Committee Meeting

of

SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

SENATE BILL No. 557

(Testimony on the Patient Safety Act; establishes medical error reporting system and provides "Good Samaritan" protections to certain health care professionals)

LOCATION: Committee Room 1
State House Annex
Trenton, New Jersey

DATE: January 26, 2004
1:00 p.m.

MEMBERS OF COMMITTEE PRESENT:

Senator Joseph F. Vitale, Chair
Senator Barbara Buono
Senator Ellen Karcher
Senator Fred H. Madden Jr.
Senator Ronald L. Rice
Senator Robert W. Singer
Senator Diane B. Allen
Senator Thomas H. Kean Jr.
Senator Walter J. Kavanaugh

ALSO PRESENT:

Eleanor H. Seel
Office of Legislative Services
Committee Aide

Aurea Vazquez
Senate Majority
Committee Aide

Olga Betz
Senate Republican
Committee Aide

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TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

TABLE OF CONTENTS (continued)

APPENDIX (continued)

lmb: 1-69

SENATOR JOSEPH F. VITALE (Chair): Good afternoon, everyone. Before I begin, I just wanted to, first, recognize the new members of this Committee: Senator Ellen Karcher and Senator Fred Madden. Welcome to the Committee.

SENATOR MADDEN: Thank you.

SENATOR VITALE: Look forward to working with you.

Senator Rice.

Senator Buono will be joining us shortly.

I also want to take a moment to recognize Senator Singer. For two years, we were Co-Chairs of this Committee, and we faced many difficult issues together and worked, I think, well together. And none of that should change now that there's a different makeup of this Committee. I want to thank Senator Singer for--

SENATOR SINGER: Does that mean I'm still Co-Chair? (laughter)

SENATOR VITALE: If you'd like to be, sure.

Thank you.

We have two issues before us today. One is a piece of legislation that this Committee approved unanimously just over a month ago. We'll call it the Patient Safety Act. And that bill is back again today -- was voted out of the Senate, but did not receive an Assembly hearing. We know that that will all change now, but the Senate still has to put this bill back on. We have that bill before us today.

In addition to taking testimony from health-care professionals, Attorney General Peter Harvey is here today, and other stakeholders in the

health-care delivery business. As you all know, we'll mostly be here today to listen to testimony and to provide testimony as it relates to the ability for institutions to share information with one another regarding their employees. And as you know, this is, in part, due to the recent revelations of Charles Cullen, who has professed to have killed at least 40 individuals under his care.

But before we take testimony and speak about those issues, I did want to ask Commissioner Lacy to come forward. Commissioner Lacy has, for over a year and a half, worked with my office in developing the patient safety bill. We think that we've made great strides and, with the Commissioner's help, we have what we believe is a terrific product before us today. Without further ado, I'd like to ask the Commissioner to make some comments about that bill.

Thank you, Commissioner.

COMMISSIONER CLIFTON R. LACY, M.D.: Thank you very much. Good afternoon, Mr. Chairman and members of the Committee. Thank you for the opportunity to testify today.

Most discussions about harm to patients focus on injury that has already occurred and what is appropriate compensation and remediation. The great significance of the legislation under consideration today is that it promotes a culture of safety to prevent occurrence of harm in the first place. We're talking today about saving lives. Every day New Jersey's health-care community saves lives by action at the bedside. Today, you -- New Jersey's legislators -- will be saving lives by action on this legislation.

I would be remiss if I did not specifically acknowledge the vision and tireless efforts of Senator Vitale. He's been the champion and prime mover of this legislation since its inception.

The Patient Safety Act is vitally important for the protection of patients. Governor McGreevey and I are committed to enacting comprehensive, sound patient safety legislation. This is a high priority of the Department of Health and Senior Services. We must create a culture of safety that encourages health-care professionals to come forward and disclose problems to help identify and develop solutions. We must understand what, why, and how errors occur so that they can be prevented.

This bill mandates the confidential disclosure of serious, preventable adverse events, and encourages the voluntary anonymous and confidential disclosure of less serious adverse events and the so-called near misses that do not result in harm. This legislation will result in greater disclosure of errors which will increase understanding of system failures. Analysis of the causes of the failures will allow development of effective prevention strategies, which can then be disseminated statewide. This bill will ultimately improve patient safety and save lives.

In every industry, there are faults in systems that produce errors. Preventable error costs in this country total approximately $17 to $29 billion, according to a 1999 study by the Institute of Medicine. Well-designed systems have processes built in to minimize errors, to detect those that do occur, and to continually improve a system's performance.

The airline industry has continued to improve its safety system since World War II. The risk of dying on a domestic flight between 1967 and

1976 was one in 2 million. By the 1990s, the risk could decrease to one in 8 million. And by 1998, there were no deaths in the United States on commercial flights. Research into safety was an integral component of the aviation industry strategy. By maintaining databases of errors and near misses, and setting process standards with very low tolerance for error at each step, the airline industry made flying safer.

The health-care industry is considerably behind aviation in error prevention. The more complex a system, the greater the risk of error. Health care, as you know, is a very complex system involving many critical steps in processes. The right therapy must be given to the right patient at the right time by the right route for the right reason.

According to the Institute of Medicine's 1999 report, between 44,000 and 98,000 deaths each year are caused by medical errors in this country. More people die each year as a result of medical errors than for motor vehicle accidents, breast cancer, or AIDS. Medical errors cost the health-care industry about $8.8 billion a year. The great majority of medical errors result from problems in systems, not issues of individual competence. As a colleague of mine so aptly puts it, every system is perfectly designed to yield the outcomes it produces. To avoid a bad outcome, one must find the mechanisms in the system that cause the errors and alter them. To prevent a bad outcome, one must change the system. To change the system, there must be an accounting of adverse events and near misses, which can be then carefully examined to find the errors that cause them.

Today, in New Jersey and around the country, there is significant underreporting of errors. The culture of today's health-care environment

focuses on assigning blame. This must be replaced with a culture that encourages disclosure, that promotes safety through continuous performance improvement. An important way to change the current environment is through the creation of patient safety committees, as mandated in this legislation.

Under the bill, experts in various disciplines would conduct extensive analyses of serious adverse events and near misses. Shielding all self-critical analysis from discovery is a key element in promoting disclosure of errors and thorough analyses that lead to the determination of root causes.

Health-care professionals are reluctant to report errors, especially their own. This is understandable when the results of speaking up could be loss of job, license to practice, or financial security. In the very punitive health-care environments, only the most egregious errors are ever revealed. The focus on finding who did wrong rather than why things go wrong is a major obstacle to improving patient safety. Health-care professionals need to be able to safely engage in a full and free exchange of information to truly make patients safer.

In today's punitive health-care environment, there is no incentive -- and actually a great disincentive -- to report errors, especially those that would not otherwise be detected and reported. Imagine the following hypothetical scenario: A nurse gives a sleeping pill to the wrong patient in a hospital. The nurse then recognizes the error and gives another sleeping pill to the correct patient in the next bed. Both patients sleep soundly through the night and both awaken refreshed. What's the incentive for that nurse to self-report? At the least, the nurse will get a verbal reprimand. He or she would

likely get a letter placed in his or her file. In very punitive situations, the nurse might lose opportunity for advancement or even risk losing his or her job. Punishment may prevent that nurse from making the same mistake again, but it won't prevent the next nurse on the next floor or in the next hospital from making the very same mistake.

In environments where safety and performance improvement are fostered, self-disclosure without fear of punishment might reveal the underlying cause of the error. In this case, that the patients were named Johnson and Johanson, and the patients with similar sounding names should not be put in the same room or even on the same hospital floor. Understanding why and how the error occurred can lead to corrective action throughout the institution that will prevent numerous similar problems in the future. And the next time, it might be chemotherapy that might have been given to the wrong patient, not just a sleeping pill.

Some interventions to improve patient safety are complicated and quite expensive, like computer order-entry and bar coding. Others are very simple, very inexpensive, but just as lifesaving. Never use a trailing zero; always use a leading zero when writing medication orders. The public's need for information and accountability must also be respected. Health-care professionals who practice with recklessness or with gross negligence must be held accountable. Patterns of problems must be appropriately addressed.

This legislation strikes the right balance between acknowledging and learning from errors, and also holding people accountable. It shields self-critical analysis from discovery, but maintains discoverable all that is now discoverable. According to a report released last year by the National

Association for State Health Policy, 21 states in this country have mandatory reporting systems for medical errors. Each state's reporting requirements vary in terms of what's required to be reported, to whom the reports go, and how it is treated in terms of confidentiality.

New Jersey is among the 21 states with mandatory reporting. Ours is based on requirements we created by rule, not by legislation. But of those 21 states, New Jersey is the only one that does not have a peer review privilege under State law. Other states have mandatory error reporting. But to our knowledge, no other state has created the anonymous, voluntary reporting system for near misses and less serious adverse events that this legislation allows.

Mandatory reporting systems in other states focus on hospitals. To our knowledge, this legislation would make New Jersey the first state to have patient safety efforts encompass all health-care facilities. We must change from a culture of blame and punishment to a culture of performance improvement and safety, from a reactive stance to a proactive posture, from injury recovery to harm prevention. We can and we must improve patient safety.

I urge you to support this important legislation for the health and well-being of the people of New Jersey.

Thank you.

SENATOR VITALE: Thank you, Commissioner Lacy.

Are there any comments from any of the members? Questions?

SENATOR SINGER: Can I ask the Commissioner something -- a little bit not related?

SENATOR VITALE: Sure.

Senator Singer.

SENATOR SINGER: Thank you, Mr. Chairman.

Of course, we all know the bill is going to come out today, Commissioner. You know it came out last time, but we appreciate your coming.

This is a little unrelated, but I have the opportunity for you to be here today. I think it is important to deal with the issue. Last week, at our county Board of Health meeting, we discussed about ordering flu vaccine for our county. And as you know, if you order too much, there is no reimbursement back; and at $14 a shot, the small county is concerned about that. I received numerous phone calls this past year from parents wanting their children to be inoculated, and of course, as you know, towards the end, they were not in the high-risk group -- some 10 to 15,000 children.

What I really need is guidance, a little bit, from the Department. Is there going to be a recommendation from the Department, coming out in the near future, that all children that are able to receive a flu inoculation next year -- so we can turn to pediatricians and people like that, and say, make sure you order enough vaccine? Or, what should we do at the county Board of Health level? Our concern is, if we have another scare like we did this year and we had to turn away children who were not in the high-risk groups, how do we deal with that from the perspective of parents.

Second of all, because you were so gracious and got additional vaccine, you know that some of the hospitals were down to only 100 doses. And you, of course, allowed us to move it around, which is not normally the

way it's allowed to be done. So, in that kind of situation -- and we hear more about the news about possible crisis in the future -- can the Department look at a direction to let us know, on the county levels and the hospital levels and the pediatrician levels, what you want to do for next year?

