, such as the CDC, that C-sections have
4 indeed increased dramatically in this country, and
5 this concerns me.
6 C-sections present a greater risk
7 to the health of both mother and their children
8 and should only be performed when absolutely
9 medically necessary. Additionally, some recent
10 data has shown an increase in maternal mortality,
11 with New York City having some of the highest
12 numbers.
13 Another issue that is being raised
14 today is women's access to mammography and
15 radiologists who specialize in diagnosing breast
16 cancer. We have heard over and over how early
17 detection is key to finding and successfully
18 treating cancers and any delays in doing so can be
19 deadly. As Chair of the Women's Issues Committee
20 and on behalf of the women of this city, I am
21 anxious to learn how we can ensure all women have
22 access to necessary, appropriate, and timely
23 treatment.
24 I'd like to thank you again for
25 your attendance as well as your attention to this

2 issue and thank the staff of both committees for
3 their work of this issue. And now Council Member
4 Elizabeth Crowley will say a few words.
5 COUNCIL MEMBER CROWLEY: Good
6 afternoon. Thank you to both our co-chairs today
7 and for the committee staff for helping putting
8 today's hearing together.
9 Pregnant women in New York City
10 face real obstacles in receiving proper obstetric
11 and prenatal care, and many women have
12 difficulties just getting to their regular
13 gynecologist appointments. Here in New York City,
14 where over 40% of our families are supported by a
15 single parent, a mother's health is crucial to the
16 entire well-being of a family. Yet, in recent
17 years we have seen a decline in ob-gyn
18 accessibility and a rise in the maternal mortality
19 rate, which, in New York City, is now twice as
20 high as the national average.
21 In an effort to identify the origin
22 of this problem, I've met with stakeholders from
23 the medical, insurance, and judicial fields. Many
24 of them are here today to testify, and we look
25 forward to hearing from them soon.

2 In New York City, the problem we
3 are facing is very complex. Currently, doctors in
4 New York City pay some of the highest liability
5 insurance premiums in the country. Private ob-gyn
6 practitioners in the Bronx bear our city's highest
7 insurance costs, with premiums averaging over
8 $176,000 a year; and in Queens, not too far behind
9 with premiums of 171,000 per year. According to
10 the Insurance Information Institute, since the
11 early 1970s rates have increased steadily about
12 10% each year, putting a tremendous financial
13 strain on high-risk specialty health care
14 providers, particularly obstetricians and
15 radiologists. This, in turn, has had a dramatic
16 impact on women's access to care.
17 According to the American Congress
18 of Obstetricians and Gynecologists, these rates
19 have forced a large percentage of ob-gyns to limit
20 the scope of their care or to eliminate obstetrics
21 altogether. We have noticed doctors moving away
22 from private ob-gyn practices towards hospitals
23 and clinic care, where the cost of liability
24 insurance is assumed by the facility. Care has
25 thus become more centralized and less disbursed

2 through our neighborhoods.
3 Even more problematic, this medical
4 liability climate discourages obstetricians from
5 practicing in low-income areas and typically there
6 are a large number of Medicaid insured cases.
7 High premiums, coupled with low Medicaid
8 reimbursement rates, makes it difficult to operate
9 in these neighborhoods. And as a result, prenatal
10 care is more difficult to obtain in parts of the
11 Bronx, Brooklyn, and Queens, where many women have
12 less means to travel a long distance in order to
13 see a provider. These women often go without
14 proper care until it becomes time to deliver,
15 thereby, increasing their chances of complication.
16 High malpractice costs are in part
17 due to medical errors. Statistics presented by
18 the Institute of Medicine estimate that as many as
19 98,000 deaths in the United States occur each year
20 as a result of medical errors. Malpractice suits
21 often results in unexpected ad--sorry, and the
22 Journal of Obstetrics and Gynecologists indicates
23 that many malpractice suits often result as an
24 unexpected adverse outcome and a lack of empathy
25 from physicians and the perceived or actual

2 withholding of essential information by hospitals.

3 Additionally, according to the
4 Journal of National Cancer Institute, the field of
5 radiology and mammagramology--mammography, sorry
6 has also experienced an exorbitant malpractice
7 cost. Nationally, misdiagnosed breast cancer is
8 the number one reason for malpractice claims, with
9 average indemnity payments of more than $438,000.
10 However, I do not believe these numbers are an
11 indication of poorly skilled physicians, but
12 rather, they point to a systemwide problems that
13 pose challenges to patients, doctors, and our
14 judicial process alike. Clearly, we must improve
15 patient safety and create a friendlier climate for
16 families and doctors alike.

17 We're here today to continue this
18 discussion and to learn more from each other about
19 what steps can be taken to improve the quality of
20 care for women throughout New York state. Thank
21 you.

22 CHAIRPERSON RIVERA: Thank you very
23 much. Next we'll move on to the first panel. We
24 have Susan Waltman, from the Greater New York
25 Hospital Association, and we have Suzanne Blundi,

2 Deputy Counsel to New York City Health and
3 Hospitals Corporation. You can take the--
4 [Crosstalk]
5 SERGEANT-AT-ARMS: --you can come
6 up now, if you have any copies of your statements-
7 -
8 [Off mic]
9 [Pause]
10 CHAIRPERSON RIVERA: Thank you very
11 much, ladies. Just state your name for the
12 record, and if you have testimony, just please
13 begin.
14 SUZANNE BLUNDI: My name is Suzanne
15 Blundi, I'm Deputy Counsel for New York City
16 Health and Hospitals Corporation, I'm responsible
17 for the Claims Management program.
18 SUSAN WALTMAN: And I'm Susan
19 Waltman from the Greater--
20 [Off mic]
21 SUSAN WALTMAN: Thank you, thank
22 you. I'm Susan Waltman, I'm Executive Vice
23 President and General Counsel at the Greater New
24 York Hospital Association.
25 I would like to present my

2 testimony through PowerPoint, I think it's loaded
3 and ready to go, is that correct, who's…? I can
4 also do it freefall, but... Let me just start
5 out, I'm very much appreciative that you have this
6 hearing, it's exceptionally important issues,
7 obviously, access to care and particularly for
8 women and women's health. There are many areas in
9 New York City, in particular, where there is a
10 tremendous lack of access. What I'd like to speak
11 to briefly is the piece of that access that might
12 be--
13 [Background noise]
14 SUSAN WALTMAN: --high medical
15 malpractice. It was up before, I don't know where
16 it went so--that might be affected by high medical
17 malpractice costs. And when I do talk about
18 medical malpractice costs or the system, I always
19 start by saying, I think it is obviously very
20 important for hospitals and physicians to focus
21 obviously on what they can do, and that is to
22 reduce adverse events. So that is our job at the
23 association.
24 [Background noise]
25 SUSAN WALTMAN: I'm so sorry.

2 [Off mic]

3 SUSAN WALTMAN: Again, the fellow
4 had it up here, is it…? You lost your IT person
5 who had it up there?

6 [Off mic]

7 SUSAN WALTMAN: Slim fellow--

8 [Crosstalk]

9 CHAIRPERSON RIVERA: [Interposing]
10 Can we call--

11 SUSAN WALTMAN: --jacket.

12 CHAIRPERSON RIVERA: --the IT
13 person, see if they can--

14 MALE VOICE: [Interposing] It's in
15 the works.

16 CHAIRPERSON RIVERA: Okay. It's in
17 the works.

18 SUSAN WALTMAN: It's okay. But we
19 really do start with the fact that we need to
20 focus on adverse events, reducing adverse events,
21 what can we do to improve the safety, to reduce
22 costs in our hospitals, and I think that is our
23 responsibility and that's where I start. We also
24 look at the tort system and not the court system
25 so much as just the way it operates and how can we

2 improve that.
3 For those of you who actually have
4 my slides, I apologize. Slide number two is a
5 slide that kind of gives you the picture of what I
6 will cover--this fellow is giving it out.
7 Obviously, it's not good to be first, it's better
8 to be somewhere in the middle. But I have one
9 slide which kind of gives you an overview of what
10 I would like to cover briefly and it really
11 focuses on the fact that when you look at what are
12 the drivers of medical malpractice costs, the cost
13 of coverage for obstetrical services is very high
14 and for some hospitals it had been as high as 50%
15 of the whole medical malpractice costs, it had
16 been 50% of their costs, it's gone down some. And
17 a great deal of those costs are attributable to
18 neurologically impaired newborns, and some of
19 those are cases where there may not be
20 responsibility by the hospitals or the doctors and
21 the result of adverse outcomes that even medicine-
22 at-large cannot affect today.
23 Overall severity is part of the
24 problem, not frequency. Our frequency has gone
25 down, severity has gone up, and I have some charts

2 on that in there. And just the overhead of the
3 system itself. We contribute to the overhead of
4 the system, so I'm not pointing fingers, I'm just
5 saying the process of the claims processing
6 system, whether it's within the provider community
7 or in the court system, is an exceptionally
8 expensive process, which contributes to the cost
9 of med mal. The cost that hospitals incur in New
10 York state across the state, $1.6 billion, we
11 estimate and some hospitals, some doctors can pay
12 as much as $200,000 a piece, which you've
13 mentioned some of the numbers. So obviously, the
14 wrong use of health care resources, it creates
15 access problems and it leads to defensive
16 medicine, recognizing that there's a tremendous
17 amount of estimates out there about extra tests,
18 et cetera.
19 I do have a slide in there that
20 talks about the different kinds of coverage that
21 hospitals have and I won't go through that, except
22 to say we don't have more traditional coverage, so
23 it's hard to collect the cost totally. Some
24 hospitals actually just pay as they go, they don't
25 actually have an insurance policy. So when I get

2 to the slide that you have which talks about how
3 much do hospitals spend statewide, and we estimate
4 1.6 billion, you will see that some hospitals, we
5 have five hospitals or hospital systems that had
6 costs in excess of $100 million each. So in our
7 downstate area, we have five hospitals or hospital
8 systems that spend in excess of $100 million each-
9 -that's a lot of money. We have and of those
10 four, they spent $120 million or more each, and of
11 those, two actually have costs in excess of $130
12 million. Some of that in costs includes the cost
13 of coverage for their doctors, but if their
14 doctors are buying coverage through MLMIC or
15 others, that's not included in there. So it's a
16 lot of money that some of our hospitals are
17 spending.
18 I had chosen to do this PowerPoint
19 because I thought it would be useful for everybody
20 to see some of the charts and the maps, but, as I
21 said, it was up there earlier. But the next slide
22 in your package does have a map which shows you
23 the what's called the lost cost, the lost cost per
24 occupied bed and shows you that New York state
25 really has among the very highest costs of med mal

2 or lost cost per bed across the country. The next
3 slide comes out of Excellis Blue Cross, but
4 actually compiled some of the med mal premiums
5 across the country, and just chose some select
6 states to show you. So it gives you a sense of
7 how low medical malpractice costs may be and now
8 I'm getting into obstetrics might be for ob in
9 certain parts of the country, how high it is in
10 certain areas of Florida, for example, and where
11 New York stands.
12 And then the next slide is one that
13 really zeroes in on New York state and it does
14 give you the breadth of the numbers that you
15 mentioned, I believe, Council Member Crowley, in
16 terms of some of the numbers or somebody across
17 the state and it gives you a sense of how low it
18 is, how low the OB premiums are in certain parts
19 of the state versus how high they are in the New
20 York City region. The drivers are, of course, and
21 in the OB area in particular, adverse events and
22 we have very significant initiatives that we have
23 hosted and have ongoing collaboratives on reducing
24 adverse events in the perinatal area. We have a
25 perinatal safety collaborative, it has been

2 wrapped into a contract that we are very pleased
3 to have just been awarded with the State Hospital
4 Association--
5 [Background noise]
6 SUSAN WALTMAN: --which includes--
7 that's okay--which includes the state Department
8 of Health, but it is a national initiative by CMS
9 to improve patient safety, and part of that is
10 perinatal safety, so we will be including that.
11 And of course, all the hospitals and the insurance
12 companies, as well as the professional societies
13 have initiatives as well.
14 There was a reference to the
15 Medical Indemnity Fund, that is another way that
16 is in effect to try to reduce the cost of medical
17 malpractice coverage for obstetrical providers.
18 It is one that, in the end, if there is deemed to
19 be liability through an award or a settlement, the
20 provider still pays for past medical expenses,
21 economic expenses, non-economic expenses; but
22 moving forward, a fund pays for the future medical
23 expenses for life for a child and eligible
24 individual, which we think is a benefit to the
25 individual. It is just getting started, we hope

2 that it actually fulfills that promise. It does
3 reduce, obviously, the premiums for us some, it
4 reduces some of the costs to the state, and,
5 again, I think the end goal is just better care
6 for the lifetime of that individual.
7 We have a lot of other initiatives
8 to reduce adverse events, but I know you're
9 focusing on OB in particular, so I have a slide on
10 that one. I talk about the fact that we have seen
11 a decrease in frequency, there is a slide in
12 there--and for those of you who have, it's number
13 ten--which shows you nationally number of states
14 and the fact that the frequency of claims have
15 gone down. I do hope that that is because we've
16 been successful with reducing adverse events, but
17 the next one shows you how the severity, meaning
18 the payouts, have gone up. So when you talk
19 about, when we talk about a contributor to the
20 cost of med mal coverage, these very high claims,
21 obviously, are things that have to be taken into
22 account in establishing premiums.
23 I have then a number of slides that
24 really talk about the tort system, and, again, I'm
25 not meaning to talk about the court system, but

2 the way the tort system works, the costs that it
3 incurs, and how much of that is really reflected
4 in med mal premiums. So I have a couple of
5 citations from articles that do discuss the
6 Harvard malpractice study or Harvard practice
7 study that was referenced and how much is actually
8 contributed--how much the tort system costs. So
9 in this one case, it says approximately $.60 of
10 every dollar expended goes to administrative
11 costs, predominantly legal fees. Huh? Oh, sorry.
12 And then some other studies that have looked at
13 number of claims brought, how many actually
14 involved errors, and the compensation associated
15 with them. But the take away on slide 15, again,
16 is just how much the tort system itself, the
17 claims processing system contributes to med mal
18 premiums, and this one indicates that 54% of
19 compensation paid to plaintiffs actually goes to
20 the cost of litigation. So we really need to
21 concentrate on how can we make that process more
22 streamlined, and I do think you'll hear about
23 some, what I view, very innovative, very helpful
24 processes that the judicial system has put in
25 place, something that HHC has been involved in--

2 active case conferencing, et cetera, which I think
3 really does reduce the cost to the system.
4 Slide 16, and maybe we'll get up
5 there by the time I'm--
6 [Off mic]
7 SUSAN WALTMAN: --up to my last
8 slide--
9 MALE VOICE: All right.
10 SUSAN WALTMAN: --I'm almost there.
11 So--
12 MALE VOICE: This slide and the
13 next slide?
14 SUSAN WALTMAN: It was up there
15 before, it was loaded and up there, I apologize,
16 there's another fellow, not with a purple shirt,
17 but a blue shirt. Okay. And I just think when we
18 get--
19 [Off mic]
20 SUSAN WALTMAN: No. When we get to
21 the end, obviously, I do think, or it's where we
22 started, is we really have to focus on reducing
23 adverse events, we know that, as it relates to med
24 mal and there are a lot of efforts afoot. We
25 really have to focus on making the tort system

2 more streamlined, less costly, and not
3 contributing as much as it does, perhaps, to the
4 med mal premium. And I do think we'll have safer
5 patient care, lower costs, a better system, less
6 defensive medicine, lower cost altogether.
7 I have one last slide where I put a
8 number of recommendations, and I know some of them
9 are very controversial and I don't speak for the
10 OBs, I think some people will be here today, but
11 to the extent that they can get scorable--and I
12 think these are important to hospitals too, but I
13 know from their perspective, how do they reduce
14 their premiums directly, scorable ways to reduce
15 their premiums similarly for hospitals. They
16 would say--see, I have these beautiful slides--
17 [Crosstalk]
18 SUZANNE BLUNDI: They are.
19 [Off mic]
20 SUSAN WALTMAN: Okay. That's all
21 right.
22 SUZANNE BLUNDI: Ta-da.
23 SUSAN WALTMAN: Okay. So they
24 would have liked a Medical Indemnity Fund. I
25 think one of the unfortunate things about the

2 Medical Indemnity Fund is it didn't really affect
3 the premiums of obstetricians, which I think is
4 noted in the proposed resolution, so they would
5 say they would like the Medical Indemnity Fund to
6 be no-fault. Right now, one does have to bring a
7 claim and have a settlement or an award.
8 Establishing caps, or let's just call them
9 compensation guidelines, on non-economic injuries
10 would be a way that could reduce premiums for
11 hospitals and doctors alike. I just want to say
12 the argument for at least guidelines and caps and
13 guidelines is it really eliminates the
14 unpredictability, inequity, and variability in
15 awards. What I don't want to do is take away from
16 someone who deserves a specific amount, but there
17 are some very, very large awards and others who,
18 with similar situations, may get smaller amounts
19 and when there is this unpredictability in awards,
20 for example, it greatly adds to med mal costs.
21 There is an argument to be made for
22 expanding the Medical Indemnity Fund to include
23 neurologically impaired persons as well, and
24 that's something to reduce the costs for surgeons.
25 And I mentioned before expanding active case

2 conferencing, judge-directed negotiation as a way
3 to really streamline the dispute resolution
4 process.
5 Health courts, whether they're
6 judicial or administrative, I think it's just very
7 important to have specially trained judges,
8 neutral experts available and guidelines. I do
9 think that's a little bit of what goes on through
10 the active case conferencing process. I think
11 clinical practice guidelines would go a long way.
12 It'll cause us to reach agreement on how to
13 deliver good care and more better care will be
14 delivered, and at the same time, providers can
15 better be able to defend themselves if they
16 followed them. And then what was mentioned
17 earlier, disclosure of the policies and early
18 offers of compensation, we've been advocates of
19 meaningful disclosure and apologies for at least a
20 decade. It would be helpful to have them
21 protected, meaning not be discoverable, not used
22 in trials, but I still think it's something that
23 we all need to be doing.
24 Thank you.
25 CHAIRPERSON RIVERA: Next.

2 SUZANNE BLUNDI: I'm here to answer
3 any questions, we have no prepared testimony.
4 [Off mic]
5 CHAIRPERSON FERRERAS: Good
6 afternoon, and thank you for your testimony, I'm
7 sorry that your slides weren't viewable, I know
8 you worked very hard on them, but we followed over
9 here.
10 SUSAN WALTMAN: Thank you.
11 CHAIRPERSON FERRERAS: So I know
12 Council Member Crowley and I'm sure other members
13 are going to have questions. In particular, I
14 wanted to know if you can speak to how the recent
15 state reforms affect access to women's health care
16 providers?
17 SUSAN WALTMAN: I don't know which
18 reforms you're talk--are you talking about the--
19 CHAIRPERSON FERRERAS: The
20 Medicaid.
21 SUSAN WALTMAN: --Medical Indemnity
22 Fund?
23 CHAIRPERSON FERRERAS: Yeah, yes.
24 SUSAN WALTMAN: Yeah, I think
25 we're--if you take a number--

2 CHAIRPERSON FERRERAS:

3 [Interposing] Can you just move the microphone a

4 little closer? 'Cause then we can hear you.

5 SUSAN WALTMAN: Okay.

6 CHAIRPERSON FERRERAS: Thank you.

7 SUSAN WALTMAN: I think a major

8 reason we supported the Medical Indemnity Fund was

9 because of the high costs of care, and in

10 particular in certain areas, you know, as you

11 could see, it's different across the state,

12 different to some extent among the boroughs. But

13 if you look at the fact that one hospital might be

14 paying $120 million in premiums and if a Medical

15 Indemnity Fund, through somewhat of a sharing of

16 some of the future medical costs, reduces their

17 premium by 10 or 20%, which has happened, it frees

18 up another 10 or 20% to be used for the delivery

19 of care. So I think it is something that helps

20 reduce the cost of care and enables providers to

21 put more into the delivery system.

22 I do think what has to go hand in

23 hand with all of these reforms is very serious

24 safety initiatives too and I know that those

25 institutions that have benefited the most have

2 been ones that have very active patient safety
3 initiatives in place on their own with us through
4 their insurers, for example. So I'm hopeful that
5 what does happen is just more, better access to
6 care, the ability to keep providing that care in
7 the communities.
8 I do want to say though, I think
9 it's very important to focus on the fact that the
10 Medical Indemnity Fund has not affected the
11 premiums paid by doctors in the way I think that
12 we had hoped. So as I said, some of the doctors
13 are covered under our insurances, if we have a
14 self-insured trust or a risk retention group or a
15 pay-as-you-go, but for those doctors who do have
16 to purchase their own insurance, they did not see
17 the Medical Indemnity Fund affect their premiums
18 in a meaningful way.
19 CHAIRPERSON FERRERAS: So I guess
20 this is a follow up to HHC in particular, but how
21 did you reduce your medical malpractice costs in
22 recent years?
23 SUZANNE BLUNDI: Clearly, HHC a
24 number of years ago, under President Alan Aviles,
25 recommitted to establishing itself as one of the

2 safest hospital systems in the country, and that
3 has started from Al and from the ground up,
4 nothing is beyond review. Our claims reduction
5 program, risk management, has been very
6 aggressive. Equally with regards to events, we've
7 instituted a initial very aggressive investigation
8 to learn what happened and, if possible, why it
9 happened, and take those lessons back to improve
10 the delivery of care.
11 Also--and I don't want to step on
12 the Honorable Ann Pfau or Douglas McKeon, who will
13 be testifying later--we partnered with the
14 Honorable McKeon up in the Bronx initially to
15 start what has been called the active case
16 conferencing, and those three efforts have really
17 helped produce the dramatic effects.
18 CHAIRPERSON FERRERAS: And I
19 understand that the president has, as you say,
20 from the top down, in your practices, have you
21 been able to compare private versus public and
22 what the cost has been?
23 SUZANNE BLUNDI: Not really. As a
24 public institution, our numbers are quite
25 available; private institutions, not as much, so

2 not really. But we believe that they compare very
3 favorably.
4 CHAIRPERSON FERRERAS: So as you've
5 aggressively been looking at your costs, have
6 there been any--has anything come up that you've
7 said, okay, this is something that we've
8 addressed, are there any flags that you can say--
9 you can speak to that have made a difference?
10 SUZANNE BLUNDI: I think that I
11 would really want to have someone who's more
12 medical here to answer those questions, but I can
13 tell you that patient safety is part of what we do
14 every day. And when we evaluate something, it's
15 not done, we reevaluate it, we look at it again to
16 see if there's any way to improve it and share the
17 lessons learned throughout our systems. So it's
18 something that we're doing all the time. So I'm
19 sure the answer is yes, but to speak to the
20 clinical elements of it, not--
21 CHAIRPERSON FERRERAS: Oh--
22 SUZANNE BLUNDI: --my strong point.
23 CHAIRPERSON FERRERAS: --okay. And
24 before Council Member Crowley asks, I have one
25 more question and then we'll probably circle back.

2 But are there any other states or model programs
3 that ease the barriers facing women's health care
4 providers that you can think of? I guess for
5 either one of you. We don't have one model state
6 out there?
7 SUZANNE BLUNDI: I think HHC is the
8 model.
9 CHAIRPERSON FERRERAS: Okay. Is
10 that how you feel also or…?
11 SUSAN WALTMAN: I do think--I will
12 say that I started a number of years ago to
13 identify ways that we can improve care and improve
14 the claims processing, and there is no question
15 that HHC is a model in that regard. And that's
16 not to say anything about other hospitals, but I
17 was very struck at least five years ago about the
18 process that they had put in place with Judge
19 McKeon in the Bronx and it is something that's
20 being expanded. I know that's not the direct
21 question about care, but I think to the extent
22 that these cases will settle, and settle in this
23 fashion, will greatly reduce the cost of these
24 cases, which will alleviate at least the cost for
25 hospitals. Hopefully, it'll reduce the burden and

2 the fears of obstetricians at the same time and
3 not cost, so maybe it's the reverse of the
4 negative, you hope that it will cause more
5 obstetricians to continue to provide care through
6 this process. It's a much more amicable, fair
7 process that they have put in place.
8 CHAIRPERSON FERRERAS: Okay. Thank
9 you. Council Member Crowley.
10 COUNCIL MEMBER CROWLEY: Thank you,
11 Chair Julissa Ferreras. I have a few questions.
12 First, when I came about looking into health care
13 needs in and around the community I represent,
14 first was back right after I got elected in 2009
15 and, unfortunately, just a few weeks into my
16 tenure as City Council member, I was beside St.
17 John's Hospital in Queens where many of--excuse
18 me--my constituents went to deliver their baby.
19 And today, like, my constituents have to go much
20 further or they're looking at Jamaica Hospital,
21 which it seems is always in danger of being
22 rumored to close or Wyckoff Heights Hospital,
23 those are the three that serve my district. But I
24 bring them up because I know a number of hospitals
25 have closed over the years, and I think that if

2 you could explain if this was part of the reason
3 as to why some hospitals have closed. Because
4 many of the hospitals that are still open, I have
5 read that certain hospitals in Brooklyn have
6 reduced or closed even their prenatal areas or
7 birthing wards. So if you could speak to hospital
8 closures and how that's affected women's access,
9 and whether liability premiums have had some
10 reasoning behind the closures, some impact.
11 SUSAN WALTMAN: There have been a
12 lot, and we do have a running list of hospitals
13 that have closed over the years. Some have
14 closed, as you know, by design through the Berger
15 Commission suggesting they aren't needed or maybe
16 they need to convert, but some have closed because
17 of financial problems, and Brooklyn has felt that,
18 I believe. And I think there is no question that
19 medical malpractice costs are a big contributor to
20 that. Are they the only? Absolutely not. But
21 who's affected when a hospital closes are those
22 who might have outstanding claims, so it's hurtful
23 to the community from a health care standpoint and
24 it's also hurtful to those who might have
25 outstanding claims in a bankruptcy proceeding.

