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Interview: Dr. Richard Scott, vice president of clinical effectiveness and medical affairs at Riverview Medical Center, discusses health care.

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STEVE ADUBATO, host:

Welcome to CAUCUS UP CLOSE. I'm Steve Adubato. For the next half-hour, we'll be talking about health care with someone who really understands the issue, not just from a theoretical perspective, but he lives it every day. He is Dr. Richard Scott. He is vice president of clinical effectiveness and medical affairs at Riverview Medical Center.

Good to see you, Rick.

Dr. RICHARD SCOTT, MD (Vice President of Clinical Effectiveness & Medical Affairs, Riverview Medical Center): Nice to see you, Steve.

ADUBATO: We should let folks know that we have a little bit of history at the Meridian System, which, in fact, is the system that Riverview's a part of. I've done some seminars down there. We've gotten to know each other. Talking about health care issues, I have to ask you--your title, vice president of clinical effectiveness and medical affairs, it sounds very lofty. What does it mean?

Dr. SCOTT: Well, actually, the vice president of clinical effectiveness and medical affairs performs the integration between new scientific methods and the medical staff. It's my job to make sure that Riverview, as part of the Meridian System, is meeting the quality parameters that are being measured around the country for all hospitals and to help integrate evidence-based medicine bundles into our own care at Riverview.

ADUBATO: You know, we're going to talk about some of the challenges that community hospitals face, but I have to ask you--we've done a lot of programming on our series looking at medical errors, right? What are some of the biggest reasons for the medical errors that take place--I mean, you live it every day--and what should we be doing about it?

Dr. SCOTT: Well, it's interesting because, often, it's a process problem. And so one of the things that's happening all around the country is doctors are banding together into groups that take seriously doing things the same way every time. We now use order sets and bundles to do things for a patient.

ADUBATO: What does that mean, "order sets and bundles"?

Dr. SCOTT: Well, 10 different physicians may have a different approach to a patient with chest pain in the emergency room. But we now carefully measure

how often we do each step of the care...

ADUBATO: Mm.

Dr. SCOTT: ...and how well we complete it for each and every patient. We've made huge progress in the last 18 months across New Jersey and across the country as part of a larger campaign called the Save 100,000 Lives Campaign, which will end in June of this year.

ADUBATO: Interesting stuff.

The challenges of community hospitals. You told our producers, 'Man, I'll tell you, it's tough running a community hospital.' What are some of the biggest challenges a community hospital like Riverview faces?

Dr. SCOTT: Well, in the New Jersey hospital environment, there isn't a lot of excess capital for hospitals to invest. I think the average margin for a New Jersey hospital is .9 percent.

ADUBATO: Translate that.

Dr. SCOTT: Well, we found out yesterday that a petroleum company makes eight and a half cents on every dollar of gasoline that it sells. For a hospital, it literally makes less than one cent on every dollar that it brings in for the care of patients. In fact, in New Jersey, almost half the hospitals don't even clear their bottom line and are at a deficit.

ADUBATO: Why?

Dr. SCOTT: Well, reimbursements have been driven down by third-party payers.

ADUBATO: Explain that.

Dr. SCOTT: Manage-care companies, in an effort to bring down the cost for consumers and for companies that purchase health care, don't give a very great margin. They, of course, want things done as lean as possible so that the health care dollar goes further. But for community hospitals, that means investing very carefully in what technology they use going forward.

ADUBATO: But, Rick, stay on this. Give us a concrete example of this lean, you know, kind of an issue that you're talking about from a patient's perspective. What would that mean in terms of decisions that are potentially made regarding, not just doctor-patient relations, but care of that patient? What might happen because of that?

Dr. SCOTT: Well, Steve, patients are buffeted every day with information on the airwaves, billboards and newspapers...

ADUBATO: And the Internet.

Dr. SCOTT: ...and the Internet about what's available to them at each location. In the Meridian System, we have three excellent hospitals, but we have to choose carefully what technology gets purchased and put where. Truly, every hospital in New Jersey can't afford its own 64-slice CAT scanner or Cyberknife or burn center or cardiac cath lab.

ADUBATO: We'll talk about the Cyberknife in just a minute. It can't afford

all those different things. So what happens?