COMMISSIONER LACY: It's a very good question. Guidance comes every year from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. And more and more, they've been moving toward not just telling states to consider vaccinating children from six months of age on, more and more it's turning into a recommendation. And we suspect, in the near future, that it will be fully recommended that children age six months and older be vaccinated for the flu.

Now, remember, this year more flu vaccine was produced than ever before -- 80-plus million doses of influenza vaccine. And I hope what happened this year will happen in the future, which is that more people will opt for influenza vaccination earlier than ever before -- that they will clamor for it of their health-care professionals, that those health-care professionals will then order those vaccines early, and that the pharmaceutical industry will then produce more and more vaccine each year so that more and more of the United States and more and more of New Jersey is covered by influenza vaccination. And that will provide the herd immunity necessary to limit the influenza outbreak.

So, I guess, to answer your question -- first, thank you very much for the nice words about how we moved flu vaccine around. Yes, I believe that very soon there will be recommendation, not just consideration, of influenza vaccine for age six months and older in children. For the foreseeable future,

however, the best way to approach this is that the highest risk groups -- those very old, very young, and those with chronic illnesses -- should be the ones to get influenza vaccination. And we hope, just as an aside -- we hope that this avian influenza that has now struck the other side of the world does not gain the ability to be transmitted person to person. That would be quite dangerous for the world community, because we would have an influenza for which people do not have immunity that, perhaps, could be transmitted person to person, and it appears to be a very virulent bug.

SENATOR SINGER: Thank you, Mr. Chairman.

SENATOR VITALE: Thank you.

Any comments from the Committee?

COMMISSIONER LACY: Oh, by the way, I should also mention that New Jersey is one of those states that has a very robust influenza pandemic plan in place, which can be accessed on our Web site, if anyone has an interest.

SENATOR VITALE: Commissioner, in your testimony, you give some examples of system errors and just a system that's designed to -- not so much designed to fail, but designed to allow those errors to take place. You talked about trailing zeros and leading zeros. Can you explain that a little bit better?

COMMISSIONER LACY: It's interesting, because some of the system fixes that could be put into place are quite expensive. You can buy elaborate computer order-entry systems for hospitals to circumvent illegibility errors. But some of the fixes are extremely simple. For example, never allowing a trailing zero and always mandating a leading zero. I'll give you the

example: If you handwrite an order for XYZ drug at 5.0 milligrams and the decimal point is missed when it's transcribed and the pharmacy gets it, the unfortunate patient gets 50 milligrams instead of 5 -- a tenfold increase which, depending on the drug, could be fatal. One should never allow trailing zeros. You order 5 milligrams, never 5.0.

Conversely, you always must mandate leading zeros. So, if you want to give 0.5 milligrams, you never write it as .5. If the decimal is missed, again, a tenfold overdose. If a pharmacist sees 05, it prompts them to ask, should there have been a decimal between the zero and the 5. Simple fixes like that.

It's interesting, because the history of patient-safety efforts in this country have found that by encouraging disclosure of near misses and adverse events, simple fixes like this can be found that then can be disseminated widely throughout the health-care environment, that translate not only into morbidity improvement, but actually lives saved. Simple things can actually translate into lifesaving.

SENATOR VITALE: Thank you, Commissioner.

I'm going to ask you to stay there for a few minutes, and I'm going to ask Attorney General Peter Harvey to come forward. I appreciate your coming here today, General.

SENATOR MADDEN: Mr. Chairman, may I ask one question?

SENATOR VITALE: Yes.

Senator.

SENATOR MADDEN: Commissioner, one question. You had, under the title of discovery -- you had mentioned that the law would prevent

things from being discoverable that are -- but it would not take things off the discovery list that currently are discoverable now.

COMMISSIONER LACY: That's correct.

SENATOR MADDEN: Could you site one example of what you mean. Let's just say the nurse that gave the two sleeping pills out-- Now, by your rule, that notice would be sent to the Department of Health. Is all that documentation to and fro -- is discoverable?

COMMISSIONER LACY: Well, the way things exist now, there is significant underreporting across New Jersey and across the country, and it may be that that nurse -- or that physician or that pharmacist -- that gave the dose of the sleeping pill to the wrong patient would never come to visibility. That we would never find out that that happened. The goal of this legislation is to change the punitive environment to one that creates a culture of safety, and encourages and enhances the sharing and the self-report and the self-disclosure of errors, so that we can find out the root causes of those errors and prevent them.

And what I meant when I said that everything that's currently discoverable remains discoverable-- What this shields is, multidisciplinary teams get together and sit and analyze and digest and try to find out what are the root causes, why did this error occur, and what safety precautions can we put into place -- redundancy, scrutiny -- whatever is necessary -- computerization. Find out the causes, find the fix to prevent not just this error, but every error like this kind in the future. Everything that's currently discoverable -- the medical record, the test results, deposition of witnesses -- all that continues to be exactly as it is now. What this legislation shields is that

self-critical analysis, the next step of analyzing -- of getting the team of nurses, physicians, pharmacists, these interdisciplinary groups -- to digest and find those root causes. That's protected. And the reporting of those things to our Department is protected.

SENATOR MADDEN: Thank you.

SENATOR ALLEN: Mr. Chairman?

SENATOR VITALE: Senator Allen.

SENATOR ALLEN: You were talking about wanting to make sure that people feel comfortable reporting. But we have another issue. And this does stray a little bit, but I want to see if these two things can work together. Another issue where, it seems, we have a nurse who has admitted to an enormous number of killings. There's legislation that's sponsored by Senator Kavanaugh that would require facilities to report under certain circumstances. Can you see these two things working together?

COMMISSIONER LACY: Yes and no. For the most part, this legislation addresses voluntary self-disclosure. And this goes a long way toward preventing errors that are nonintentional in origin. A health-care professional who is very knowledgeable and wants to intentionally harm will probably-- I mean, this doesn't do much more than allow an understanding of, perhaps, clusters of events to take place, and allow review of those clusters by multidisciplinary groups. There are other fixes that can be put into place to better assist in identifying those who wish to cause intentional harm. I'd be happy to address those after this discussion, if you'd like.

SENATOR ALLEN: But you feel that we could move in that direction as well -- having a facility forced to report certain things. For

instance, someone resigning when suddenly they're being reviewed, or something along those lines. Could you see that happening at the same time? Could those pieces of legislation move forward?

COMMISSIONER LACY: Yes. I think it requires a different piece of legislation with a different intent. But certainly, our goal is to improve patient safety, whether caused by unintentional system flaws or intentional acts by people who would do harm to others.

SENATOR ALLEN: Thank you.

COMMISSIONER LACY: I'd be happy to address it and support that.

SENATOR VITALE: Thank you, Senator.

And that brings us to the next subject, which is why most of us are here today. We've asked the Commissioner to come, and Attorney General Harvey, and other stakeholders in the health-care delivery business -- notably the hospital association, the nurses, the association of others from around the state, and teaching hospitals -- to talk to us about possible solutions to this latest crisis. I thought it was important that this Committee-- Before anyone is inclined to author legislation to fix the system, where we don't know where the fixes need to take place first, we need to ask the smart questions. We need to have a dialogue with the stakeholders, so that we not only can ask the questions that we already have, but potentially form additional questions to the point. So, to that end, I've asked the Committee to come together today to have a dialogue with all of you. Understanding, General Harvey, that there are certain questions that you cannot answer and we should not ask, because of the ongoing investigations.

We want to be able to get a sense of where it is that this State should take policy, particularly to the next level as it relates to the sharing of information between employers and employees -- information that could potentially be protected, how it is that we could learn from what happened to, potentially, 40 individuals. We don't know yet what the disposition of all those cases will yield, and we cannot wait until that happens. It could be years before we fully understand what happened. That isn't to say, though, that we cannot move forward with something that makes sense in the short term. And so, to that end, I've asked you to come today, and others. And General Harvey, if you would be so kind.

ATTORNEY GENERAL PETER C. HARVEY: Sure.

Thank you, Senator Vitale, for inviting me here, and members of the Committee.

SENATOR VITALE: Is your red light on? (referring to PA microphone)

ATTORNEY GENERAL HARVEY: Yes, I think so.

SENATOR VITALE: Bring it a little bit closer to you.

ATTORNEY GENERAL HARVEY: Let me move it a little closer.

SENATOR VITALE: Just pull it right out of there.

ATTORNEY GENERAL HARVEY: It's not quite my style to bellow, so--

SENATOR VITALE: Give it your best shot.

ATTORNEY GENERAL HARVEY: Thank you.

I think there are some steps that our State can take to better protect patients. As we do that, I want to caution us with the reality that no

matter what we do, ultimately, the solution is going to have to come from Congress. Because we live in a multi-state region. The world has changed from what it used to be. People live in New York, work in New Jersey; live in New Jersey, work in New York; live in both states, work in Pennsylvania. We all know, or know of, persons who perhaps commute from Philadelphia to New York on a regular basis, which means that this is a regional problem. And no matter how much we protect our state borders, our rules will only be applicable to facilities in New Jersey and to professionals in New Jersey. And let me share one additional concept with you.

I don't think we should limit our analysis to doctors and nurses. I think we have to cover all employees who work in health-care facilities, because the janitor can kill if the janitor chooses to do so. So, with that as a backdrop, let me make one suggestion.

We have a statute in the State, N.J.S.A. 262H-12.2, which now requires health-care facilities to report, to a panel of the Board of Medical Examiners, conduct by a doctor that threatens the safety of patients where that doctor has had his or her privileges suspended, revoked; where he or she has resigned, or been fired, and an investigation regarding that patient-care issue is either pending or planned. There is no companion statute for nurses, and there should be. That will cover doctors and nurses.

Now, there are regulations that apply to nurses. For example, nurses have the obligation to report conduct which they observe or know about which they believe, in good faith, violates the provisions of the Nurse Practice Act. Also, obviously, nurses have a self-report obligation, as do doctors. If a

nurse or a doctor is indicted, for example, he or she must report that to the appropriate regulatory authority.

But I think that we need, as a first measure, to impose upon the nursing profession the same obligation that doctors now have, and that obligation would be imposed through regulating health-care facilities -- both hospitals and HMOs. I think also that we really have to give attention to nonprofessionals who work in health-care facilities. I'm talking about background checks relating to janitorial workers, to candy-stripers working in hospital facilities, other persons who have regular roles working in a hospital facility, because they have access to the same areas and they have access to patients just like medical professionals do. We cannot overlook them. We should not assume that because of the recent reports about Mr. Cullen that the next angel of mercy or death -- however he or she wishes to describe himself or herself -- will be a professional. They may not be.

There's an additional issue here too. I think there has to be, at least on the State level and probably on the national level, a board or entity to which reports can be made by health-care facilities with respect to persons who work there, currently, or used to work there at a particular period of time. But I think we have to be very, very careful about what we do when we permit this kind of reporting.