2 But I think, for example, in
3 Brooklyn where I know people have talked about the
4 Bronx, but in Brooklyn where there have been a
5 number of hospitals that have closed, the Brooklyn
6 Medicaid Redesign Team report really does look at
7 that particular borough from the standpoint of
8 health care and what needs to be done to service
9 the health care needs, looking also at the
10 hospitals, but recognizing that there's much more
11 to health care than, as they put it, the big
12 boxes. But doing things that can help preserve
13 the hospitals, but also should deliver care and
14 where it's needed. And I think it's an excellent
15 planning document, what we need to do is move it
16 forward.
17 But I want to make one comment
18 about hospitals closing. I think it's very
19 unfortunate when a hospital closes that's needed
20 in the community, but what is really needed is the
21 prenatal care, and where someone ultimately
22 delivers, you know, that's one time and what you
23 want to do is make sure it's close enough that
24 they can get there when they go to deliver. The
25 most important thing is having that prenatal care

2 in the community. And from the health of the
3 child, it's also exceptionally important that that
4 mother has health care when she conceives the
5 baby. Now I'm getting way over the line in terms
6 of what I know clinically, but just having sat
7 through a panel on that subject, the health of the
8 mother and the health of the baby are very
9 dependent on the health of the mother when they're
10 born, which means they have to have a primary care
11 physician, whether it's their GYN, ob-gyn or not,
12 as well as throughout their pregnancy. So it's
13 where that health care and prenatal care are; less
14 important, maybe where the hospital is provided
15 provided that the doctors don't disappear 'cause
16 there's not a hospital immediately there.
17 So I'm hopeful that that is going
18 to be the long term goal, which is to get health
19 care in the right places and enough places for the
20 delivery.
21 COUNCIL MEMBER CROWLEY: Would you
22 agree that it's more difficult for a woman to
23 access health care if they don't have a
24 gynecologist in their neighborhood? And you
25 mentioned big box, I mean, I, you know, could

2 compare it to a local hardware store versus going
3 to Home Depot, in relation to going to a small
4 practitioner's office in comparison to a larger
5 hospital, and you, I would imagine, not get the
6 intimacy of care during the process of prenatal
7 care. And traditionally you've always gone to the
8 hospital for delivery, but my fear is that in the
9 city we are moving towards only clinics and
10 hospitals providing prenatal care. From research,
11 I haven't found any private practitioner
12 practicing in the Bronx, and I know the numbers
13 are dwindling in Queens and the other boroughs,
14 and that's part of the reason we're having that
15 hearing.
16 So I guess my question is, would
17 you agree that it seems like there's an access to
18 care problem that affects a woman deciding when
19 the right time is to go to see the physician or to
20 get prenatal care or regular care for oneself if
21 they don't have access to a nearby doctor?
22 SUSAN WALTMAN: No, I think there's
23 no question that there's an access issue. I do
24 want to say, though, I think a lot of our
25 hospitals, those in the Bronx, have really made

2 an--and that's not to say something negative about
3 Brooklyn, and just hospitals have closed in
4 Brooklyn, but those in the Bronx, there are very
5 major effort to do outreach and to serve their
6 communities, and the fact that it's a hospital, a
7 physician affiliated with a doctor isn't bad, it's
8 very good, 'cause then you have a larger support
9 service. But I know what you're saying, in
10 certain communities which are accessible to many,
11 you know, where individuals would seek their care,
12 there is no question there's inadequate primary
13 care or clear access to ob-gyn, no question.
14 COUNCIL MEMBER CROWLEY: And just
15 last question because I know some of my colleagues
16 have more questions and there are a number of
17 people who are here to testify today. I
18 understand that there are hospitals that were
19 about to close, but they redesigned the way they
20 deliver care and they were able to bring down
21 their malpractice rates because they had less
22 occurrences. I think maybe Bronx Lebanon was one
23 of them or Presbyterian in Manhattan, I've heard.
24 Do you know of any particular hospitals that have
25 done that?

2 SUSAN WALTMAN: I think we all try
3 very hard to reduce adverse events, and not just
4 to--not because of the medical malpractice, but
5 because it's what we're supposed to do, which is
6 to provide safe patient care, and there is no
7 question that we've made progress, and I do think
8 it's reflected by the reduction in the frequency
9 of claims. And, you know, I think our
10 collaborative has demonstrated reductions in
11 claims and many of our hospitals have done that as
12 well. But you're still going to have a trajectory
13 up, you know, maybe it's mitigated how much the
14 rates have gone up, but we do see them going up
15 some and we see at the same time frequency of the
16 claims going down. I do think that they are
17 working very hard, particularly perinatal because
18 of the costs associated.
19 COUNCIL MEMBER CROWLEY: Well you
20 believe what the governor's Medical Indemnity Fund
21 that hospital costs will go down in terms of
22 malpractice.
23 SUSAN WALTMAN: Yes, we have seen
24 for some of the hospitals, sometimes it's based on
25 where they're located and the costs that they were

2 incurring have experienced reductions in what
3 their costs are. It has not, however, affected
4 what the doctors who purchase their own insurance,
5 it's not affected--
6 COUNCIL MEMBER CROWLEY: Right.
7 SUSAN WALTMAN: --their premiums,
8 and in part because the savings were at very, very
9 high levels and the doctors are only buying up to
10 $1.3 million, so it's not affected favorably that
11 particular layer.
12 COUNCIL MEMBER CROWLEY: Could
13 there be a way that that fund could sort of
14 capture where the private practitioners are losing
15 to help them in some way if they were to work--
16 [Crosstalk]
17 SUSAN WALTMAN: [Interposing] I
18 won't speak for the obstetricians, I know that
19 that's why I put at the top of the list of
20 recommendations the two things that OBs would say
21 would save them costs, other than what I've been
22 talking about and we all work on, reducing adverse
23 events. But is the notion of making the fund no-
24 fault, as well as having some kind of compensation
25 guidelines that might moderate--or caps moderate

2 the amounts that are paid out, which would reduce
3 some of the premiums, but I will let them speak
4 to.
5 COUNCIL MEMBER CROWLEY: Okay.
6 Thank you, Chair, I have no further questions.
7 CHAIRPERSON RIVERA: Thank you very
8 much. I just have a couple of questions. Thank
9 you for joining us. I'm looking at the, I guess,
10 the slide four of the New York State Hospital
11 Malpractice Coverage Costs. You said that 50% of
12 the statewide hospitals contributed to this survey
13 and was about $1 billion. How many hospitals was
14 that?
15 SUSAN WALTMAN: Well we did it by
16 50% of statewide hospital operating costs, I don't
17 know, I assume that when we look at systems, we
18 probably had maybe at least 60 hospitals included
19 in that number, but it represented what the--what
20 I have here is it represented half of the
21 operating costs statewide and from that we
22 extrapolated to get the number of 1.6 billion
23 'cause I think the costs upstate are lower, med
24 mal costs, et cetera, are lower, so that's how we
25 did the extrapolation.

2 CHAIRPERSON RIVERA: So that's 1.6
3 billion in medical malpractice--
4 SUSAN WALTMAN: Costs.
5 CHAIRPERSON RIVERA: --covered
6 costs.
7 SUSAN WALTMAN: Yes.
8 CHAIRPERSON RIVERA: Right, is that
9 broken down by specific field, like obstetrics,
10 cancer, or is that just like overall?
11 SUSAN WALTMAN: That's overall, but
12 I will say when we first started to do our survey,
13 the amount of that costs that was represented by
14 OB coverage was ranging from 35 to 50% of that
15 amount, depending upon the hospital and where they
16 were located. So a very significant portion of
17 the med mal costs a couple years ago when we first
18 started were attributable to OB, we have not asked
19 that specific question for 2010, we didn't ask
20 that for 2010. But I know that it is a very high
21 proportion of the med mal costs.
22 And you asked about hospitals
23 wanting to close or the financial impact, there
24 was one that was in the paper couple years ago
25 which asked to close their OB service, they were

2 denied that request by the state Department of
3 Health, I'm thinking their OB costs were--of their
4 med mal costs were 40% of their total coverage
5 costs and a--contributed greatly to the losses of
6 the hospital, yet OB only represented maybe 12% of
7 the discharges or something. So you see that it's
8 a--if there are high med mal coverage costs, it
9 contributes significantly to the financial strain
10 on hospitals.
11 And I just want to emphasize, we
12 are very committed to reducing adverse events, as
13 you heard from HHC, and that's what our members
14 are very focused on, but there are a lot of costs
15 as well that are from the system itself, the
16 dispute resolution system, some of the claims are
17 ones that don't actually involve errors or
18 negligence, and so we really, really hope that we
19 can work together to reduce unnecessary costs from
20 that process.
21 CHAIRPERSON RIVERA: Okay. Just as
22 a follow up, you'll probably make it from my,
23 like, my edification for, like [off mic]
24 edification, you know, do you have, like, a
25 breakdown over the past few years, maybe ten

2 years, of what the different malpractice costs for
3 the ob-gyn versus cancer and other related fields
4 would be, and the differential from each of those
5 different fields as it breaks down, or do you not
6 have that data?
7 SUZANNE BLUNDI: I don't have that
8 data with me for HHC; to some extent, I could
9 create it. As you may know, in 2006, HHC took
10 over the full responsibility for the medical
11 malpractice claims and it had been a work in
12 progress. And one of the ways that becomes
13 important to what you're asking right now is that,
14 unlike other city agencies or quasi city agencies,
15 our malpractice costs come directly out of our
16 budget, which, as you know, has been, through
17 Medicaid and Medicare changes, has been greatly
18 impacted. Adding into that, every dollar that we
19 pay out comes out of our budget and then we have a
20 pass along to the facilities involved. So when we
21 have a facility that has a number of high payouts,
22 they pay the payout dollar for dollar almost,
23 there's a little bit of a cushion from the
24 hospital itself, the corporation itself. So since
25 2006, I can look into that and get back to you

2 with more data information.
3 CHAIRPERSON RIVERA: Yeah, it'll
4 just be helpful. In terms of the adverse events,
5 I mean, obviously, we all have the same goal and
6 want to make sure that the experience is a safe
7 one and is efficient for the patient. What steps
8 and measures are we taking? And I see in one of
9 your slides, I think it's on page nine, you said
10 that some adverse events cannot be prevented. Can
11 you explain what that means?
12 SUSAN WALTMAN: There are adverse
13 outcomes that occur in medicine that may not be
14 due to negligence, and there are studies that are
15 done by group out of Harvard and others who many
16 groups study med mal claims and they would say
17 that the greatest predictor of payment is the
18 degree of disability and not the presence of
19 negligence. Which means somebody has a
20 devastating injury and that needs to be
21 compensated, whether it's through, you know,
22 Medicaid program does cover medical, you know,
23 people with high medical needs, for example,
24 health insurance, but there are a lot of outcomes
25 that are adverse and not the ones we had hoped

2 for, but that are not due to negligence. So that
3 the construct for bringing a claim is whether
4 somebody didn't follow the standard due care, was
5 negligent, and there are adverse outcomes that
6 occur in medicine that are not due to negligence.
7 So we really strive to reduce all adverse events
8 and some that obviously cannot.
9 You ask about quality initiatives,
10 Greater New York Hospital Association, and we're
11 not alone here, have a very large number of
12 initiatives, collaboratives with our members to
13 try to reduce adverse events from infections,
14 perinatal safety, surgical safety, a lot going on.
15 And, as I indicated, we just received this
16 contract from the federal government--the state
17 association and all of those will be wrapped in,
18 we will be working with the state Department of
19 Health on that. Another thing that'll be
20 exceptionally helpful, Commissioner Shaw is very
21 much focused on bringing together all the data
22 that we can at the state level, and data helps us
23 analyze the adverse events and what can we do
24 better and where are some of the places that are
25 causing the problem. So I think that'll be very

2 helpful to our ability to do more.
3 CHAIRPERSON RIVERA: Okay. And
4 then I guess in just follow up to what I asked
5 previously, the question also is what departments,
6 you know, receive the most medical malpractice
7 suits and what can be done, you know, to lower the
8 costs of those medical malpractice suits?
9 SUSAN WALTMAN: Well I think that,
10 you know what becomes a little difficult from the
11 hospital data standpoint is go back to the slide
12 that talks about the fact that hospitals have many
13 different ways that they cover their malpractice
14 because there isn't the availability or
15 affordability of insurance, so some of them have
16 their own little risk retention groups or trusts
17 or pay as you go, which means there's no central
18 way to aggregate data with respect to hospital
19 claims in the same way as there is within the
20 insurance department, financial services
21 department for physicians who buy insurance. So
22 the better data almost in terms of claims for
23 doctors is within that world because it gets
24 collected a little more centrally. Clearly,
25 people who pay higher claims are higher med mal

2 are neurosurgeons, for example, orthopedic
3 surgeons, and OBs. That's the dollars. I don't
4 have in front of me the number of claims, which is
5 what you asked.
6 CHAIRPERSON RIVERA: Okay. All
7 right, and then just on a different line of
8 questioning, what role do you see the Department
9 of Financial Services, you know, playing and how
10 do you guys work with them?
11 SUSAN WALTMAN: Well the Department
12 of Financial Services regulates the insurance for
13 those physicians who buy insurance, what I'll
14 call, admitted carriers, regulated carriers, so we
15 don't have much involvement with them because most
16 of our hospitals will be self-insured or have risk
17 retention groups that are not--where their rates
18 are not set by the insurance department. They may
19 buy one initial layer that may maybe be regulated
20 by the insurance department, the hospitals don't
21 have as much interaction. The physicians can
22 speak to this, but I think what would be very
23 useful is to have premium reductions that are
24 related to quality and patient safety initiatives.
25 So, you know, you can see the way the premiums on

2 these maps work, you've got one number for Queens
3 or something, you know, or Brooklyn, and there are
4 some reductions for doctors who have not been sued
5 for a number of years, for example, or certain
6 premium discounts. We would like to see more
7 discounts related to participation and quality
8 improvement initiatives. So that's something that
9 comes from insurance, the Department of Financial
10 Services.
11 CHAIRPERSON RIVERA: Okay. And now
12 the State Department of Health, what role do you
13 see them playing and how do you work with them?
14 SUSAN WALTMAN: We work very well
15 with them, and I think what we really do
16 encourage, and we recognize it's a time of reduced
17 resources, but I think it would help--we are very
18 pleased that the State Department of Health is
19 working with us statewide on this initiative that
20 I've mentioned a couple times. I do think it'll
21 be very helpful that the Commissioner of Health is
22 pulling together the data that I mentioned and we
23 would really like to work with them as much as
24 possible to develop guidelines to really
25 understand ways in which we can improve the care.

2 Yes, doctors will individually know how to do
3 things better or within a hospital, but it helps
4 immensely to have statewide data on what makes a
5 difference to improve a delivery or prenatal care
6 or others. And so we work very well with the
7 State Department of Health.
8 CHAIRPERSON RIVERA: Okay. Thank
9 you. Next we have questions by Council Member
10 Margaret Chin.
11 COUNCIL MEMBER CHIN: Thank you.
12 Just to follow up on the earlier question, so what
13 you were talking about hospital that pays up to
14 $100 million, $120 million, is that just the
15 insurance premium or does that includes a
16 malpractice suit payout?
17 SUSAN WALTMAN: Oh, okay. Well
18 it's we use the term coverage costs, so if you're
19 a hospital that actually pays premiums, let's say
20 you have your own trust or risk retention group,
21 you might actually get charged a premium by your
22 own insurance entity, so it's their premiums. And
23 with the premiums, they pay over time the payouts.
24 So the premiums are include the payouts and the
25 defense costs over time.

2 COUNCIL MEMBER CHIN: What's the
3 percentage of that as like their operating budget,
4 part of their operating budget?
5 SUSAN WALTMAN: I think that we
6 found on average, hospitals will spend at least 3%
7 of their operating expenses on medical
8 malpractice. And if you figure 60%, 55, 60% of a
9 hospital's budget is personnel, it becomes an even
10 higher proportion of their operating expenses that
11 are non-personnel, so it gets closer to 8 or 9% of
12 the non-personnel expenses. So I'm giving it to
13 you in two increments: 3% of total operating
14 expenses and then 8% of their non-personnel
15 operating expenses. It can be a very high
16 proportion. I am aware that it's much lower
17 percentage across the country, it could be 1%--
18 COUNCIL MEMBER CHIN: Oh.
19 SUSAN WALTMAN: --in other parts of
20 the country. It's a lot of money.
21 COUNCIL MEMBER CHIN: Now the
22 points you also in your testimony you were saying
23 that some hospital do not have insurance policies?
24 SUZANNE BLUNDI: HHC doesn't have
25 insurance to cover its medical malpractice claims,

2 it's self-pay.

3 COUNCIL MEMBER CHIN: By the doctor

4 or are you talking--

5 SUZANNE BLUNDI: [Interposing] By

6 HHC. We can't go out and buy commercial insurance

7 to protect the corporation against claims, it

8 comes out of the operating budget. You know.

9 COUNCIL MEMBER CHIN: Oh, okay, so

10 that's different from the other volunteer

11 hospital.

12 SUSAN WALTMAN: There are volunteer

13 hospitals that, non-HHC hospitals who are

14 similarly self-insured or will have a very large

15 self-insured layer. That's why we don't always

16 speak in terms of premium cost, we speak in terms

17 of coverage costs. So a hospital that pays

18 premiums, that's their number; HHC's is what they

19 pay out and what they spend on attorneys and

20 claims throughout the year. Other members may

21 give us a combination 'cause they may have one

22 layer that is insured and a large $15 million

23 self-insured layer and an excess. That's why I

24 have that one slide that gives you the

25 permutations just to explain it's not all just

2 premiums.

3 COUNCIL MEMBER CHIN: So when you

4 look at that in terms of comparison, and you were

5 saying that HHC could be a model, I mean, is that-

6 -

7 SUZANNE BLUNDI: [Interposing] For

8 patient safety.

9 COUNCIL MEMBER CHIN: Yeah, for

10 patient safety, so but that also translates into

11 costs, right, the malpractice costs, and so I'm

12 just saying that do you have any kind of study

13 where hospitals like HHC or some of the other

14 volunteer hospital where they're self-insured, are

15 there some, you know--

16 [Crosstalk]

17 SUSAN WALTMAN: [Interposing] Well

18 keep in mind a hospital that pays premiums to a

19 risk retention group, it's typically three or four

20 hospitals that have come together that they want

21 to be involved in this insurance product with.

22 They're not overcharging themselves the premiums

23 either, so they have chosen this RRG or self-

24 insured trust model as a way to reduce costs and

25 at the same time kind of put aside reserves. So

2 their incentive is to keep their insurance costs
3 as low as possible too in a somewhat different way
4 from HHC, which doesn't have pure insurance, but
5 of course, wants to keep its costs down because it
6 pays as it goes.
7 So it's a form of the model that
8 you're suggesting which keep your costs low by
9 self-insuring in their way, which is pay as they
10 go, or create your own little trust with people
11 that you want to share some risk with or do
12 quality improvement with, and you're certainly not
13 overcharging yourself in that system. So that's
14 one thing I want to emphasize. I know there's a
15 lot of discussion about insurance carriers perhaps
16 charging more than they need to, but most of the
17 hospitals, you're either self-insured by having no
18 insurance for certain layers or insured through
19 these risk retention groups that they themselves
20 control and their actuaries will tell them what
21 the premium should be so they're not overcharging
22 themselves there either.
23 COUNCIL MEMBER CHIN: Are the
24 hospitals helping the physicians that do buy their
25 own malpractice insurance? If they're affiliated

2 with a hospital, do they get some support from the
3 hospital in terms of with the malpractice
4 insurance or not?
5 SUSAN WALTMAN: I don't know how to
6 answer that for everybody, but there's no question
7 that I would assume it's lower cost for the
8 doctors who are employed by and covered by that
9 risk retention group, and it obviously affords a
10 better opportunity to coordinate care and defense
11 and identify adverse events through the process.
12 I just want to say your idea is absolutely right
13 on the mark, which is couldn't more hospitals do
14 what HHC has done, I just think they've done a
15 variation of it.
16 COUNCIL MEMBER CHIN: Okay. I
17 think ultimately, I mean, it's patient safeties
18 and those kind of policy that you recommend that
19 really we need to really push for those. Thank
20 you.
21 SUSAN WALTMAN: Absolutely.
22 CHAIRPERSON RIVERA: Thank you.
23 Next we have Council Member Ruben Wills, followed
24 by Council Member Helen Foster.
25 COUNCIL MEMBER WILLS: Good

2 afternoon. Could you just delve a little bit into
3 the patient safety initiatives and the tangible
4 benefits besides the savings that are a product of
5 that?
6 SUSAN WALTMAN: That's what we are
7 here for. I mean, I really--you know, I think
8 that health care providers are supposed to provide
9 safe patient care and so we--and this isn't about
10 me, I know this, but, I mean, my area has--I have
11 many people who work for me and they're attorneys
12 and nurses and their total responsibility is to
13 develop initiatives to reduce adverse events, to
14 improve patient safety, and that's replicated over
15 and over in our hospitals. And I think though the
16 collaborative approach that we've put together,
17 which we've tried to do collaborate collaboratives
18 to help hospitals learn from each other and
19 collect data together again and what are the
20 barriers and how can you do things better. I
21 think we'd like to think that that is a good way
22 to help improve safety, you can generate more
23 data, you can know what works better.
24 COUNCIL MEMBER WILLS: I understand
25 that, but I would assume that that would be the

2 norm trying to make sure that those things were a
3 result of it, but isn't there a savings, didn't
4 like New York Presbyterian, didn't they save $25
5 million, was that in relation to the initiatives?
6 And if there is a financial savings, is that money
7 used or is it ever in the future going to be used
8 to offset some of this medical malpractice?
9 SUSAN WALTMAN: I think everything
10 that is saved through patient safet--I just want
11 to say, our focus on patient safety is to have
12 patient safety.
13 COUNCIL MEMBER WILLS: No, no, I
14 understand that, that's why I say that--
15 SUSAN WALTMAN: [Interposing] But--
16 COUNCIL MEMBER WILLS: --I'm hoping
17 that would be the foremost--
18 SUSAN WALTMAN: --whether you save
19 from a case or you save your med mal premium, we
20 are all not-for-profits and we put those savings
21 wherever they come from back into the system and
22 there's, therefore, more to provide the outreach
23 or to provide better care. I'm not answering your
24 question--
25 [Crosstalk]

2 COUNCIL MEMBER WILLS:
3 [Interposing] No, no, you're answering my
4 question, but I was just looking for more of a
5 specific because, being in city government, we
6 understand how the money goes into one huge pot,
7 but that money does not necessarily mean that it
8 reaches the areas that it needs to reach. You
9 know, you can have a $60 plus billion budget and
10 still have certain areas like senior citizens and
11 youth, those areas might not get the money or
12 attention that's needed. So what I'm asking is,
13 the savings, is it not, for lack of a better word,
14 there's no earmarking, there's nothing that says
15 that this money will be going towards that to
16 offset some of the malpractice issues?
17 SUSAN WALTMAN: I think how someone
18 spends what they didn't spend is different in
19 every single circumstance, but I do know that it's
20 very important for our hospitals who are not for
21 profit, who are very committed to their
22 communities to not spend money unnecessarily on
23 medical malpractice costs or just delivering the
24 wrong care, delivering poor care. And it'll be a
25 different answer in every institution where the

2 savings that they might have experienced from the
3 Medical Indemnity Fund or some other efficiency or
4 quality measure went. But I, you know, that's the
5 value I will say of their being a very much not-
6 for-profit system, which is the money goes back,
7 is rededicated to the health care system.

8 COUNCIL MEMBER WILLS: Okay.

9 CHAIRPERSON RIVERA: Okay. Next we
10 actually have Inez Dickens and then Helen Foster.

11 COUNCIL MEMBER DICKENS: Thank you,
12 Chairs. Thank you for your testimony. To follow
13 up on Council Member Crowley's question, have you
14 amassed any data that details the additional cost,
15 if any, on malpractice and negligent suits as it
16 relates to hospital or clinic closings versus the
17 purported cost savings for closing those hospitals
18 and clinics? And I'm being very specific because
19 I'm really talking about St. Luke's Birthing
20 Clinic and parts of the prenatal and postnatal
21 that was transferred to St. Luke's Roosevelt. But
22 it could be at any institution, but I'm just--
23 that's what came to mind.

24 SUSAN WALTMAN: I don't know the
25 specific calculus, I will say again--and I don't

2 want it to sound as though I'm answering with
3 respect to St. Luke's Roosevelt--but I do think
4 what's very important is having the prenatal care,
5 having the primary care and then the prenatal care
6 where the patients are and it's important that the
7 mother who needs to deliver has access to the
8 hospital. I think though where the prenatal care
9 is the most important part of it and I do know,
10 obviously, it's easier, as we all know, to go
11 north south in Manhattan than it is to go east
12 west, so it's not that far to go from St. Luke's
13 to Roosevelt or the concentration of where
14 deliveries are, but I think the most important
15 thing is what we talked about earlier is having
16 prenatal care available where the mothers are.
17 COUNCIL MEMBER DICKENS: Well I
18 certainly agree with you, but that was a question
19 because when they make these closures, they say
20 that there's going to be so much in savings, so
21 that's why I was trying to relate the two, get a
22 correlation between the savings that they claim
23 for the closing of these institutions and causing
24 the residents in a neighborhood to have to
25 transfer all their medical records and travel

2 significantly far versus the malpractice suits
3 that may arise out of having to do that.
4 SUSAN WALTMAN: I'm not aware of
5 the numbers, but I appreciate the point that
6 you're making.
7 COUNCIL MEMBER DICKENS: Well thank
8 you, I appreciate you taking--
9 SUSAN WALTMAN: Sorry.
10 COUNCIL MEMBER DICKENS: --the
11 question.
12 SUSAN WALTMAN: I just I don't
13 know.
14 CHAIRPERSON RIVERA: Thank you.
15 Council Member Helen Foster.
16 COUNCIL MEMBER FOSTER: A couple of
17 quick questions, and I'm going to ask you to just
18 walk me through so that I understand. Are
19 Medicaid rates that are reimbursable to hospitals
20 or physicians the same across the board or are
21 they lower or higher, depending on where the
22 physician is actually practicing? Do you know?
23 SUZANNE BLUNDI: I don't know the
24 answer to that.
25 SUSAN WALTMAN: I don't know with

2 respect to physician rates, I'm sorry.
3 COUNCIL MEMBER FOSTER: Okay. And
4 the--
5 [Crosstalk]
6 SUSAN WALTMAN: Some of the later
7 physicians--
8 COUNCIL MEMBER FOSTER:
9 [Interposing] And the reason I'm asking is I'm
10 wondering if there is a correlation between
11 reimbursement rates or in terms of higher or lower
12 in those areas where there are--and this kind of
13 ties into Council Member Dickens' question--in
14 terms of services for prenatal care and such that
15 then we're talking about saving money, but people
16 are actually traveling farther because if, in
17 fact, reimbursement rates are lower, Medicaid
18 rates are lower if you practice in Harlem as
19 opposed to the Upper East Side or things like
20 that. So that's the reason I was asking. But
21 since you don't know, does it really--
22 SUSAN WALTMAN: [Interposing] I
23 don't know how physician rates are set.
24 SUZANNE BLUNDI: They don't change
25 within the city limit--

2 [Crosstalk]

3 COUNCIL MEMBER FOSTER:

4 [Interposing] Okay. So throughout New York City,

5 the reimbursement rates are the same.

6 SUZANNE BLUNDI: That's my

7 understanding.

8 COUNCIL MEMBER FOSTER: Okay. Now

9 at HHC, have you seen an increase or decrease or

10 about the same in your medical malpractice

11 payments or--and I don't know if that's the right

12 term because you're self-insured, but payments

13 over the past five years or has it just stayed the

14 same?

15 SUZANNE BLUNDI: For fiscal year

16 2003, HHC had its highest on recorded payout for

17 medical malpractice claim settlements of almost

18 196 million, and we have brought that down

19 considerably last year to approximately 139

20 million.

21 COUNCIL MEMBER FOSTER: And does

22 that include--and well I should say and I assume

23 that includes across the board HHC, so for the

24 services you provide at Rikers, everything.

25 SUZANNE BLUNDI: It wouldn't

2 include correctional health.

3 COUNCIL MEMBER FOSTER: It would

4 not.

5 SUZANNE BLUNDI: It would not.

6 COUNCIL MEMBER FOSTER: So this is

7 just--

8 SUZANNE BLUNDI: [Interposing] This

9 is HHC, that's a--correctional health is a city

10 Department of Health. When--

11 [Crosstalk]

12 COUNCIL MEMBER FOSTER: Okay. I--

13 go ahead, I'm sorry.