Dr. SCOTT: Well, in systems--and I think in New Jersey you see hospitals coming together in systems--whether it be Saint Barnabas, Meridian, Virtua--to try and...

ADUBATO: Or Atlantic. You got all these different systems?

Dr. SCOTT: Or Atlantic, absolutely. There's a consolidation in the industry. And then inside that consolidation they have to make the hard choices about what to put where in order to serve their patient population.

ADUBATO: And how do you survive in that? See, you describe the situation with the margin being so incredibly tight, with a whole range of economic pressures that you face, with reimbursement from the government for the services you provide being what it is--and you haven't even talked about charity care, right? Which means if you go to the emergency room, whether you have insurance or not, you're getting taken care of. If you're an immigrant to this country, whether you're legal or illegal, you're getting taken care of. It's got to get paid for. The reimbursement isn't what it needs to be, obviously. So how the heck can a community hospital survive?

Dr. SCOTT: Community hospitals have to offer a wide variety of services, and some of their service lines will be profitable. Imaging is one of them. X-ray therapy, radiation treatments, outpatient surgery, generally, are on the positive side. The general medical care of patients often are not. And so one hand has to wash the other, and I believe the government carefully weighs what it's going to reimburse its different diagnoses across the board. And so reimbursement for Medicare patients are based on what are called diagnostic guidelines that the government sets. At the end of the day, they try and make sure we make just enough money to get by.

ADUBATO: How'd you get into this business? And by the way, I'm sorry I call it a business. Is it a business?

Dr. SCOTT: Medicine is a business--and more than ever, unfortunately, because failure to realize that will just lead to failure of your endeavor.

ADUBATO: But it--was it your intent to get into a business or to get into the medical field? We've talked off the air--I mean, your passion for this is pretty intense, and I never heard you talk about the bottom line when you said when you got into it. Tell folks how you got into it.

Dr. SCOTT: Well, I think like many physicians, it's something that you gravitate toward very young in life, whether it was watching "Marcus Welby" or "Medical Center" on TV or, in my case, my own family doctor, who was truly inspirational, a real part of the community.

ADUBATO: Who was that?

Dr. SCOTT: His name was Dr. Robert Friedman, and he was a primary care doctor in Highland Park, New Jersey, and, like many at that time, delivered babies and came to the house to give you shots if you needed it.

ADUBATO: Big impact on you?

Dr. SCOTT: Looked after my whole family from birth to death, and, you know,

that's still an underserved area of medicine today.

ADUBATO: Had an impact on you.

Dr. SCOTT: Had a huge impact on me. I think that's what drove me toward medicine. During my time in medical school, I chose orthopedic surgery and did that for 19 years in Red Bank. Now I'm the vice president of clinical effectiveness, trying to make a difference for thousands of patients instead of just one at a time.

ADUBATO: Look, when I was down at Riverview a few months back, I was taken on a tour to see some of the facilities,, and one of the things that struck me was this whole Cyberknife. I kept--I saw a big sign when I was coming in. It said, `Cyberknife,' and I'm thinking--and I'd heard about it, but I didn't know what it was. We're going to roll some video of the Cyberknife itself as you talk about it and try to make sense of it, because it really is groundbreaking technology. Talk about it, Rick.

Dr. SCOTT: It truly is. Not too long ago, we thought of radiation therapy as a treatment. Now we talk of radiosurgery.

ADUBATO: What're we looking at right there?

Dr. SCOTT: Well, Cyberknife is an image-guided radiosurgical technique. It's a machine that cost Riverview, with construction, about \$6 1/2 million. It marries the technology of robotics with an incredibly well-directed beam of radiation therapy. It can treat both malignant and benign conditions. What you're seeing on the image is the X-ray therapy being guided by the robotic head, but it marries the technology of high-speed digital imaging to it, so that in this patient, even as he takes gentle respirations...

ADUBATO: Right.

Dr. SCOTT: ...the Cyberknife is actually accommodating those motions to make sure its beam is still directed with submillimeter accuracy, literally .3 millimeters.

ADUBATO: But how is that different from more traditional treatment?