First, I think health-care facilities ought to enjoy some kind of protection. If a health-care facility reports right now a former worker, it opens itself up to two kinds of claims, at least -- one, defamation; second, interference with perspective economic opportunity, namely the chance for that worker to go on and work for a new employer. And I think that is why most lawyers who

advise health-care facilities tell health-care facilities to only identify the dates of employment of a former employee, as well as the employee's responsibilities or position. By the way, that's generally the advise given by employment lawyers to every employer, not just restricted to the health-care field, because we are a litigious society. There are some in our society who look upon litigation as an opportunity to hit Lotto, and they will not hesitate to file suit if they believe that it can yield a settlement of some kind. Because the costs of litigation are so enormous, most employers will simply settle the case rather than fight it out.

So, if we're going to have that reporting requirement, we have to protect facilities. We also have to be sure we protect employees. We all know, from the extensive body of case law and jurisprudence out there relating to employee/employer disputes, there are some employees who face all kinds of problems in the work place, from sexual harassment to race discrimination claims to other kinds of just uncomfortable working relationships. Those employees, from time to time, will leave and go elsewhere. I can envision an employer or someone working for the employer fashioning a claim to blackball someone from the industry, and that claim could be false. But it is sufficiently vague that you can't demonstrate how it came to be. There are difficult working relationships all the time, and all you need to do, for example, is to say, "Well, nurse so and so used to work here, and nurse so and so left because of concerns about patient care." A future employer probably won't go near that worker in the future, in light of what has been reported about Mr. Cullen. You have essentially shut them out of the profession for good.

So you have to develop some requirement of the person making the report, attesting to the truthfulness of it, and making it based upon personal information so that you don't allow rumor and innuendo to essentially foreclose someone's future employment opportunities.

SENATOR VITALE: General, just on that point, and I guess -- I appreciate your saying that. We've had some informal discussions about that very issue. That's also -- it's not just the information that is shared and what's appropriate to be shared, it's what we do with that information. You had just suggested that there ought to be a Federal repository of all this information, whether it's nurses or pharmacists or other caregivers. And that all makes sense. And, I know Senator Corzine, Senator Lautenberg have begun to advocate for that. But also, we need to have that here in New Jersey as well. My only concern I think is, and you would agree, that this is sort of an undertaking of epic proportions with respect to infrastructure -- that we have the right resources dedicated to a system like that, whether it's Federal, whether it's statewide. And also, how quickly could that information be disposed of.

If we look at some, sort of, other agencies in this state and other states that are given information with which to investigate and they haven't done it in a timely manner, what happens to that individual? The case of the nurse who would like to go from Hospital *A* to Hospital *B* and has some report, regardless of what level it is or how severe it is, how long would it take? We just have to make sure that we have not just the infrastructure, but the will and the ability to analyze the information and get on with the disposition of that information. Otherwise, we're going to have workers out there spinning in the

wind until it's resolved. On the other hand, it's also a good thing that we have that system in place so that we can potentially catch someone who doesn't have patient safety as their first priority.

ATTORNEY GENERAL HARVEY: Well, let me suggest a model that sets up an independent entity that does nothing more than collect data and respond to inquiries for data. Because that is the question that is fundamentally asked about Mr. Cullen, for example. How is it that he was able to move from point to point to point without anyone knowing about it? Well, that's because whenever you try to check on a worker, the response you get from a former employer is, "Well, he worked here from this date to this date, and he was paid this salary in this position." Maybe if you had some central location and you gave protections to employers to communicate that information to the central location, you gave protections to employees about the kind of information that was reported -- giving them the right to understand that information and respond to it, rebut it, if you will; and you allowed perspective employers to check with that entity just to find out if *X* has ever been reported or if someone has ever made a representation about *X*, and if so, what was the nature of it -- then that future employer now has a chance to learn and now has a chance to conduct its own independent evaluation of that candidate. It can ask the candidate about the assertions. It can decide to hire the candidate after exploring the assertions. It can hire an outside private detective to look into the matter further. It can take it's own steps. But you will have, in some measure, protected the health-care facility, protected the employee, and allowed the perspective employer to learn something so that the

perspective employer can make it's own determination about whether to hire or not hire this person.

I share your view about the processing time. I would ask that if you are inclined to follow such a model, make sure that it's properly funded. Because if it's not, what you will have is reports coming in on day one, and 90 days later they're getting into the system. Meanwhile, somebody has already been hired. Hospitals and business organizations being what they are, they're very busy. And different facilities have different staffs to check, and different measures of competence to check, these kinds of background facts. So it ought to be funded in a way that the information can be processed quickly.

SENATOR VITALE: Senator Singer.

SENATOR SINGER: Just one concern about that. This almost sounds like we have to set up a civil-service type of approach to how we deal with employees in a hospital. Number one, if you're under some kind of scrutiny, are you suspended with pay? Do you know what I mean?

ATTORNEY GENERAL HARVEY: I know exactly what you mean.

SENATOR SINGER: That concern you have to go through-- In other words, you're right. We have to fund it so that someone looks at the reports, but it's also going to be a tremendous expense from the hospital's perspective to investigate these things. As you know, many of these things are-- Our mutual understanding is, we're all going to go our own ways and that's it. Now you're going to require the hospital to document everything, and the employee the right to respond and have representation to this aspect. I'm just -- we're making a civil service issue here like we do, for arguments

sake, with our police and this and that, that all these rights suddenly come into effect -- to be able to document all that. And it's going to be a very expensive aspect. I'm not saying we're not going to do it, but there is a very big expense at both ends. To look at the reports, but prior to that for the hospital to do that and let the employee have proper representation concerning that. Because again, the hospital is going to come onboard with their attorneys and their HR professionals. What does the employee have if they're not unionized? Who represents that employee as an attorney? Who pays for that attorney or that person representing the employee?

ATTORNEY GENERAL HARVEY: Senator Singer, you raise a very important consideration and something that I've given some thought to. Here's the alternative that concerns me, just as an issue of fundamental fairness. If the report is an anonymous one or if the report goes to an entity and the employee doesn't know about it, you can virtually shut that employee out of the industry forever. And that employee will never know why he or she can't get hired. Don't even know that somebody has placed something uncomplimentary in a central database, so that whenever they go to interview for a job, the person pulls up that information that says something that's vague. And this is what you get in a lot of allegations.

I suggest to you that in situations like the Cullen scenario, some of his conduct was so vague at facilities that they weren't sure what they would have reported had you had a reporting mechanism. Their lawyers, I assure you, would have told them, "Do you know this for a fact?" And if they're answer was, "Well, no, this is what we believe," the lawyer would have said, "Don't report this." Because once he finds out about this and sues you, he's

not only going to win, he's going to hit for punitive damages. Because in our state -- it's been my experience, and I've tried these cases before -- juries do not play around when you're messing with people's employment, because that's how we feed our families and take care of our children. If they suspect you've been unfair about employment, they will not only tag you, but they will knock you to the moon.

So, when I think about how much protection to give, it's a balancing question. I'm just a little uncomfortable, as I work it through my own mind, allowing for anonymous reports or, number two, allowing for reports that the employee cannot respond to. And so, kind of, what I'm suggesting to you for consideration is a central repository. Having somebody in the facility, who has some personal knowledge about it, give as detailed report as they can, and that they do so with a penalty of some sanction attached to false reports, and allowing the employee the chance to at least respond to it. Not an adversarial proceeding, but at least in the way you have a chance to respond to a credit reporting agency now. You have a chance to write and say, "That isn't true. What really happened is, it wasn't me. It was Joe Bochegaloopoo who did this."

SENATOR VITALE: I know him.

Senator Rice had a question. And after Senator Rice, I want to ask Commissioner Lacy to make comments.

SENATOR RICE: I think you pretty much answered, because I would have a real great concern with my experience in life, and particularly in New Jersey, with government institutions and politics. Whistleblowers don't get protected in this state. I don't care what we write about. We've been

writing whistleblower laws for years. I don't think the government wants to protect. My experience with government and institutions -- given the politics, they protect who they want, when they want. And the same thing with unions, depends on leadership. I've seen too many people get hurt with unions, whether they have lawyers or not. I get a little concerned because, unfortunately, I don't want a bunch of hearsay information, as you indicated, registered someplace, and I'm blackballed from the industry for the rest of my life, and it's destroyed. And then come to find out, if anybody will tell you, it was not even right in the first place. It's not truthful information. So I have those concerns.

But I guess my greatest concern is that -- maybe I've been in government too long and around too many elected officials and their contributors, and what I see with contracts and protection of people. Government protect who they want. Too many of us get hurt in the process. So, unless there's a way to truly identify valid information, we can't ignore information. That's the problem. If, in fact, people allege something is happening, particularly with the number of people -- take the Cullen situation and some of the others -- I mean, you can't let it go. But the question is, how much time do you spend on it; and then the question is, what happens if it's not valid? I don't know. Those are the things that concern me. And that's based on experience, and I think I have as much experience as my colleagues and anyone else, in the politics of what happens in these situations when people come forward with valid information and expect to be protected by someone. The poor person, with low income, in that institution rely on the

union representation, and it's not there. And if it's there, it's weak in many cases.

Someone else in that same union, they're taken to the hill. I guess they do more politicking when it comes time to do that. You go to the Attorney General -- not you, sir -- but our agency, SCI, or locals, and the problem is, the system says, "Well, it ain't important enough. What is--" That's the problem I'm having. I don't know how to explain about thinking, where I'm coming from. I kind of share your views, but you answered pretty much what I was concerned about, and it seems like it concerns you too.

Just a final question, though is, I know that our congressional delegation and U.S. senators oftentimes do things they should be doing, respectfully, but are they talking to you? I know they're talking to New Jersey residents, but it seems to me if you have senators who are going to put a bill in, they at least want to talk to the institutions and people affected. But it seems to me, they want to speak to the Attorney General and other people like Dr. Lacy too.

ATTORNEY GENERAL HARVEY: Senator Rice--

SENATOR RICE: If they represent New Jersey.

ATTORNEY GENERAL HARVEY: Yes. Senator Rice, I have been in contact with Senator Corzine about my thoughts on this matter, and I make myself available and, of course, my staff available to anyone who wishes to work on this problem. I think it is the kind of problem that really must be addressed if we are to develop a systemic solution to this issue. Otherwise it's going to happen over and over again.

SENATOR VITALE: Thank you.

I just wanted to ask for comment, Senator (*sic*) Lacy -- Congressman Lacy -- Dr. Lacy-- (laughter) I just demoted you. You just took a big pay cut, Commissioner.

But in a former life, Commissioner Lacy was the Chief of Medicine at Robert Wood Johnson University Hospital, and is still a physician there as well. So, from your perspective, Commissioner, and as Commissioner, thank you.