14 SUZANNE BLUNDI: It's my

15 understanding that when an inmate comes into a

16 facility, be it Elmhurst or Bellevue, that's HHC,

17 but when they're at--

18 COUNCIL MEMBER FOSTER:

19 [Interposing] At a--

20 [Crosstalk]

21 SUZANNE BLUNDI: Right, it used to

22 be years ago that that was all HHC, but now it's

23 Correctional Health, which is separate.

24 COUNCIL MEMBER FOSTER: Okay. And

25 obviously, I guess I'm thinking years ago when it

2 was that way. And specifically, you said 2003 you
3 quoted?
4 SUZANNE BLUNDI: Fiscal year 2003.
5 COUNCIL MEMBER FOSTER: Fiscal.
6 And of that number, what percentage if you know
7 was--okay.
8 SUZANNE BLUNDI: I do not know how
9 much of that was ob-gyn.
10 COUNCIL MEMBER FOSTER: All right,
11 thank you.
12 CHAIRPERSON RIVERA: Thank you very
13 much. We now go back to Council Member Elizabeth
14 Crowley.
15 COUNCIL MEMBER CROWLEY: Thank you
16 to both our chairs, I'll be brief, but just wanted
17 to follow up just a few short questions to HHC.
18 Do you know the percentage of Medicaid cases you
19 have versus private insurance that come into your
20 HHC hospitals?
21 SUZANNE BLUNDI: I don't know, I do
22 know that 70% of all our clinic patient visits are
23 uninsured.
24 COUNCIL MEMBER CROWLEY: Does that
25 mean that they have Medicaid or they don't even

2 have Medicaid?

3 SUZANNE BLUNDI: Uninsured means

4 not--

5 [Crosstalk]

6 COUNCIL MEMBER CROWLEY:

7 [Interposing] But everybody who is seeking

8 prenatal treatment is covered by Medicaid in the

9 city.

10 SUZANNE BLUNDI: I am not sure that

11 that's accurate. I don't believe undocumented--

12 COUNCIL MEMBER CROWLEY:

13 [Interposing] If they fall into the income

14 brackets.

15 SUZANNE BLUNDI: I don't believe

16 undocumented individuals, but that reimbursement

17 is not my area, so I'm sorry.

18 COUNCIL MEMBER CROWLEY: With the

19 closing of hospitals throughout the city, have

20 your clinics experienced higher volume?

21 SUZANNE BLUNDI: Yes, as have all

22 of our facilities, Bellevue has seen an increase

23 in emergency room presentations, Elmhurst Queens

24 as well.

25 COUNCIL MEMBER CROWLEY: Has this

2 impacted the quality of care that HHC delivers?

3 SUZANNE BLUNDI: I don't believe

4 so.

5 [Crosstalk]

6 COUNCIL MEMBER CROWLEY: Just in

7 terms of your being self-insured, you as a

8 hospital that--and as a system that self-insures

9 itself, the city is insuring the work that the

10 doctors are doing.

11 SUZANNE BLUNDI: Well I would draw

12 distinction between the city because unlike, let's

13 say NYPD, you know, it's not coming out of the

14 City budget, it comes out of the monies that HHC

15 has.

16 COUNCIL MEMBER CROWLEY: It's

17 tracked, but it goes through the Corporate Council

18 of the City of New York.

19 SUZANNE BLUNDI: It does not.

20 COUNCIL MEMBER CROWLEY: Does not.

21 SUZANNE BLUNDI: It does not.

22 COUNCIL MEMBER CROWLEY: Is it

23 such--

24 SUZANNE BLUNDI: That change is

25 part of our initiative.

2 COUNCIL MEMBER CROWLEY: Are there
3 separate guidelines, if I was to sue HHC hospital
4 as opposed to a private hospital with different
5 private insurance, is there a certain amount of
6 rights that one gives up as a patient in an HHC
7 hospital?
8 SUZANNE BLUNDI: I don't believe
9 so.
10 COUNCIL MEMBER CROWLEY: No, not in
11 terms of the length of time when one could file a
12 lawsuit?
13 SUZANNE BLUNDI: [Interposing] We
14 are covered by the notice of claim and the statute
15 of limitations that affects municipal entities,
16 yes. As far as OB care, baby care, for all birth
17 cases, there's a 10-year statute of limitations,
18 whether or not you deliver at an HHC facility or--
19 I don't want to name another private, but a
20 private.
21 COUNCIL MEMBER CROWLEY: Right,
22 right, right. And can Greater Hospital New York
23 speak to that? Is there a difference that you see
24 in terms of the coverage of liability that the
25 city has versus a private liability for a private

2 hospital?

3 SUSAN WALTMAN: I apologize, I'm
4 not quite sure the question is. I do, you know,
5 the distinction that I have always seen is what
6 Suzanne--Ms. Blundi mentioned about the notice,
7 the early notice requirement.

8 COUNCIL MEMBER CROWLEY: Is there
9 any difference with court settlements or
10 settlements prior to going to trial? Is the
11 malpractice incidents greater at a hospital that
12 is a public entity versus a private entity? Are
13 the payouts greater at a private hospital versus a
14 public?

15 SUSAN WALTMAN: I don't have those
16 data, and I apologize but I do draw attention
17 going back to what you will hear more about and it
18 is the active case conferencing, the judge-
19 directed negotiation which began with HHC in the
20 vision of Judge McKeon and HHC with respect to
21 starting in certain boroughs, and it is something
22 that we really encourage expanding because it
23 reduces the cost of the claims resolution process.
24 And so we hope what they had the vision to develop
25 and which helped reduce their costs will be

2 expanded even more than it has now to the private
3 hospitals for--
4 [Crosstalk]
5 SUZANNE BLUNDI: [Interposing] I
6 think that one of the things that we're known for
7 in the area is that we willingly settle matters
8 early and even aggressively, it's part of our--the
9 fiber of who we are to acknowledge when we've made
10 an error and try to get reasonable compensation to
11 that patient as quickly as possible, and that's
12 something that we're seeing emulated by private
13 hospitals.
14 COUNCIL MEMBER CROWLEY: Right,
15 I've read that that actually brings down
16 malpractice costs--
17 [Crosstalk]
18 SUZANNE BLUNDI: [Interposing] Yes,
19 and not only do we believe directly, you know, but
20 also the costs associated in defending or
21 litigating case. The costs for us with regards to
22 attorney fees, the cost to the court systems with
23 regards to carrying the case on its calendar.
24 COUNCIL MEMBER CROWLEY: But with
25 HHC knowing that many private practitioners are

2 stopping in certain areas, the cities, certain
3 neighborhoods and that women have to travel
4 further distance, part of what my colleague Inez
5 Dickens was going into, do you see that as a
6 problem, health care crisis problem where you
7 would be willing to, as an entity, HHC, work with
8 private doctors to keep them in the neighborhoods
9 that they're practicing so that the malpractice
10 insurance rates are not driving them out or
11 whatever, whether it be the Medicaid
12 reimbursements? We want to make sure that these
13 practitioners are practicing in neighborhoods
14 close to people in need.
15 SUZANNE BLUNDI: We are governed by
16 our enabling statute and we can do what we can do,
17 which is provide health care for all residents of
18 New York, and I think that's something that, you
19 know, could we do more? With more money we could
20 definitely do more, and we would love to do more.
21 We take that commitment very seriously. But you
22 know--
23 COUNCIL MEMBER CROWLEY:
24 [Interposing] No, I know you do and I really
25 appreciate you being here today testifying, both

2 HHC and the Greater New York Hospital Association,
3 so thank you for the good work that you do. No
4 further questions.
5 SUZANNE BLUNDI: Thank you.
6 CHAIRPERSON RIVERA: Thank you very
7 much. We have Council Member Inez Dickens for
8 another follow up, and if anyone else has any
9 questions, please keep them short, we do have an
10 extensive list of people testifying today, we want
11 to give them the opportunity to testify as well.
12 Thank you. Inez.
13 COUNCIL MEMBER DICKENS: Thank you,
14 I just wanted to get clarity on my colleague's
15 initial question that's about undocumented
16 patients. HHC does apply for insurance for them
17 that follows an undocumented patient during
18 pregnancy from the time they come in until
19 childbirth, is that correct? Only, I mean, I know
20 at that point, they're given over to family
21 planning.
22 SUZANNE BLUNDI: I can only tell
23 you that--and I apologize that I'm outside my
24 scope of Medicaid rules and regs--obviously, if
25 someone is eligible for emergency Medicaid, we

2 would want to get that for them. I do know that
3 that's an area that's under review, what qualifies
4 for emergency Medicaid and how long someone can
5 stay on that, but more than that I wouldn't want
6 to be misleading.
7 COUNCIL MEMBER DICKENS: Well they
8 can stay on it, at least my understanding, until
9 they give birth. Afterwards, they're now no
10 longer on it, the child though would continue on--
11 SUZANNE BLUNDI: Right.
12 COUNCIL MEMBER DICKENS: --am I
13 correct? Thank you. And so I just wanted to get
14 clarity and make sure I understood.
15 SUZANNE BLUNDI: Yes, thank you.
16 COUNCIL MEMBER DICKENS: Thank you
17 so much, and thank you for your testimony.
18 CHAIRPERSON RIVERA: Thank you.
19 Seeing no other questions, thank you very much.
20 We've also been joined by Council Member Gale
21 Brewer. We'll now move on to the next panel,
22 thank you.
23 The next panel comprises of Leslie
24 Kelmachter, I hope I pronounced it correctly, also
25 Christie Rich and John Singleton, Mary Anne

2 Walling, and Elizabeth Colin.

3 [Off mic]

4 LESLIE KELMACHTER: I believe

5 somebody's going to bring them up in a moment.

6 FEMALE VOICE: Thank you.

7 CHAIRPERSON RIVERA: Again, it's

8 Mary Anne Walling, Christie Rich and John

9 Singleton, we have Leslie up there, and Elizabeth

10 Colin.

11 [Off mic]

12 CHAIRPERSON RIVERA: Do we need

13 more seats up there?

14 [Off mic]

15 CHAIRPERSON RIVERA: Okay.

16 Whenever you're ready, you just state your name

17 for the record and provide your testimony. Thank

18 you.

19 LESLIE KELMACHTER: My name is

20 Leslie Kelmachter.

21 CHRISTIE RICH: My name is Christie

22 Rich.

23 JOHN SINGLETON: John Singleton.

24 CHRISTIE RICH: And John Jr.

25 MARY ANNE WALLING: And Mary Anne

2 Walling.
3 CHAIRPERSON RIVERA: Okay. You may
4 begin.
5 LESLIE KELMACHTER: My name is
6 Leslie Kelmachter and I'm President of the New
7 York State Trial Lawyers Association. I am
8 testifying today on behalf of our 4,000 members
9 and their hundreds of thousands of clients. I'm
10 here to give the patient's point of view on issues
11 that are being discussed today, and I want to
12 thank the Chair for inviting us to speak at this
13 hearing.
14 NYSTLA has always supported efforts
15 to improve access to affordable health care
16 services, and the issue of access to obstetrical
17 and gynecological care is of special importance to
18 me. We have also supported comprehensive
19 solutions to help stop medical mistakes before
20 they happen, which hospitals and doctors in New
21 York City have proven can improve patient outcomes
22 and lower the cost of medical malpractice.
23 NYSTLA also believes, however, that
24 as we work to find ways to improve the health care
25 delivery system, we must not sacrifice the civil

2 justice rights of patients who have become victims
3 of preventable medical errors, especially those
4 whose injuries mean a lifetime of pain and
5 constant care.
6 The City Council must approach this
7 complex issue with all facts at hand.
8 Unfortunately, many of the assumptions in Council
9 Resolution 84-A are misleading and create the
10 false impression of a malpractice insurance
11 crisis--one which lobbyists for the health care
12 industry say demands that we significantly curtail
13 the rights of the tens of thousands of patients
14 who are hurt or even killed by inexcusable medical
15 errors. There is no medical malpractice crisis in
16 New York.
17 First, New York as a whole is not
18 experiencing a shortage of ob-gyn practitioners.
19 In fact, New York has the third highest ratio of
20 ob-gyns to the population of any state. According
21 to a SUNY Albany Center for Health Workforce study
22 estimate, this ratio is projected to increase.
23 From 2006 to 2030, the demands of ob-gyns is
24 projected to rise by .9%, while the supply will
25 rise by 5.1%.

2 Nor is the rate of malpractice
3 insurance premiums seeing exponential growth.
4 According to a report from Public Citizen, between
5 1991 and 2007, the average annual premium increase
6 in New York State was 3.5%--far less than the
7 overall rate of health care cost inflation. In
8 2008 and 2009, New York's medical malpractice
9 insurance premiums were unchanged, and in 2010 the
10 State's Department of Financial Services approved
11 an increase of only 5%. In 2011, both the Medical
12 Liability Mutual Insurance Company and Physicians
13 Reciprocal Insurers, which together insure the
14 vast majority of New York physicians, approved a
15 7.5% claims-free discount, which will benefit over
16 half of their insured physicians.
17 Contrary to Resolution 84-A,
18 malpractice costs are not driving significant
19 numbers of doctors away from our state. Every
20 year, the SUNY Albany Center for Health Care
21 Workforce Studies conducts an annual survey of
22 graduating residents. Of those who are planning
23 to leave New York State, only 1% responded that
24 the main reason for doing so is the cost of
25 medical malpractice insurance in New York.

2 In addition, recent legislation
3 enacted in Albany--which has been discussed here
4 today--is already set to lower malpractice premium
5 costs for New York ob-gyns. According to the
6 Greater New York Hospital Association and the
7 Medical Indemnity Fund for Neurologically Impaired
8 Newborns, established in 2011, could reduce
9 insurance costs for hospitals by as much as 20%.
10 As we have heard today, access to
11 high quality obstetrical and gynecological care in
12 low income and minority areas continues to be
13 woefully inadequate. But what is the driving
14 problem? Liability insurance costs are not a
15 barrier to health care access in New York. There
16 is little evidence that doctors' decisions on
17 where to practice are determined by malpractice
18 insurance costs. Medical malpractice insurance
19 premiums are higher in New York City and the
20 surrounding communities than upstate New York, but
21 according to the SUNY Albany Center for Health
22 Workforce Studies Annual New York Physician
23 Workforce Profile, in 2009 there were 29% more
24 physicians per population downstate than upstate.
25 In Nassau County, which has the highest

2 malpractice insurance premiums in the state, there
3 were 85% more physicians per population than in
4 upstate communities.
5 Health care disparities for low-
6 income and minority patients are a nationwide
7 problem and New York City is far from unique in
8 this regard. But state health care policy clearly
9 contributes to the problems we are hearing about
10 today. In 2009, 75% of all deliveries in the
11 Bronx, for example, were funded by Medicaid or
12 Family Health Plus, compared to 45.7% statewide.
13 Yet in 2008, New York had the 47th lowest Medicaid
14 obstetrical care fees, according to the Kaiser
15 Foundation State Health Facts. From 2003 to 2008,
16 Medicaid reimbursement rates for obstetrical care
17 increased 8.8% nationwide, but were unchanged in
18 New York, even as costs for doctors providing such
19 care continued to rise.
20 Since 2008, Albany has raised
21 Medicaid reimbursement rates for obstetrical care,
22 but many years of having some of the lowest rates
23 in the country have had an enormous impact on
24 providers of ob-gyn services in low-income areas,
25 and reimbursement rates are still far too low.

2 Liability premiums could be reduced
3 now. Although malpractice insurance costs are not
4 the driver of health care disparities or doctor
5 shortages, NYSTLA continues to support initiatives
6 to lower these costs that do not sacrifice the
7 rights of patients. There is every indication, in
8 fact, that the rates for New York practitioners
9 could be lowered right away without any changes to
10 health care policy. In 2010, the Medical
11 Liability Mutual Insurance Company, which insures
12 most of New York's doctors, ran a surplus of $837
13 million, up from $491 million in 2009 and $162
14 million in 2006. And while the number of
15 malpractice claims has continued to drop, MLMIC's
16 new 7.5% discount rate for safe doctors is a good
17 start, but there should be more reductions in
18 premium prices immediately.
19 Curbing medical errors is the best
20 way to save money, but the biggest driver of
21 malpractice insurance costs is the tragic and
22 preventable medical errors themselves. Numerous
23 recent studies indicate that rates of hospital and
24 doctor error can be significantly reduced simply
25 by implementing rigorous patient safety programs

2 and common sense measures like checklists and
3 mandatory hand-washing. According to an article
4 in the American Journal of Obstetrics and
5 Gynecology, a comprehensive safety program
6 implemented from 2003 to 2009 at New York
7 Presbyterian-Weill Cornell Medical Center reduced
8 yearly obstetric-related malpractice payments by
9 99%, saving $25 million a year while dramatically
10 reducing maternal and fetal injuries--and this has
11 been, of course, discussed here today. The
12 program included steps as simple as enhanced
13 communication among staff, improved medical record
14 charting, standardized staffing requirements,
15 proper training and supervision, and stricter
16 controls on the use of dangerous medications.
17 The Hospital Corporation of
18 America, a nationwide chain of hospitals,
19 implemented a comprehensive redesign of patient
20 safety processes in obstetrics that more than
21 halved--excuse me--that more than halved the
22 numbers of obstetrical claims against HCA
23 facilities and resulted in nearly a fivefold
24 reduction in the costs of claims, and this is
25 according to an article in the American Journal of

2 Obstetrics and Gynecology. In this nation's
3 health system, with nearly 200 hospitals
4 nationwide, obstetric malpractice claims currently
5 ranks behind accidents on the hospital grounds in
6 terms of litigation loss and cost, according to
7 that study's authors.
8 If New York Presbyterian-Weill
9 Cornell and HCA can do this, so can others.
10 Unfortunately, many New York hospitals have a long
11 way to go when it comes to leadership in patient
12 safety. The annual HealthGrades Patient Safety in
13 American Hospitals Study, both for 2010 and 2011,
14 ranked New York as one of the ten worst states for
15 hospital patient safety. And in 2010, the U.S.
16 Agency for Healthcare Review and Quality reported
17 its annual National Healthcare Quality Reports
18 that New York State's hospital care quality is
19 weak, based upon how well hospitals performed on
20 31 measures of care quality.
21 So in conclusion let me state, we
22 can do better than this. The New York State Trial
23 Lawyers Association stands ready to work with
24 elected leaders in the City Council and partners
25 in the health care industry to find ways possible

2 to improve patient safety, increase quality of
3 care, and as a result, lower medical--excuse me--
4 lower medical malpractice costs and greatly
5 improve patient outcomes.
6 And let me just say because this
7 came up today, that the notion of caps on the pain
8 and suffering of victims of medical malpractice
9 disproportionately prejudices children and women
10 who are the subject of this hearing.
11 Thank you so much to Council
12 Members for the chance to submit this testimony
13 and the chance to allow us to share our voice in
14 this very important issue. Thank you.
15 CHRISTIE RICH: Okay. Good
16 afternoon, member of Council, I'd like thank you
17 for allowing us to speak and hear our story. I'm
18 no health expert, I have no statistics to give
19 you, I'm just a mother, will like to share my
20 story.
21 CHAIRPERSON FERRERAS:
22 [Interposing] I'm so sorry, before you proceed, we
23 would like to know your name for the record.
24 CHRISTIE RICH: [Interposing] Oh,
25 I'm sorry, Christie Rich--

2 CHAIRPERSON FERRERAS: Thank you.

3 CHRISTIE RICH: --I reside in

4 Staten Island. This is my family, and while I was

5 pregnant I had unexplained bleeding and I was

6 discharged in hospital five times. I gave birth

7 at 26 weeks and I gave birth to extremely

8 prematurely twins, a boy and a girl. My daughter

9 survived only two months. John has been diagnosed

10 with spastic quadriplegic cerebral palsy, he has a

11 feeding tube, he cannot talk, he cannot walk, he

12 has no trunk control, and it's very difficult.

13 His father and I take turns taking care of him. I

14 am a New York City correction officer for 23

15 years, I can't retire, it's very difficult on one

16 household income.

17 My son does not qualify for a

18 nurse. I would like to share something with you.

19 John requires specialized care and it's just been

20 very difficult. I suspect my children's premature

21 birth and John's condition is caused by negligence

22 of the doctor.

23 Right now, the case is still

24 pending. A lot of the expenses are being paid out

25 of pocket. We have a very problems with the

2 insurance company. My son been denied a chair to
3 sit in; my son cannot sit in a conventional chair,
4 okay, because he can aspirate. My son has seizure
5 disorders, I worry that he would choke while
6 having a seizure. You know, it's just very
7 difficult, and it's going to be difficult for the
8 rest of our lives.
9 That's all I have to say. I just
10 want you to think about and remember John. Thank
11 you.
12 CHAIRPERSON RIVERA: Does your
13 husband want to say a few words also or…?
14 JOHN SINGLETON: Yes, my name is
15 John Singleton, I don't have a PowerPoint, I have
16 my son, as you see. She basically touched on
17 everything.
18 It's a long fight, and we're
19 struggling. And you know, with these proposals or
20 whatever they want to do with these--excuse me,
21 I'm sorry--with the putting caps on liability for
22 malpractice, I don't think it's fair. No one,
23 unless you're going through this, you'll
24 understand. Just imagine you just breaking your
25 leg and you got to take off of work, and you take

2 off of work for a couple weeks, that costs you.

3 We have something that's going to

4 be for the rest of our lives, something he has to

5 deal with. And I don't think it's--I'm not

6 looking for the taxpayers to foot the bill, I'm

7 not asking for nothing, I'm asking for what's

8 right and what my son is entitled to. And there

9 was some negligence. And basically, we just need

10 help, for us and other families that's going

11 through this, 'cause there's many more that's not

12 up here, that is not speaking or don't have a

13 voice, and we just need help.

14 And to pass something that's decent

15 for human beings, I mean, he has a right to live,

16 it wasn't his fault. I went in with twins in a

17 hospital, I come out with one--we came out with

18 one, and a son with cerebral palsy. Yes, sir.

19 I don't want to spend too much

20 time--

21 [background noise]

22 JOHN SINGLETON: but whatever you

23 can do or--

24 [background noise]

25 CHRISTIE RICH: --Okay, John, okay,

2 okay.

3 JOHN SINGLETON: He wants all of my

4 attention.

5 CHRISTIE RICH: Yes, yes, it's his

6 two cents in.

7 JOHN SINGLETON: And that's all I

8 have to say, thank you, appreciate it.

9 CHAIRPERSON FERRERAS: Thank you

10 very much for your testimony, I know that it is

11 not an easy one, and I'm sorry that you have to

12 give it, but I'm glad that you're here to give it.

13 I just wanted to say thank you, and we're going to

14 hear--I don't know if you--you know, I'm sure my

15 colleagues will have questions and maybe one of

16 you can choose to sit there, I don't want--

17 JOHN SINGLETON: Okay, okay.

18 CHAIRPERSON FERRERAS: --I want to

19 be the most comfortable for you--

20 JOHN SINGLETON: Okay.

21 CHAIRPERSON FERRERAS: --whatever

22 is more comfortable for you, you're more than

23 welcome to stay. We're going to have the two

24 other panelists give their testimony, but we would

25 love to have you stay, so if there's any questions

2 for you specifically, okay?

3 JOHN SINGLETON: Thank you.

4 CHAIRPERSON FERRERAS: Thank you.

5 JOHN SINGLETON: Appreciate it.

6 [Off mic]

7 JOHN SINGLETON: Okay. I'm going

8 to go out--

9 [Crosstalk]

10 CHRISTIE RICH: Okay. Go ahead.

11 JOHN SINGLETON: So thank you.

12 CHAIRPERSON FERRERAS: Bye, John.

13 [Off mic]

14 MARY ANNE WALLING: --PowerPoint.

15 MALE VOICE: You need the

16 PowerPoint--

17 [Crosstalk]

18 MARY ANNE WALLING: Good afternoon,

19 my name is Mary Anne Walling--

20 [Off mic]

21 MARY ANNE WALLING: Okay. I'm an

22 attorney, a partner with the law firm of Sullivan,

23 Papain, Block, Mcgrath & Cannavo, and I represent

24 victims of malpractice, but you also need to know

25 that I graduated from Hunter-Bellevue School of

2 Nursing in 1971 and practiced nursing up until
3 1987. My last job was at Jacobi Medical Center,
4 and I did research in the burn ICU. So I believe
5 that entitles me to have a unique perspective on
6 both sides of this debate. I have empathy and
7 understanding on both sides.
8 Now a lot of what I'm going to say
9 today you've heard on, and I apologize for any
10 repetition. Okay. Click to... So we've started
11 with the PowerPoint already, okay. You're going
12 to have to do this. Let me just--I'll just speak
13 as we go. As this Council knows, maternal
14 mortality in New York state surprisingly, and in
15 New York City, is among the highest rate in the
16 country, which you wouldn't expect, not for New
17 York.
18 With respect to medical errors, as
19 has already--Councilman Crowley said, in 1999, the
20 Institute of Medicine reported that there were
21 98,000 deaths and over 1 million injuries on
22 average per year in this country, which is
23 surprisingly; but more significantly, 90% of them
24 approximately were due to failed systems and
25 could've been prevented. Now in response, there

2 was a major initiative that over the next ten
3 years was proposed to address this. And
4 unfortunately, ten years later in what was then
5 published in the New England Journal of Medicine,
6 it found that harm resulting from medical care
7 remains to be very common, and it found that it
8 was--okay, which one, sorry?
9 [Off mic]
10 MARY ANNE WALLING: Space bar, oh.
11 It found that it was disappointing, but not
12 surprising, that there hadn't been a significant
13 increase because there was only a modest attempt
14 to put in the evidence-based safety practices that
15 we knew were--could've made the difference. Okay.
16 So with respect to New York state,
17 unfortunately, we know that the U.S. Department of
18 Health and Human Services has identified us as a
19 weak performer. We also know that we have been
20 ranked--let's see if I can do this--we have been
21 ranked 36th out of 51 states in quality
22 performance when it came to hospital care. The
23 Annual HealthGrades Patient Safety in American
24 Hospital surveys put New York at the bottom ten of
25 states.