Dr. SCOTT: The more traditional treatment, essentially, is light years behind this. Not too long ago, if someone had a lesion on their leg, they would go down to the radiation therapy suite--we didn't call it radiosurgery then--and they would have, on their skin, marked, the way the X-ray beam would be directed to treat the lesion.

ADUBATO: So wait a minute, there would be, on your leg, this box, if you will, with a target?

Dr. SCOTT: There would be, literally, a purple box, often in two directions, because all we could do would be to aim our radiation therapy at it from front and from side, a 90-degree angle. Think of it as the accuracy of throwing a handful of sand at the lesion.

The Cyberknife, and some of the newer techniques, especially the image-guided ones, literally direct the beam with accuracy never before imagined. The Cyberknife, truly, is able to--instead of throwing a handful of sand--to throw each grain one at a time and from up to 300 different directions, so that we

can treat that lesion with what's called a conforming beam of radiation. If it's shaped like a peanut, the Cyberknife will paint that peanut inside the body. And it reaches places that surgeons can't reach safely with knives or with scalpels. It has--it has truly been a boon to neurosurgeons. But Cyberknife is able to treat soft-tissue tumors, as well, and that's what makes it so extraordinary.

ADUBATO: What has it really meant in terms of--not just the treatment, but the impact on patients and, ultimately, recovery.

Dr. SCOTT: I can remember, clearly, having a patient who had his purple box marked for his X-ray therapy--and this wasn't more than a decade ago--and it was sad because, when he came back to the office, he said to me, 'The problem is, I know the treatments are going well, but every time I take a shower, I have to look down and remember that I have a tumor in my thigh. And that's hard to deal with for me, for my wife and for my children.' With the Cyberknife, the imaging is all done by high-speed X-ray digital cameras. It coordinates the treatment with each breath. For patients, they literally can drive themselves in and drive themselves home. There's no incision, there's usually no pain, there's no nausea. You can be back at work the same afternoon. We've treated over 80 patients now at Riverview, ranging, literally, from age 13 to over age 90. Some of them have malignant conditions; others have benign conditions that can be well-treated by Cyberknife, as well.

ADUBATO: What does it cost?

Dr. SCOTT: Well, the machine cost Riverview, with construction, between 6 and \$7 million. So that was our largest capital outlay over the last five years. Meridian made a decision, as a system, that Riverview would be the place for the Cyberknife. Every hospital can't afford that kind of capital outlay. Many New Jersey hospitals don't make \$1 million in a whole year.

ADUBATO: Well, I want to understand this. I bet you there are people watching--and again, we're not just seeing it in New Jersey, we're seeing it all along the East Coast--they're saying to themselves, 'Wait a minute! I hear this guy, Dr. Scott, talking about this Cyberknife'--and, by the way, you can keep rolling the video a little bit, folks, because I don't want to assume people have watched this all the way through from the beginning--'I want that Cyberknife at my community hospital.' Because you could understand that reaction, particularly if someone is suffering, someone in their family is suffering. Why does or doesn't that make sense?

Dr. SCOTT: Well, from an economic standpoint, it wouldn't make sense. There really aren't, probably, enough patients to justify one of these at each of New Jersey's 83 acute-care hospitals.

ADUBATO: But, wait--excuse me--how do you calculate justifying it economically because if, in fact, for one person--if it can have that kind of impact and give them the potential to survive and improve their quality of life, I mean, how do you calculate that from an economic perspective?

Dr. SCOTT: Well, fortunately, in New Jersey, we're not very far from major centers. We have major centers for open-heart surgery. We have major cath labs--Jersey Shore's cath lab does 11,000 CATs a year. They certainly can do it better than places that may do just a few hundred. But I can tell you that, from a medical standpoint, it wouldn't be feasible to invest the money

in the technology everywhere. You need to invest in what's going to work for your community. And because we have such rapid access to these things, if it's not at your hospital, it may well be in one just 10 miles away.

ADUBATO: What happens when someone says, 'Wait a minute, let me get this straight. I appreciate all the explanation about'--(coughs) excuse me--'how it's more precise'--right?'--'than some other technology and you get right to where the potential problem is with the tumor. But wait a minute, this robotic thing is scaring me. Are you telling me that, on some level, you may have a robot performing surgery on me, as opposed to a human being?' You ever get that reaction?