COMMISSIONER LACY: Thank you very much. I approach the issue of intentional harm to patients from the viewpoint of a medical scientist, if you will. So I divided this into what are the determinants of risk and what are the determinants of protection. When you look at determinants of risk, the first one that comes to mind is the number of practitioners that have access to a patient that could do harm, should he or she want to. And if you look at the numbers in New Jersey, there are 16,000 licensed pharmacists, there are 30,000 licensed physicians, and there are 136,000 licensed nurses between the RNs and LPNs.

The next determinant is access to patients. Who has access to patients? The next is, who has access to medications and equipment? Who has unsupervised access? Who has unsupervised access while the patient is unaware -- a sleeping patient, a comatose patient? Who has access to patients destined to die soon from their illness? Who has knowledge of diseases, knowledge of medications, and especially knowledge of medications that cannot be traced, that cannot be tested for? Who goes unaccompanied into patient rooms? Do physicians have unaccompanied access? Do pharmacists, respiratory therapists, nurses have unaccompanied access?

We talk about giving a medication the patient isn't on, but in some cases, the harm might be caused by running an IV in too fast, running an IV in too slow; putting saline, salt water in instead of an anti-rhythmic drug. How do you detect the absence of a needed drug that can't be tested for by blood tests? How do you detect a pharmacist who chooses to adulterate medications? Perhaps it's easier if it's discriminate. But if it's indiscriminate and somebody just adulterates a medicine destined to go somewhere in a hospital, how do you track that? How do you find it? How do you stop it?

Well then, to the determinants of protection: Most important, monitoring and surveillance, medication tracking systems, and inventory control. Tighter inventory control translates into better control of what's given. The recognition of unexpected or unexplained events. Unusual behavior in health-care providers, either too aloof or too close. The ability to test for drugs or alcohol in patients. The ability to test for drugs or alcohol in providers. And as we've talked about today, protection for information sharing and fostering information sharing, to develop track records, to look at background checks, to have mandatory reporting, to -- as the General mentioned, the very important aspect of multi-state reporting -- to add nurses and pharmacists to the National Practitioner Databank. To have stress management for health-care employees and health-care practitioners in hospitals and other high-stress settings. To be able to perform cluster evaluations. And ultimately, for hospitals to have some capability, some understanding, some knowledge of forensic evaluation as well. These are rare events. We believe these to be extremely rare events, but of such importance and such magnitude that they need to be addressed.

Thank you.

SENATOR VITALE: Any questions from the members of the Committee? (no response)

Before we move on, I just wanted to ask General Harvey -- Charles Cullen had a criminal history. He was arrested and convicted for, I believe, criminal trespass, harassment. As I understand it, he attempted suicide and spent at least one, if not two, stints at a psychiatric hospital, and that was all in succession. Currently, New Jersey, upon initial licensure of a nurse, for example -- I hate using nurses as an example, but in this case we will -- there's a criminal history background check that's required and provided. But a subsequent biannual relicensure of nurses -- all the information that they provide is voluntary. It's required, but it's voluntary. So the likes of Charles Cullen would never have volunteered that he had a criminal history or that he spent time in a psychiatric hospital, that he tried to kill himself. In that case, I'm sure logic will follow that no one, or very few, would report an incident that may keep them from future employment opportunities.

Someone has suggested that we provide criminal history background checks every two years upon relicensure. It's expensive; it's cumbersome; it takes time. But do you think that -- and we'll ask this question to both Commissioner Lacy, and in turn, General Harvey -- what your opinion is of that? And not just for nurses, but for all of those who have direct patient access.

ATTORNEY GENERAL HARVEY: It's helpful, Senator. I won't tell you that it's not helpful. But I just want us to keep this in perspective. Most persons who kill like this don't have a criminal record. You would never

know that one day they're just going to up and start killing patients in a hospital. That just isn't the way experience and history has told us that these incidents happen. Serial killers like this -- and I don't-- When I say, like this, I mean those who have been convicted. Mr. Cullen has not been convicted of anything, and of course, he's presumed innocent. But most persons who engage in this kind of behavior you would not detect from that kind of a rule. And so we should just keep that in perspective. It is helpful, but I dare say that we are not going to develop a series of rules that will protect us from every conceivable harm that could be inflicted upon us by a health-care worker or an employee in a health-care facility.

What we have to do is figure out: How do we tighten the system so that when legitimate questions are raised about someone, informed decisions can be made by a health-care facility. Because that health-care facility will be bearing the risk of that person's conduct. That's really the question that I think we have to try to address.

If I run a hospital and I have questions about someone, how can I satisfy myself that I've answered those questions? How can I conduct and perform my own due diligence to be sure that I know as much as I can know before I hire this person?

SENATOR VITALE: Commissioner.

COMMISSIONER LACY: Senator, I think criminal background checks need to be part of the debate and the discussion. We're talking about vulnerable populations, in general. I can tell you from the vantage point of my agency alone, we do criminal background checks on nurse's aides. That's within our purview, our responsibility. And we detect nurse's aides that have

had convictions of physical violence, and theft, and other kinds of -- and drug abuse and other issues, and some of whom have histories of recidivism and repeat run-ins with the law with multiple convictions. We need to protect vulnerable populations -- whether they're the vulnerable elderly, the vulnerable young, or the vulnerable in the middle -- in hospitals during acute illness. And I think it needs to be part of the debate.

SENATOR VITALE: Thank you.

Anyone else? (no response)

Thank you very much for your attendance today.

Thank you, General, Commissioner.

COMMISSIONER LACY: Thank you.

ATTORNEY GENERAL HARVEY: Thank you.

SENATOR VITALE: I'd like to ask Mada Liebman to come forward to read a brief testimony into the record.

Mada.

Mada is senior advisor to Senator Jon Corzine. I know Senator Corzine has been involved in this issue from the beginning. The Senator could not be here today, but you are here in his place.

Thanks for coming, Mada.

M A D A L I E B M A N: Thank you, Senator, and thank you to the Committee. Senator Corzine wants to thank Senator Vitale, for his leadership on this important issue, and the Committee for the courtesy of allowing his testimony to be read.

SENATOR VITALE: Mada, is your red light on (referring to PA microphone)? Red means go, for some reason.

MS. LIEBMAN: There, sorry.

Again, the Senator thanks the Committee and Senator Vitale for leadership on this issue and allowing this testimony to be read.

"Chairman Vitale and members of the Senate Committee on Health, Human Services and Senior Citizens, I commend you for convening this important hearing to discuss recommendations to improve the integrity and safety of our health-care system in the wake of the tragic murders carried out by Charles Cullen.

"As you know, Senator Frank Lautenberg and I have called for similar Federal hearings into this tragedy. While the regulation of medicine is first and foremost a state responsibility, the Federal Government, through its federally administered health programs such as Medicare and Medicaid, has a strong interest in ensuring patient safety and quality of health care. The Federal Government also has a critically important role to play in the tracking of health-care practitioners, many of whom hold licenses and/or practice in multiple states, as was the case with Charles Cullen.

"In the last few weeks, Senator Lautenberg and I have spoken with many New Jerseyeans at length about this matter, including some testifying today, so that we may understand how this one nurse was able to skirt existing laws and procedures in the perpetration of as many as 40 murders, over the course of at least nine years, in Pennsylvania and New Jersey.

"While these conversations have resolved very little about how Mr. Cullen got away with murder so easily, they have revealed serious fault lines in our health-care system. Today, nurses and other licensed health-care practitioners play an increasingly critical role in the provision of health care in

our country. Nurses provide more direct care to patients than physicians do, and individual nurses care for more patients today than they ever have before. Yet, our health-care system often does little to recognize this important role. State boards of nursing across the country are grossly underfunded and are, therefore, unable to fully perform their oversight duties. Nurses fear reporting violations of appropriate standards of care, because they fear retaliation. And hospitals, too, fear liability if they provide negative employee references or report violations to state authorities.

"Since 1986, the Federal Government has mandated that hospitals, state licensing boards, and insurance companies report physician licensure disciplinary actions, professional review actions and malpractice payments to a federal registry, the National Practitioner Databank. In 1987, Congress authorized expanding this Databank to include the reporting of licensing and disciplinary actions taken against nurses and other licensed health-care practitioners. Yet, more than 17 years later, the Federal Government has still not implemented this law. It is disgraceful and shameful that it has taken 17 years and the deaths of so many patients to call attention to this critical failure.

"Soon, Senator Lautenberg and I will be introducing Federal legislation to expand and improve upon the National Practitioner Databank, to ensure that nurses and other licensed health-care practitioners who provide direct patient care are included. Hospitals, state licensing boards, and peer review organizations must have a duty to report on nurses who violate expected standards of care. Our legislation will afford these entities protection from liability when they report in good faith to the databank. Importantly, our

legislation will also ensure that there are strong whistleblower protections in place to encourage nurses to share any information they might have on wrongdoings by their peers, and will contain meaningful penalties for noncompliance.

"Such legislation is critical to improving patient safety, but it alone is not a solution. We must work together as State and Federal legislators to create a uniform system that improves patient safety while also preserving the privacy and integrity of our health-care professionals, the majority of whom are dedicated to their patients and the institutions they serve, and provide high quality care.

"I look forward to working with all of you to ensure that criminals and unqualified practitioners have no place at the bedside."

And Senator Corzine wants to thank Commissioner Lacy and Attorney General Harvey for their very valued input.

Thank you very much.

SENATOR VITALE: Thank you, Mada.

Thank the Senator for us. Thank you for your help.

Next is David Knowlton. David is President (*sic*) of the New Jersey Health Care Quality Institute.

Thank you, David.

D A V I D L. K N O W L T O N: Thank you, Mr. Chairman.

My name is David Knowlton, as the Senator said, and I serve as Chairman of the New Jersey Health Care Quality Institute. It's a not-for-profit foundation that was formed by the New Jersey Health Care Payers Coalition.

The purpose of our foundation is to provide an impartial voice in health-care quality issues in New Jersey.

Let me begin by applauding Chairman Vitale for convening a hearing on the issue of medical errors prior to drafting legislation. It is our belief that we need a systemic solution to the issue of medical errors, which can only be created by a proactive and planned approach, rather than a reactive manner.

The problem of medical errors is epidemic in the United States. The Institute of Medicine report in 1999 indicated that 98,000 Americans die each year from preventable, medical mistakes. This means more of us die, as Commissioner Lacy alluded, from medical errors than from AIDS, breast cancer, and motor vehicle accidents. It means that if the Vietnam War Memorial in Washington were a memorial to those who die annually from preventable medical errors, it would contain nearly twice as many names. You would have to build two of them, and you'd have to do it every year.

It means that over 1,700 New Jersey citizens die annually from medical errors that were preventable. It means that errors and poor quality cost more than $18 billion in direct cost and 9 billion in lost productivity. However, your focus here, today, is not merely on the scope of the problem. We've talked about that before. The scope here, today, is what can be done about it.

All of these concerns in quality were exacerbated by the recent allegations that an individual charged with the care of patients may have been instrumental in taking the lives of up to 40 of his charges. This has added a sense of urgency to this issue.

