24

amsny

Educate · Advocate · Collaborate

Testimony of:

Lee Goldman, MD, MPH
Executive Vice President for Health and Biomedical Sciences, Columbia University;
Dean, Columbia University College of Physicians & Surgeons;
Chair, Associated Medical Schools of New York (AMSNY)

And

Jo Wiederhorn
President & CEO, Associated Medical Schools of New York (AMSNY)

At a Joint Hearing of the New York State Assembly Committee on Ways and Means
& the New York State Senate Committee on Finance
On the Executive Health Care Budget

February 8, 2012
10:00 am
Legislative Office Building
Albany, New York

Good afternoon Chairman DeFrancisco, Chairman Farrell, Chairman Hannon, Chairman Gottfried and other distinguished members of the State Legislature. Thank you for this opportunity to testify on the Executive proposed budget for fiscal year 2012-2013.

My name is Dr. Lee Goldman and I am Executive Vice President and Dean of Columbia University Medical Center. As the newly elected Board Chair of the Associated Medical Schools of New York (AMSNY), I am here today to represent the consortium of sixteen public and private medical schools in New York State. With me is Jo Wiederhorn, President & CEO of AMSNY. The organization works in partnership with its members to promote high quality and cost-efficient health care by assuring that New York State's medical schools provide outstanding medical education, patient care and biomedical research.

We are grateful for the programs that were included in the Executive budget, including continued funding for stem cell research and the AMSNY diversity in medicine pipeline programs. In addition, AMSNY supports the State's expanding economic development strategy. In our testimony today, we would like to address the importance of the medical schools and their affiliated teaching sites in: 1) producing the future physician workforce; 2) promoting biomedical research and strengthening local economies; and 3) improving the health of the communities they serve. We will close our testimony with discussion of the public medical schools.

Health Care Workforce

New York's medical schools educate approximately 10,000 students each year. All our schools strive for excellence in providing quality medical education, knowing its ultimate impact on the future physician workforce and their ability to provide comprehensive care to an increasingly diverse population. In tandem with sweeping changes resulting from health care reform, the medical school curriculum has greatly evolved to include the importance of outcomes-driven patient care; inter-professional team-based models; cultural competency; and training in basic and translational research to further knowledge acquisition.

For several years, AMSNY and the NYS medical schools have worked with the state Departments of Health and Education, and local and national societies, to address the gap between the future demand and supply of the health care workforce. The Association of American Medical Colleges (AAMC) has called for a 30% increase in medical school enrollment by 2012. Although many schools have increased class sizes and new medical schools have opened (including Hofstra on Long Island and Touro in Harlem) there is a need to take a more expansive approach that will adequately fill the workforce gap without sacrificing quality of care.

AMSNY strongly believes in the importance of a multi-faceted strategy to meet the growing demand for primary care and specialty physicians, while simultaneously tackling the current need to decrease access barriers in underserved areas. Since 1985, AMSNY has supported an array of pipeline programs across the state with the intent of expanding the pool of students choosing careers in health and medicine. The goals of these programs, which have been endorsed by the Departments of Health and Education, are to provide academic enrichment and support to students from educationally and/or economically underserved backgrounds. These programs provide an opportunity that a majority of participants would not have had due to cultural and financial barriers.

Minority physicians play a critical role in the physician workforce shortage. While underrepresented[1] in medicine populations (URM) make up 32.9% of the New York State population, they only account for 9.5% of New York State physicians. Increasing the number of URM in New York State is vital for the state's health. URM physicians are more likely to work in primary care or obstetrics/gynecology (39%) compared to all other physicians (27%). Additionally, URM physicians are more likely to work in downstate New York (82% vs. 69%) and in urban areas (94% vs. 91%) compared to all other physicians.[2]

Programs such as the Columbia-Bassett program in Cooperstown, the Rural Medicine (RMed) program at Upstate Medical University and the Sophie Davis College of Biomedical Education provide unique models for immersing students in underserved areas. The Columbia-Bassett program, of which I am most familiar, provides a distinctive educational experience for students interested in rural medicine. Students in the program spend their first eighteen months of medical school in New York City taking the basic sciences curriculum. They then spend their clinical years at Bassett, after which they earn their M.D. degree from the Columbia College of Physicians & Surgeons. The program is in its second year with the first group of ten students just having started up in Cooperstown last month.