2 So what's the answer? I
3 respectfully submit to you the answer is not to
4 restrict the victims' access to the legal system
5 or even to limit the system's ability in
6 malpractice cases to make the victim whole.
7 Rather, quite frankly, the moral, ethical, and
8 practical way to address this problem is to
9 prevent the errors in the first place, and as a
10 result, you'll decrease the victims, you'll
11 decrease the harm, you'll decrease the
12 compensation, and therefore, premiums should come
13 down.
14 Now we know this can be done
15 because it is being done. Since this Council is
16 most concerned with ob-gyn, I'm going to really
17 concentrate on those efforts in the ob-gyn arena.
18 But we know that it started in anesthesia, we know
19 they took a big page out of the airline industry
20 at looking at checklists. You watch TV and you
21 know about time outs before surgery; you see that
22 what we need are systems and protocols that can be
23 enforced. Steven Clark in the American Hospitals
24 Corporation which you happen to know is in 21
25 states, and I believe it's over 200 hospitals, not

2 all big medical centers associated with
3 universities, but some are small, just like in
4 Queens, like in the Bronx. All ranges, what the
5 Health Care Corporation did was before 2008 put in
6 a very strict and mandated program for its ob-gyn
7 practices. As a result, they had a fivefold
8 decrease in the cost of claims. In 2011, Dr.
9 Clark came back to show in his publication, the
10 American Journal of Obstetrics and Gynecology,
11 that in fact, they were sustaining the efforts and
12 sustaining the reductions.
13 The Joint Commission Journal on
14 Quality and Patient Safety reported that in
15 Cincinnati at the Healthcare Partners, which is 16
16 centers in providing ob-gyn care, that when they
17 put in a systemic and enforced program, they had a
18 65% decline from 2003 to 2008 in birth-related
19 injuries. And, thus, there was a reduction from 1
20 million to less than 500,000 per cost per OB and
21 new claims reduced to 48%.
22 Now closer to home is what a lot of
23 us have been hearing about: The efforts at New
24 York Presbyterian Hospital, and New York
25 Presbyterian Hospital, which is now Cornell and

2 Columbia, they not only have private patients, but
3 they have a very poor population. And what they
4 did was, similar to Dr. Clark, they put in a
5 program of OB safety and they started in 2003 and
6 published recently in 2011 in the American Journal
7 of Obstetrics and Gynecology, and what they found
8 was they reduced their events dramatically.
9 Now just to look at what they did,
10 the key elements, there was an interdisciplinary
11 team training first focusing on better
12 communication. Now not only do these efforts
13 reduce claims and what we call sentinel events,
14 adverse outcomes, but when you have these kinds of
15 efforts made, you have satisfaction among the
16 entire health care team, and what they find is
17 that you have less over--turnover of nurses,
18 physicians, physicians assistants, all the people
19 that you have to have a stable team. They had
20 obstetric emergency drills, so they actually
21 practiced, not unlike practicing for a fire drill.
22 What happens if a baby becomes stuck in the
23 mother's canal, called shoulder dystocia? Or if
24 there is an event where the baby becomes severely
25 oxygen deprived? So they were trained, they knew

2 what to happen.
3 Electric medical record charting
4 for all patients in labor and delivery was put
5 into force. And if we do, in fact, have those
6 remote prenatal care centers with a centralized
7 hospital, electronic medical records are going to
8 make all of your concerns about getting the
9 records from the clinic over to the hospital at
10 the time of birth, it'll all be there on the
11 computer, it will all be there that can be
12 remotely access.
13 The most important thing that I
14 think, as a former nurse, was a clear chain of
15 communication from the nurse up to the chairman of
16 the department. Every member of the team is, not
17 only allowed, but expected to speak up if there is
18 an unsafe practice. When I taught nursing, I used
19 to say to my students we learn that skin is the
20 first line of defense for the body, but when the
21 patient comes into the hospital, you, the nurse,
22 are the first line of defense 'cause you're at the
23 bedside. Well this sort of takes the same
24 approach. Everybody in the health care team will
25 know that they will not be chastised, they will

2 not be reprimanded if they speak up. Then the
3 drugs oxytocin, which is a stimulant or an
4 augmentation for labor, they made sure that they
5 were specific, specific guidelines before they
6 could be used, and also when they were putting
7 certain medications together, it's very easy to
8 have medication errors, not only with the
9 medication, but as well as the concentration, they
10 made them be color-coded. They employed an
11 obstetric patient safety nurse who was there to
12 enforce drills, implementation of protocols, et
13 cetera. Three new physicians and a laborist,
14 which is a physician, who would be there all the
15 time. Electric fetal monitoring interpretation
16 certification was required, and this was
17 mandatory, and it's very important in the
18 obstetrical area. And then if a patient was going
19 to have a C-section, there was routine orders for
20 preventing clots. And then retrospective review
21 of every compensation payment or every adverse
22 outcome to see what did we do wrong, what can we
23 do better.
24 What is the result? It's already
25 been touched on in previous speakers, but it

2 brought it down significantly. And has continued
3 to do so.
4 So New York Presbyterian, in their
5 American Journal of Obstetrics article, said that
6 they show that implementing a comprehensive
7 obstetric safety program, not only decreases
8 severe adverse outcomes, but can also have an
9 immediate impact on compensation. Okay.
10 Now CRICO, CRICO is a medical
11 malpractice insurance company that is located in
12 Massachusetts. It is the controlled risk
13 insurance company which is owned and serving the
14 Harvard health care system. Jock Hoffman, Patient
15 Safety Education Director, has said frivolous
16 malpractice suits are really less common than
17 politicians espousing them would have us believe.
18 He has advocated that, rather dwelling on
19 frivolous bogeymen, politicians and health care
20 providers will be likely to be more successful at
21 reducing patient injuries, therefore, costs, and
22 lawsuits by studying the underlying causes. His
23 vice president of loss prevention, Robert Hanscom,
24 has said, I don't think that the answer is for
25 caps, rather, we need to provide a higher reliable

2 and enforceable as possible--I'm sorry, safety
3 environment for our patients. So what they did,
4 in order to do this, was they put into practice a
5 compensation reduction program. If the hospital
6 put together a program which was enforceable
7 similar to that at Columbia Presbyterian and it
8 was successfully completed by the obstetrician,
9 they would get a reduction in their premium, but
10 they had to complete successfully the program.
11 Now this had been preceded by the anesthesia
12 program, and I know we're not here to talk just
13 about anesthesia, but since many women who have
14 deliveries do get a degree of anesthesia, it's
15 important to know that the anesthesiologists
16 actually were proactive and they asked CRICO to
17 put together a program and eventually, over a
18 matter of years, those who were able to complete
19 it successfully had a 19% reduction in their
20 premiums.
21 Now with respect to obstetrics,
22 what they did was they offered a carrot. To those
23 ob-gyns who can pass the program with an 85% or
24 higher completion rate, they get a 10% reduction
25 in their premium, which you can see on the next

2 slide.

3 At Boston--sorry, at Beth Israel
4 Deaconess Medical Center, which is one of their
5 central hospitals there, they found that by having
6 a training and implementation, their adverse
7 outcomes showed a 55% drop over the very same year
8 that it was put into implementation.

9 Now I won't go over this, but you
10 know that Health and Hospital Corporation has also
11 reported that when they put in their efforts in
12 decreasing malpractice and looking at events, they
13 too have had a significant decrease in the number
14 of tort claims, and I believe it was reported as
15 low as 26% reduction. And another carrier is MCIC
16 of Vermont, which also established a loss
17 prevention program in obstetrics, pediatrics,
18 emergency care, and neurosurgery, and it began in
19 2004, and as a result of safety culture and
20 enforced policies, they also had a significant
21 reduction.

22 So I respectfully submit to you the
23 answer to New York and New York City's present
24 public health concern regarding the level of care
25 to all of its citizens, but in particular to

2 women, is one that requires safe and effective
3 care being given in clear and unambiguous policies
4 and procedure. It requires a system based on
5 programs of safety and these programs must include
6 education; enforceable policies that are
7 unambiguous; and procedures, communication, and
8 teamwork where no person is afraid to speak up
9 and, in fact, is expected to speak up; where each
10 bad outcome is studied and learned from so it can
11 be implemented into a future systemwide correction
12 to prevent any reoccurrence.
13 Medical malpractice carriers are
14 doing this in Massachusetts, as well as
15 Connecticut. Health care corporations negotiated
16 premium incentives for its attendings, those who
17 successfully completed their program. For its
18 employees, it was mandatory to complete these
19 programs as a condition of employees, but for
20 their attendings, who they could not, they used
21 the carrot, which was incentives for reducing
22 their premiums.
23 And we know that the claims and
24 numbers of payouts will be reduced. We know this
25 can be done. It can be done and you still will

2 protect your citizens, but for those who are
3 harmed, they will still be allowed access to the
4 legal system and fair and just compensation.
5 Thank you.
6 ELIZABETH COLIN: I'll refer to my
7 notes, if you don't mind. And excuse me in
8 advance if I have to pause, which, after listening
9 to the heart rendering testimony, I could hardly
10 speak.
11 My name is Liz Colin and I thank
12 you for letting me share my testimony with you. I
13 am someone who has been affected by malpractice
14 and I know how this can turn a family's life
15 upside down.
16 In 2004, I saw three doctors after
17 feeling a lump in my breast. I had a mammogram,
18 but the doctors assured me that everything was
19 fine and that I should come back in a year for a
20 routine visit. After a few months, the lump got
21 bigger and I went back to my doctor, who finally
22 referred me to a breast surgeon. By that point,
23 there was a spot on my spine and I was told that I
24 may have stage IV cancer. Because of the concern
25 about the advanced stage of the cancer, the

2 doctors were not sure that I was even a candidate
3 for chemotherapy. I never thought that I would be
4 praying to be able to at least have that therapy,
5 which I did in fact have.
6 What I went through next I would
7 not wish on anybody. Throughout the next nine
8 months, I endured surgery, radiation, and
9 chemotherapy. My singular focus was getting
10 through these enervating treatments, anxiously
11 hoping that they were not in vain. It wasn't
12 until I finished months of chemo, followed by
13 weeks of radiation therapy, that I thought I may
14 be the victim of malpractice.
15 I hope that I'll have years ahead
16 to enjoy my family and I am very fortunate that I
17 reached the age of 60. Five years ago, I said, I
18 can't wait 'til I'm 60 'cause at least I will have
19 had those years. But I know that many people are
20 not so lucky. I truly cannot fathom what it would
21 be like to have gone through what I did and have a
22 young family and not be able to take care of them
23 properly and worry that you might not be there for
24 them. Many women younger than I do not make it
25 because they are treated negligently--thank you--

2 they are treated negligently by their doctors, and
3 it's unimaginable to think that they and their
4 families might not have recourse.
5 I hope that, whatever the outcome
6 of this hearing, it does not include further
7 injustice to those who have already suffered
8 terribly from malpractice. Thank you.
9 CHAIRPERSON RIVERA: Thank you very
10 much. The first line of questions will be from
11 Council Member Crowley.
12 COUNCIL MEMBER CROWLEY: Thank you
13 to our chairs. My heart goes out to both
14 Elizabeth and Christie for your experience,
15 clearly, from what you've said, you've experienced
16 medical malpractice. And by no means is this
17 resolution that was introduced trying to diminish
18 your malpractice, or earlier you're heard from the
19 trial lawyers saying that this was calling on
20 caps. There's nowhere in this resolution that we
21 call for caps on malpractice.
22 What we want to do is prevent
23 future malpractice cases and that's why we're
24 having this hearing today. We understand and, you
25 know, there could be a disagreement on numbers,

2 but access to care is diminishing in New York
3 City, and because of that women are experiencing
4 more situations where malpractice is happening
5 because the level of care is not there. It could
6 be the Medicaid reimbursement, it could be that
7 their insurance isn't taken by the closest
8 physician that is practicing privately, but
9 clearly, in some areas of the city, especially the
10 Bronx and in Queens, there's a limited number of
11 ob-gyn and gynecologists that are practicing, and
12 those are the doctors that would be able to
13 determine whether you had breast cancer usually,
14 initially, or ovarian cancer. And they should be
15 there and they should be there to detect them, if
16 they don't, then that's their fault.
17 But if they're not there, if a
18 woman is not going once a year or when they feel
19 that they want to expand their family, then it's
20 dangerous for her health, it's dangerous for her
21 family's health as well. And my fear is that if
22 we don't do something in this city--and it is the
23 state that will have to step in--to create an
24 atmosphere where you have more private
25 practitioners practicing, because as a woman I

2 know I don't want to go to a hospital clinic for
3 health care.
4 And it seems as if there's a
5 growing number of women that have no choice but to
6 go to the hospital. And how can you have that
7 one-on-one patient relationship that you receive
8 in a smaller doctor's office and that you continue
9 to have a rapport with the doctor over a course of
10 time because you've grown to depend on your
11 doctor? Hopefully, if a woman is able to have
12 that, they don't have to travel too far to see
13 that doctor, or if they even have the ability to
14 do that.
15 But in some cases, we're seeing
16 there's s a clear problem in the city and it's a
17 scary a problem. And we're not saying that if a
18 doctor makes a mistake that he cannot be held
19 liable or that we have a system set in place that
20 could make sure that reimbursements are made for
21 pain and suffering, that's not what this hearing
22 was ever about. This hearing is about access to
23 care and the numbers that the trial lawyers are
24 presenting today as it relates to a woman and the
25 number of physicians, I don't see them as broken

2 down by neighborhoods. And it's clear there are
3 neighborhoods in this city where there are no
4 private practitioners and where women have to go
5 miles and miles to get to probably a hospital, in
6 the case of the Bronx and in a lot of parts of the
7 city, just to see a gynecologist or an
8 obstetrician. That affects her care.
9 I want to see private practitioners
10 practicing in the city, I want to see them
11 practicing safely, and I think that our state and
12 our city has to step in because there is a clear
13 problem.
14 CHAIRPERSON FERRERAS: Thank you,
15 Council Member Crowley. My question is just for
16 clarification purposes and to get it on the
17 record. How does the Medical Indemnity Fund,
18 which we hear seems to be for lifetime care, what
19 role does that play in this particular case--I
20 mean, I don't want to speak specifically of the
21 case, but I know she's here to testify--and why
22 would that not apply, or is that something that is
23 part of the process? Can you walk me through
24 this?
25 LESLIE KELMACHTER: Certainly, if I

2 may, and this is a case that hasn't been resolved,
3 but let's assume that there is a case today in the
4 system that involves a child who was born as a
5 result of birth trauma and obstetrical care with
6 regard to issues and pain and suffering as well as
7 lifetime care. Then the case would go through the
8 same course as prior to the initiation of the
9 fund, there would have to be proof of medical
10 malpractice, a deviation of standard by the
11 doctors, and if such was proven, then the child
12 and family would be entitled to the pain and
13 suffering for the child, for the past pain and
14 suffering up to the time of trial, for the future
15 pain and suffering from the time of the trial into
16 the life expectancy of the child, and the past
17 medical bills would also be something that would
18 be subject to a jury verdict.
19 What's changed is the cost of care
20 for the child going forward for a lifetime has now
21 been relegated to the Medical Indemnity Fund and,
22 since that was often, as a result of verdicts, a
23 very high number because the cost of care for
24 these traumatically injured children is very high,
25 then by having this fund which should cover all of

2 these costs regardless of the amount that is
3 attributed to the fund, then it lowers the cost
4 for the medical providers and their carriers.
5 Does that make sense? And I know that Judge
6 McKeon is probably our greatest expert on this and
7 could probably best answer any questions you have
8 with that.
9 CHAIRPERSON FERRERAS: Okay. Thank
10 you, and I will definitely hopefully have the
11 opportunity to follow up with the judge. And my
12 other question is, you know, we have met with
13 several ob-gyn, former practicing ob-gyns,
14 currently ob-gyns, and I know that the numbers
15 that were in a lot of the testimony spoke about
16 physicians per capita and how we're doing a lot
17 better. And one thing that was mentioned by
18 Council Member Crowley is very true, we don't see
19 the borough breakdown and we don't see the
20 specialty breakdown 'cause we could have a lot of
21 podiatrists, right?
22 LESLIE KELMACHTER: That's true,
23 these statistics that we've seen, and we rely very
24 heavily on what comes out of state agencies,
25 statistics show us that there is a very high per

2 capita number of ob-gyns in Long Island, in
3 Manhattan. There's certainly more than the
4 national average, even in the Bronx, Queens, and
5 Staten Island. It's a very complex issue as to
6 why doctors choose to practice in the areas that
7 they choose to practice in. Our position is, and
8 what we believe that the data supports, is it's
9 not related to the cost of medical malpractice or
10 the cost of premiums to the physicians.
11 Again, it's there are a lot of
12 different reasons doctors choose to practice in
13 the areas that they choose to practice in. There
14 are other issues, of course, in terms of the
15 overall quality of care that women receive, as
16 Council Member Crowley mentioned. And the
17 healthier a mother, or a potential mother, goes
18 into the process, the more likely you're going to
19 have a better outcome in terms of the birth of the
20 child.
21 So we support access to all women,
22 to all people in the city of New York to quality
23 health care, and we believe that the way to do
24 that is through the patient initiatives that bring
25 down preventable incidents of malpractice.

2 CHAIRPERSON FERRERAS: Now in your
3 experience is there a comparable, where it's ob-
4 gyn but that you can see that there's comparable
5 lawsuits that are brought and in different type of
6 practice, medical practice, or does this stand
7 alone? Let me rephrase my question--
8 LESLIE KELMACHTER: [Interposing]
9 I think I understand now--
10 CHAIRPERSON FERRERAS: Oh, okay,
11 good.
12 LESLIE KELMACHTER: --I think
13 you're asking if there are more lawsuits involving
14 children with traumatic brain--I'm sorry,
15 traumatic injuries at birth. I haven't seen the
16 specific statistics on that, that's something that
17 the court to some degree would be able to clarify,
18 but I don't believe anecdotally that there are
19 more cases involving children with birth injuries.
20 These are cases that, when resolved, cost more to
21 the health care providers because of the nature of
22 the injury to the children, though the Medical
23 Indemnity Fund should bring those costs down
24 substantially.
25 CHAIRPERSON FERRERAS: Thank you.

2 And I believe Council Member Crowley has a follow-
3 up question.
4 COUNCIL MEMBER CROWLEY: Just to
5 clarify. The Medical Indemnity Fund does not
6 impact a private practitioner who practices in his
7 own office or her own office.
8 LESLIE KELMACHTER: [Interposing] I
9 would disagree with that, and I did hear the prior
10 testimony, and also this is something that was
11 enacted in the 2011 legislative session and I
12 think that we need to give it time to work its
13 way. And, while I'm not an expert in insurance,
14 determinations with regard to the costs are often
15 something that occurs result of years. I mean,
16 premiums that are being paid today have to take
17 into consideration, not only what happens today,
18 but into the future. But it would appear that all
19 of the savings that are anticipated by the Medical
20 Indemnity Fund have not yet occurred, and they
21 should impact on the premiums to physicians.
22 In fact, because of the surpluses,
23 there have been discounts this year, substantial
24 discounts, to physicians and, particularly
25 physicians who have not been found liable for

2 malpractice. So we believe that there will be a
3 significant impact in reduction of premiums to
4 individual doctors.
5 COUNCIL MEMBER CROWLEY: Okay. But
6 the law was written to help the hospitals and
7 mainly saves the hospitals monies, we have yet to
8 see that it will, in fact, help private
9 practitioners.
10 LESLIE KELMACHTER: I don't know
11 that that's true, and I think that, again--
12 COUNCIL MEMBER CROWLEY:
13 [Interposing] I'm just trying to figure out how it
14 would if they're paying for a premium of $1.3
15 million for liability, which is very small, and
16 it's the hospitals that have the liability, that
17 it's very large. As what the hospital said
18 earlier, it seems that the hospitals have the
19 majority of the liability upon them and that the
20 smaller practitioners, they're not paying for much
21 in malpractice coverage, but the amount, the ratio
22 of what they're paying per year to that amount
23 seems much, much greater than a hospital is paying
24 and so I could see how the hospital saves money.
25 I'm not seeing where the, you know, overall the

2 industry and settlements, they'll probably be a
3 different amount and it'll be affected overall,
4 but as it relates to the individual practitioner,
5 I don't see the relief.
6 LESLIE KELMACHTER: Well and again,
7 I think that there might be others here who can
8 speak to this also, but many individual
9 practitioners have coverage in excess of initial
10 policy, and they have excess policies. And as a
11 result of the fund, for many of them it won't be
12 necessary to either go in or to exhaust those
13 excess policies and that should result in savings
14 in premium dollars to individual physicians.
15 COUNCIL MEMBER CROWLEY: And the
16 federal government, the national Department of
17 Health has declared areas of New York City with a
18 shortage of physicians, especially ob-gyns, and in
19 the Bronx there are like 15 different
20 neighborhoods that have been identified as such.
21 LESLIE KELMACHTER: I haven't seen
22 those statistics, I apologize, we can certainly
23 take a look and do an analysis, if that would be
24 of assistance to the Council.
25 COUNCIL MEMBER CROWLEY: Do you

2 think that malpractice is more common in New York
3 City?
4 LESLIE KELMACHTER: I think that
5 poses a very interesting question. I think that
6 if you're talking about low-income areas and
7 you're talking about the complex problems that
8 women have in low-income areas where they're not
9 getting the initial health care, then they often
10 go into a situation or pregnancy where they're not
11 as healthy to start, that you have complicating
12 factors like obesity, high blood pressure, other
13 things that are going to impact on the outcome of
14 their care. And very often in these areas, these
15 may be women who are more likely because of their
16 lack of sophistication and perhaps they're not--
17 English is not their primary language, they're
18 going to be more likely to encounter situations
19 where there is a deviation from what should be the
20 standard of care in taking care of these
21 individuals.
22 COUNCIL MEMBER CROWLEY: As it
23 relates to lawsuits against private hospitals and
24 HHC, can you speak to the difference in terms of
25 how they go about trying to settle earlier and

2 does it make it easier for the job of a trial
3 lawyer or an advocate of somebody who has been a
4 victim of malpractice to work with the HHC
5 hospital as opposed to a private hospital?
6 LESLIE KELMACHTER: I think that--
7 and it has been spoken about today--there are
8 different legal requirements, and certainly with
9 regard to HHC hospitals, notice of claim has to be
10 filed within 90 days, that's often very difficult
11 to do in a medical malpractice situation. There
12 are opportunities to ask the court for permission
13 to file a late notice of claim.
14 We have longer statute of
15 limitations with regard to private institutions,
16 but as mentioned, with babies who have been
17 injured, there is the same medical malpractice
18 statute of limitations because the toll is to
19 infants.
20 If you talk anecdotally, we applaud
21 the efforts through the court system of bringing
22 early settlement to victims of medical
23 malpractice, and that's whether done by HHC or the
24 private institutions. But I can't speak to the
25 fact that we can materially demonstrate that there

2 is a difference, other than with regard to the
3 statute of limitations, in terms of litigating
4 cases with the city, as opposed to those who are
5 from private hospitals.
6 COUNCIL MEMBER CROWLEY: Right, but
7 it's generally better for the family to have a--
8 not have a lengthy litigation process and to
9 settle within a reasonable amount of time due to
10 all the care and costs--
11 [Crosstalk]
12 LESLIE KELMACHTER: [Interposing]
13 Absolutely, in that, obviously, the--particularly
14 where people are grievously injured, such as
15 you've been hearing about here today, there are
16 tremendous costs involved, there are tremendous
17 problems that are faced by the family, and an easy
18 resolution or an earlier resolution which is fair
19 and just, obviously, benefits everybody.
20 And, again, we applaud the programs
21 of Judge McKeon and the program that Judge Pfau is
22 bringing statewide--
23 COUNCIL MEMBER CROWLEY: Right.
24 LESLIE KELMACHTER: --for that
25 reason.

2 COUNCIL MEMBER CROWLEY: Okay. I'm
3 going to wrap it up, I know it's getting late, I
4 just want to thank you for all being here today to
5 testify, especially I didn't get to ask any
6 questions from Mary, I believe, was it?
7 MARY ANNE WALLING: Yes.
8 COUNCIL MEMBER CROWLEY: Mary?
9 [Crosstalk]
10 COUNCIL MEMBER CROWLEY: Mary
11 Walling. And I totally agree with your testimony
12 in terms of how hospitals can put protocols and
13 procedures into place to limit the number of
14 malpractice situations, right? However, I just
15 would like to see something like that trickle down
16 to the private practitioners so then they could
17 save on their malpractice costs and in turn we'll
18 have better access as females.
19 MARY ANNE WALLING: And one of the
20 ways that maybe to do that is for them--
21 CHAIRPERSON FERRERAS:
22 [Interposing] Can you speak into the mic?
23 MARY ANNE WALLING: Sorry, one of
24 the ways that maybe to do that and also help them
25 to get the education is to have them have

2 partnerships with the institutions. In Queens,
3 you have Long Island Jewish Medical Center and New
4 York Hospital of Queens, Mount Sinai of Queens,
5 which have associated with Mount Sinai New York
6 Hospital. For them, that partnership may be
7 something that in the future would give them
8 access to great education, as well as the support
9 of that institution, yet still be a private
10 practitioner who can have his office, but be able
11 to work within a very good and formal system. So
12 there are ways to look at that that would be
13 something different than premiums and caps and or
14 even how to entice them. It's job satisfaction.
15 If you look, job satisfaction's a very important
16 aspect of where a physician is going to work,
17 where a nurse is going to work, where a nurse
18 practitioner or a midwife's going to work.
19 MARY ANNE WALLING: Thank you.
20 COUNCIL MEMBER CROWLEY: Thank you.
21 CHAIRPERSON FERRERAS: Thank you
22 very much. Again, thank you for your testimony.
23 I am going to be stepping out for a few minutes, I
24 have a meeting with a commissioner, but the co-
25 chair will continue. And it's interesting and I

2 was just speaking to our counsel that this is, you
3 know, a women's issue on both sides of this
4 conversation, there is women and children on both
5 sides of this conversation. So this hearing is
6 very important to us and we want to hear
7 everyone's testimony.

8 I don't usually like to do this, so
9 we're not going to put the clock on just yet, but
10 if we have to, we'll put on the clock. If we can
11 just get our testimonies abbreviated so that
12 everyone can be heard, I would greatly appreciate
13 it. And, again, thank you very much for your
14 testimony.

15 LESLIE KELMACHTER: Thank you.

16 CHAIRPERSON RIVERA: Thank you.
17 Next we have Council Member Brewer. No, no, we
18 actually have one more Council Member who has
19 questions.

20 MARY ANNE WALLING: Oh.

21 CHAIRPERSON RIVERA: Council Member
22 Brewer?

23 LESLIE KELMACHTER: Excuse us.

24 COUNCIL MEMBER BREWER: I'll be
25 very quick. I guess my overall question is I

2 think we're all trying to get at the same issue,
3 which is, how do you address the quality of care
4 and the environment in which it's provided. And
5 my question is, is that something that in a most
6 general sense, other than this resolution--which I
7 do think has challenges--do you think that there
8 are ways that government should be looking at
9 this? You talked about the environment in the
10 hospital, but either for the attorneys or for
11 those who had to deal with the system, are there
12 some just general specifics, I guess? I'm being a
13 little--you know, we're trying, we're all trying
14 to get the same goal here, but we go about it
15 differently.
16 LESLIE KELMACHTER: I believe that
17 we need to look at the patient safety initiatives,
18 and patient safety initiatives can be
19 legislatively mandated. And I think that it's
20 been demonstrated time and time again that they
21 work. Hopefully hospitals and doctors employ them
22 voluntarily, but there are ways that government
23 can intervene and mandate certain things and
24 provide funding for good patient safety programs.
25 COUNCIL MEMBER BREWER: Okay.

2 Thank you. Thank you.

3 CHAIRPERSON RIVERA: Okay. Thank

4 you very much, thank you.

5 LESLIE KELMACHTER: Thank you.

6 Thank you.

7 CHAIRPERSON RIVERA: We'll call up

8 the next panel, it's going to be Dr. [off mic]

9 Hoskins, Milton Haynes, and Ross Frommer from

10 Columbia University.

11 [Off mic]

12 SERGEANT-AT-ARMS: If you have any

13 copies or statements, we'll take them--

14 [Background noise]

15 DR. IFFATH ABBASI HOSKINS: Do I

16 start, what do I…?

17 CHAIRPERSON RIVERA: Okay. Just

18 state your name for the record and you may begin.