From where I sit to attack this problem, you'll need to have a number of elements in place. You'll need to have a mechanism whereby medical errors are reported in a timely fashion by all those providing care. These reported errors will then need to be aggregated so that patterns become visible. There will be a need for a process for communicating with hospitals throughout the state as an error pattern becomes apparent. There will also need to be some alternative for a nurse, a physician, or other caregiver to provide information confidentially or anonymously when they feel patients are in jeopardy.

Finally, there needs to be a requirement that health-care institutions provide honest and fair feedback on job references. This requirement must be coupled, as the Attorney General alluded -- must be coupled with some form of legal protection for the reporter and some form of fairness guarantee for the individual seeking employment.

I'd like to suggest a couple of options that may bear fruit in addressing this issue. The State of New Jersey already has a vehicle for dealing with some issues, particularly in death. The New Jersey State Department of Health and Senior Services gathers information on the death of anybody who dies within the state. This information is gathered in a timely fashion. However, this information needs to be gathered electronically so it can be placed directly into a database. Additional information regarding caregivers and medication may need to be added, although this is not without complication, as was alluded earlier. There's a wide variety of caregivers that touch a patient. What about visitors? What about the lady who sells you a pack of gum in the gift shop? There's incredible complexity to this.

More importantly, however, screens have to be developed for use with database to flag concerns, which could then be reviewed by a clinical team. The use of such a database to discern patterns of medical errors and even to identify abuse will have some practical concerns. But I believe they are surmountable and I believe at least the dialogue has to start here.

I must emphasize that critical to this effort will be an absolute requirement that New Jersey hospitals cooperate in fairly identifying errors that occur within their institutions. A hospital's current medical liability concerns are not sufficient reason to withhold this information, required by New Jersey law, and essential to tracking and reducing medical errors.

As I mentioned earlier, I believe there also needs to be an opportunity for health professionals to report their concerns anonymously. Our Quality Institute is joining with the New Jersey Institute of Nursing in just such an effort. We are proposing a patient-safety reporting system patterned after the Aviation Safety Reporting System run by the Federal Government. In the Aviation Safety Reporting System, any member of a flight crew, a ground crew, a cabin crew, or an air traffic controller can file a report, which after review and rewriting are shared throughout the aviation system. Near misses are caught through this process. Likewise, we are proposing a system whereby health professionals could anonymously report concerns they witness via our Web site maintained by the Quality Institute.

The Institute of Nursing will provide the clinical oversight to these reports, which will then be shared across the care delivery system and -- to the extent that an anonymous report talks about some concern about level of care

or criminal activity -- to the appropriate authorities. Recently, the Veterans Administration initiated a similar program with significant success.

As I mentioned at the outset of this discussion, I applaud Chairman Vitale for initiating this dialogue. I sincerely hope there will be additional opportunities for discussion, with an eye toward ultimately putting systems in place to monitor, intercept, and eventually mitigate medical errors.

Thanks for the opportunity to participate in the dialogue.

SENATOR VITALE: Thank you, David.

Any questions from the members of the Committee?

Senator Rice.

SENATOR RICE: No, but--

Thank you, Mr. Chairman.

It's obvious there's going to be an ongoing dialogue. And I disagree with you. I don't really disagree that cost isn't a factor. But the way life is, whether you like it or not, if, in fact, the institution liabilities are not taken into consideration when information is provided -- and I think of all the frivolous lawsuits, people seek everything-- I don't know where you live, but where I live, we keep closing hospitals. We can't pay when things are normal. And then given the politics of the institutions, etc.-- So, in this debate, there has to be a consideration, and has to be in such a way where the information can come forward; and it's valid information, hopefully, in most cases. The employer is protected, the employee is protected. What happens after is one thing. If not, the investigation gets killed once again, we don't know.

I just wanted to say -- because what I've seen happen here in Trenton over the last 17 years -- there are those who line up and say, "Well,

the cost doesn't make -- the liability doesn't make a difference." Lawyers will agree with that, and that's not putting the lawyers down. There's got to be a middle road as to how much liability. At what point does liability really kick in? Providing information shouldn't be something that institutions -- they should be protected against liability for providing information. Now what happens after the information is found to be invalid, then there should be something else to work that through, too.

So we got to start thinking that way here. If not, it just becomes a political football again, and residents and patients just get harmed. I mean, listen to your numbers. Maybe it's best we don't even go to the hospital. That's why--

MR. KNOWLTON: Senator Rice, just a comment.

I agree with you. I agree that there should be limits on that level of liability and reporting, and I applauded this Committee's bill to do exactly that, that was supported by Senator Vitale and Commissioner Lacy.

My point is that even while we await this, there has to be, (a) a mechanism for some anonymous reporting to see these patterns. And number two, as we study the aviation industry-- The aviation industry does not have immunity from liability. Yet, if an airplane goes down in Mercer County today, there will be a National Traffic Safety Board investigation. There will be a clear airing of what happened on that -- that incident -- probably for fewer lives lost than we're talking about here in the United States today.

So my issue is only that this not be an impediment -- this quest for the perfect immunity, this quest for this perfect data set -- not become an impediment to the possible things that we can do to start to mitigate this

problem right away. No way am I suggesting that any attempt to limit liability is not an excellent idea. It's just to move the debate forward while we try to mitigate these errors.

SENATOR RICE: Well, I don't think -- Mr. Chairman, through you -- and I'll be silent on this. Right now, for such an incident, even to call it an incident, it's no different than aviation. It came to someone's attention, maybe a little late, and it's going to be some liability that's being looked into. So, I mean, those comparisons to me are the same. My concern is where we go in the future. And I'm telling you again, that we'll harm institutions because people said that does not count, and I said it does matter, when you're going to get sued and what you're being sued for. And some people sue too prematurely, and it comes back to haunt folks, because traditionally we don't care here. We line up on who is coming down lobbying, or trial lawyers versus institution of people, political folks versus people they don't like in institutions. And that's been the history; no one can deny that. And I still live it every day. So I'm just saying to the Committee, as we move forward, make sure this time we balance, and be ready to balance, instead of a lot of arguing on one side versus the other side. Because information should be coming, not 34 deaths later. There should be some indication. Most of us see things in our lives-- We would get indications. The body will give you indications when you're getting sick. And those who have worked in the environment know when people's personality are starting to change or there may be a problem there, regardless of what the problem is. The key is the initial stage -- not to let it get so far, but to identify those types of things that may give you some

indication that something is wrong. And since you can look into it without anybody being hurt at that point-- That's all I'm saying.

SENATOR SINGER: Through the Chair, if I might.

SENATOR VITALE: Thank you.

Senator Singer.

Thank you, Senator.

SENATOR SINGER: The point that I just was trying to make before, that's of concern to me, is, I understand what you're saying. But in the case of aviation, I don't know of an airlines that isn't all unionized. My concern is, who is the ombudsman for the employee in these aspects of things? Do you know what I'm saying to you? In other words, you make the accusation concerning the employee. The hospital or facility has attorneys on staff, HR people on staff. But if there's just an employee, who do they have that they go to to say, "Help me in this aspect of it, to show that this was not correct"? There has to be a balance there, so that the employee isn't found themselves, by themselves, up against a line of professionals who are doing this investigation, and don't have their own safety net. In other words, you're right. If it's a union situation, you're right. The union will step in there and represent them properly. But if they're not unionized--

SENATOR RICE: Ahhh--

SENATOR SINGER: Well, but I'm only-- Do you follow what I'm saying? In other words--

MR. KNOWLTON: I agree with you.

SENATOR SINGER: --I agree with what you're saying is-- But there has to be somebody that an employee can go to knowing that they will

help them show that they are innocent, also, in this action. That's my concern that--

MR. KNOWLTON: There is also the problem, Senator Singer, that people report-- We can give all the protections from lawsuits in the world for people reporting, but there's other circumstances why people might not report if they have a concern. I believe, in the Cullen case, there were people who had concerns, but they -- if they're a nurse, they have to report it to a supervisor. The supervisor takes it up the chain. You can put your job at jeopardy, even though you would be protected if it actually went to the extreme of a whistleblower. So you would be protected if you reported it, under the new bill that you've just approved, that would provide immunity. You'd be protected from a medical liability suit. But you wouldn't necessarily be protected from retribution in your employment. So, by creating an anonymous system where you can start to look at patterns, you can start to at least get to these near misses, get to these errors. That's why the aviation system put it in. I don't know who's calling this in. I'm using the nurses -- the Institute of Nursing -- to say there's a valid, clinical concern here, let's share it with the other hospitals and see if we can make progress. Is it the perfect system so you can pin down a bad person? No. But I think it gets to some of the reporting. And done outside of government and outside of intervention, that maybe will prevent it from scaring people off from making these reports public.

SENATOR VITALE: Thank you, David.

MR. KNOWLTON: Thank you.

SENATOR VITALE: Dennis Miller.

Thank you, Dennis.

Dennis is -- and he'll introduce himself -- but Dennis is the present CEO of Somerset Medical Center. Dennis, I just want to, first -- and we've had informal discussions about this issue. You and I have talked about some possible solutions, but I just want to publicly commend you and your organization for being *the* organization -- it was the one that learned about Charles Cullen, went to the prosecutor, and ended this reign of death around our state. So I want to recognize you and your efforts, and your colleagues, as well, in your institution.

D E N N I S M I L L E R: Thank you, Senator Vitale.

Yes, my name is Dennis Miller. I am the President and CEO of Somerset Medical Center. I've been the President for the past four years. As a matter of fact, this week is my anniversary date.

I certainly, first, want to commend the Senate, yourself, and the other members for the -- pushing forward the patient safety bill, which you have heard earlier today. I also want to let you know that I agree 100 percent with the comments made by Commissioner Lacy on why this is important.

I am not here today, though, to talk to you much about that bill, but to talk to you about what happened with Charles Cullen, and what I think can be done and needs to be done, both here in New Jersey and across the country, to prevent this from ever happening again.

I certainly want to applaud, also, Senator Kavanaugh, as well as Assemblyman Jerry Green and others, for proposed legislation to try to deal with this.

As I indicated to you, I've been the President for four years, and have felt very proud to be the President of the Somerset Medical Center. But I probably have never been more proud of the way we have responded to the situation and have dealt with it, starting with our ICU nurses, our pharmacists, our laboratory people, and our medical staff. I believe there are three things that need to take place to address this issue. The first is that employers -- certainly licensed health-care providers -- need to have immunity from liability when giving the following: honest and accurate information to the best of their ability about why a former employee may have left their institution. I think that's the first thing.

The second thing, I believe that anytime a person or employee, a licensed health-care professional, has been investigated for criminal activity as it relates to patient-care services, we need to make sure that -- whether it's the district attorney's office, the prosecutor's office -- the State Police report that investigation immediately to the respective licensing board, whether it be pharmacist, nurse, physician, respiratory therapist, or social worker.