Thank you for your support of the diversity in medicine pipeline programs. We ask that you maintain funding for these programs as they are vital to getting young people interested in medicine and provide the necessary support in helping them become physicians.

Research & Economic Development

[1] "Underrepresented in medicine means those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population." AAMC's Executive Council, June 2003

[2] Martiniano R, Mulvaney; P, Moore J, Armstrong D. A profile of New York's underrepresented minority physicians. Renssleaer (NY): The Center for Health Workforce Studies; 2008 Jul.

In 2008, AMSNY commissioned a study from the health economic analysis firm Tripp Umbach to examine the impact of the academic medical centers (medical schools and their affiliated hospitals) on the state of New York. The report noted both the social benefit such institutions provide, as well as their significant contributions to economic growth and workforce development.

In 2008, academic medical centers had a statewide economic impact of more than $85.6 billion in the aggregate, accounting for eight percent of the state's total economy, and nearly $4.2 billion in tax revenue. Academic medical centers collectively supported nearly 700,000 full-time equivalent jobs as a result of their operations. The report also found that the state received a return of $7.50 for every $1 invested in research at the medical schools.

Research is a critical component of NYS' medical schools and acts as a catalyst for economic development across the state. Each of our schools is engaged in a variety of initiatives with the hopes of expanding knowledge and improving the health of the population at large. AMSNY is particularly grateful for the state's continued support of the Empire State Stem Cell Program (NYSTEM).

NYSTEM has proven extremely successful and continues to drive medical innovation and job creation. Funding for this Program positions the state as a national and global leader in stem cell research, and brings hope to millions of people suffering from a range of debilitating diseases. Scientists say that in the future, stem cells may be used to replace or repair damaged cells and have the potential to drastically change the treatment of conditions like Alzheimer's disease, amyotrophic lateral sclerosis (i.e. ALS or Lou Gehrig's disease), burns, macular degeneration, cancers, spinal cord injury, Parkinson's disease, juvenile diabetes and other conditions. The infusion of state funds for stem cell research has been the mechanism by which institutions have been able to leverage the state's investment to obtain significant amounts of external funding through federal grants and philanthropic sources.

The state's investment in stem cell research has created new jobs and is attracting top researchers from around the world. Leading scientists and medical professionals are coming to New York because they are able to conduct cutting-edge research in the state. In doing so, these scientists are often bringing their NIH grants and post-doctoral students. Furthermore, medical schools and research laboratories are hiring new researchers to compliment the stem cell programs. The growing research infrastructure brings increased revenue for research facilities and staff and the ability to train new graduate students, develop new drug therapies, and spin off clinical businesses throughout the region.

It is also important to note, that even with the new federal policy in place, there are certain areas that the NIH cannot fund. NYSTEM funding can be used to support capital expenditures and researchers can

use the funds to test new hypotheses, thus providing the ability to collect data that can then be used to apply for a National Institutes of Health (NIH) grant. NIH funding does not allow for either of these expenses. Having NYSTEM funds available to meet these needs puts New York at a great advantage.

The state must, however, continue to invest in research infrastructure, both in terms of facilities and talent. It is extremely important to remember the value of programs that seek to recruit and retain scientific talent from outside of NYS. In previous years, the Foundation for Science, Technology and Innovation (NYSTAR) conducted the Faculty Development Program that did just that. The program, which unfortunately lost funding in recent years, enabled institutions to attract up and coming researchers, foster university-industry collaborations, and harness technologies that emerged from basic research into real-world application. NYSTAR-funded scientists have had tremendous success in commercializing their research. For instance, at Columbia University, eight faculty received awards of approximately $750,000 each, for a total state investment of $6 million during the period of 2002-2009. These eight faculty members have received more than $80 million in federal and foundation grants. From 2001-2011, eight researchers at Stony Brook University Medical Center received approximately $5.7 million in NYSTAR awards. Their research has led to six start-up companies, 33 invention disclosures, 57 patent applications, and 21 issued patents. In addition, they have brought in a total of $38.8 million in funding from federal sources. AMSNY estimates that for every $1 in NYSTAR funding for the Faculty Development Program, there was a return of $7 to the state. In total, out of seventeen institutions that received Faculty Development Program awards, there was a resulting impact of $253,000,000 in revenue, cost savings, and capital improvement projects (as per 2009 data from the Empire State Development Corporation).