19 DR. IFFATH ABBASI HOSKINS: Thank

20 you so much, and good afternoon. I'm Dr. Iffath

21 Abbasi Hoskins and I'm a practicing obstetrician

22 gynecologist and a sub specialist in Maternal

23 Fetal Medicine, which is high risk obstetrics. I

24 work at Lutheran HealthCare System in Brooklyn,

25 and I'm also here representing the American

2 College of Obstetricians and Gynecologists, in
3 which I serve in several leadership positions,
4 including past national vice president, I
5 currently chair the Communications Committee, and
6 I'm a member of the Legislative Committee for ACOG
7 New York. I want to thank the Council Members for
8 recognizing that meaningful medical liability
9 reform in New York City must become a reality for
10 the sake of the health of our women and our
11 newborns.
12 In the interest of time, especially
13 at the request of the co-chair, I will keep my
14 comments short--applause--and the background is
15 available in the detailed testimony that all of
16 you have. However, some facts do require
17 repetition and that's what I would do today to
18 piggyback onto the compelling statements that have
19 already been made by the co-chairs and Ms.
20 Crowley, and several others you have heard today.
21 Nearly 95% of New York ob-gyns have
22 had at least one medical liability claim filed
23 against them during their careers. Ninety-five
24 percent of the ob-gyn doctors in New York are not
25 bad doctors, yet we continue to be burdened with

2 astronomical and untenable malpractice rates.
3 Each ob-gyn doctor in New York state can expect to
4 be sued over three times in his or her clinical
5 career--this is clearly higher than the national
6 average. The rising amount of an obstetric claim
7 contributes to the rising costs of our medical
8 liability premiums. Because of the cost of
9 liability insurance, many ob-gyns have quit
10 obstetrics--you've heard that, and you'll hear
11 some more about it in my testimony as well. In
12 2007, for which we have some data, 63 ob-gyns have
13 dropped clinical obstetrics and now only practice
14 gynecology; 122 have changed their coverage to
15 uncomplicated obstetrics, which means no
16 surgeries, no cesarean sections, et cetera; and 30
17 obstetricians did not get renewal of their
18 malpractice coverage by their insurance carriers,
19 and of course, these represent the information
20 from only one of the malpractice carriers within
21 our state.
22 If an ob-gyn doctor decides to stop
23 practicing obstetrics, clearly his or her
24 liability cost will decrease, and this happens by
25 approximately three-fourths. For example, an ob-

2 gyn in clinical practice usually pays in the range
3 of 176 to $180,000 per year in the premium.
4 However, if the same clinician decides to drop
5 obstetrics, that premium drops to approximately
6 $40,000 per year--this is clearly a very big drop,
7 and this is happening across our state where the
8 clinician is making a practical decision to drop
9 clinical obstetrics because of the significant
10 difference in the costs.
11 As chair of ob-gyn and residency
12 director at Lutheran Medical Center, I work every
13 day with medical students and residents. I'm very
14 aware that many of our future doctors are choosing
15 to move away from the specialty of obstetrics and
16 gynecology. Many of them cite these concerns
17 about malpractice issues as part of the issues
18 that help them in their decisionmaking. As an
19 aside, if these doctors choose to move away from
20 New York state, that is a double whammy, they're
21 not only may they not be practicing in our state,
22 but they're not practicing in our specialty, even
23 though we are very much aware that we spend a lot
24 of effort, time, energy towards training them and
25 exposing them to the wonderful art of obstetrics

2 and gynecology. This is a drain on our best
3 resource, our valuable doctors, it's a valuable
4 treasure we have, we're draining these talented
5 people away from our specialty and possibly away
6 from our state.
7 Almost 70% of my ob-gyn colleagues
8 who were recently surveyed by ACOG have reported
9 making significant and drastic changes in their
10 clinical practice. This includes decreasing the
11 numbers of high-risk obstetrics patients that they
12 see--I know because I get a lot of these referrals
13 in my high-risk practice--increasing the numbers
14 of c-sections they perform as a defensive measure,
15 or giving up clinical obstetrics all together.
16 Again, as I stated earlier, and you've heard some
17 testimony before that the ob-gyn doctors numbers
18 may be increasing, so although these colleagues
19 would be counted as an ob-gyn, if they're not
20 practicing clinical obstetrics, as I've just
21 explained, that clearly is going to make an impact
22 on the ability of our patients to access care.
23 Obviously, none of these are a
24 recipe for good quality medical care. For
25 example, you've heard before, clinical practices

2 in the Bronx, there is not a single private
3 practice group in the Bronx right now. The
4 clinicians cannot afford these liability premiums.
5 I would like to repeat, not one private ob-gyn
6 practice in the Bronx right now. Hospital labor
7 and delivery units are also closing across New
8 York state and as--I'm sorry, and also throughout
9 our city. You're well aware of the numbers of
10 hospitals that have closed or moved away from
11 offering obstetrics in regard to costs and other
12 measures over the past several years.
13 Whenever an obstetrical unit
14 closes, the entire community will pay that price.
15 Patients in need will likely lose access to
16 quality and affordable health care. A pregnant
17 patient who needs high-risk care will not be able
18 to have a doctor close by and therefore, make her
19 chances of accessing prenatal care very much
20 tougher.
21 Of course, any type of medical
22 negligence must be dealt with appropriately. Over
23 the years, New York ACOG has developed and offered
24 significant obstetric risk reduction strategies.
25 These include, but are not limited to, teaching

2 simulation, doing clinician education, putting in
3 quality and safety improvement measures as well.
4 Both New York State and the
5 institution where I work have worked tirelessly to
6 try to help maintain the significantly good
7 quality care that we already provide while making
8 sure that the access remains to every single
9 patient within our state. Governor Cuomo and the
10 legislature have worked hard to make significant
11 changes in the medical liability system--you've
12 heard about that in this afternoon today--yet,
13 there is little evidence that this program will
14 continue to reduce the liability premiums for
15 private ob-gyn providers and not also, there will
16 be no reduction for safety net hospitals like
17 Lutheran Health System, where I work, because of
18 these significant legislative improvements that
19 are on the table now.
20 So I'd like to finalize by saying
21 that the current medical liability system, of
22 course, it hurts the physician/patient covenant,
23 that relationship where we are now, as clinicians,
24 practicing purely defensive medicine. Many of the
25 malpractice claims would be left uncompensated

2 anyway, a lot of the income is expended in
3 overhead and transaction costs for these medical
4 liability issues, and none of this is the recipe
5 for good medical care. Clearly, our patients
6 deserve much better than this. Thank you.
7 DR. MILTON HAYNES: Thank you. My
8 name is Dr. Milton Haynes, and I'm a Board
9 Certified Obstetrician Gynecologist and I have
10 been practicing in New York for 37 years. I am a
11 Senior Attending Physician in the Department of
12 Obstetrics and Gynecology at Lenox Hill Hospital;
13 a Clinical Associate Professor of Ob-gyn at New
14 York University School of Medicine; and I'm a
15 former past president of the New York County
16 Medical Society. I also chair the Medical Society
17 State of New York Committee to Eliminate
18 Disparities in Health Care; and I also sit on the
19 American Medical Association Commission to address
20 issues of health care disparities in United
21 States.
22 You've heard quite a bit of
23 testimony so far about the high premiums that ob-
24 gyns pay, you've heard an excellent presentation
25 by my colleague, and I will also, in the interests

2 of time, cut short my presentation. You have a
3 copy of my statement before the committee.
4 However, as a minority, Black
5 physician, I would like to focus this part of my
6 presentation for your consideration.
7 According to a report by the joint
8 Center for Political and Economic Studies that was
9 published in 2009, over 30% of direct medical
10 expenditure for patients who were African-
11 Americans, Hispanic, and Asian-Americans were
12 excess costs linked to health inequalities.
13 Between 2003--and it's on page four of my
14 testimony--between 2003 and 2006, these excess
15 costs were $229.4 billion. Indirect costs of
16 racial inequalities associated with illness and
17 premature deaths accounted for more than a
18 trillion dollars over the same three-year period.
19 Eliminating these inequalities would have saved
20 the U.S. economy a grand total of $1.25 trillion,
21 according to this report.
22 There's a large body of evidence
23 that documents the disparity in health care that
24 exists today. The death rates for diabetes, heart
25 disease, hypertension, nutritional deficiency, and

2 all types of cancer in Black women, African-
3 American women, Hispanic and Latino population are
4 significantly higher than in the White population.
5 Maternal death rates and infant mortality rates in
6 the minority populations are also higher. There's
7 also a lack of diversity on the professional
8 level, with Black, Hispanic, and Asian-American
9 physicians comprising only about 6% of physicians
10 in United States. And yet, projections from the
11 latest Census Bureau statistics indicate that by
12 2042, there will no longer be a White majority
13 population in the United States.
14 A 2004 Association of American
15 Medical Colleges study revealed that 51% of
16 African-Americans, 33% of Hispanic medical school
17 graduates planned to practice in underserved
18 areas. Only 18% of White graduates had similar
19 intentions.
20 Available data indicate that nearly
21 half of the patients seen by Black physicians and
22 one-third of the patients seen by Hispanic
23 physicians are on Medicaid or uninsured.
24 Albany University's Center for
25 Health Workforce Studies published a report in

2 March 2010 that looked at the under-represented
3 minority population and physicians--Black,
4 Hispanic, American Indian, Alaska Native--in New
5 York State. In 1995, the URM population was 28%
6 and in 2008 it was 33%. In 1995, the percentage
7 of under-represented minority physicians was 7%,
8 and in 2008 it was 8%. About 30% of these
9 minority physicians reported patient case loads of
10 at least 50% Medicaid patients, compared to 12% of
11 all other physicians. It is generally recognized
12 that compliance and outcomes are better when
13 patients and physicians share the same racial
14 ethnic background and physicians can provide
15 culturally competent care. The director of CHWS,
16 Jean Moore, stated, these findings suggest that
17 UMR physicians who improve the diversity and
18 cultural competency of the physician workforce,
19 can potentially increase access to care and
20 quality of care for underserved populations in New
21 York. Issues that we are looking at today.
22 Given the monumental amount of
23 money that is wasted on direct and indirect costs
24 as a result of the disparity in health care, and
25 given that this disparity can be reduced by an

2 increase in the diversity of physician providers
3 who are more likely to serve in minority
4 populations, it is imperative that every effort
5 should be made to make it viable for minority
6 physicians to practice in New York. It is clear
7 from the Albany University study that while the
8 under-represented minority population increased by
9 5%, the minority physician population only
10 increased by 1%.
11 The large overhead costs, including
12 the exorbitant malpractice premiums, are having a
13 disproportionate impact on the ability of minority
14 physicians to practice and serve the communities
15 that need them most. Every effort should, and
16 must, be made to make New York an attractive state
17 to which to practice medicine. With our many
18 outstanding hospitals, top-rated medical schools,
19 and superbly trained physicians, our health care
20 providers should be able to remain in New York and
21 practice both the science and art of our
22 profession without having to practice defensive
23 medicine and contribute to additional billions of
24 dollars being waste.
25 The physicians of New York and New

2 York County Medical Society are strongly in
3 support of Resolution 84-A. However, we also
4 believe that maximum benefit will only be achieved
5 if and when a comprehensive reform of the medical
6 tort system is addressed and reconsideration is
7 given to some of the medical liability proposals
8 that were recommended by the Medicaid Redesign
9 Team and supported by the Medical Society of New
10 York.
11 And as a follow up to my
12 colleague's presentation, I would also like to say
13 in passing that I am one of those ob-gyn
14 physicians who gave up my obstetrical practice a
15 few years ago because of the high cost of
16 malpractice premium in Manhattan.
17 Thanks for giving me the
18 opportunity to speak to you today.
19 ROSS FROMMER: Thank you, my name
20 is Ross Frommer, and I am Deputy Vice President
21 for Government Community Affairs and Associate
22 Dean at Columbia University Medical Center.
23 Located in Washington Heights, Columbia University
24 Medical Center consists of the School of Nursing,
25 the College of Dental Medicine, the Mailman School

2 of Public Health, and the College of Physicians
3 and Surgeons. We have three basic missions: We
4 educate the next generation of dentists, doctors,
5 nurses, and public health professionals; we
6 conduct innovative research; and we provide the
7 highest quality patient care. Our faculty
8 practice consists of 1,200 doctors, making it the
9 largest group practice in the northeast, and that
10 includes an ob-gyn department who delivers over
11 1,600 babies each year.
12 I want to thank the Council for
13 holding this hearing and applaud Councilwoman
14 Crowley for introducing Resolution 84 because I
15 think it recognizes that we do have a problem in a
16 access to ob-gyn care. And I must say I take
17 serious issue with one of the statements made by
18 earlier panelists that there is no crisis. I
19 believe there is a crisis, I think the data shows
20 us there's a crisis, I think if you talk to
21 anybody in the medical field, especially in the
22 ob-gyn field, they will tell you it's a crisis.
23 I have no written testimony,
24 however, I have submitted to you recommendations
25 made by my boss, our Dean, Dr. Lee Goldman, who

2 was a member of the Medicaid Redesign Team Task
3 Force on medical malpractice reform serving with
4 Judge McKeon. As he notes, the three very
5 important goals of medical malpractice reform
6 should be to increase patient access to health
7 care, protect and improve patient safety, and
8 reduce cost to providers and to the health system
9 overall. And I want to emphasize, these goals are
10 not mutually exclusive.
11 Too often, the debate is cast as
12 one of malpractice reform versus patient safety.
13 That is a false choice. We need and can reduce
14 both the number of preventable medical errors and
15 the malpractice premiums that providers pay.
16 He would also add that no one is
17 seeking to deny just, prompt, and reasonable
18 compensation to patients who suffer harm as a
19 result of the negligence of a hospital or doctor,
20 but the system as it exists today, and especially
21 as it exists today in New York, is out of control.
22 And our state has some of the highest malpractice
23 premiums in the country and almost every survey
24 that you do that you see for malpractice climate
25 always lists New York either in the top and it's

2 going to be the bottom two or three in terms of
3 malpractice climate.
4 Even worse is we have a real
5 disconnect in our system. A disconnect between
6 the quality of care and the likelihood of recovery
7 of damages. The tortious--excuse me, the tort
8 system should compensate for and punish bad
9 medicine, but all too often it seems to do so
10 merely for bad outcomes. And I think you need no
11 further evidence than the statistics that Dr.
12 Hoskins cited, that 95% of ob-gyns will get sued
13 at some point in their career. Yes, there are bad
14 apples in every field, I don't think anybody here
15 would honestly claim that 95% of the ob-gyns are
16 bad apples.
17 I've also heard that 50% will be
18 sued five times or more during their career. I
19 cannot believe that 50% of the ob-gyns in New York
20 state are that bad.
21 I'll also add our numbers were part
22 of MCIC, which was referenced earlier, our numbers
23 mirror those of Dr. Hoskins. I'll add even
24 further that if a GYN stopped performing surgery--
25 excuse me--premiums will drop even further.

2 Med mal Reform will lower costs,
3 okay? At Columbia University Medical Center, we
4 spend about $40 million a year on medical
5 malpractice premiums--$40 million a year. The
6 Congressional Budget Office estimates that reform
7 would cut costs--cut premiums about 10%. Imagine
8 what we could do with $4 million; imagine the
9 programs we could create; the services we could
10 provide; frankly, the jobs we could create; the
11 financial aid we could provide to our students
12 with an extra $4 million a year. I don't know
13 what we would do with it, but right now, that's
14 money that's not going to the mission of the
15 medical center, that is going to these other
16 costs.
17 I would also add that med mal
18 reform could lower the costs for the City. The
19 same CBO study estimates that reform will lower
20 overall health spending, not just medical
21 malpractice costs, but overall health spending, by
22 .5%. I don't know how much the City spends on
23 overall health care, but I imagine it's quite a
24 lot.
25 Leaving aside HHC for the moment,

2 but if you add up the prison health system,
3 Medicaid, employee health, retiring health,
4 retiree health, I suspect you're talking several
5 billion dollars, if not more--$6 billion, okay, so
6 we're looking at .5%, that's an easy $30 million
7 savings for the City right away--if I've done my
8 math correctly.
9 Medical malpractice reform will
10 also improve access, and I think that's the key
11 point that the Councilwoman is concerned about.
12 States that have enacted medical malpractice
13 reform see an increase in doctors. The most and
14 best--excuse me, the best and most recent example
15 is Texas. And I must tell you, normally I'm not a
16 fan of the way Texas passes its laws and does its
17 business, but in this case, in 2003 they enacted
18 comprehensive medical malpractice reform. The
19 number of applicants seeking to take the medical
20 boards each year in Texas is up by 60%--60% over
21 the last nine years. More doctors going to Texas.
22 I would encourage you if you get
23 the chance to talk to your colleagues in Houston,
24 Dallas, San Antonio, see how they're dealing with
25 the shortages. I bet you--and I know this for a

2 fact--they don't have the type of shortages in ob-
3 gyn that we have in New York. In fact, I heard
4 that the Catholic health system has no openings
5 for ob-gyns in their system in Texas.
6 The final point I want to make is
7 oftentimes I've heard the insurance companies cast
8 as the villain in this, that it's really not the
9 doctors, it's the insurance companies. I'm not
10 here to defend the insurance companies, but I will
11 tell you that we at Columbia are insured through
12 MCIC, which is essentially a self-insurance plan.
13 If there are savings to be had, they will be
14 passed along to the doctors.
15 And that I will thank you for
16 having me here today, be happy to answer any
17 questions you may have. Thank you very much.
18 CHAIRPERSON RIVERA: Thank you very
19 much. And also the actual number would be $300
20 million in savings--
21 ROSS FROMMER: Okay. Well--
22 CHAIRPERSON RIVERA: --for the City
23 of New York, so it's a pretty large number. Do we
24 have any questions, Council Member Crowley?
25 COUNCIL MEMBER CROWLEY: Sure.

2 CHAIRPERSON RIVERA: Yeah.

3 COUNCIL MEMBER CROWLEY: I thank
4 you all for being here today to testify. The
5 representative of ACOG, Dr. Hoskins, how many
6 people belong to--how many physicians that are
7 registered as practicing obstetricians are part of
8 your group in New York City?

9 DR. IFFATH ABBASI HOSKINS: Thank
10 you for asking this question. It is in the
11 documents that you have, but for New York, it's
12 approximately 4,500--I'm talking about New York
13 state--we have 4,500 practicing ob-gyns.
14 Nationally, we have about 55,000 ob-gyns.

15 COUNCIL MEMBER CROWLEY: And how do
16 you feel about the Medical Indemnity Fund and how
17 do you believe that--will that have any impact on
18 medical malpractices that the private
19 practitioners--

20 DR. IFFATH ABBASI HOSKINS:
21 [Interposing] Again, that's an excellent question.
22 The Medical Indemnity Fund is a big step in the
23 right direction, it's not enough. What ACOG has
24 said, if you really peel away the layers of the
25 onion, with that Medical Indemnity Fund there is

2 still the requirement that the patient or the
3 family or whichever category you want to look at,
4 has to access the judicial system, has to access
5 the courts. It takes several years, on average it
6 may be eight to ten years before any conclusion
7 can be made and that conclusion may be for
8 providing financial and other resources for the
9 alleged victim versus not.
10 What ACOG has said for a long time
11 now is that a no-fault concept would be far
12 better. Every child who has incurred some damage
13 would have access to help, whether that's
14 financial, whether that's rehabilitation, as you
15 heard from the child today, John--who by the way,
16 had one of the best smiles in the world--or, you
17 know, every one of the children would be able to
18 access the resources. And therefore, a no-fault
19 idea would be far better, a greater number of
20 families would be served. And even those where
21 there is--because you would also capture those who
22 don't have the wherewithal and the savviness, so
23 to speak, of being able to access the health care-
24 -the judicial system. So while the indemnity fund
25 is a good step, we feel that a no-fault idea would

2 be far better.

3 COUNCIL MEMBER CROWLEY: You
4 mentioned that there's not one private
5 practitioner ob-gyn in the Bronx. When did that
6 happen and how quickly did it happen?

7 DR. IFFATH ABBASI HOSKINS: Well I
8 don't know the rate at which it happened, but when
9 ACOG we--in our work with ACOG, we are constantly
10 having communication with our own doctors and in
11 the many boroughs that we have, and I would say
12 that certainly I've been hearing it definitely
13 over the last three to four years. It's been a
14 trickle, a little bit at a time, and as practices
15 have made that decision due to various malpractice
16 issues, they have sort of first made themselves
17 smaller, and then completely stopped doing
18 clinical obstetrics. So it's taken a while, but
19 certainly it's become very urgent, very critical
20 over the past three years or so.

21 DR. MILTON HAYNES: If I may
22 interject here quickly, I think part of the
23 problem is that the Bronx has the reputation of
24 having some of the highest awards in malpractice
25 cases and also the highest number of suits tend to

2 be tried in the Bronx, for whatever reason.

3 COUNCIL MEMBER CROWLEY: Right, but

4 still when you look at the liability insurance,

5 it's 176,000 compared to a place in Queens or--

6 DR. IFFATH ABBASI HOSKINS:

7 Correct.

8 COUNCIL MEMBER CROWLEY: --Staten

9 Island, they're comparable cost, they're 170-ish,

10 100--

11 [Crosstalk]

12 DR. IFFATH ABBASI HOSKINS:

13 [Interposing] And I would like to add one other

14 slightly to the side subject but very important

15 for today, those of us who run residency programs

16 like myself, we talk amongst ourselves and one of

17 the things we do is we're very proud of having

18 trained our own doctors to very high standards

19 with the depth and breadth of the--and the scope

20 of our practice. Many of us residency directors

21 have spoken with colleagues in Bronx and have

22 found that when they bring in new doctors into

23 their faculty practices, into the employment

24 within the institution, they are having trouble

25 getting coverage for these doctors and the doctors

2 are coming in pristine, they have not yet been
3 sued, have not yet had a bad medical outcome, and,
4 again, it's because of this concern of the medical
5 liability issues. So it's got numerous impacts,
6 there are many facets to this.
7 Again, that's not your question,
8 but I did want to throw that out as well, that
9 that's one of the reasons that some of our
10 brightest are draining away to other states or to
11 other communities.
12 COUNCIL MEMBER CROWLEY: Are there
13 statistics on that, the number, declining number
14 of residents choosing to practice obstetrics?
15 DR. IFFATH ABBASI HOSKINS: Well
16 that's very well known across the board and it's
17 usually in the range of 30 to 40%--I'm flubbing
18 the number a little bit because I don't know the
19 exact percentages, but it's not insignificant. We
20 put in a lot of effort and energy into training
21 our doctors, we spend many nights with them, we do
22 a lot of work with them, and yet we see them go
23 away to a better area based on their own inherent
24 choices.
25 COUNCIL MEMBER CROWLEY: Do you

2 think there's a way that the government could step
3 in without putting a cap on the malpractice rates
4 doing something like the indemnity fund for
5 private practitioners, something to keep them
6 practicing?

7 DR. IFFATH ABBASI HOSKINS:
8 [Interposing] Well they could close Texas, I'm
9 just kidding. Well, you know, yes, anything that
10 we do towards making this burden significantly
11 less is going to make a big difference.
12 Everything you suggested certainly couldn't hurt,
13 it would help. But again, if we're going to take
14 the big step of trying to make the correction, of
15 trying to move in a direction that would be
16 agreeable to all, those babies that have been
17 harmed must be compensated. But we have to come
18 up with the most practical, the most appropriate,
19 the most fair, the most accessible way to be able
20 to do that, which is why we're talking about the
21 no-fault idea.

22 ROSS FROMMER: Council Member, I'll
23 just add on two points, one on the Bronx. I would
24 also add that Northern Manhattan, we're in
25 Washington Heights and Inwood, other than Columbia

2 University physicians, there are no ob-gyns in
3 Northern Manhattan if you'd find it north of 155th
4 Street. In terms of the Medical Indemnity Fund,
5 we are already starting to see the benefits from
6 it. We are not a hospital, we are just a very
7 large group practice, so even though we are not a
8 hospital, we are also seeing the benefits from the
9 Medical Indemnity Fund.
10 COUNCIL MEMBER CROWLEY: How are
11 you different? What is your liability insurance
12 is more like a practitioner's versus a hospital's?
13 ROSS FROMMER: For a couple
14 reasons, because we are so large, our exposure is
15 larger. We are, like the hospitals, we are a
16 deep-pocketed defendant so we've traditionally
17 been subject to higher liability, and so like the
18 hospitals, the fund protects us against some of
19 these higher verdicts that we've seen in the past.
20 COUNCIL MEMBER CROWLEY: And why do
21 you think that there are no other private
22 practitioners practicing in Upper Manhattan?
23 ROSS FROMMER: I think a lot of the
24 same reasons you stated here, the cost of
25 practicing medicine--first of all, the cost of

2 attending medical school and going through
3 residency and training is very, very high. An ob-
4 gyn--correct me if I'm wrong--requires at least
5 five years of post-training so you don't even
6 start to earn a real living until you're--
7 [Crosstalk]
8 COUNCIL MEMBER CROWLEY:
9 [Interposing] But I'm trying to get at the socio-
10 economics--
11 ROSS FROMMER: Yeah.
12 COUNCIL MEMBER CROWLEY: --do you
13 believe that it has to do with the number of
14 Medicaid or non-insured people who live in that
15 particular community?
16 ROSS FROMMER: I'm not so sure it
17 has to do with the patient population, other than
18 the fact that, in the Washington Heights and other
19 communities, the patient population there cannot
20 afford to pay private practice rates the way they
21 can with, let's say, on the Upper East Side or the
22 Upper West Side so a doctor practicing on 76th
23 Street, yes, if it's high if their rates are a
24 quarter million dollars a year, but they have the
25 opportunity at least to build that into their fee

2 structure. In Northern Manhattan, in the Bronx,
3 you cannot build that type of fee structure which
4 would allow you to pay for premiums in the double
5 six-figure range.
6 DR. MILTON HAYNES: If I can follow
7 up on that. I practice on East 76th Street. But
8 yes, I think many of the medical students who come
9 out by the time they're finished training and they
10 have their medical school expenses, which are in
11 excess of $100,000 and they're going into private
12 practice, they're looking at ways to be able to
13 repay those high medical school loans plus the
14 high premiums that they have to pay. And if
15 you're working in the population, for example,
16 let's say, predominantly where the patients are
17 either uninsured or no insurance or Medicare or
18 Medicaid or if you have dependent on a large HMO
19 reimbursement where the payments are so low,
20 again, there's a great discrepancy between what
21 your expenses are and what your income is and it
22 makes it very difficult for someone who is coming
23 into practice to go into private practice. And
24 that's where you'll find that there has been a
25 trend over the past year for more and more

2 residents completing their training programs to go
3 and work either with hospitals or with large
4 groups or some other type of organization where
5 they do not have that burden of overhead expenses
6 or malpractice insurance premiums.

7 COUNCIL MEMBER CROWLEY: Thank you,
8 Dr. Haynes, and thank you all the physicians who
9 are here today. I have no further questions.

10 CHAIRPERSON RIVERA: Thank you very
11 much. Next we have Council Member Brewer.

12 [Crosstalk]

13 COUNCIL MEMBER BREWER: So I just
14 had a question, you mentioned that the insurance
15 companies are not to blame for that example in the
16 Bronx where people are leaving after they have a
17 wonderful experience. Why aren't they to blame,
18 the insurance companies? I mean, are they--

19 [Crosstalk]

20 ROSS FROMMER: [Interposing]
21 Council Member, I apologize if I misstated myself.
22 My point was that in general when you hear this
23 debate, overall, the insurance companies are often
24 cast as this bogeyman, if you will. I am not
25 familiar with what happened in the Bronx, I can

2 just tell you that in our case, our insurance
3 company is, in effect, self-insured, it's a
4 separate company, but we are the board of
5 directors to it. So if there are savings to be
6 had, they will be passed on to the shareholders,
7 which in this case is the doctors.
8 As I understand it, a large
9 majority of physicians in New York state are
10 insured by some sort of self-insurance risk
11 retention group or cooperative. In New York,
12 there are very few doctors who are insured in the
13 traditional for-profit model. So it is the
14 doctors who are, in effect, have a seat on the
15 board, if you will, of the insurance companies.
16 COUNCIL MEMBER BREWER: And there's
17 no way to do it less expensively given the
18 situation that you all have described, even though
19 you're self-insured.
20 ROSS FROMMER: [Interposing] Look,
21 we are constantly looking for cheaper options and
22 including on the open market. We are probably
23 slightly less expensive than we can do on the open
24 market, but we're not significantly less expensive
25 than we could do if we were to go for some private

2 insurance company.

3 COUNCIL MEMBER BREWER: Okay. I

4 have a brother who's a doctor, so what he does is

5 he has affiliation with a hospital and then he has

6 his own private practice. Even that doesn't work

7 is what you're saying, like in an example in the

8 Bronx.

9 ROSS FROMMER: Well, again, if--

10 COUNCIL MEMBER BREWER:

11 [Interposing] I mean, I'm just trying to

12 understand why it's absolutely impossible to have

13 this private doctor situation.

14 DR. IFFATH ABBASI HOSKINS: Well I

15 think for the Bronx specifically uniquely for ob-

16 gyn--I don't know what practice your brother

17 functions in--in ob-gyn, the problem is exactly as

18 we stated, that the malpractice premiums, the

19 malpractice costs and the concern of future

20 litigation are a very big umbrella all the time on

21 the heads or the shoulders of these clinicians.