The third-- My Sudafed is kicking in, so I need just a little bit of water. The third must be some type of agency, both within New Jersey and, eventually, in the country, where an employer of licensed health-care professionals can contact this agency and find out whether or not there has not only been a conviction, which is available in a lot of places, but whether there's been a pattern of investigation of criminal activity, as it was with Charles Cullen -- which would have prevented him from being employed by a lot of people and perhaps saving a lot of peoples lives.

So the three things are: Immunity from liability when you give honest and accurate information about a former employee. Two, make sure any criminal activity, not just convictions, of our patient care service are reported to the licensing board; and a place both in New Jersey and in Washington that an employer can go to. It is my understanding that in New Jersey we have relationships with Pennsylvania and New York on when you get points on your license. Clearly, we must develop some mechanism to have a collaboration among our neighboring states when you've been investigated for criminal activities.

Those are my comments. I'd be glad to entertain any questions that you may have on either of the two subjects for discussion this afternoon.

Thank you.

SENATOR VITALE: Senator Allen.

SENATOR ALLEN: Did your institution try to find out about Mr. Cullen, and about others, as to why they would have left a former or several former places of employment? And when you do, what is it that you're struck with?

MR. MILLER: Yes, Senator Allen. With the case of Charles Cullen or anybody, when we contacted -- on his job application, which he lied to, indicated that his former place of employment was St. Luke's Hospital in Pennsylvania. We contacted them as we normally would for an employment check, and they indicated, quite simply: name, rank, and serial number, dates of employment, and the last date of employment, and what his position was. And that's all the information they give you. We also have a policy where we contact -- a personal reference check at another hospital, which was here in

New Jersey, and we pretty much got the same thing -- name, rank, and serial number.

It was outrageous to me when we, certainly, learned of not only the potential that someone in our hospital could be doing a malicious act -- and had cooperated with the prosecutors for two months in terms of this investigation -- but to learn on a Monday morning that, not only that he was arrested -- I was glad that he was arrested -- to find out that he had worked in two states for 16-some years, and had been investigated for serious criminal activity for three hospitals in two states -- was outrageous to me as a CEO.

SENATOR ALLEN: But did any of those hospitals, particularly the one that you checked, the St. Luke's Hospital, did they have specific information? Because that's really what I think we need to get at.

MR. MILLER: Well, to my understanding -- and again, I'm not here about any individual institution, but at St. Luke's Hospital he was under investigation for overmedication and for possible homicide. He had been reported to the Pennsylvania State Police, the Pennsylvania Board of Nursing, and the district attorney's office. I do not know who in the institution reported him. I don't know if it was the administration or a former employee. But to think the fact that somebody left that organization with that type of background, and that information is given as name, rank, and serial number-- I don't have the words to describe what that's like. To find out it not only happened at one spot, but also at another hospital here in New Jersey, is just outrageous to me. And I think it's all out of the fear of liability, the fear of being sued, Senator, and as Attorney General Harvey said, the fear of both defamation of character and economic damages.

SENATOR ALLEN: Would it be your sense, though, that we need something that says that if an employer says something that isn't true-- You're talking about immunity from civil liability when you tell the truth -- which is absolutely wonderful, and I would be 100 percent behind that -- but what if the truth is shaded? Or what if it isn't the truth? How do we deal with that?

MR. MILLER: I don't have the immediate answer to that, because I've been asked a lot, lately, over the past month or so. I just do know that here we have an individual that, sort of, skated through the radar screen for 16 years because he was investigated, not convicted. I think clearly, if the truth had been told-- I don't agree, by the way, of -- there may be anonymous reporting for patient safety. I'm not sure I agree with anonymous reporting on criminal activity. I think that needs to come from either the facility itself, to document it, or from a police authority -- and there's a document to that.

I would like to know, as a perspective employer, to say -- well, not in your case, but certainly -- "Ms. Allen, you worked in Iowa. There was an investigation of criminal activity. Can you explain that to us?" and have you give us an intelligent explanation as to why it took place. And then be able to call that former employer and have it confirmed that, yes, it was going on, but we're okay with that. I think you need to err on the side of public safety.

SENATOR ALLEN: Did you also do a criminal background check?

MR. MILLER: Yes. What's interesting -- we began criminal background checks about 60 days before Charles Cullen became identified. But even in that case, when he was an ICU nurse and, I guess, had a trespassing charge against him-- I'm not sure, in hindsight, any hospital -- that

probably would not have hired a nurse, particularly without any other background, who had just been -- trespassed on a former relationship. Clearly, have information about his psychiatric background -- could be a different story, but it was just coincidently-- We actually did criminal background checks on all employees about 60 days ahead of time, before that happened.

SENATOR ALLEN: I have one final question. And that is, would you think -- and you were speaking as an employer, not just as an employer running a health-care facility -- do you think that this is something we should look at across the board in business?

MR. MILLER: Well, the answer is yes to that, but I would hope that we would focus immediately, because of the public trust, on licensed health-care facilities. When I have discussions with other people, whether it was with Katie Couric on the "Today Show" or Wolf Blitzer on "CNN", I mean, every organization-- If you ask NBC or GE or CNN, all their employees say the same thing. But I can't tackle the world's problems right now, as one simple hospital CEO in this state. Because of what happened to us, it's changed, certainly, our lives and my life, particularly, forever. I think we need to focus in on restoring the public trust of our community. And by doing that, we need to have information available to us on employees that our community relies upon to help them in those patient-care efforts. So I would start with licensed health-care facilities first. Solve that before I would span it to larger employers.

SENATOR VITALE: I think, earlier, there was some discussion from some of the others who offered testimony about what information would be relevant. And I think, that in the very first place, we have to understand

what questions that we want to ask. And that because we're using labor law and civil rights protections that all of us enjoy, in addition to those who work in health-care facilities, we have to be very careful how we craft language. We also have to also reconcile the fact that New Jersey doesn't have relationships with reciprocity with other states. We have an interstate compact with Maryland and with Delaware as it relates to nursing issues, but not with Pennsylvania, not with New York, and those are just border states. And there are 45 other states in this country that we have to be concerned about. We just can't call Iowa and say, how is it that--

MR. MILLER: Well, Senator, I agree with you. I mean, Attorney General Harvey indicated it is a regional problem. It's a national problem. In addition to my reaching out to you and Senator Kavanaugh, the members of our State Legislature, I did reach out to Senators Corzine and Lautenberg immediately as well. I do think it's going to eventually need to be resolved at the national level. However, I do think we should do everything we can at the State level to set the model for what should take place nationally. I believe in that.

SENATOR VITALE: I think you're right. I think of all that happened here.

MR. MILLER: I do think that we should be able to ask the questions about -- would you rehire this individual, and if not, why not? That's a very important question to ask. I also think that we should require prospective employees, if we don't have immunity for liability, to sign a waiver of liability that we can ask their former employers what happened; and then give the former employer some liability. But that's what we have to ask.

I also, as I indicated, would limit my discussion about criminal activity as it relates to patient-care services. Whether someone has been convicted for criminal activity on a minor traffic accident, or whatever, is, perhaps, maybe broadening the scope. But in this case, with Charles Cullen -- 16 years of, say, potential reign of terror for criminal activity as it relates to patient-care services -- that information must be available to us.

SENATOR VITALE: Dennis, we had talked about standards within that type of a system, and New Jersey having a central repository for that information, a clearing house. We have to get clear down to the basics to, sort of like, whittle this down to, in the very first place, where these questions, how these questions can be asked, and what questions are appropriate. I just think it has to relate to patient care.

MR. MILLER: Yes.

SENATOR VITALE: It can't be: "Let's repeal those labor laws as it relates to anyone else." I mean, in your institution, you're not making nuts and bolts, you're saving people's lives. In every hospital and every long-term care facility in the state, it's about keeping people safe who are sick, who are vulnerable.

MR. MILLER: Right.

SENATOR VITALE: So it should really only apply to health-care facilities. And I think with the help of the Attorney General and the Commissioner, and the experiences that you've had--

MR. MILLER: Yes.

SENATOR VITALE: --and others, I think we'll be able to come to-- We weren't going to solve this today.

MR. MILLER: No.

SENATOR VITALE: And today is just for the purpose of trying to ask these questions and hear from you and others. So I appreciate your testimony today.

MR. MILLER: Well, Dr. Lacy had discussed it maybe about a month ago on the telephone -- that I want to welcome his support and have a chance to give my input as to try to resolve this, certainly here in New Jersey, as well as nationally, as soon as we can. And again, I applaud your efforts, Senator Vitale and others, for the opportunity to have this testimony today.

SENATOR VITALE: Thanks, Dennis. Thank you for coming. Thank you for your work.

Gary Carter, New Jersey Hospital Association. Is Gary still here? There is Gary.

Is the red light on, Gary? (referring to PA microphone)

G A R Y C A R T E R: It is on. I still have this voice condition, and to the members of the Committee, I'm not contagious.

SENATOR SINGER: They always say that. (laughter)

MR. CARTER: Yes, I know exactly. Yes, there's nothing wrong with me, other than I can't talk very well.

I'll comment on both issues. First, we have been an advocate of what you proposed under patient safety. We have testified before the Committee last year in favor of this legislation. We're still in favor of the legislation, although we understand there are amendments that we have yet to review. It is our understanding you are committed to working with us on some

of our concerns, and we will be here with you to work on those things in the future. Okay.

In terms of the issue of Mr. Cullen. I would like to be the, kind of, voice of caution here. I agree with Attorney General Harvey that this is a national issue. It has a national solution. As a result, I have been working with both of our senators about this, as well as the American Hospital Association. But we, in this country, tend to go in extremes. And as you listened to Commissioner Lacy, of all the people we would be talking to who have access to the patient, the family -- are we going to do background checks on the family because they have access? But that's the extreme we go to in this country. What concerns me is we have wonderful nurses in this State and throughout the country who provide excellent health care. And if we go too far, we are, in fact, indicting the profession. I don't think we want to do that. I know you don't want to do that, but I think we have to be careful. When a teacher is caught committing a criminal act with a child, we don't register every teacher. Yet, we want to register every nurse because of one person's criminal activity.

I think there's no question that we need to do a better job with the references and the forms that we can use, and the liability. I also think we need to look at what the State Board of Nursing requires us to report, and it should be uniform throughout the country so that we have consistency when we call another state.

I also think that we have to be willing to fund these organizations appropriately so that all of the boards can do their job. And then finally, I think we need something for impaired providers of health care. We have

something for the physicians, but it doesn't expand to all providers. And what we have for physicians is not funded appropriately. I would like to see that expanded, because I think that could help here.

I appreciate your time. We look forward to working with you on this in the future.

SENATOR VITALE: Thank you. Thank you, Gary.