New York has an established and rich resource in academic medicine. AMSNY encourages the state to look at academic medicine as a means for future economic development. Currently, regions of the state (Buffalo, Rochester, Syracuse, Albany, LI and NYC) that have academic medical centers understand the importance of continued investment and growth; however, the state has yet to make this connection and recognize the importance and potential economic growth opportunities that exist.

Patient Care & Medical Malpractice Reform

As a member of the Medicaid Redesign Team Medical Malpractice Reform Work Group, Dr. Goldman witnessed firsthand the ongoing difficulties with developing solutions to this contentious issue. There is a need to develop real and comprehensive medical malpractice reform in order to achieve three very important goals: 1) increase patient access to health care, 2) protect and improve patient safety, and 3) reduce costs for providers and to the health system overall. These goals are not mutually exclusive. Too often the debate is cast as one of malpractice reform vs. patient safety. This is a false choice. We need

and can reduce both the number of preventable medical errors and the malpractice premiums that providers pay.

No one is seeking to deny just, prompt, and reasonable compensation to patients who suffer harm as the result of the negligence of a hospital or doctor. But the system as it exists in New York today is out of control, with our State having among the highest, if not the highest, costs in the nation. During the course of his or her career, 99% of physicians practicing in a high-risk specialty, like obstetrics or neurosurgery, will face a malpractice claim. We can argue about what percentage of these types of doctors practice bad medicine, but I would hope that we could agree that it is nowhere near 100%.

Dr. Goldman's complete memo to the Medicaid Redesign Team can be found at the end of this testimony.

State University of New York (SUNY) Hospitals

Finally, New York State's public medical education system is one of the best in the country. Their affiliated hospitals are the safety net hospitals within their communities and as such treat some of the most complicated (and often rarest) medical conditions. And yet, this medical education system is facing decimation after years of draconian budget cuts to both the medical schools and their affiliated hospitals. This is a foremost concern to all members of AMSNY.

The SUNY medical schools and their affiliated hospitals are inextricably linked. They share major administrative resources i.e. human resources, physical plant, payroll, information technology, security, as well as faculty and education costs. In FY 10-11 the hospitals transferred $225 million to their academic campuses to maintain operations:

- Downstate: $94 million
- Upstate: $59 million
- Stony Brook: $72 million

AMSNY requests the Legislature restore the SUNY hospitals' annual subsidy to $115 million.

Closing

Thank you for the opportunity to testify today and for your continued support of medical education. We welcome any questions you may have.

Respectively Submitted:

Lee Goldman, MD, MPH

Jo Wiederhorn

The Associated Medical Schools of New York (AMSNY) is a consortium of the sixteen public and private medical schools in the state. The organization's mission is to promote high quality and cost-efficient health care by assuring that the NYS medical schools can provide outstanding medical education, care and research.

AMSNY Member Institutions

- Albany Medical College
- Albert Einstein College of Medicine of Yeshiva University
- Columbia University College of Physicians & Surgeons
- Hofstra North Shore-LIJ School of Medicine of Hofstra University
- Mount Sinai School of Medicine
- New York College of Osteopathic Medicine
- New York Medical College
- New York University School of Medicine
- Sophie Davis School of Biomedical Education at City College of New York
- State University of New York Downstate Medical Center
- State University of New York Upstate Medical University
- Stony Brook University Medical Center
- Touro College of Osteopathic Medicine
- University at Buffalo State University of New York School of Medicine & Biomedical Sciences
- University of Rochester School of Medicine & Dentistry
- Weill Cornell Medical College

Memo from Lee Goldman, MD to Ken Raske and Joseph Belluck, re MRT Med Mal Work Group ideas

To: Joseph Belluck, Esq.
Kenneth Raske

From: Lee Goldman, M.D.

Date: November 1st, 2011

Re: Work Group Recommendations

First let me start by thanking you both for serving as Co-Chairs of the Medicaid Redesign Team Medical Malpractice Reform Work Group. No doubt, it was not an easy task to bring a group such as ours together, but the meetings have been informative and productive.