22 The reason why we cite the Bronx is because it's

23 the most obvious, it's the most egregious example,

24 and the others are similar but not as egregious or

25 significant. That was the only reason we stated

2 the Bronx. Every county, every community has
3 concerns about the large amount of dollars that go
4 into the premiums, the concern of the malpractice
5 claims, and every new person coming into our
6 specialty has access to the same information that
7 we shared here today, the numbers of doctors who
8 can expect to be sued in their clinical practice.
9 I've been practicing for 30 years,
10 I'm a high-risk OB doctor, I worked in the Health
11 and Hospitals Corporation system for 11 years as
12 chief of obstetrics at Bellevue. I have a total
13 of five malpractice suits in my background. I
14 consider myself a reasonably good doctor, I hope
15 my patients say the same thing, and the fact that,
16 you know, I spend time teaching, doing research,
17 doing a clinical practice, all of the above, I'm
18 walking around with five cases in my background.
19 Somebody whom I mentor or if I serve as a role
20 model to him or her is going to know that already
21 in our conversations.
22 What we're suggesting here is that
23 those are the kinds of people who will say, wait a
24 minute, I need to recompute and set the reset
25 button, do I really want to be looking at a future

2 like that.

3 COUNCIL MEMBER BREWER: Thank you.

4 ROSS FROMMER: And I think that's a

5 key point in that it got to the point where the

6 quality of medicine is not what's determining

7 whether or not we have malpractice, it's the

8 outcome. And it puts doctors like Dr. Hoskins,

9 who are high-quality doctors, at risk, even though

10 they're practicing good medicine.

11 COUNCIL MEMBER BREWER: It's been

12 going on for a very long time, I mean--

13 ROSS FROMMER: Very long time.

14 COUNCIL MEMBER BREWER: --my

15 family, everybody's been complaining about this

16 for 50 years so--

17 DR. IFFATH ABBASI HOSKINS: Have

18 you been listening?

19 COUNCIL MEMBER BREWER: No.

20 CHAIRPERSON FERRERAS: As a follow

21 up to Council Member Brewer's question, on average

22 in other practices, what is the malpractice cases?

23 'Cause I know you cited five, is that, you know,

24 egregious--I mean, not egregious, is it a high

25 number compared to other practices?

DR. IFFATH ABBASI HOSKINS: Well other specialties, you mean outside of a--yes, clearly. You know, three to five in obstetrics is like every day life, but about 10 years ago, 15 years ago, it wasn't like that, you know, it was far less. I mean, there wasn't a doctor who walked around saying I'm going to bank on the fact that I will never have a malpractice claim. And, again, a reminder that the malpractice claims are not a reflection of bad medical care. There are--I'm sad to say and I'll be very honest up here--there are many bad things that happen, but they don't go to a malpractice court and lawsuit and a conclusion and a payout. There are some that do go through all this process, but it couldn't have been prevented, nothing bad could have happened. So it's become so mixed up and so messy that at some point we're just going to have to clean it out.

Ob-gyn three to five is on the top side of the normal band. There are some who have had seven, eight, nine; there are others who have had one, two, three. But when we talk amongst ourselves over the years, when I talk with

2 colleagues nationally and internationally, if I
3 talk about five in my background, everybody will
4 sagely nod their heads and say, yes, I know kind
5 of thing because that's become our new normal.
6 Other specialties maybe, other than
7 the very high exposure ones like neurosurgery,
8 emergency department, which we're not talking
9 about today, maybe even radiology, but the other
10 everyday specialties have far less numbers.
11 ROSS FROMMER: Neurosurgery is
12 probably the only specialty that even rivals ob-
13 gyn.
14 DR. MILTON HAYNES: If I may also
15 add here too that a number of ob-gyns get sued,
16 not for malpractice, but for things that are mild
17 occurrences. For example, you may have a
18 premature baby, example, those twins for example,
19 who may have delivered at 22, 24, 26 weeks, you
20 would expect there's going to be some type of
21 neurological deficit in those premature infants,
22 but yet there's still--the obstetrician is still
23 sued and, in many cases, is blamed for causing
24 that neurological deficit in that child, while a
25 lot of this evidence would suggest that it is

2 because of factors that had nothing to do with the
3 delivery, but had to do with the severe
4 prematurity of the child.
5 DR. IFFATH ABBASI HOSKINS: Just a
6 reminder to all of us in the room, in obstetrics,
7 the statute of limitations is 18 years plus three
8 years as a tail. My children didn't go to Harvard
9 and Yale or whatever, even though I had the
10 resources, they sort of gave me the look. My
11 point is, you know, we can't be expected to be
12 responsible for the outcomes of these children way
13 out into the future, regardless of what was done
14 or not done at the time of the obstetrical care.
15 This is something that follows the clinician on
16 average, you've heard discussions, it takes many,
17 many years even to get to the court system and
18 then the decisions and the conclusions, on
19 average, that's eight to ten years. That
20 clinician is now wearing the mantle of this
21 potential lawsuit and the concerns for all these
22 many years, even when, you know, before
23 conclusions have been made. For example, this
24 indemnity fund, that's going to the same model,
25 eight to ten years to wait for a conclusion.

2 Today in the malpractice world, it's on average
3 eight to ten years.
4 So even when we analyze these data
5 that come in front of us in terms of articles in
6 journals, in conversations we have where we put in
7 corrections, we put in safety implementations, we
8 are really looking at eight to ten years down the
9 road will these work or not work. It's not an
10 overnight thing, it's not within the same year.
11 And we are looking always at a statute of
12 limitations of 18 years.
13 CHAIRPERSON RIVERA: Thank you very
14 much. Seeing no other questions, thank you very
15 much, ladies and gentlemen.
16 DR. IFFATH ABBASI HOSKINS: Thank
17 you.
18 CHAIRPERSON RIVERA: We'll move on
19 to the next panel, we have Judge Ann Pfau and
20 Judge McKeon.
21 [Off mic]
22 JUDGE ANN PFAU: Good afternoon.
23 Thank you for including the judiciary in this most
24 important hearing, we were so delighted to be part
25 of the conversation. And you have my written

2 testimony, so I will be very brief in describing
3 what it is we wanted you to be aware of and, of
4 course, we're happy to answer any questions.
5 And with me today is Judge Douglas
6 McKeon, who is the administrative judge of the
7 Supreme Court in the Bronx, but also her2e today
8 particularly really the pioneering judge who
9 brought to the court system the new way of doing
10 business that we're looking to expand, and which
11 is so important to us.
12 Today, if you bring a medical
13 malpractice case in the New York courts, by the
14 time you get a resolution, it is probably well
15 beyond six or seven years since we even filed that
16 case in court--and that doesn't take into account
17 when the event actually occurred. So that's just
18 the time it takes within our court system to get
19 cases resolved, and that was our status quo for
20 many years. At some point in time, Judge McKeon
21 took a new look at this and said there's a better
22 way to do business. Because if you think of six
23 years or seven years or eight years to families
24 who are before us--you saw some of those families,
25 you heard from the doctors--everybody is suffering

2 during that period of time until they can get
3 resolution; get resources, if that's what's coming
4 to them; get a verdict, if that's what's coming to
5 them. There is this, really, umbrella of
6 uncertainty that everybody lives with while this
7 is all going on.
8 So what Judge McKeon started to do-
9 -and he can certainly explain it to you--is to try
10 to cut through some of this, to take a very, very
11 aggressive approach from the point of view from
12 the judiciary that traditionally, of course,
13 always is rather isolated, separated from the
14 problems of society, handling cases one by one on
15 a very isolated basis. We don't do things that
16 way anymore in the court system and that's a very
17 good thing. Under the former Chief Judge Kay we
18 now have things like drug courts that really try
19 to use the resources of the court to help solve
20 society's problems.
21 And Judge McKeon has brought that
22 approach to medical malpractice cases, to say is
23 there something we can do to do better. With
24 medical malpractice, it'll make a difference for
25 the families out there, make a difference for the

2 health care providers, and get them through our
3 system faster because we are so overburdened with
4 cases.
5 So he started bringing this very,
6 very hands-on approach to early on bringing cases
7 in to see if they can be resolved. And the data
8 here is fascinating. That if you look at the
9 number of filings that we have for medical
10 malpractice, and at any one time we have about
11 11,000 pending, probably double the number within
12 New York City as outside New York City at any one
13 period in time. So we have this huge number of
14 cases pending, and the question is what do you do
15 with them, what happens to them.
16 You hear a lot of people talk
17 anecdotally about how many cases go to trial, how
18 many verdicts, high verdicts come out for the
19 plaintiffs, how many verdicts come for the
20 defendant. Of those 11,000 cases that go through
21 our system every year that are pending, only a
22 small tip of the iceberg actually go to trial, and
23 I'm talking about less than 5%. So of those, 100%
24 of the cases go through, at least 95% are going to
25 be settled. But where are they settling? The

2 data shows us that right now, before Judge McKeon
3 changed that trajectory, they were settling right
4 before they go to trial, but they go to trial
5 seven, eight, nine years after they're filed. So
6 you have a case that's going to settle, it's going
7 to settle anyway, but everybody's suffering during
8 this long spectrum while this case waits to get
9 settled.
10 The other piece of it that I think
11 is so important that you heard about today is, we
12 have a lot of valuable information coming from the
13 cases that are filed with us that perhaps can help
14 improve patient safety, data that we could feed
15 back to the hospitals and the health care
16 providers. But by the time we get it and the
17 cases are resolved, that is stale data because
18 it's so old. So now what's starting to happen,
19 what Judge McKeon started in the Bronx, we have a
20 federal grant to see if we can expand it with some
21 participating hospitals in New York City. And my
22 position, as the statewide coordinator for all of
23 this, is to try to expand it where it's
24 appropriate statewide, is to have the active
25 participation of, obviously, the plaintiffs, all

2 of the different health care providers, the
3 insurance carriers to work with a very engaged
4 judge early on to say, instead of having a case
5 that statistically we know is going to settle
6 anyway, instead of having it settle so far out
7 that the families suffer, the doctors are living
8 with this specter over their head, any valuable
9 information is lost, to bring that in closer. And
10 the conclusions are really quite remarkable in
11 that--and Judge McKeon can expand on this--we're
12 getting resolutions of cases now sometimes within
13 months because a judge is grabbing hold of the
14 case, is saying to the participants, let's talk
15 seriously about resolving this, the costs of
16 prosecuting these cases, the cost of defending
17 these cases is extremely high.
18 So just thinking of the dollars
19 that can be saved for everybody by not having to
20 go through the extensive discovery, having to hire
21 experts for the trials, that is significant.
22 Savings can be achieved also because we know that
23 when cases settle earlier they often settle for
24 less than they might later, and so that's a
25 savings that can be achieved. All in all, we

2 think it's approach that makes sense, makes sense
3 as part of what happens in the Bronx and how
4 appropriate that this started in the Bronx, where
5 Judge McKeon was experiencing the significant case
6 loads, but we do think it's something that makes
7 sense as we go forward.
8 And coupled with this, of course,
9 is the creation of the new Medical Indemnity Fund.
10 You know, each case is individual as to how the
11 settlement or the decision gets allocated between
12 fund and non-fund resources, and that's part of a
13 judge's determination. But what we do see is
14 that, let's say it's a 50-50 allocation which many
15 of them are, the cost directly attributable to the
16 health care provider, if there is a settlement,
17 are half of what they otherwise would have been,
18 and those are significant cost savings.
19 So I'm going to let Judge McKeon
20 speak more specifically, but we think that this is
21 something that is achievable. I know everyone
22 talks about different tort reform measures or
23 talks about patient safety, and all of those are
24 outside of our kind of control as the judiciary,
25 we're just trying to deal with what comes before

2 us in a way that does not require legislation,
3 does not require policy change, but we can use our
4 resources with the cooperation of all those
5 involved in the health care justice system to see
6 if we can come up with a better way that benefits
7 everybody and can benefit New York.
8 So we think this is something that
9 we at least wanted you to be aware of, it's
10 something that, again, those hospitals that are
11 choosing to participate in this program I think
12 are seeing results. And certainly my
13 conversations with them, with the insurance
14 carriers, with the plaintiffs bar have all
15 indicated a great desire to participate to see if
16 there are things that can be resolved faster.
17 So I'm going to turn it over to
18 Judge McKeon, and, of course, we're happy to
19 answer any questions that you might have.
20 JUDGE DOUGLAS MCKEON: Thank you,
21 Judge Pfau. Leader Rivera, Councilwoman Ferreras,
22 and Council Member Crowley, thank you for the
23 invitation today.
24 Let me begin, I guess, in an area
25 that we've heard some inquiry about and that's the

2 Medical Indemnity Fund. On January 1 of 2011,
3 when Governor Cuomo took office, among the things
4 that he sought to achieve was to reduce Medicaid
5 costs and to reduce medical malpractice premiums.
6 Now we know--and I think there's no dispute about
7 this--that probably 50% of malpractice costs today
8 are due to obstetrical cases, and so it was an
9 idea was presented--and it had been, frankly,
10 floating around for a number of years before--to
11 devise a process whereby a fund would pay for
12 future medical expenses for youngsters, rather
13 than a hospital or an insurance company paying
14 upfront cash.
15 Assuming two years ago before the
16 fund we settled a case for $5 million. Either the
17 hospital or the insurer or both would have to
18 write out a check for $5 million. Now with the
19 fund, the future medical expense part of that $5
20 million is not paid in cash, rather the youngster
21 is provided services which are paid for by the
22 fund, the hospital saves that cash or the
23 insurance company saves that cash, which they
24 would have ordinarily had to pay for these future
25 medical expenses.

2 Now before the fund, we were
3 getting obstetrical cases which would be settled
4 and youngsters still receiving Medicaid benefits.
5 Might say, well how is that possible. In the law
6 there was a device known as a Supplemental Needs
7 Trust and if you created one of these trusts, even
8 though you received a recovery in a malpractice
9 case, a youngster could still receive Medicaid
10 benefits. Now with the creation of the fund which
11 provides the same services as Medicaid, Medicaid
12 is no longer paying those costs, rather the fund
13 is, and there is the savings for Medicaid as part
14 of this program.
15 Now Councilwoman Crowley is quite
16 right. With respect to individual obstetricians
17 and the insurance companies which insure them--
18 MLM, PRI--they have not received as much a benefit
19 as some of the hospitals have. And the reason for
20 that is basically this: Obstetrical cases are
21 very, very costly; the payout is extremely costly.
22 These obstetricians have limited amounts of
23 insurance and what used to happen is this: Using
24 my $5 million example, if a doctor only had $3
25 million in insurance coverage, that case would

2 probably be settled for $3 million or $2,900,000.
3 You couldn't pay the 5 million because you didn't
4 have insurance coverage to do that. Now what the
5 fund does is allow a payment in excess of that $3
6 million because the insurance policy and the
7 coverage is there of 3 million plus the fund picks
8 up where there was inadequate insurance before.
9 So what happens? The insurance
10 companies are basically paying close to that $3
11 million, which they paid before, but under the
12 fund they have to pay part of the youngster's
13 legal fees so that when all is said and done,
14 these companies aren't really receiving that much
15 of a saving because they had a very limited amount
16 of coverage to begin with for a case that is very,
17 very expensive, some call it the Rolls-Royce of
18 tort litigation.
19 And so we heard the gentleman from
20 Presbyterian speak about the fund helping their
21 group, and that's because they had greater limits
22 of insurance coverage than the ordinary doctor who
23 is practicing in an office somewhere in--or what
24 formerly was the Bronx, I guess they're not
25 practicing much there anymore, according to

2 Councilwoman Crowley. And so in order to benefit
3 from the fund, we're talking about the cases that
4 would settle for huge sums of money for which now
5 the fund is a partner, so to speak, and that
6 saving inures to the benefit of the hospital or
7 the insurance company.
8 Let me just touch if I may on just
9 a few short points that came up. I noticed in the
10 resolution there was some reference made to the
11 University of Michigan program, Mr. Boothman's
12 program, and you should know, ladies and
13 gentlemen, that out in Michigan, they have caps on
14 recovery. And when you have caps, it's a lot
15 easier to settle cases for a lot less money
16 because lawyers are more inclined to want to
17 settle them because the caps will kick in if they
18 go to trial and they're not going to recover what
19 they could here in New York.
20 In addition, there were some
21 disclosure and apology programs as part of that
22 University of Michigan program. In Michigan, a
23 conversation with a doctor and a patient
24 apologizing, so to speak, or explaining why an
25 adverse event occurred are insulated and protected

2 and cannot be used in court. Such is not the case
3 here in New York.
4 And then thirdly, as Mr. Boothman
5 himself has conceded to me, when we get into the
6 area of obstetrics, that particular program
7 doesn't work very well because, again, if you have
8 a youngster who is profoundly damaged, one of the
9 major costs is custodial care--who's going to
10 provide for that youngster for any number of years
11 when we know that some of these homes today are in
12 excess of $100,000 a year and escalating in cost
13 as things go on.
14 We heard something about patient
15 safety, and I think it's a little unfair and,
16 frankly, misleading to try to suggest that patient
17 safety alone is going to solve this problem,
18 because it's not. If we were to follow that
19 logic, then the fact that a hospital up in Chemung
20 County is paying significantly less than Mount
21 Sinai or Columbia Presbyterian or Montefiore,
22 should mean that it's a safer hospital, but we
23 know that's not the case and we know if we had a
24 sick relative, we'd rather see them in Columbia
25 Presbyterian or Mount Sinai rather than some

2 community hospital somewhere upstate. Having
3 nothing against community hospitals upstate, but
4 the quality of care and the ability to provide
5 cure for certain kind of illnesses is certainly
6 far better here in New York City.
7 And so why are these hospitals like
8 Presbyterian--and you heard something about their
9 program in obstetrics--and listen, patient safety
10 we can't get enough of, but the reality is that
11 the Presbyterian system, even today,
12 notwithstanding what we heard, is paying in excess
13 of $100 million in malpractice premiums. So it
14 has to do with more than just patient safety.
15 And what I suggest, members of the
16 committee, is that we look outside of the tort
17 reform area, and this is why this session today is
18 such a wonderful one. We have to look at non-tort
19 reform innovations to try to deal with the
20 problem. A good doctor who is practicing safe
21 medicine in New York City maybe should get a tax
22 credit to help deal with that premium. Maybe the
23 reimbursement rate should be different for areas
24 what I call malpractice zones. If we're using
25 malpractice premiums as the barometer, we don't

2 have a statewide problem, we have a problem in
3 eight counties here, and that's what Judge Pfau is
4 wrestling with--the City of New York, Suffolk,
5 Nassau, and Westchester. Of 3,800 filings last
6 year, about 3,000 were in those eight counties.
7 That's because that's where these suits are being
8 brought and that's, frankly, why--and there's a
9 greater likelihood of recovery in these counties.
10 Now we could spend four hours
11 talking about why that is, but the reality is that
12 I think we have to look at this particular problem
13 in a real honest way, which is, caps are not going
14 to pass the legislature, health courts are not
15 going to pass the legislature, so we have to look
16 at other things. In the leader's borough and my
17 own, we saw Montefiore Hospital go from $50
18 million in malpractice costs in 2005 to 115
19 million in 2009. Montefiore happens to be our
20 chief employer in the borough and so, in addition
21 to skyrocketing malpractice costs, that increase
22 represented loss of jobs, loss of other programs
23 that benefited the community. At the very same
24 time, Montefiore was losing $8,000 every time they
25 delivered a Medicaid baby. That particular fact

2 is unconscionable whether you be a trial lawyer, a
3 judge, or anything else. A hospital shouldn't be
4 penalized for delivering the children of poor
5 families in any place or in any borough.
6 And so these are the kind of issues
7 that have been raised today and I think that we
8 have to look at ways, innovative ways, different
9 ways to deal with the problems that we have in the
10 areas where these particular dilemmas exist--here
11 in the city, the outlying area--and think of
12 innovative ways to help these doctors, help these
13 hospitals who are practicing safe medicine.
14 JUDGE ANN PFAU: I would also say
15 that, you know, you have asked today for some
16 different kinds of data as far as claims that are
17 brought. We really can be very responsive to that
18 because we have information about these cases,
19 again, from our perspective, there is so much that
20 can be done within the umbrella of what exists
21 now. If people are willing to come to the table,
22 if they're willing to have meaningful
23 conversations, looking innovatively at ways to
24 address this, I think that there is a great deal
25 that could be done that would significantly

2 benefit, you know, the people, particularly the
3 women, of New York City. And we'd be happy to
4 answer any questions.
5 CHAIRPERSON FERRERAS: To both, I
6 want to just thank you because it's often that we
7 get the judicial perspective, and I think it adds
8 a lot of value to our conversation today and to
9 our hearing 'cause we kind of go back and debrief
10 and take all of this into account, so it really
11 means a lot to all of us that you are here. And I
12 know that Council Member Crowley has some follow
13 up questions. But just the mention of the
14 malpractice zones, I think it's just an
15 interesting language that we need to start
16 adopting in a lot of our conversations and that
17 will be priceless to how we follow up, at least
18 for me, as Chair of the Women's Issues, and I'm
19 sure as Maria del Carmen Arroyo in the Health
20 Committee.
21 So your suggestions we're going to
22 be taking very seriously and we're all taking
23 aggressive notes here. So I thank you and I want
24 to give Council--
25 JUDGE ANN PFAU: [Interposing] And

2 I don't mean to interrupt you, I just want to--
3 CHAIRPERSON FERRERAS: Yes.
4 JUDGE ANN PFAU: --say this whole
5 idea of zones, if you think of just the
6 disbursement of resources and kind of the comstat
7 approach, if you look at where the resources are
8 needed, where the cases are being brought, we can
9 be much more flexible in trying to apply those
10 resources to the places where we need them from
11 the judiciary's point of view to try to have a
12 more focused approach.
13 CHAIRPERSON FERRERAS: Yes, and I
14 think even just as elected officials it allows us
15 to have other conversations to support the zones
16 because it's a lot of systems that are failing
17 before they even get to your courtroom--
18 JUDGE ANN PFAU: Yes.
19 CHAIRPERSON FERRERAS: --there's a
20 lot of things that fail a lot of these families.
21 Council Member Crowley. Thank you.
22 COUNCIL MEMBER CROWLEY: Thank you
23 to our co-chairs. And thank you, to the Honorable
24 Pfau and Honorable McKeon, for being here today.
25 I agree with my colleague that you have brought

2 the voice of reason here and in terms of one
3 finger is being pointed at trial lawyers by the
4 physicians and the trial lawyers are pointing
5 their finger at the physicians, but we know in the
6 city that our access to care is dwindling and
7 because of that, women and families are suffering.
8 So what can we do to move forward--yeah, I realize
9 that medical malpractice caps are not the answer
10 or weren't the answer I was pushing in my
11 resolution and nor did I ever believe that New
12 York State would consider passing them or haven't,
13 and so I don't think all of a sudden they would.
14 But I do think that your ideas on, you know,
15 looking outside of the box and taking into
16 consideration reimbursement rates in areas where
17 there's an underserved population and possibly
18 giving some sort of tax credit makes absolute
19 sense.
20 And also I do like the way that
21 you've gone forward with settling cases in a
22 shorter amount of time. As we saw earlier with--
23 JUDGE ANN PFAU: Right.
24 COUNCIL MEMBER CROWLEY: --the
25 family that testified, their case hasn't been

2 settled yet and all these years their son is
3 suffering without the proper care--didn't have a
4 wheelchair, couldn't afford it, and shouldn't have
5 had to pay for it out of their own pocket.
6 Nonetheless, here we are and you're doing stuff in
7 the Bronx that reduces the amount of time and the
8 length and all--
9 JUDGE ANN PFAU: [Interposing]
10 Yeah, and if I could just expand. While this
11 started in the Bronx, it is now expanded to
12 Brooklyn and I, as a trial judge, participate in
13 them, and in Manhattan; it's also happening in
14 Westchester and upstate in Erie County. And my
15 particular goal with Judge McKeon's support is to
16 spread it certainly throughout New York City.
17 COUNCIL MEMBER CROWLEY: And do you
18 have the resources to spread it?
19 JUDGE ANN PFAU: We have our
20 judges--
21 COUNCIL MEMBER CROWLEY: Right.
22 JUDGE ANN PFAU: --you know, that's
23 judges we have. I think more important than
24 resources, there's a willingness from all the
25 participants to engage in this process. And I

2 know earlier in your hearing there was discussion
3 about the difference between the public hospitals
4 and the private hospitals, and when you talk about
5 resolving these cases, you take something like HHC
6 that, number one, is self-insured, you know,
7 everybody's included in that self-insurance, just
8 getting to resolution can be a much easier process
9 than when you have a private hospital, you have
10 attending physicians, you have different competing
11 interests in the resolution so that can just be
12 more of a challenge.
13 JUDGE DOUGLAS MCKEON: Let me just
14 say, Council Member Crowley, that--and I can't
15 give you good reason for it, but it happens to be
16 the case--we find that we settle cases with the
17 Health and Hospitals Corporation for less money
18 than with a private hospital, all things being the
19 same, in the same venue. And I think it's partly
20 almost a tradition or a sense by the trial bar
21 that a municipality should not pay as much as
22 perhaps a private entity. And in reality, they
23 are probably more of a deep pocket than any other
24 defendant, but that happens to be the way it is.
25 And I know you asked about that, you know, with

2 respect to one of the earlier speakers.

3 COUNCIL MEMBER CROWLEY: Thank you

4 both for being here--

5 JUDGE ANN PFAU: Thank you.

6 COUNCIL MEMBER CROWLEY: --today

7 for your testimony. I have no further questions.

8 CHAIRPERSON RIVERA: Thank you very

9 much. Thank you both for coming down here--

10 JUDGE ANN PFAU: Thank you.

11 CHAIRPERSON RIVERA: --today and

12 for being here for the entire duration of the

13 hearing, I know it's a very long one. I'm just

14 shocked that if a doctor apologizes for something

15 that could not have been prevented, that could be

16 used against them in a court of law, an apology?

17 [Crosstalk]

18 CHAIRPERSON RIVERA: So pretty much

19 in a parent or in anybody's, you know, most tragic

20 of situations where they hear something bad has

21 happened and they look to the doctor for some

22 solace, that doctor has to pretty much be

23 emotionless.

24 JUDGE DOUGLAS MCKEON: I'm sorry,

25 go ahead.