Mimi Cappelli. Andrea Aughenbaugh, New Jersey State Nurses Association. I note Sharon Rainer, and also Irma Lupia, if you all want to--

M I M I C A P P E L L I, R.N.: Good afternoon.

Chairman Vitale and distinguished members of the Committee, thank you for calling this important hearing today, and for inviting the New Jersey State Nurses Association to give you our thoughts on how best to keep patients safe.

My name is Mimi Cappelli, and I am President of New Jersey State Nurses Association, and I've been a nurse for 31 years. I am here on behalf of our members, all of whom are registered nurses with many years of experience and diverse backgrounds in providing patient care.

NJSNA has, and continues to express, great concern when a nurse intentionally harms a patient. Such cases erode the public's trust in nurses, who are crucial to patient care in all settings. Above everything that is said here today, we, along with the American Nurses Association, want to emphasize the importance of self-reporting of any type of impaired practice, and our duty as professional registered nurses to report suspicious activities of our fellow professionals, as an important safeguard to the public. I want to be clear that nurses take this ethical mandate very seriously. The nurse's primary

commitment is to the patient, and we are ethically mandated to preserve integrity and safety, and to maintain competence in practice.

NJSNA recognizes that there is a need for systems to be developed that will document and gather data about recurrent problematic or suspicious behaviors among professionals. Also, that tighter systems are needed to separate out those people, early on, who are unfit to provide patient care. In order to accomplish this goal, we advocate a two-way approach as most appropriate. Certainly, there is a need for investigating instances where patient safety has been compromised. This approach requires the collection of evidence so that legal action can be taken. However, sometimes this evidence is insufficient to warrant sanctions, and the licensee is free to continue to practice.

Another mechanism of providing for patient protection is early intervention with individuals who have demonstrated behaviors that indicate underlying problems. I emphasize the term *behaviors* that indicate underlying problems. This objective can be accomplished by much more active procedures that includes these two requirements: the licensee is referred to qualified professionals who can assess the nature of the problem and recommend whether the individual should be referred for treatment and eventual return to practice, or should be restrained from practicing in the profession. Those licensees who are recommended for treatment and return to practice should also enter a monitoring program where all phases of clinical practice are under the strict supervision throughout the entire process.

NJSNA already has such a program available through the Recovery and Monitoring Program of New Jersey, also called RAMP of New Jersey. This

program benefits licensees and employers alike, by continued surveillance of all aspects of the nurse's practice, collecting data from many different sources in order to assure compliance with treatment, and continued cooperation with the treatment contract. Certainly, employers need to have information about nurses whose practice has resulted in patient harm, but there is more to ensuring patient safety than sanctions for past actions. We need to be more assertive in the area of prevention as well.

Using the Cullen case as an example, perhaps the outcome might have been different if he had been referred for competency evaluation at the first instance of problematic behavior. He then could have been referred for treatment in an approved psychiatric treatment program and participated in a monitoring program that would have followed his everyday performance. This method would have ensured that he stayed the course of treatment and did not present a threat to himself or others. Those program participants who violate the terms of their contracts are then reported to the board for appropriate action. We believe that such a system is needed in order to increase the number of cases reported and investigated, and at the same time keep potentially unsafe nurses from harming patients.

It is clear to all of us who practice in health care, and from criminal cases both current and historic, unsafe practitioners are among us. They may not be homicidal or psychotic, but they may have some form of impairment, often hidden from even their closest colleagues. Such complex emotional and physical problems do not happen overnight, nor do they resolve themselves without proper treatment. Before a nurse's impairment endangers a patient

or imperils a career, we want to offer this recommendation for legislative action that will intervene and provide a solution.

On behalf of the New Jersey State Nurses Association, I would respectfully request consideration of a bill to put a monitoring program in place for nurses in New Jersey. I have a copy with me of a 1998 petition for regulations, published in the New Jersey *Register*, from which a bill could be crafted.

In closing, NJSNA is deeply concerned about the rendering of unsafe care to patients. We look forward to working with you and the other stakeholders to make patient care safer.

Thank you.

SENATOR VITALE: Can I get a copy of that document, Mimi?

Andrea, would you want to-- No.

MS. CAPPELLI: Any questions?

SENATOR VITALE: Any questions from the Committee? (no response)

Thank you. Thank you very much.

Richard Goldstein, Dr. Goldstein, New Jersey Council of Teaching Hospitals.

There are two more to testify, including the doctor.

It's not that thick is it (referring to statement)?

J. R I C H A R D G O L D S T E I N, M.D.: I'm sorry?

SENATOR VITALE: It's not that thick, is it?

DR. GOLDSTEIN: No, no. I just have a brief statement--

SENATOR VITALE: Okay, just kidding.

DR. GOLDSTEIN: --in case you had a question.

Thank you.

I'm Dr. Richard Goldstein, President and CEO of the New Jersey Council of Teaching Hospitals. Three of our member institutions touched nurse Cullen -- Warren Hospital, Somerset Medical Center, Mid-Atlantic Health. Therefore, as you can imagine, my membership has a keen interest in this issue. They did recently get together and try and sort this situation out, and basically they came up with the same ideas that have already been expressed here today, so there's no need to be redundant.

Immunity is required, and it would be best if your immunity were on a national basis so that there would be intercooperability between states; and some kind of national database required, similar to the physicians, that would also include nurses.

On the subject of immunity, it would appear that that is a very high hurdle, considering the protections of individuals that's at stake. So I was rather surprised when it came out that 30 other states have passed such immunity. I don't know if I have all 30 with me, but I've got a lot of them. I'll just read you one paragraph, because it goes right to the heart of what we're talking about: "North Dakota joins 26" -- it's in the press release -- "North Dakota joins 26 other states" -- this was in 1999, so it's up to 30 -- "in enacting a job reference immunity law that offers employers protection from lawsuits. The new lawsuit" -- that is, the North Dakota one -- "creates two levels of immunity. There is absolute immunity for providing basic employment information, including dates of employment, pay level, job description, and duties to a perspective employer. There is a more detailed,

limited level of immunity for employers who provide such detailed information about job performance.

"The law says that an employer who provides such detailed information to a perspective employer is presumed to be acting in good faith. An employee may still win a lawsuit against the employer if he or she can show that the employer provided information knowing it was false or with reckless disregard for the truth, was deliberately misleading, or rendered with a malicious purpose. Similarly, the immunity will not apply if the information is provided in violation of a nondisclosure agreement or was otherwise confidential."

At any rate, there are 29 other examples of states that have passed immunity protection. So what I initially thought would be a very high hurdle appears to be something that has been surmounted elsewhere, and I think it would behoove us to become more familiar with these bills, and factor out those that would apply to New Jersey nicely and eliminate that which would not be relevant to New Jersey. But as I said, it really is going to require that be put into a national bill, so that the people cannot fall between the cracks by moving from state to state.

SENATOR VITALE: Thank you, doctor.

Do you have a copy of those documents?

DR. GOLDSTEIN: We can provide it to your office.

SENATOR VITALE: Would you please? Thank you.

SENATOR SINGER: Could we all get a copy of that document?

DR. GOLDSTEIN: So-- Our group is continuing to meet on this. We'll come up with our set of recommendations as soon as they've had a

chance to look at all of these laws and to see if we can provide greater input to you. It's because my membership is particularly involved that the Council of Teaching Hospitals is so involved in this issue.

SENATOR VITALE: Thank you very much. Thank you, doctor. Thanks for your patience in waiting.

DR. GOLDSTEIN: Thank you. Thank you to the Committee.

SENATOR VITALE: Maureen Swick. Maureen is still here, Organization of Nurse Executives.

Hi. Is your red light on (referring to PA microphone)?

M A U R E E N S W I C K, Ph.D.: Good afternoon. Yes, I do.

I am Maureen Swick, President of the Organization of Nurse Executives in New Jersey, and Vice President of Patient Care Services at Monmouth Medical Center. Nurses throughout the country have been outraged by the reported horrific loss of patient lives, allegedly caused by a nurse, Charles Cullen, in numerous health-care facilities in New Jersey and Pennsylvania.

The Organization of Nurse Executives of New Jersey has been working with the New Jersey Hospital Association in helping identify improved employment processes in order to protect the public from any future criminal acts of this nature. Nursing leadership in all health-care facilities take their responsibility to safeguard patients entrusted in their care very seriously, and therefore wish to also work hand-in-hand with state and Federal lawmakers, regulators, and other interested parties to have supporters and employer protections in place to adequately screen health-care professionals prior to hiring.

To further support our efforts as key advocates for patient safety, ONE/NJ supports the proposal of the New Jersey Hospital Association to: Explore the expansion of the National Practitioner Data Bank to include nurses and other health-care professionals; provide immunity for employers, to allow for open and honest reviews and evaluations from former employers of potential employees; impose licensure penalties if a prospective employee fails to honestly disclose employment history; and increase the resources to the health-care professional licensing boards in order that they can properly and promptly investigate complaints regarding licensees.

As ONE/NJ collaborates with lawmakers and other health-care officials to address this tragedy, we wish to affirm that nurses as well as other health-care professionals are dedicated to the welfare of those committed to their care. We pledge our commitment to making sure that such a tragedy does not occur again.

Thank you.

SENATOR VITALE: Thank you.

Any questions from the Committee? (no response)

Just for members of the Committee, for the purposes of the bill that was before us earlier, we're just waiting on a discussion on an amendment. Give it five minutes, and if we haven't had resolution, we're going to vote the bill out without amendments. But we want to give the stakeholders the opportunity to have some further dialogue.

I just want to thank everyone for coming.

I'm sorry. Jeanne. Jeanne Otersen, HPAE, come on up.

SENATOR VITALE: Is this on the bill?

J E A N N E O T E R S E N: I put it down on the bill, but it was on this testimony as well, the Cullen case. My name is Jeanne Otersen. I'm with the Health Professionals and Allied Employees, and we are a union of nurses and health-care workers. And I wanted to, I guess, refocus a little bit. First, thank this Committee, especially for its sensitivity today to how to protect employees and nurses, and comments many of you have actually made in the newspaper in the last few weeks. To remind ourselves that we got many, many phone calls when this first happened, as everybody has said. Nurses who were horrified by this. We got lots of calls from the press that, for the first week, we actually avoided. And those of you who know me well, know that's unusual. But it just felt like it was such a painful -- such an awful process, you didn't want to comment. And then you realized that you had no choice but to do that.

I want to go back -- and starting -- to what Commissioner Lacy said, about our system being one about blame and not disclosure, and differentiate a little bit between one case that we're trying to fix -- which is about one person causing intentional harm -- and the issue of medical errors that you are passing a very important bill on, which is what we're most often dealing with -- unintentional harm caused by systems where individuals are blamed -- and not confuse the two, and not try to craft a solution that muddies the two. One of the concerns that nurses raised with us in their phone calls to us over the last few weeks is: Why is all the emphasis on reference checks and what was going on between Cullen's employment, not what was going on while he was working? That so much is about fixing and telling the next employer that he might, in fact, be a murderer, rather than a recording system to

institutions that are already in place, like the Board of Nursing, like prosecutors' offices. Too often, it's easier to let someone go and hope for the best than, in fact, deal with the issue.