The Work Group should strive to meet three very important goals (1) increase patient access to health care, (2) protect and improve patient safety, and (3) reduce costs for providers and to the health system overall. These goals are not mutually exclusive. Too often the debate is cast as one of malpractice reform vs. patient safety. This is a false choice. We need and can reduce both the number of preventable medical errors and the malpractice premiums that providers pay.

No one is seeking to deny just, prompt, and reasonable compensation to patients who suffer harm as the result of the negligence of a hospital or doctor. But the system as it exists in New York today is out of control, with our State having among the highest, if not the highest, costs in the nation. Perhaps even worse, there is also often a disconnect between the quality of care and the likelihood of patient recovery of damages. The tort system should compensate for and punish bad medicine, but all too often it seems to do so merely for bad outcomes. During the course of his or her career, 99% of physicians practicing in a high risk specialty, like obstetrics or neurosurgery, will face a malpractice claim. We can argue about what percentage of these types of doctors practice bad medicine, but I would hope that we could agree that it is nowhere near 100%.

One other theory often espoused is that somehow the real villains are the insurance companies who are using the medical malpractice reform movement as a way to increase profits and who will not return any savings to the doctors. Whatever the case may be in other states, this is not so in New York. An overwhelming majority of the

physicians and hospitals are insured by non-profit organizations, provider-owned companies, or other forms of cooperatives. They do not get their insurance from traditional for-profit companies, so if there are savings to be had, they are normally distributed to the providers in the form of dividends or the reduction in future premiums. We are insured through MCIC Vermont, which we, along with several other academic medical centers, control. If the problem was greedy for-profit insurance companies, our rates from our own insurer would be significantly less than we could get elsewhere. They are not.

Along these lines, I am very wary of any solution which looks at the medical malpractice issue as just an insurance problem. We must reform the system and not just attempt to regulate or subsidize premiums. That would miss the point and not be fair to taxpayers and ratepayers.

Recommendations

Caps on Non Economic Damages: Caps have been demonstrated to be the best and quickest way to lower medical malpractice costs. They are however very controversial. In order to achieve consensus, perhaps we could explore ways to provide some flexibility or even rare exceptions to the caps.

Strengthening and Expanding the Medical Indemnity Fund: Although it is still early, preliminary indications are that the Medical Indemnity Fund is a successful tool to lower costs and ensure the patient receives quality health care throughout the course of his or her life. The work group should look at ways to ensure the fund is adequately funded and perhaps expand it to cover other types of cases.

Safe Harbor: As mentioned earlier, too often the system awards damages for bad outcomes, not bad medicine, and even providers who meet and exceed the standard of care incur large medical malpractice costs. This should not be. Providers who practice according to accepted guidelines should be exempt from liability, and we need to develop a system under which the guidelines are more clearly set forth and can be fairly applied by a judge or jury.

Expert Witness Testimony: Expert witness testimony should be subject to discovery and deposition. This is just basic fairness and, to the best of my knowledge, New York is the only state which disallows this common sense approach, and it does so only in medical malpractice cases. The federal courts also provide for expert witness discovery. The purpose of a trial is to determine a just result based on the law and the facts. The outcome should not be based on surprising the other party, who is then

unprepared to question a witness. In addition, legitimate expert disclosure gives greater information to all litigants and provides both sides with greater opportunities to evaluate their cases. Broader pretrial expert disclosure also would aid the courts in identifying legitimate opportunities for pretrial resolution. As such, many believe that it will promote settlements. The argument that experts would somehow be subject to intimidation or peer pressure is simply specious. With all the advances in evidence based medicine, physicians often testify against other doctors when they feel the situation warrants it.

Joint and Several Liability Reform: As with non-economic damages, defendants, especially those who were minimally responsible for the plaintiff's harm, should be held responsible only for their share of the economic damages. This is simple fairness and will lead to quicker and more efficient disposal of cases against certain defendants.