Dr. SCOTT: We haven't so far. In fact, I think people are more impressed with the marriage of the technology. When you have a high-speed computer that is making the calculations beforehand, there's a certain planning stage each patient goes through and it employs a radiation therapist, a treating physician, and a medical physicist...

ADUBATO: Mm.

Dr. SCOTT: ...who calculates the size of your lesion and problem and the exact dose of radiation therapy needed to treat it. So it really is a coming together of many different areas of science to treat in a way which is far more sophisticated than we could do even five or 10 years ago.

ADUBATO: Technology is really driving so much of what is going on in health care today, Rick. And the Cyberknife is just a piece of it--and, by the way, 64-slice CT means...?

Dr. SCOTT: The 64-slice CAT scanner is able to take rapid images at high resolution faster than any before, and, in fact, I had a 64-slice CT angiography done last week on myself at Riverview. We just opened the unit, and our cardiologists are using it now to better determine who is going to need an invasive cardiac catheterization. It will be a superb screening tool going forward, and the images are unbelievable.

ADUBATO: But there's other technology I just want to cover here. Recently, I had to deal with a kidney stone.

(To offscreen crew member) And, Bill Berlin, our long-time great producer, you gave me the name--what was the name of the technology? I want to say this right: lithotripsy? Did I get it right?

Dr. SCOTT: Lithotripsy.

ADUBATO: Lithotripsy.

Dr. SCOTT: Correct.

ADUBATO: We were--Bill, we were close on that.

What is it?

Dr. SCOTT: Well, if you've had a kidney stone, you'll know that there are few things in medicine more painful than the pain of a kidney stone.

ADUBATO: OK, clarify for this--for me this one, Doctor. I have said, when I

was passing the kidney stone--and I said this to my wife, and I've said this to many of our producers, most of whom are very talented young women who have given birth to little babies--and I said, 'There is no way that giving birth to a child is as painful as the passing of the kidney stone.' Please confirm that I'm right on this.

Dr. SCOTT: Many patients would absolutely agree with you.

ADUBATO: You're not going with me on this, are you?

Dr. SCOTT: Certainly the men would, I know that.

ADUBATO: Yeah, but...

Dr. SCOTT: It--they are highly painful.

ADUBATO: By the way, I just heard everyone yelling out, 'You're a wuss, Steve!' They're right, but it is painful. But go ahead....

Dr. SCOTT: It is absolutely painful.

ADUBATO: ...what's the technology here?

Dr. SCOTT: Well, you're probably amazed if you see that stone when you pass it. It may be no bigger than a match head.

ADUBATO: That's what threw me off, because I couldn't believe it was that painful.

Dr. SCOTT: Well, not too many years ago, the only way to try and get that stone would be invasively, to have to basically go up through the urethra into the ureters with a basket or grabber that would try and pluck it out, or even open surgery. With lithotripsy, we actually use sound waves targeted at the kidney stone. It's differentially more dense than the surrounding tissue, and by bouncing the sound shock waves off it, we can break that kidney stone up into parts much smaller.

ADUBATO: So it means that it's easier to pass and not as painful?

Dr. SCOTT: Absolutely. It breaks it down into grains of sand, ideally. Now, patients'll know, it doesn't work for every single patient...

ADUBATO: Right.

Dr. SCOTT: ...but it has saved thousands of New Jerseyans from more invasive procedures.

ADUBATO: Again, you said, Doctor, that your expertise as you came into this field was the orthopedic side. Lot of changes on your end, as well. I mean, I told you when we first met--I started complaining about my shoulder surgery. I had a bicep tendon tear--by the way, I won't make this all about my medical problems, I assure you--and you were saying to me, 'Well, what did they do with you when you were, you know'--it was after the fact, after three surgeries. I was struck by the fact that, as you were talking--as we were talking about it--I bet the way people were trained to deal with something like a bicep tendon tear or whatever sort of issue that you have--maybe orthopedic or otherwise--the way you deal with it today as opposed to even 10

or 15 years ago may be dramatically different because of the technology. How the heck does a physician stay up to date with those changes if he or she was changed--was trained based on a totally different paradigm and a different set of technology in place at that time? Am I making too much of that?