2 JUDGE ANN PFAU: I'm sorry, I was
3 just going to say, that same thought, if you
4 translate that to the settlement side, the father,
5 Mr. Singleton, said today, you know, I wish our
6 problems were over and I don't wish this on
7 anybody else. What we hear from plaintiffs over
8 and over again is I want my problem resolved and I
9 want to be part of the solution, I don't want this
10 to happen anybody else. So when you get to the
11 settlement part, if there can be a constructive
12 conversation between a doctor and a patient at
13 that point to say, you know, this happened to me
14 but can't you do something to make sure it doesn't
15 happen to somebody else. That's when, at least
16 right now in our system, those very meaningful
17 conversations can take place because it's that
18 thought that it's so damaging, I don't want this
19 for anybody else, I want some acknowledgment of
20 what's happening to me, that can really make a
21 difference in resolving a case or not.
22 JUDGE DOUGLAS MCKEON: You know,
23 Mr. Leader, and I don't want to, you know, prolong
24 the hearing, one of the remarkable things about
25 malpractice litigation is that there is an

2 emotional component that's attached to it, not
3 only for the family bringing the lawsuit, but for
4 the doctor sued as well, and very often you see
5 that kind of work its way into the negotiations.
6 Very often I speak to families who have brought
7 these kind of cases because they do want to speak
8 to somebody, they do want to unburden themselves,
9 they do want to, you know, get off their chest
10 what they believe was wrongly done to them. And
11 so whenever we talk about this subject, the
12 emotional component of it is very, very
13 significant.
14 JUDGE ANN PFAU: For everyone
15 involved.
16 CHAIRPERSON RIVERA: Yeah, and I
17 want to thank you also for the idea of the tax
18 credit, I think, you know, one of the other
19 panelists mentioned earlier that one of the
20 biggest concerns would be ob-gyn practitioners is
21 the fact that they had to pay their student loans
22 and then the high cost of malpractice insurance,
23 possibly so there should be something like a loan
24 forgiveness program for those who are practicing
25 within high Medicaid, you know, recipient

2 localities and things of that nature to
3 incentivize it, and maybe something combined with
4 the tax incentives.
5 JUDGE DOUGLAS MCKEON: You know,
6 we're sitting in the greatest city in the world
7 with some of the greatest minds and the wonderful
8 thing about this committee's approach today is we
9 should get a hold of those great minds and solicit
10 suggestions as to how to deal with this problem,
11 not in a tort reform way, but in a common ground
12 way.
13 JUDGE ANN PFAU: And it's something
14 we all experience as individuals, so it's such a
15 important area and it touches so many lives that
16 we are very appreciative that you included the
17 judiciary today, thank you.
18 JUDGE DOUGLAS MCKEON: Thank you.
19 CHAIRPERSON RIVERA: Thank you very
20 much. Next we'll call the following panel will be
21 Joanne Doroshow, Patrick Krug, and Jesse Laymon,
22 and Sam Senders.
23 [Off mic]
24 CHAIRPERSON RIVERA: Okay. Again,
25 you know, we do have still an extensive amount of

2 people who want to speak so we're going to try to
3 limit the amount of testimony, we don't want to
4 put on the clock so we'll try to keep it short.
5 So we're looking for Joanne Doroshow--I hope I--
6 okay, Patrick Krug, Jesse Laymon, and Sam Senders.
7 Just state your name for the record and you may
8 proceed--
9 JOANNE DOROSHOW: [Interposing]
10 Start?
11 CHAIRPERSON RIVERA: Yes.
12 JOANNE DOROSHOW: Thank you, I'm
13 Joanne Doroshow, I'm the Executive Director of the
14 Center for Justice & Democracy at New York Law
15 School. And this is a national public interest
16 organization that works on civil justice issues,
17 and I'm also co-founder of Americans for Insurance
18 Reform, which is a project of ours that works on
19 accountability of the property/casualty insurance
20 industry. I also served on Governor Spitzer's
21 Medical Malpractice Task Force in 2007 and '8 and
22 worked closely with insurance experts in the most
23 recent MRT med mal working group last year, and
24 have testified in Congress six times on this issue
25 since 2002. It is a big issue in Congress, you

may know.

And, you know, I'm going to skip over a lot of what I was actually planning to say since listening to the testimony today, particularly the concerns of Council Member Crowley and some of the others about the access issue. And, you know, when I first read the resolution, I have to be honest, it was as if I was looking at the opening statement of the Republicans in Congress that I tend to testify before, so I was a little shocked by that, but I'm getting to understand the nature of the problem here, the concern that the Council has and I'm just going to go right to the 800 pound gorilla in the room, which is the insurance industry and their responsibility for what is causing a potential problem in this city.

We've been working on insurance industries in this state for a number of years and I can tell you that when it comes to transparency and information that public and lawmakers have about why this industry does what it does, this is one of the least transparent states in the entire nation. Texas has better disclosure laws than

2 they have in this state. And for example, the
3 laws do not force the medical malpractice
4 insurance industry to disclose even basic
5 information to lawmakers or the public to
6 substantiate anything about their financial
7 health, about why doctors are being charged
8 certain premiums, not just with regard to certain
9 regions of the state, but within certain parts of
10 New York City. We have no idea why certain
11 doctors are charged what they are. When we ask
12 for this kind of information, it comes back in big
13 redacted documents. Unlike a state like
14 California, where they have a very strong
15 disclosure law where whatever is filed with the
16 Department of Insurance is allowed to be inspected
17 by the public.
18 So there is an urgent need for data
19 disclosure here, and the impact of this goes far
20 beyond simply harming confidence in the city and
21 the state and major institutions, there is also
22 serious public safety implications to this because
23 lawmakers and the public never learn the reasons
24 why claims arise and are being paid.
25 In addition, in states like

2 Illinois, where for a time they had a very strong
3 disclosure law, which was tied in with a cap that
4 was then struck down as unconstitutional, but
5 during the time that law was in effect, there were
6 significant enhancements to the insurance market.
7 There were lower premiums because competition was
8 increased and other benefits that could improve
9 the entire health care situation in Illinois.
10 And I should also note that late
11 last year eight health--the health insurers in New
12 York with 90% of the market, they gave up their
13 fight to keep secret this kind of information, but
14 the medical malpractice insurance carriers in New
15 York have not. So meanwhile you are being asked
16 to make policy recommendations based on some
17 outlandishly inaccurate information that cannot be
18 analyzed. And if you look at my written
19 testimony, I think beginning around page six,
20 you'll see all of the things that we believe this
21 industry needs to release to lawmakers and to the
22 public in order to properly analyze what is going
23 on with the insurance situation in this state.
24 I'm not going to go into any real
25 detail about the tort reform proposals since I

2 know that that's really not where we're going
3 right now. I will say that we are totally in
4 agreement with Judge McKeon's sense that there are
5 other ways of dealing with the situation. For
6 example, in Oregon in 2004, the governor pass--
7 well they signed a law there, this was
8 particularly to help rural doctors, which is also
9 a problem here, we're talking about underserved
10 communities, but they passed a law there that said
11 that doctors in rural communities are going to
12 seek reductions of up to 80% in their professional
13 liability costs as a result of a state
14 reimbursement program that went into effect
15 January 1st.
16 So other states have tried these
17 kinds of innovative proposals with regard to
18 underserved areas, whether it's rural areas or
19 urban areas. So I would definitely encourage
20 that.
21 I do want to make one point about
22 the Department of Health and its record of
23 disciplining bad doctors, I mean the really bad
24 ones, because I think we all know that there's a
25 problem there. In 2007, Public Citizen, for

2 example, did a report that found 3,052 physicians
3 had made three or more malpractice payments in the
4 year that they studied, but yet these physicians,
5 who represent no more than 4% of the state doctors
6 at the time, had been responsible for nearly half
7 of the dollars paid out for malpractice, and only
8 10% had received any kind of license action.
9 Even more troubling is the fact
10 that less than a third of the doctors who made ten
11 or more payments had a reportable licensure
12 disciplinary action. So much of this problem is
13 due to the fact that the Department of Health is
14 still not weeding out the very small number of bad
15 doctors that we know are committing most of the
16 malpractice, paying out most of the money, and the
17 good doctors are ending up paying for that. So
18 more that to the extent that they can do more to
19 solve that problem, I think that would really help
20 the situation here.
21 The University of Michigan program
22 that Judge McKeon did reference, we also we would
23 agree with his sense about that in these kinds of
24 cases, but also remember that they also have a
25 transparency problem there, that we don't really

2 understand anything about the kinds of claims that
3 are being brought and what the level of
4 compensation is to victims there compared to what
5 they would have gotten in court.
6 So I'm just going to conclude
7 'cause I, you know, I'm happy to answer questions
8 about any of the--anything in my written statement
9 or anything about the tort system that has been
10 brought up today, I just don't want to waste a lot
11 of time doing that right now, but I do hope that
12 the Council does explore these other alternatives.
13 We've seen a lot of different states try a lot of
14 different things and we would be happy to assist
15 the Council in providing that kind of information.
16 Thank you.
17 SAM SENDERS: Thank you. My name
18 is Sam Senders, I'm a structured settlement
19 consultant, I live and work here in New York City,
20 in Councilwoman Jessica Lappin's district. And
21 I'm here on behalf of NSSTA, the National
22 Structured Settlement Trade Association.
23 First, three quick disclaimers.
24 This is the first time I've ever testified
25 publicly so if I sound a little nervous, please

2 forgive me.

3 Secondly, many people associate
4 structured settlements with these late-night
5 commercials where people sitting on the bus and
6 say it's my money and I want it now. That is
7 actually not what we do; we're in the business of
8 creating those future payment plans.

9 And most importantly, NSSTA does
10 not have a position for or against any tort reform
11 that's being discussed today. Our mission is to
12 find ways to help settle claims in the most cost
13 effective way while protecting the injured victim,
14 whether it's a claim of general liability or
15 medical malpractice.

16 Some of you may know that many
17 years ago there was a morning sickness medication
18 called Thalidomide back in the sixties and
19 seventies that was widely distributed and it
20 caused horrible birth defects. That was one of
21 the first times that as negligence law formed in
22 this country that the insurance companies and the
23 defendants behind this product were forced and
24 confronted with the reality of how do we settle
25 this enormous mass tort claim with today's dollars

2 while taking care of these children in the future.
3 And at the time, essentially a great big trust was
4 created into which all the money was paid and,
5 depending on the class of claim, children would
6 draw funds from that. In a rare moment of
7 compassion, the IRS allowed the growth in that
8 trust to grow on a tax-free basis. And so from
9 that concept was born in 1982 when the tax code
10 was amended future periodic payments and
11 structured settlements to help liability carriers,
12 self-insured defendants, and the plaintiff
13 attorneys settle liability claims while creating
14 guaranteed future income for injured parties.
15 Most commonly we use life insurance
16 annuities to do this, so it is very common amongst
17 many of the parties you've heard from today--
18 whether it's Judge McKeon, representatives of a
19 hospital, members of the Greater New York Hospital
20 Society, the plaintiff attorneys that you heard
21 from today--to use this concept of structured
22 settlements to resolve their claims.
23 Structured judgments are part of
24 the existing New York State tort reform called
25 CPLR 50(a) in which any verdict over a quarter of

2 $1 million on a medical malpractice case, has the
3 annuity concept applied. Annuities, of course,
4 are life insurance vehicles. And where in
5 ordinary life insurance, we might pay a small
6 amount of money every month or every year and when
7 someone dies, a large benefit is paid. Annuities
8 function in reverse, where a large sum of money is
9 paid to a life insurance company and that life
10 insurance company promises to pay according to a
11 particular schedule more money, presumably, than
12 you paid to them, and the longer they pay it out,
13 the more interest you will get. And therefore,
14 they get--plaintiffs get an additional tax-free
15 payment as a result.
16 This has become, and historically
17 has been, one of the best vehicles for reducing
18 the amount of money that a defendant might
19 otherwise have to pay while creating guarantees
20 for the plaintiff that last into the future, very
21 often for the rest of their life. Life companies
22 that are used are solid, they rarely go out of
23 business, companies today are New York Life,
24 MetLife, Prudential and no one throughout all this
25 whole financial crisis that we've just lived

2 through has experienced any loss of any payment.

3 So I would encourage the Council as

4 they consider cost saving methods for how do we

5 find a balance between an injured person's right

6 to receive compensation, lowering the cost of

7 whatever costs are associated that are denying

8 women, particularly, the opportunity to access

9 health care, that structured settlements in some

10 form or fashion might be the opportunity to find

11 that balance.

12 I hope I said that artfully.

13 JESSE LAYMON: Thank you. If it

14 makes you feel better, you're not the only one

15 testifying before the Council for the first time.

16 My name is Jesse Laymon and thank you for the

17 opportunity to testify, members of the Council.

18 I'm here on behalf of Citizen Action of New York.

19 Citizen Action is a statewide membership

20 organization of consumers that advocates for

21 racial, social, economic, and environmental

22 justice, and we have chapters and affiliates

23 across the state, including one here in New York

24 City. And our organization has for decades now

25 been a leader in efforts to expand access to

2 quality, affordable health care across New York.
3 Citizen Action helped lead the campaign in this
4 state for the passage of the Affordable Care Act,
5 the landmark federal health care law. And we now
6 coordinate the Health Care Disparities Task Force
7 of Health Care for all New York, which is the
8 coalition working for health care reform in New
9 York state. And so we are deeply concerned with
10 the shortages of skilled physicians in certain
11 areas of the state where those exist, and the city
12 has some of that.
13 However, we strongly urge you, your
14 committees not to pass resolution 84--A in its
15 present form because we feel it focuses too much
16 public attention on the narrow question of medical
17 malpractice and malpractice insurance rates rather
18 than the more fundamental questions, including
19 patient safety, as has been raised. Citizen
20 Action believes that the Council should instead
21 call on the state Department of Health to focus on
22 this serious threat to quality medical care and
23 the inadequate measures that are in place to
24 address patient safety.
25 As has been discussed by some of

2 the others--and I will try to not restate some of
3 these statistics--the resolution contains some
4 statements which we think are misleading and put
5 too much weight on the question of medical
6 malpractice rates with regard to the availability
7 of ob-gyn especially.
8 We also have seen and think it's
9 compelling the SUNY Albany Center for Health
10 Workforce Studies study that found that, you know,
11 the ob-gyn to population ratio in New York has
12 been steadily increasing and that the number of
13 ob-gyns has essentially remained unchanged while
14 the number of pregnancies has declined. And in
15 addition, some of the particular examples across
16 the state don't seem to support the theory that
17 malpractice rates are the cause of the lack, where
18 there is a lack, of specialists. Long Island has
19 some of the highest rates of malpractice insurance
20 across the state, but does not have that lack of
21 ob-gyns.
22 And as a statewide organization,
23 Citizen Action can certainly attest to the fact
24 that there are several--and I think we've got 11
25 upstate counties that we're deeply concerned about

2 where they're mostly rural counties upstate with
3 severe ob-gyn shortages, and yet those counties
4 have some of the lowest medical malpractice
5 insurance rates across the state. So there does
6 not seem to be a strong correlation between those
7 rates and the availability of this care.
8 And so while we're very concerned
9 about the lack of care where it exists, we don't
10 think we should put all the blame for it on the
11 issue of medical malpractice. Instead, we think
12 that, particularly in the area of women's health,
13 we recommend that the Council urge the Department
14 of Health to implement serious new measures to
15 focus on patient safety.
16 I also think--and this is not in my
17 prepared testimony--that some of the things that
18 the judges brought up just recently are good ideas
19 and if this resolution were being rewritten, that
20 a resolution focused on some of these other ideas
21 about how to generally improve access and then
22 help improve resolution of claims, that would not
23 be a resolution that I would be here testifying
24 against. But in particular, the patient safety
25 measures that we're very excited about and would

2 like to see aggressively implemented across the
3 state include those that I think have been
4 referenced at New York Presbyterian Hospital,
5 which had, during a period of six years, a rather
6 astonishing 99% decrease in the amount of claims
7 that they paid out, as well as also the Hospital
8 Corporation of America example where HCA across
9 the nation with roughly 200 hospitals nationwide
10 was able to achieve a fivefold reduction in
11 claims, again, from changing policies and
12 procedures within their hospitals, not because of,
13 you know, changes in malpractice law.
14 So to us this is not just the right
15 thing to do, but it's obviously a critical factor
16 in reducing medical liability insurance costs.
17 And I also, you know, the statistic that was just
18 recently cited that 4% of the doctors in New York
19 State accounted for half of all the malpractice
20 incidents should certainly lead us to believe that
21 stronger enforcement and investigation we think by
22 the Office of Professional Medical Conduct is
23 certainly called for.
24 One other thing that I haven't
25 really heard discussed a whole lot is the question

2 of the Affordable Care Act and how we can use that
3 to improve access to care. Under the federal
4 Affordable Care Act, New York State must establish
5 these health insurance exchanges, market places
6 for health insurance for individuals and small
7 businesses, by January 1st of next year. And, in
8 fact, Governor Cuomo has proposed legislation to
9 do just that.
10 Once those state exchanges are
11 established, health insurers, particularly those
12 serving New York City and other large population
13 centers, should have strong incentives to gain
14 access to the hundreds of thousands of new
15 customers that are expected to enroll. That
16 provides us an opportunity for the state through
17 legislation to negotiate strong terms for
18 consumers, including a mandate that health
19 insurers operate in the state exchange, have
20 strong provider networks, provide care throughout
21 different communities across the New York state,
22 across the state, including some that are
23 underserved in these particular specialties of
24 reproductive and maternal and infant care.
25 And we could also through that

2 process encourage the state to pass legislation
3 implementing some of these ideas for improved
4 patient safety taking the examples like New York
5 Presbyterian. It is a great moment that we have
6 in time here to use this landmark federal
7 legislation to actually improve health care
8 quality and bring down costs, rather than going
9 back to the discussion about medical malpractice
10 insurance.
11 So in closing, once again, I ask
12 that you broaden the proposed resolution and bring
13 some of these other ideas into it and reduce the
14 narrow focus on medical malpractice rates. We
15 should be more focused on the fundamental concerns
16 to consumers, including patient safety and the
17 availability of specialists across the state, in
18 every region of the state--rural areas and here in
19 New York City. Thank you.
20 PATRICK KRUG: Sorry. Hello, my
21 name is Patrick Krug, and I'm here representing
22 NYPIRG. The New York Public Interest Research
23 Group is New York state's largest nonpartisan,
24 nonprofit, student directed, consumer protection,
25 public health, and environmental preservation

2 organization, and I thank you for the opportunity
3 to speak. Our executive director, Rebecca Weber,
4 was here earlier, she had to go to another
5 appointment, so I'm speaking on her behalf. And
6 I'll try to be brief, you have several pages of
7 our written testimony.
8 NYPIRG agrees that the costs of
9 medical liability insurance are suspiciously high.
10 In fact, along with other health care consumer
11 advocacy groups, such as the Center for Medical
12 Consumers, we've called for a forensic audit to be
13 conducted by an independent actuary to put medical
14 insurers' books under the microscope.
15 The theme of the resolution is--and
16 we applaud this--concern for women's access to
17 obstetricians and gynecologists, but we feel that
18 it creates the inaccurate impression that there's
19 a crisis in medical liability insurance caused by
20 an unreasonable proliferation of malpractice
21 lawsuits. The numbers, we think, tell a far
22 different story. Despite the claims that--excuse
23 me--that doctors are fleeing the state, as of
24 2009, New York state had the fourth highest ratio
25 nationally of ob-gyns per number of women of

2 childbearing age, and the total number of
3 physicians was increasing faster in New York than
4 nationally. The number of doctors working in New
5 York has grown at a significantly higher rate than
6 the state's overall population. Between 1995 and
7 2008, the number of active physicians practicing
8 in New York increased over 20%. During the same
9 period, by comparison, the state's population grew
10 a mere 6%.
11 The sad truth is that more than a
12 dozen years after the landmark, To Err is Human
13 report by the Institute of Medicine, which found
14 that as many as 98,000 Americans die annually from
15 preventable medical errors in the United States
16 hospitals, we're not doing a much better job today
17 at reducing medical errors and negligence that
18 result in injury or death.
19 NYPIRG believes that individuals
20 and their families who have suffered serious
21 injuries or have been killed due to substandard,
22 negligent care have a right to go to court to seek
23 redress for their injuries and to ensure that they
24 have resources to address their future health
25 care, quality of life, and financial needs. This

2 is a fundamental right based on fairness as
3 embedded in our system of liberty and democracy.
4 The facts show that what's really
5 at the heart of the so-called medical liability
6 crisis is unrelenting, epidemic numbers of medical
7 errors and the failure of liability insurers to
8 manage their risk, navigate market cycles, and
9 provide a transparent process for their
10 underwriting, investment, claims handling, and
11 rate setting practices. We urge your committees
12 to focus on ways to reduce medical errors at New
13 York City's hospitals and health care providers,
14 including the need to augment the state's Office
15 of Patient Safety and ensure state funding for
16 independent hospital report cards on patient
17 procedure outcomes.
18 Thank you.
19 COUNCIL MEMBER CROWLEY: Just more
20 of a statement. I think that today's resolution
21 is one of many resolutions that have been
22 introduced. This was introduced back in 2009 when
23 a local hospital closed in my communities, part of
24 the reaction to that and it is my hope that the
25 other resolutions will be heard soon, but

2 resolutions that have to deal with insurance
3 companies covering costs that they aren't
4 providing cost coverage for, and the idea of, you
5 know, a physician practices that would mitigate
6 malpractice, and also idea of some type of
7 compensation for those that would practice in
8 areas that are underserved. But I thank you all
9 for being here today and for your testimony.
10 Thank you.
11 CHAIRPERSON RIVERA: Thank you very
12 much for your testimony, thank you. We're going
13 to merge the last two panels together and we're
14 going to call Jay Tartell, David Friedman,
15 Patricia Burkhardt, Kraig Cook, and Ebony Constant
16 all to join us on a panel.
17 KRAIG COOK: I'm merged.
18 CHAIRPERSON RIVERA: Thank you very
19 much for being patient and staying with us the
20 entire time. Just--
21 PATRICIA BURKHARDT: I'll go.
22 CHAIRPERSON RIVERA: --state your
23 name for the record and you may begin.
24 DR. DAVID FRIEDMAN: My name is
25 David Friedman, I'm a practicing gynecologist in

2 Manhattan. I'd like to thank the Council for
3 their copious amount of time they're spending on
4 this issue. It's a very important issue and I
5 think this shows that you have your finger on the
6 pulse of the community because this really is
7 affecting your constituents.

8 The unfettered access to the courts
9 for medical malpractice has been abused lately and
10 actually is harming access to quality health care
11 for all New Yorkers. I think we've heard a lot of
12 testimony today that will back that up.

13 I'm going to just very briefly use
14 my own recent experience as an example of the
15 unfortunate path we're headed if some kind reform
16 is not instituted. Back in 2008 I was practicing
17 obstetrics and gynecology in Brooklyn and I was
18 paying $168,000 a year for malpractice insurance.
19 I decided I can't do that anymore. The money that
20 you bring in and the money that you put out was
21 not adding up. I either had to leave New York or
22 stop practicing obstetrics.

23 So what I did was I gave up OB and
24 I moved my practice from Brooklyn to Manhattan.
25 It sounds strange, but if you move your practice

2 across the river, even if you're the same doctor,
3 it cuts 20% from your premium. So it has nothing
4 to do with what kind of doctor you are, it has to
5 do with what county you practice in.
6 I didn't put any quality measure
7 increases into my practice, I was the same doctor,
8 but I did cut out my obstetrics and I saved
9 $100,000 a year. That's not insignificant, and
10 other doctors are catching on. Now I'm at Lenox
11 Hill Hospital and Mount Sinai Hospital, and every
12 week another doctor or two shows up from Brooklyn
13 that got the idea, get out of Brooklyn, pass it
14 on.
15 So the old canard that a few bad
16 doctors spoil it for the rest of us simply isn't
17 true. If you look at malpractice rates upstate in
18 New York in Syracuse for an ob-gyn, it's $51,000 a
19 year, and in Brooklyn, Kings County, it's 166,000,
20 according to MLMC. You know, as the judge said
21 earlier, that doesn't mean that the doctors up in
22 Syracuse are better doctors.
23 So what it all boils down to is
24 that the specialty of obstetrics and gynecology is
25 now being torn apart and patients are being

2 affected. You could see that maternal mortality
3 rates, as been mentioned in the New York Times,
4 have gone down every year since obstetrics and
5 gynecology became a specialty. Now the specialty
6 is being torn apart and so now we're seeing
7 maternal mortality rates go up.
8 So briefly, I think we've already
9 hit on the things that we can do to make this
10 better, such as curbs on pain and suffering, loser
11 pays, no-fault, medical courts, and specialized
12 judges. But whatever we have to do, we have to do
13 something, and I think we shouldn't reinvent the
14 wheel, we should look for things that have already
15 been tried and true. Thanks.
16 KRAIG COOK: Good afternoon, let me
17 begin by thanking you for the opportunity to
18 testify here today. My name is Kraig Cook and I'm
19 here reading the testimony of Deborah Axt, the
20 Deputy Director of Make the Road New York. Make
21 the Road promotes economic justice, equity, and
22 opportunity for all New Yorkers through community
23 and electoral organizing, strategic policy
24 advocacy, leadership development, youth and adult
25 education, and high quality legal and support

2 services. For many years, Make the Road has
3 actively campaigned for legislation and other
4 initiatives that promote equal access to health
5 care and tackle health problems that
6 disproportionately impact low-income communities.
7 The proposed resolution is a
8 distraction from real health care issues that
9 confront our communities--the issues of access,
10 not just to women's health services, but to
11 quality health care for all. Medical malpractice
12 insurance premiums are not one of the reasons why
13 in lower income communities, too many women do not
14 have adequate access to obstetrical services and
15 to primary care in general. After all, medical
16 malpractice insurance premiums are higher on Long
17 Island than they are in New York City, yet Long
18 Island has far more doctors per capita than does
19 New York state overall.
20 The real reason is chronic under
21 funding of primary care in lower income
22 communities. According to the Kaiser Family
23 Foundation, as of 2008, New York ranked 47th in
24 obstetrical service fees and 48th in primary care
25 fees paid to Medicaid physicians. It's no wonder

2 that, according to the resolution, there are
3 primary care shortage areas in the Bronx.
4 It's true that New York spends more
5 than any other state on Medicaid, but in New York,
6 43% of Medicaid spending goes to long-term care,
7 compared to 33% for the U.S. overall, according to
8 Kaiser. That has meant that our clinics that
9 serve low-income women are barely holding on. It
10 has also meant that several hospitals that served
11 primarily a low-income population recently closed
12 and others are on the verge of closure. Many of
13 these hospitals had or have obstetrics
14 departments.
15 St. Vincent's Hospital is a case in
16 point. Although it was located in Greenwich
17 Village, St. Vincent's treated mostly Medicaid and
18 other low-income patients. A New York Magazine
19 article in 2010 that examined why the hospital
20 closed reported that inadequate Medicaid funding
21 was a major factor, noting, "the hospital industry
22 complains that since 2007 the New York State
23 Legislature has cut Medicaid funding nine times,
24 at a cost of $900 million to local hospitals.
25 Health care providers in New York City low-income

2 communities also bear a heavy financial burden for
3 treating uninsured women. In 2007, the Office of
4 the New York City Comptroller released a study on
5 health care disparities in New York that included
6 a disturbing table listing communities where at
7 least 30% of the residents were uninsured. In
8 Sunset Park, for example, 40% were uninsured, in
9 East Harlem 37% were uninsured, in Hunts Point-
10 Mott Haven 36% uninsured. Hospitals and community
11 health clinics that treat the uninsured have to
12 subsidize uninsured patients with funds from other
13 important parts of their budget or by
14 unsustainable levels of borrowing. The city has
15 been trying to enroll more Medicaid-eligible
16 uninsured New Yorkers, but there is still a long
17 way to go.
18 The growth in New York City's
19 foreign-born population has been a major driver of
20 these high uninsured percentages. According to
21 the City's health department, in 2007, 52% of
22 births in New York City were to foreign born
23 women, increase from 48% in 1998.
24 Unless Medicaid funding and
25 payments for treating the uninsured are increased

2 substantially, we can expect even more hospital
3 closures in lower income communities. Earlier
4 this month we spoke out against the possible
5 closure of Wyckoff Heights Medical Center. We
6 said it would be disastrous for our community. I
7 now add that it would eliminate needed obstetrical
8 services--in 2009, 1,675 babies were delivered
9 there. Other endangered Brooklyn hospitals with
10 maternity departments include Brooklyn Hospital,
11 which delivered 2,829 babies, and Brookdale
12 Medical Center, with 1,686 deliveries. The
13 possible closures and mergers of these hospitals
14 are a serious threat to obstetrics services in
15 Brooklyn, but the reasons these hospitals are
16 threatened have nothing to do with their medical
17 malpractice payments, which are a minute fraction
18 of operating expenses.
19 As the New York Magazine article on
20 St. Vincent's explained, New York City's hospitals
21 serve more uninsured patients, face higher costs,
22 and receive lower Medicaid and Medicare payments
23 for services than do hospitals elsewhere in the
24 country. As one chief operating officer of a
25 Bronx community hospital said, we're asked to do a