Current New York law limits a joint tortfeasor's liability for non-economic losses to its proportionate share provided if he/she is 50% or less at fault. However, the joint and several liability rule remains in full effect for economic damages. In many cases, economic damages are by far the largest portion of the award, meaning that a defendant who is found to be only partially or even minimally at fault could be responsible for most, if not the entire damage award, if other, more culpable defendants are insolvent or cannot satisfy their allotted shares of the award. The perverse result of the current law is a system that rewards limited insurance coverage and penalizes those who are fully insured. New York needs to adopt a "fair share" rule such that, unless a defendant's liability exceeds 50% or is based upon willful, reckless, or malicious conduct, damages are tied to the appropriate share of liability. The joint and several liability limitations applicable to non-economic damages need to be applied in the same way to economic damages.

Affidavit of Merit: The Certification of Merit requirement should be strengthened to require an affidavit from an appropriate qualified provider stating that the case against each defendant has merit before an action can be commenced. This will cut down on the number of frivolous lawsuits and the number of defendants sued simply because they were someone how involved in providing care to the plaintiff.

Currently, in order to satisfy this requirement, a plaintiff's attorney need only provide a certificate saying that he/she has consulted with a physician who believes the case has merit. The attorney does not have to provide the physician's name nor any other information. Certainly if a physician believes a case has merit, he/she should be required and willing to attach his/her name to that statement. There is also no requirement that the consulting physician practice in the field or area of the case at hand or that he/she still be in practice and knowledgeable about the current state of clinical practice and science. Under New York's current law, a retired dermatologist who hasn't seen a patient or read a medical journal in five years and who practiced in a

completely different setting can be the basis for a certification in a complex OB/GYN case. Furthermore, the consulting physician can base his/her her opinion solely upon the information provided by the plaintiff's attorney without even reviewing the medical records. The Certificate of Merit requirement was designed to guarantee that a physician would review a case prior to its even being brought in order to support a good faith basis for bringing the lawsuit, but the current law falls far short of that goal.

Apology and Quality Assurance Statements Protections: Statements made by providers apologizing to a patient should not be able to be used against the provider in future litigation. Doing so inhibits doctor-patient communication and forces the doctor and patient to take on adversarial roles. Allowing the doctor and patient to work together to solve problems and resolve disputes will, in many cases, lead to a quicker resolution that is better for both parties. Furthermore, statements made to review or quality assurance committees should be absolutely protected from discovery. The best way to ensure safety is to allow providers to be open and honest with each other and have free, frank, and often difficult conversations concerning adverse events. This will allow all providers to learn from experience and mistakes. This is not possible if those statements can be used in a future litigation. In the event a provider makes a medical error, the first thoughts should be how to fix it and prevent it from happening again, not how to limit the chances of getting sued.

Early Settlement: The efforts in the Bronx and other courts to encourage early settlements have been fruitful and should be continued and expanded. Judges should be further encouraged to dispose of cases earlier on in the process, especially where the defendant played only a tangential role in a patient's care. Judges should also be more aggressive, as is the case in federal court, in imposing sanctions against litigants and their attorneys who bring meritless cases or raise unreasonable defenses and claims.

Expert Discipline: It is fundamental to American jurisprudence that the jury hear expert opinion only from those who are both responsible and truly qualified. Nonetheless, in too many cases juries are allowed to hear from those whose views are not justifiable. It should be a form of professional misconduct for a doctor to give false expert testimony. The problem of irresponsible "experts" is compounded by the fact noted above that experts do not need to be disclosed and are not deposed prior to trial, minimizing the availability of motions designed to challenge the legitimacy of the expert's theory. Currently, the only recourse available is to report such a physician to his professional society, a number of which now have specific requirements for legitimate expert testimony. However, the enforcement is highly variable among societies, and the penalties too light. A professional misconduct charge by the Office of Professional

Medical Conduct would be much more effective, particularly if it could have some jurisdiction over physicians from other jurisdictions who testify in New York.

Specialty Courts: One of the best, and fairest, methods of controlling the costs and delays inherent in our current medical malpractice system would be to have all such disputes settled by specialized courts where the judges are specially trained in medical malpractice issues. Estimates are that as little as 46% of premium dollars are ultimately received by plaintiffs. These "Specialized Courts" would shorten the time taken to resolve such disputes, decrease the costs of such disputes and result in more accurate and fairer results for both sides.