Dr. SCOTT: No. Good physicians are dedicated to continuing medical education. In fact, it's a requirement for our license in New Jersey. But in the specialty of orthopedics, we all would go off to training courses in the area of our specialty. When I trained to do hip replacements and knee replacements, we did them through incisions that might've been this long (holds fingers approximately one foot apart). The last hip replacement I did, last fall, was through an incision of about three and a half inches.

ADUBATO: Hmm.

Dr. SCOTT: So we got it down to about this size now. The technology has changed, the instrumentation has changed, the technique has changed.

ADUBATO: Outcome's changed?

Dr. SCOTT: The outcomes, so far, have been equal, and the patients would tell you that they like the smaller incisions better because they look better at the beach, they don't take quite so long to heal. In the end, they're about the same in terms of blood loss and discomfort, but the knee replacements that are being done now through small incisions probably are rapidly ready to go home in one or two days--some of them even done as outpatients.

ADUBATO: Back to the training issue. When we were looking at the Cyberknife, training people to do it--because I remember meeting the folks who are really running that operation--did they get special training, different from the training anyone else would get, because of what they're dealing with and this is such new technology?

Dr. SCOTT: They absolutely do. Part of the Cyberknife program involves providing the education to the practitioner he needs to use Cyberknife as one of the tools in his armamentarium. And so we've sent neurosurgeons for training; we've sent orthopedists for training; we've sent urologists and general surgeons for training. We literally bring up to speed the medical staff at Riverview and across Meridian so that they can take advantage of these new technologies. One of our cardiologists just achieved his certification for CT angiography so that now we can begin to use our 64-slice CAT scanner for that procedure.

ADUBATO: Did you ever think you'd see these things? Did you envision them?

Dr. SCOTT: I have to tell you that, in the last five years, medicine has truly taken off as the technologies from other areas--robotics, computing, imaging--have been married into what we've done in medicine by our own two hands for thousands of years, and the advances have been incredible.

ADUBATO: Isn't it somewhat ironic, at best--confusing and weird in the worst case scenario--given the technology, given the changes, given the advancements, given the fact that you say in the last five years there's been this revolution--right?--we treat people differently, the technology makes all these difference, but we can't seem to solve our problems in terms of how to pay for people who come into the emergency room and can't pay for themselves;

the reimbursement rates from the government to people who, in fact, are performing the surgeries, these services; and the fact that people who are in your profession--the medical malpractice thing is out of control and more and more people in high-specialty fields are saying, 'I can't afford these medical malpractice insurance rates. I got to get out,' or, 'I wish I had never gotten in.' Isn't--that's--why is one thing--one area, we experience these tremendous advancements, and the other one, we seem stuck.

Dr. SCOTT: It is...

ADUBATO: Am I overly simplifying it?

Dr. SCOTT: No, I think both sides are correct. I think both your facts are, unfortunately, correct. Medical technology is more expensive than ever before. The companies that produce it for us charge us for it. A total hip replacement now, just the parts alone, cost more than my first three automobiles. And those things are going to have to come down going forward.

I think the second problem is even bigger. And, you know, one of my other hats I wear is vice president of the Medical Society of New Jersey.

ADUBATO: Right.

Dr. SCOTT: That has been a huge problem for New Jersey physicians. For three years in a row, we were unable to keep a single obstetrician who trained at our medical school in Newark in state to practice. We've seen an out-migration of specialists.

ADUBATO: Why? Why couldn't they stay? Why didn't they stay, rather?

Dr. SCOTT: Well, interestingly, all 50 states solve the problem a little bit differently. In Texas, they recently passed tort reform that included caps on noneconomic damages.

ADUBATO: Explain that; it's a little bit jargony for folks. Break it down.

Dr. SCOTT: Well, in the many lawsuits which occur in our land--and certainly in the world of medicine--they break down the payments to the person based on what was their real loss...

ADUBATO: Mm.