2 dollar's work for 70 cents. Executive
3 compensation is another burden on hospital
4 finances. While many hospitals face financial
5 ruin, in 2008, the president and CEO of New York
6 Presbyterian, Herbert Pardes, received $9.8
7 million in pay and compensation. As a result of
8 so many financial pressures, many New York
9 hospitals are saddled with unsustainable debt that
10 can lead to bankruptcy and closure.
11 One of the clauses in the proposed
12 resolution is especially disturbing. It
13 recommends a Michigan program that would
14 disproportionately hurt people of color. In this
15 program, the heath care provider that made a
16 serious medical mistake apologizes to the injured
17 patient and offers quote fair compensation outside
18 of the civil justice system, with no judge, jury,
19 or lawyer to protect the patient's interests.
20 Patients are pressured to settle for less than
21 they could get if they filed a legal claim. It is
22 an unfortunate reality that people of color in the
23 U.S. are disproportionately harmed by substandard
24 medical care. Numerous major studies have
25 documented that they more frequently experience

2 delayed treatment, missed diagnoses, medications
3 that are not administered, and higher rates of
4 death or adverse incidents as a result of
5 malpractice. For people of color, this is already
6 a matter of life and death. Replicating the
7 Michigan program in New York would strip patients
8 of their legal rights and protections in a system
9 that already discriminates against minorities.
10 This proposed resolution does
11 nothing to address the real barriers to quality
12 care that exists in New York City communities.
13 Therefore, Make the Road must respectfully ask the
14 Health and Women's Issues Committees reject the
15 resolution in its entirety.
16 Thank you again for granting Make
17 the Road the opportunity to testify today.
18 DR. JAY TARTELL: I actually have
19 my copies of my testimony for distribution. I
20 actually have two copies, one is the full copy
21 with all the statistics, one is the abridged copy,
22 and then while I was sitting here, I abridged the
23 abridged copy, so I'm going to be reading from the
24 abridged abridged copy.
25 Good afternoon or I should say good

2 evening, my name is Dr. Jay Tartell, and I'm a
3 radiologist and president of the Queens County
4 Medical Society. I'm Associate Director of
5 Radiology at Mount Sinai Hospital of Queens, and
6 President of Advanced Radiological Imaging,
7 Queens' oldest radiology practice, founded in
8 1958. On behalf of the Medical Society, as well
9 as the Medical Society of the State of New York,
10 we very much appreciate the opportunity to testify
11 today.
12 Resolution 84-A addresses only one
13 small aspect of liability-related challenges
14 facing health care in New York City. Physicians
15 practicing in New York City and surrounding
16 suburbs pay liability insurance premiums that far
17 exceed most other states, yet their ability to pay
18 these extraordinary premiums shrinks daily due to
19 ongoing payment cuts by public and private
20 insurers. Large numbers of New York physicians
21 are now closing or selling their practices due to
22 years of unrelenting payment cuts. Since medical
23 malpractice premiums comprise one of the largest
24 overhead items for many physicians, cutting
25 premiums is of utmost importance to maintain the

2 viability of physician practice, especially for
3 litigation prone specialties.
4 So you're right, I agree with you,
5 the problem is not the premiums, the problem is we
6 can no longer afford them. Resolution 84-A
7 appropriately calls for action by the New York
8 State Department of Health and Department of
9 Financial Services, but action, of course, must
10 actually come from the State Legislature and the
11 governor for some of these initiatives.
12 Liability premiums for New York
13 physicians increased 55 to 80% from 2003 to 2008,
14 and an average of additional 5% in 2010, for some
15 specialties, even higher. While nominal rates
16 were on average held steady in 2011, 2012, the
17 rates are now at extraordinarily high levels.
18 Moreover, my specialty, radiology, on average, was
19 hit with an 8% increase.
20 Now one state was made earlier that
21 the people that find the breast cancer are the ob-
22 gyns, yes, they do find it, but really the ones
23 who are the screeners are the radiologists and
24 we're the ones that are getting hit. And
25 actually, what's very interesting is that the

2 attorneys who were here and presented to you
3 earlier talked about the percentages that I just
4 mentioned and 5% doesn't sound too much, 3%, they
5 actually held them flat by one year, but actually
6 it's the additional surcharges that account for
7 the increase in premiums. Nobody has brought this
8 up today and that's extremely important to be on
9 the radar of the committee. Those in our group
10 who do breast imaging pay premiums 50% higher than
11 the others because they are surcharge. When you
12 have one or two occurrences, 25% surcharge. When
13 you have a two or three occurrences, 50%, 75%,
14 100%, sometimes they'll put you into the assigned
15 risk pool. Ironically, our best radiologists in
16 our group are all paying much higher premiums than
17 the other radiologists in the group.
18 Many New York City physicians, as
19 we have mentioned, pay over 100,000, and many
20 exceed 200,000 in their premiums.
21 Since I'm trying to keep my remarks
22 concise, in the handouts which you've received, I
23 have enclosed the facts and figures and graph
24 showing how the true and meaningful medical
25 malpractice reforms in Texas and California have

2 driven down malpractice premiums markedly. And I
3 will tell you, I know that we're unhappy with the
4 idea of caps, but that's what's responsible for
5 the difference. It's been studied and it's a
6 known fact that Texas and California have lower
7 premiums for their physicians because caps are for
8 non-economic damages are in place, and that has to
9 be on the radar also.
10 Not surprisingly, since Texas
11 reformed its tort law in 2003, over 1,200
12 physicians who trained in New York have located to
13 Texas, according to the Texas Alliance for Patient
14 Access. And you have graphs showing what's gone
15 on in Texas and what's gone on in California, and,
16 unfortunately, what's gone on in New York.
17 The issue is not just access to
18 care, but fiscal as well. As New York State
19 struggles financially, we can no longer afford the
20 costs that arise from a deeply flawed and
21 expensive medical liability adjudication system.
22 New York physician practices are the sixth largest
23 employer in New York state. However, the
24 extremely difficult practice environment
25 physicians face makes moving to other states, and

2 taking crucial jobs with them, an increasingly
3 attractive option, particularly as more and more
4 states enact legislation to reform their medical
5 liability laws.
6 As part of last year's Medicaid
7 Redesign Team, we know that Mr. Cuomo proposed a
8 package of comprehensive liability reforms similar
9 to those enacted in Texas in 2003 with the caps,
10 and to our extreme dismay, this package was
11 excluded at the last minute from the final state
12 budget. As New York reins in its high Medicaid
13 costs, hospitals and physicians are facing
14 substantial payment cuts and increased
15 administrative burdens. And you can talk all that
16 you want that we have to improve this and we have
17 to improve that, but that costs money and when
18 we're being cut, where is the money going to come
19 from? And how can hospitals and physicians
20 survive these burdens when key costs, such as
21 medical liability, are not addressed as an offset?
22 More and more states are passing
23 malpractice reform measures to help their
24 physicians cope with cuts in the face of rising
25 overhead. In just the last year, North Carolina,

2 Oklahoma, and Tennessee enacted laws to provide
3 meaningful limits on non-economic awards in
4 medical liability suits, bringing to over 30 the
5 number of states who have enacted limitations on
6 non-economic damages in medical liability actions.
7 I'll ask the rhetorical questions,
8 why is New York in the minority? Most of us know,
9 but it's still a huge problem. Other states have
10 grappled with it and come to accept that this is
11 the way to really knock down the costs.
12 The enormous liability costs are
13 driven by an unpredictable medical liability
14 adjudication system that numerous studies have
15 concluded results in cases where awards and
16 settlements are made, despite the absence of
17 negligence, and conversely, patients who deserve
18 payment often receive none.
19 Now I'd like to just discuss
20 briefly the unfortunate young patient who sat in
21 the seat next to me, he was skillfully presented
22 to you by the attorneys earlier, and this was
23 admittedly suspected negligence, the verdict is
24 not in the case, and the reality is that in many
25 of these cases cause and effect are very difficult

2 to establish. So what often happens is that the
3 patients parade before the lay jury, eliciting
4 understandable sympathy, and I did see tears in
5 people's eyes and, frankly, I was upset too. And
6 so the lay jury says to themselves, well really
7 what can we do to help this poor patient and their
8 family, and judgments and pretrial settlements are
9 rendered based on that. Whether negligence was
10 truly present can be ambiguous at best. And this
11 is really another major problem.
12 So physicians who treat the most
13 high-risk patients are sued with astounding
14 regularity in New York state--we went over some of
15 those statistics. I find that the majority of
16 lawsuits in our radiology group are related to
17 women's imaging, especially mammography. The best
18 doctors in my group who take on high-risk
19 procedures, such as women's imaging, have the
20 highest malpractice premiums. The doctors in my
21 group are the most defensive in their practice
22 style by avoiding high risk procedures, ordering
23 additional tests, they're rewarded with the low
24 premiums. So everybody looks at these low
25 premiums and says, these are great doctors, they

2 deserve a discount, and the best doctors in my
3 groups are getting the opposite end of the stick.
4 There's a well known shortage of
5 women's imaging radiology specialists in New York
6 state as a result of the same malpractice problems
7 afflicting ob-gyns. For this reason, my practice
8 required an almost three-year search before we
9 were able to hire a women's imager. So this has
10 to be put on the record that the women's imagers
11 are scarce in all areas in the downstate area and
12 it took us almost three years.
13 Furthermore, there's also a well-
14 documented decrease in the number of mammography
15 facilities in New York over the last decade.
16 Women's imagers face the same crisis as
17 obstetricians, but radiologists have inexplicably
18 been dropped from the newest draft of your
19 resolution.
20 The problem of the medical
21 liability adjudication system doesn't just affect
22 physicians, the impact is on all health care.
23 Studies have shown that billions of dollars in
24 health care costs are unnecessarily spent each
25 year on the practice of defensive medicine, such

2 as unnecessary tests and specialty referrals, and
3 the cost of this phenomenon vary based on the
4 studies, but they're present in the long handouts,
5 which I gave you.
6 To encourage young physicians to
7 stay to practice in New York, to have enough
8 physicians able and willing to practice high-risk
9 specialties, and to reduce the huge health care
10 costs in our state budget attributable to medical
11 liability, we recommend that the following actions
12 be taken. I'm going to list them and there are
13 descriptions in your long handouts. Alternative
14 Dispute Resolution Forums, we've touched on that;
15 Medical Expert Witness Reform; Certificate of
16 Merit Reforms; Reasonable Caps on Non-Economic
17 Awards; Reducing Frivolous Lawsuits; Immunity from
18 Apologies, that was discussed and that should be
19 included; Peer Review. Then there are Insurance
20 and Structural Reforms, Subsidization of
21 Insurance, Re-creation and Redoing of the High
22 Risk Indemnity Pool--Mama Mia--Periodic Payment
23 Structural Reform, Personal Asset Protection for
24 the Physicians.
25 So to finalize, and I am

2 finalizing, MSSNY and I wish to thank you again
3 for advancing this resolution and holding this
4 hearing today. The spirit of the resolution we
5 support. However, since the resolution raises
6 larger issues critical to all New York citizens'
7 care and our state's fiscal health, we ask that
8 the City Council not be shortsighted by focusing
9 only on ob-gyns. It's imperative that efforts to
10 control health care costs include malpractice
11 relief which will ensure that New York's women,
12 and hopefully men too, have access to physicians
13 in all specialties.
14 Your resolution should really
15 include reduction of malpractice premiums for all
16 doctors. After all, women don't just need
17 gynecologists. The shortage of radiologists to
18 read their mammogram and sonogram is just as real,
19 and don't women need surgeons, cardiac surgeons,
20 neurosurgeons, and vascular surgeons? We agree
21 that New York State Department of Health and
22 Financial Services must be involved, but the
23 resolution must through statutory action by the
24 state legislature. By bringing these very
25 critical issues to the attention of our citizens

2 and our legislators in Albany, the New York City
3 Council makes clear its relevance as a force for
4 the public good.
5 Thank you very much for the
6 resolution and your consideration.
7 PATRICIA BURKHARDT: See if I
8 could--
9 [Crosstalk]
10 PATRICIA BURKHARDT: You're an
11 early-to-bedder then. Good afternoon, I'm Pat
12 Burkhardt, and I wish to thank you for inviting me
13 to this hearing today and inviting the New York
14 State Association of Licensed Midwives, NYSALM, of
15 which I am the president.
16 I am a midwife licensed in New York
17 state, certified with the American Midwifery
18 Certification Board, and I hold a doctorate in
19 Public Health. I've done clinical practice here
20 in New York City for about eight years and then I
21 moved to NYU, where I started and directed the
22 education program for midwifery for 14 years. I
23 am currently the president of NYSALM, the New York
24 state midwifery professional organization that
25 engages in activities to assure access to midwives

2 and choices for women in their health care.

3 Resolution 84-A is critically

4 important in what it seeks to accomplish, however,

5 the formal goal, to devise a comprehensive

6 solution to address the financial and professional

7 barriers to women's access to obstetric care--and

8 that's an interesting focus on care--is very

9 exclusive in its approach. Only obstetricians

10 appear to be affected by financial barriers that

11 negatively impact women's access to obstetric

12 care. In reality, there are other providers in

13 New York City and New York state who share the

14 excess burden of costs, some in more

15 disproportionate ways than obstetricians. I will

16 speak to the situation of licensed midwives, who

17 attended 11% of New York births in 2010.

18 Although the malpractice rates for

19 obstetricians are high in comparison to those of

20 midwives, the salaries are equally disparate.

21 Midwifery salaries range from 75 to $100,000 in

22 New York. Malpractice premiums range from 20,000

23 to 37,000. The best case calculation between

24 these two elements has a midwife paying 20% of her

25 gross salary for malpractice. Worst case

2 scenario, she's paying 49% of her salary from her
3 gross earnings.
4 In additions, midwives are often
5 reimbursed significantly less doing exactly the
6 same procedure or care as a physician--back to how
7 much you can earn in addition to how much you pay
8 out. Unfortunately, the current health care
9 system rewards the doing of procedures rather than
10 the support and maintenance of health.
11 Midwives have been forced to make
12 concessions in practice, as have the
13 obstetricians, because of the high cost. Some
14 midwives chose to practice without insurance, in
15 which case they lose hospital privileges or cannot
16 get them in the first place. Or they stop
17 delivering babies and function solely as if they
18 are nurse-practitioners, or lose their jobs to
19 nurse-practitioners or physicians assistants who
20 do not have the same training in obstetrics that
21 midwives do, but whose malpractice insurance cost
22 is significantly less.
23 The cost of malpractice insurance
24 has impacted access to care especially in rural
25 areas. One of our former members who was one of

2 only three obstetrical providers in her upstate
3 county, closed her practice and moved to North
4 Carolina when she could no longer afford the
5 malpractice insurance with the proceeds from her
6 mostly Medicaid clientele.
7 In addition to focusing on
8 malpractice insurance premiums, strategies that
9 reduce the likelihood of a suit should be explored
10 to facilitate this resolution's goal of removing
11 financial barriers to women's access to
12 obstetrical care. These strategy includes:
13 incorporation of shared decisionmaking as a basic
14 component of care for all women so that they are
15 treated with respect and given an opportunity to
16 be real partners in their care; family-centered
17 care that supports physiological birth needs to be
18 supported by institutions and providers so it is
19 available for those women who choose it, medical
20 intervention is only warranted when there are
21 developing complications. Some of you aren't
22 going to like this one. If an untoward outcome
23 occurs, disclosure and apology by health care
24 practitioners and institutions needs to occur.
25 One program that provides education and training

2 for this approach is Sorry Works. They address
3 patient harm in a thoughtful, expeditious way, and
4 have had excellent results in lowering the
5 incidence of malpractice suits. That of course,
6 is predicated on discoverability of the data
7 that's passed and the information that's shared in
8 a disclosure and apology context.
9 Most critically, licensed midwives
10 must be included in any efforts to remove
11 financial barriers to women's access to, in
12 quotes, straight from the resolution language,
13 expertise in pregnancy, childbirth, including
14 preventive care, prenatal care, detection of
15 sexually transmitted diseases, pap test screening
16 and family planning--all areas in which midwives
17 are as skilled as ob-gyn physicians.
18 Women's access to care requires an
19 inclusive approach, not one that is exclusive and
20 narrow. Exclusive in providers or in approaches
21 and should include some--it's a complex problem
22 that doesn't have a single one strategy solution
23 so safety, prevention of preventable adverse
24 outcomes. Resolution 84-A is a start, but must be
25 amplified to reach the stated goal: Removing

2 barriers to women's access to and, I would say,
3 women's health care, not just obstetric care.
4 Thank you. And I'll let you get
5 over here.
6 EBONY CONSTANT: My name's Ebony
7 Constant, I'm an organizer at the Black Institute,
8 and I'll be reading the testimony of Bertha Lewis.
9 Good afternoon, Chairs Arroyo and
10 Ferreras, and thank you for the opportunity to
11 testify before this joint hearing for your
12 committees today. My name is Bertha Lewis, and I
13 am the founder of the Black Institute. The Black
14 Institute, based here in New York City, is an
15 action tank whose mission is to shape intellectual
16 discourse and impact public policy from the
17 perspective of Black people in America and people
18 of color throughout the diaspora. I'd like to
19 begin--excuse me--by commending Council leaders
20 for their decision to focus on barriers to women's
21 health care providers. I applaud your effort to
22 seek new and innovative ways to improve access to
23 women's health care across the city.
24 Women of color in New York City,
25 and across the country, are disproportionately

2 affected by limited access to quality health care,
3 particularly the primary care they need to live
4 healthy lives. Black doctors providing women's
5 health care also face unique challenges and--
6 excuse me--obstacles because of the communities
7 they serve and their place within the medical
8 profession.
9 However, I take great exception to
10 the resolution under consideration here today.
11 Addressing only malpractice insurance premiums
12 ignores the many complex issues standing in many--
13 excuse me, standing in the way of providing first
14 class health care to all New York City women, and
15 particularly women of color. Bringing clinics and
16 hospitals back to low-income communities and
17 ensuring that everyone receives quality care
18 demands far more than improving the bottom-line
19 for insurance companies.
20 The committee is right to address
21 the issues of access to women's health care. Low-
22 income communities of color do face significant
23 barriers to adequate women's health care,
24 including proper ob-gyn care. However, this
25 resolution addresses only malpractice premiums

2 which are insignificant when compared to the
3 greater challenges facing our communities. For
4 example, low-income communities of color heavily
5 rely on Medicaid. Up to three-quarters of all
6 births in the Bronx are funded by Medicaid and
7 Family Health Plus. Historically, New York's
8 Medicaid reimbursement rates have been far too
9 low. As recently as 2008, New York had the 47th
10 lowest Medicaid--excuse me--obstetrical care fees
11 among the 50 states, according to the Kaiser
12 Foundation. Since 2008, New York has increased
13 its Medicaid obstetrics reimbursement rates
14 somewhat, but many years of having among the
15 lowest rates in the nation has exerted enormous
16 financial pressures on clinics and other women's
17 health care providers in low-income communities of
18 color.
19 And reimbursement rates for
20 obstetric care are still way too low.
21 Reimbursement for a routine delivery, including
22 postpartum care, is only $1,720. Reimbursement
23 rates paid by private health care plans for the
24 same services in more privileged communities are
25 many thousands of dollars more. How can doctors

2 and clinics be expected to maintain their services
3 in low-income communities under these financial
4 circumstances?
5 Improving access to women's health
6 care in our communities depends on increasing
7 state and federal investment in health care,
8 particularly primary care and women's health
9 providers, and increasing Medicaid reimbursement
10 rates. Tinkering with insurance premiums will do
11 little or nothing to address long-standing under-
12 investment in our communities' health care
13 systems.
14 I strongly condemn the suggestion
15 raised by this resolution that women and children
16 of color harmed by medical malpractice, whether in
17 the delivery room or in the radiologist's lab, are
18 unjustly compensated for their injuries. Children
19 injured by malpractice during childbirth face
20 terrible injuries that last a lifetime; women die
21 when a radiologist misreads a mammogram. The
22 costs of compensating women and children of color
23 gravely harmed by malpractice are small when
24 compared to the harm done by negligent doctors and
25 hospitals.

2 Sadly, people of color are
3 disproportionately impacted by medical
4 malpractice. They suffer more missed diagnoses,
5 more instances of medically needed procedures and
6 emergency interventions not done or delayed, or
7 important medications that are not timely
8 administered, and, as a result, more medical
9 errors and poorer outcomes.
10 According to the report of the
11 Institute of Medicine, research has consistently
12 demonstrated what people of color, especially
13 women of color, have known all along: Minorities
14 and people of color experience low-quality health
15 services, and are less likely to receive even
16 routine medical procedures regardless of their
17 income level or insurance status. The Institute
18 of Medicine documented consistently lower quality
19 care received by people of color in cancer
20 testing, pediatric care, and all kinds of surgical
21 procedures.
22 And do not make the mistake of
23 thinking that this is the type of medical
24 discrimination--that this type of medical
25 discrimination could not be a problem here in

2 liberal New York. The U.S. Agency for Healthcare
3 Research and Quality found that the quality care
4 provided to minorities and people of color in New
5 York, measured by deaths and adverse events, was
6 weak or below average. Worse still, minorities
7 were found to be more likely to die from
8 complications during hospitalization.
9 According to a Harvard Medical
10 Practice Study of hospitals in New York, people of
11 color not only experience low quality care, but
12 they also much more likely to be treated in
13 hospitals with higher rates of negligence. In
14 other words, access to high quality health care is
15 a life or death issue for people of color. This
16 resolution's repetitive focus on premiums does
17 nothing to address this critical issue.
18 Improving the quality of health
19 care for people of color and all New York City's
20 health care consumers is vital, achievable, and,
21 coincidentally, would do much to bring down the
22 cost of malpractice for hospitals and insurance
23 companies. Hospitals nationwide have had a great
24 success in reducing medical errors, particularly
25 in the field of obstetrics. At the Hospital

2 Corporation of America, a wholesale redesign of
3 patient safety measures in obstetrics more than
4 halved the number of malpractice claims against
5 their hospitals, and resulted nearly in a fivefold
6 reduction in the cost of claims, according to an
7 article in the American Journal of Obstetrics and
8 Gynecology.
9 One New York City hospital has done
10 an excellent job of replicating this success. New
11 York Presbyterian Hospital implemented a
12 comprehensive safety program, including enhanced
13 communications amongst staff, improved medical
14 record charting, standardized--excuse me--
15 standardized staffing requirements, proper
16 training and supervision, and controlled
17 medication usage. The hospital reduced yearly
18 obstetric-related malpractice payments by 99% and
19 eliminated maternal deaths and other injuries
20 during labor and delivery. If New York
21 Presbyterian can do this, so can other New York
22 hospitals.
23 Women of color have far too long
24 suffered and died as a result of medical
25 malpractice. This committee should be focused on

2 encouraging and implementing measures such as
3 those adopted by New York Presbyterian throughout
4 New York City's hospitals to ensure that all New
5 Yorkers receive high standard of care they
6 deserve. It is an affront to frame the issue of
7 women's access to health care they deserve as
8 simply as a matter of malpractice insurance
9 premium. As a voice for the black community, I
10 respectfully ask that you reconsider this
11 resolution in its entirety.
12 Thank you once again for the
13 opportunity to testify today.
14 CHAIRPERSON RIVERA: Thank you.
15 Council Member Crowley?
16 COUNCIL MEMBER CROWLEY: Thank you
17 to our chair. I want to thank all the panelists
18 for waiting as long as you've done today to
19 testify. For Dr. Tartell, your comments about
20 radiology are included in the genesis of the
21 resolution and it's ever evolving, and so in the
22 beginning I know it was in there and it should
23 have been reflecting access to radiology, breast
24 imaging, mammography care.
25 As for the Black Institute, I'm not

2 sure if you heard earlier when Dr. Haynes, who's
3 African-American physician, spoke and he said--and
4 pretty much prior to that, you had HHC say that
5 there's not one private practitioner practicing
6 obstetrics in the Bronx, that's a problem. And
7 you may say it has to do with the number of people
8 or recipients on Medicaid, but when you take the
9 borough of Bronx and you compare it to a county
10 like Nassau County, you don't have as many people
11 on Medicaid and you have much more of a percentage
12 of a community on private health insurance. So
13 you have different socio-economics, but the
14 problem exist. Not so much that, you know, in
15 Nassau County you don't have that problem to
16 access to care, but in the Bronx, you do.
17 And so no private practitioner, as
18 what Dr. Haynes was saying, wants to practice in
19 the Bronx because the malpractice rates are so
20 high, so everybody in the Bronx that wants to get
21 care in the Bronx has to go to a hospital or a
22 clinic and not a private gynecologist's office.
23 And that's happening in Queens and it's happening
24 in Brooklyn and Staten Island as well.
25 And so while the majority of this

2 resolution is focused on malpractice, as I said
3 earlier, there are a number of resolutions that
4 I've introduced as it relates to women's access to
5 health care and this happened to be the one on the
6 agenda for today.
7 EBONY CONSTANT: Well you don't
8 actually have to speak to me on what's going on in
9 the Bronx, I am a life resident of the Bronx and I
10 am one of the uninsured who lives there, so I
11 definitely am aware of the situation.
12 COUNCIL MEMBER CROWLEY: Right, and
13 would you prefer to go to a private practitioner's
14 office or a hospital if you needed care?
15 EBONY CONSTANT: In all honesty, of
16 the hospitals in the Bronx, I would rather go
17 private.
18 COUNCIL MEMBER CROWLEY: You'd
19 rather go private. And it's better to have a
20 rapport with a private practitioner when you just
21 have to go in for a routine visit, you don't need
22 to go to a hospital, you don't need emergency
23 care, or not about to deliver a baby.
24 I know that this hearing has gone
25 on for longer than we expected and I have to thank

2 both our chairs and especially the chair that has-
3 -
4 [Crosstalk]
5 DR. JAY TARTELL: [Interposing] Can
6 I just say one sentence which really sums up the
7 problem. The problem is not that the malpractice
8 insurance is too high, the problem is that you
9 cannot serve an area where the reimbursements are
10 so low because of the high Medicaid population,
11 you can't service the area properly and either you
12 have to raise the rates of payment or you have to
13 lower the overhead costs or some combination
14 thereof, and that's how you're going to get--
15 [Crosstalk]
16 COUNCIL MEMBER CROWLEY:
17 [Interposing] I understand and there needs to be a
18 remedy, but the problem clearly exists and it
19 needs to be addressed.
20 And I have to thank our chair for
21 today, Council Member Joel Rivera, for being so
22 patient. And thanks again everybody.
23 CHAIRPERSON RIVERA: No problem.
24 [Crosstalk]
25 CHAIRPERSON RIVERA: Thank you very

2 much, Council Member Crowley. Thank you for
3 everybody who participated today and especially
4 those who stayed until the very end. Thank you,
5 and this meeting is adjourned.
6 [Off mic]
7 MALE VOICE: Do we get a midnight
8 snack?
9 COUNCIL MEMBER CROWLEY: Yes, you
10 do, Newman's--
11 [Off mic]
12 MALE VOICE: Nutritious, approved
13 by the AMA.
14 [Off mic]
15 DR. JAY TARTELL: Thank you very
16 much.
17 [Off mic]

C E R T I F I C A T E

I, Tammy Wittman, certify that the foregoing transcript is a true and accurate record of the proceedings. I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

Signature Tammy Wittman

Date _February 24, 2012_