We would like to see a focus more, I think, in three areas: And one is on monitoring, as people have already talked about, not just of our unemployment history. We agree with many of the proposals. I think I agree with what Gary Carter was saying, which, of course, again, is very unusual.

SENATOR VITALE: You're scaring me.

MS. OTERSEN: I know, I'm scaring myself.

But also monitoring of institutions and the care. I think that what you did or are doing now on medical errors is very key. You're going to develop and look at patterns to fix systems. I think in doing that you'll find a way to spotlight individuals whose care may be substandard, in violation of practice, and I think, in rare cases, deliberately harmful. So I think the bill -- and one of the things we've said in the papers, a lot in the last few weeks, was medical errors reporting was one solution.

We think the issue of what the boards report across state lines is a second critical issue. And in fact, I should have known better, but I was pretty surprised we didn't already do that when I saw that in the paper. And one of the issues that we face sometimes in our hospitals is when they bring in so many out-of-state temporary nurses, almost overnight. We think, again, that across-state reporting would help us deal with a lot of issues of care.

I think we also would hope this Committee, if not in the immediate today of dealing with this issue, would look at what causes some of these problems. What are some of the root causes of what really affects our

system more often, which is the 98,000 deaths we talk about from medical errors? Things like staffing, that you've heard us talk about for the last few years. But when we look at blame to individuals versus systems, the nursing shortage, the understaffing in our hospitals, the floating, the temporary nurses -- that's all leading to a system where we're looking less at individuals, looking less at care, and are unable to look.

As one nurse said to me, "I always used to work with the same nursing staff every day. We were there 10 years, 20 years. Now people are floating in and out. They're coming in and out of temp agencies. I don't have the same ability to look at what they're doing. I'm caring for too many patients, and I don't know who they are."

So I think if we can look at that issue down the road, sooner rather than later, I think we'll also deal with, in some ways, a case like the Cullen case. We all know that nurses reported Cullen. And so what you put in the bill in terms of whistleblower is also really important. I've seen cases where nurses report other cases of unsafe care and either they are, in fact, discriminated against or, in fact, sued. So that issue is really important, and I think you've addressed that in the whistleblower bill.

So I think if we look at -- across the state board lines, monitoring of institutions, not just the RNs. Look at the underlying errors of staffing and floating-- One example -- I'm again going back to Commissioner Lacy -- he talked about the Institute of Medicine report in '99 about the deaths. Their follow-up report this year, December '03, says that one of the best ways to reduce medical errors is to improve the work environment of nurses; that when you've transformed that -- they talk about excessive hours, which this State has

taken a lead on, and about staffing. They also say that two studies reveal that nurses are responsible for intercepting 86 percent of medication errors. So, if we have fewer nurses, less continuity of care, we're not going to do anything about the issue of medical errors.

So, in closing, I just want to, I think, raise again the concern that nurses have -- that it's not just about reference checks. Let's improve that data if we need to, but how are we monitoring care while it's going on. Why was that person allowed to just leave a hospital and not have that death or any of those suspicious activities fully investigated? It's not just about telling, "Oh, guess what? You might be hiring a murderer." It's about doing something in the first place.

SENATOR VITALE: Thank you, Jeanne.

MS. OTERSEN: Thank you.

SENATOR VITALE: Very good.

I also liked the way you worked staffing ratios in there.

MS. OTERSEN: You knew I couldn't not say that. You knew that, but it's part of it.

SENATOR VITALE: It's very good. It's very good.

Dr. John Brennan, from St. Barnabas Health Systems (*sic*).

John, thanks for coming down. Thanks for your patience today, waiting.

J O H N A. B R E N N A N, M.D.: Thank you, Mr. Chair and the Senate Health Care Committee (*sic*), for letting the St. Barnabas Health Care Systems speak to the safety bill. I'm John Brennan. I'm a physician and a

patient. I'm the Senior Vice President of our Clinical and Emergency Services, and Chair of our Patient Safety and Quality Committee.

I come to you because health care is complex and enormous. Even if we were 99.9 percent right, we would still have 291 inappropriate pacemakers installed per year in our country, and 12 babies a day would be given to the wrong parents. That's if we were 99.9 percent accurate. And what this bill does is, it makes a culture change.

I was in the Air Force. And while in the Air Force, I was at a tanker place where we refueled the fighter pilots. And there was a way that errors were dealt with, where the actual person committing the error would report it, and the system would be changed. And how does that relate to medicine? Well, we had in our system -- we see 2 million patients a year -- and we had a number of cases where a nurse self-reported a med error. That med error had to do, ultimately, with a computer chip that wasn't working appropriately in an electronic IV pump. Now, it's because those nurses actually took the time and went out and reported themselves, reported the error, that we actually discovered there was an issue with IV pumps. And that's the system changes that we're going to see with this bill, and why we support this bill. We would like further time to look at the amendments.

I thank you for your time.

SENATOR SINGER: Mr. Baxter, would you like to come forward?

L O U I S E. B A X T E R SR., M.D.: Yes. My name is Dr. Baxter. I'm the Executive Medical Director for the Physicians' Health Program. I'm very happy to have an opportunity to offer some comments as well.

I would like to say that we have a part of the solution to the problem, in the offering of a comprehensive professional health program as is mandated now by the joint commission. I know that beyond providing better training and developing better equipment, lie the issue of health-care professional impairment and how it may impact the public safety and welfare of our patients.

There are over 200,000 licensed health-care professionals in New Jersey. Conservative estimates in addiction medicine literature states that 13.7 of all Americans will suffer a problem with alcohol, 7.7 due to drugs. Over an individual's lifetime, there is at least a 30 percent chance of suffering from an impairing medical condition. The impairing condition may be a transient reactive depression, anxiety, living and workplace stress, substance use disorder; the cognitive impairment that we see with undiagnosed and untreated metabolic conditions of diabetes, thyroid disease, post-stroke syndromes, senility, or Alzheimer's. Health-care professionals, like the general public, are subject to the same impairing conditions that might affect the safe delivery of patient care. It is, therefore, important that there be a way to quickly identify and evaluate health-care professionals with impairing conditions, so that they may be adequately and effectively treated for the illnesses or the behavioral problems, before patient care is impacted and compromised.

The Physicians' Health Program has been identifying and treating impaired health-care professionals for nearly 22 years. It has developed a system of prevention -- through education, and early identification, and intervention -- to remove potentially ill and impaired providers from practice until they are effectively evaluated and treated for their impairing conditions.

Once the impaired provider is cared for and is deemed fit to resume his or her practice in health care, the PHP continues to monitor that individual, as medical doctors monitor other patients with chronic conditions, to assure that the recovery or stability that is attained continues. This ongoing monitoring of the condition provides ongoing confidence and assuredness that the provider is safe, and thereby the safety of the patient is further supported.

Currently, this system of identification and monitoring is only occurring in an official capacity -- which is the result of a regulated agreement with the State Board of Medical Examiners -- for the doctors. While the PHP has been accepting self- and colleague referral of other nonhealth-care professionals, it does not have a formal mechanism or relationship with the various other licensing boards as it enjoys with the State Board of Medical Examiners. Since 1982, the PHP has enrolled and successfully treated many nonphysician health-care providers, including nurses, dentists, pharmacists, veterinarians, psychologists, counselors, respiratory therapists, and others. In the year 2000, we developed a program entitled the "Healthcare Professionals' Program," without funding, to more effectively address the impairment issues of the nonphysician providers. The PHP believes that patient safety would be greatly enhanced if the nonphysician practitioners were afforded all of the same advantages that are currently enjoyed by the doctors.

The PHP would like to request that the State Senate Health Committee sponsor/fashion legislation that would mandate that the other licensing boards of health-care professionals enter into a similar agreement that the physicians have with the Physicians' Health Program, or another similar organization, that would create an impairment review committee and an

alternative resolution program. We have found that the impairment review committee allows for colleagues to report other colleagues, and it allows for individuals who recognize that they have difficulty to self-report. The alternative resolution program then allows those individuals to be evaluated and treated for their problems, and were able to, sort of, define whether there's any basis to the concern. And if so, we remove the individuals and allow them to get the treatment that they need.

As stated in previous testimonies and letters, the programs for health-care professionals can be funded by earmarking $10 annually from the existing biannual license renewal fees for the operation of the program.

In closing, I would like to thank you for the opportunity to appear and to testify. I would also like to commend you for doing the work that you do to help safeguard the patients and the citizens of New Jersey. I would like to re-emphasize what the commissioner said in terms that we really need to foster a culture of disclosure. By providing this mechanism of which I spoke, we will find that the number of individuals that are self-referred and that are referred by colleagues will, in fact, increase. In some way, I believe that that will help foster patient safety and help address the problem that we are facing today.

Thanks.

SENATOR VITALE: Thank you, Dr. Baxter. I know you've been before us before -- it was last year -- to discuss all the things that you do at PHP, and we appreciate the fact that New Jersey is a model for many other states in these matters. I appreciate your work. I know the Committee does as well.

DR. BAXTER: Thank you.

SENATOR VITALE: Thank you.

I just want to read off some names. I know that they're here. They're not asking to testify. Ray Cantor from the Medical Society; Lynn Nowak, American Physical Therapy Association; both in favor of the bill. And, thank God, the New Jersey State Chamber of Commerce is in favor of the bill as well. So we have it all there.

There are amendments or -- one or two amendments being offered to the Committee substitute. There's a discussion going on next door. I'm going to give you another 15 seconds, and if no one walks through this door, I'm going to move the bill as it is -- the Committee substitute. Where's a watch?

SENATOR SINGER: Fifteen seconds is up, Mr. Chairman.

Senator Rice and I want to move the bill.

SENATOR RICE: Move the bill.

SENATOR VITALE: The bill is moved.

Is there a second?

SENATOR SINGER: Second.

SENATOR VITALE: Eleanor.

MS. SEEL (Committee Aide): On the Senate Committee Substitute for Senate Bill No. 557:

Senator Singer.

SENATOR SINGER: Yes.

MS. SEEL: Senator Kean.

SENATOR KEAN: Yes.

MS. SEEL: Senator Allen.

SENATOR ALLEN: Yes.

MS. SEEL: Senator Rice.

SENATOR RICE: Yes.

MS. SEEL: Senator Madden.

SENATOR MADDEN: Yes.

MS. SEEL: Senator Karcher.

SENATOR KARCHER: Yes.

MS. SEEL: Senator Buono.

SENATOR BUONO: Yes.

MS. SEEL: Senator Vitale.

SENATOR VITALE: Yes.

MS. SEEL: The bill is released.

SENATOR VITALE: Thank you.

Meeting is adjourned.

(MEETING CONCLUDED)