Dr. SCOTT: ...what was their time lost from work, how much were their expenses for physical therapy, and then on top of that they put a component which is harder to quantify in a uniform manner: What is pain and suffering worth? And the problem, I think, really, is that justice, to be real, has to be applied equally. And one jury in Camden County might find someone's injury worth \$50 million...

ADUBATO: Right.

Dr. SCOTT: ...and another jury in Hunterdon County might find it worth \$50,000.

ADUBATO: So what do you do about that?

Dr. SCOTT: Well, what doctors have been doing, unfortunately, is trying to

migrate to the places in the country where they feel they're treated more fairly.

ADUBATO: You know, you told a story in one of the seminars we were doing. We do a lot of doctor-patient communication. Really, it is around communication, because it's an area that has fascinated me--and some of the issues and problems associated with doctor-patient communication and also the impact that has on medical errors--one of the issues having to do with--by the way, why do you all have such bad handwriting? That's a whole 'nother show.

Dr. SCOTT: That's a whole 'nother show.

ADUBATO: But here's what's interesting, in one of those seminars--I'll never forget the story you told, and--(to crew members) we have about three minutes left, guys? I'm going to ask Rick to do this--you told us a story in the seminar about this young woman who had gone into medicine. Quickly, set it up, because it has a powerful moral to it.

Dr. SCOTT: Well, this happened just a couple of years ago, but a second-year resident who'd finished her training in medical school and was training in anesthesia was working in a hospital not too far from here. During her stay in that hospital, a child who had had recent surgery pulled out his endotracheal tube and it needed to be reinserted. She responded to the code call as any physician would in that situation and did everything she could to get the tube back where it belonged. She was unable to get it there. An attending came down from another part of the hospital and succeeded in doing so. But it wasn't clear if the child may have had additional impairment during that period of time when they may not have been well-ventilated. As I recall, the jury found in that verdict that she was liable for \$75 million.

ADUBATO: The doctor?

Dr. SCOTT: The doctor--and the hospital system for an additional sum, I think, which was almost equal to that amount. For that physician, it was virtually the end of practice. She never got to follow through on her career, and yet, by any judgment, she didn't do a single thing wrong. She did everything she could within the limits of her training. She responded and did her best. I think at some point society has to appreciate people will stop responding if they're going to be held to a standard of perfection.

ADUBATO: But, Rick, at the same time, shouldn't those parents have some recourse if, in fact, their child has suffered in some way and, they believe, unnecessarily? I mean, where is the balance there?

Dr. SCOTT: Steve, I think they absolutely should, but I think the problem is in the degree. When you pull 75 or \$100 million out of a health system for one episode...

ADUBATO: Is it over at that point?

Dr. SCOTT: It's over for the physician. They won't be able to get insurance for the rest of their life. But for the health system? They will have similar problems for the insurance company; they will need to turn to all the other policyholders to be made whole.

ADUBATO: And what does it say to other physicians? Because you told this story and, again, I'm sure it's told and retold within the medical

community--what message did that send--does that send to other physicians?

Dr. SCOTT: The message is chilling: that they're liable for those cases in any excess to their policy. In the state of New Jersey, that could mean losing everything they've ever earned and everything they ever will earn. It makes people ask themselves, 'Why do I go into medicine if I'm putting myself so much at risk?'

ADUBATO: Got about 30 seconds left. After everything you just said, after the story you just told, after the "chilling" effect--your words, not mine--that it has had, do you have any regrets about going into medicine?

Dr. SCOTT: Absolutely none whatsoever. It is still, without a doubt, the most honorable field I can think of.

ADUBATO: What's the greatest satisfaction you get out of your work?

Dr. SCOTT: I get great satisfaction in knowing that the little things we do make the hospital a better, safer place for every patient who comes in. I get great satisfaction in my community--because I'm well-grounded there now for 20 years--in seeing all the patients I've treated--whether it be in the grocery store, on the soccer field, or at the movies--you really make a difference. You make it one at a time as a physician, and in the hospital I can make it for thousands of people going forward.

ADUBATO: Dr. Rick Scott, you have made a difference for our entire audience. Thank you very much. Great job.

Dr. SCOTT: Thanks for having me.

Announcer: The preceding program has been a production of the Caucus Educational Corporation, NJN Public Television and Thirteen/WNET New York.

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