HB
412

COMMITTEE REPORT

HOUSE

FURTHER: JUDICIARY

ADDED 4/23

March 20, 1979 Date: 4/26/79

Mr. Speaker:

The Committee on HESS has had HB 412

"An Act providing for minimum standards for hospital care."

under consideration and (a majority of the committee) (~~the committee~~) ~~reports it back with the following recommendations:~~ [illegible]

[ ] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[X] replace with CS for HB 412 [X] same title [ ] new title

and recommends

[ ] AND attaches a "Letter of Intent" [ ] New Fiscal Note

[X] reports it back with ~~out~~ individual recommendation

[ ] referred to the Committee

MEMBERS SIGNING DO PASS

[illegible signature]

[illegible signature, crossed out]

T Buchholdt

MEMBERS HAVING OTHER RECOMMENDATIONS:

[illegible signature] Do Not Pass

Vernon Hurlbert [illegible, crossed out] No Rec.

T Buchholdt
CHAIRMAN

From Cliff Warren

Dear ~~Legislator~~ Charlie:

I write you regarding CSHB 412, which requires a doctor to be on duty at all times in the five major hospitals of Alaska to not only give emergency care to patients brought to an emergency room but also to regular patients in the hospital -- and to give full protective care to those regular patients. In smaller hospitals, medical staff doctors would be in the hospital or standing by in the near vicinity.

I have done extensive research, and know from personal experience, that presently the following takes place:

> If a hospital patient's condition becomes critical, a nurse calls the attending physician if she is qualified to know the danger signs (she is not a doctor) or is not afraid to endure the wrath of a doctor who doesn't want to be bothered. While some doctors come running, many will not; those doctors may tell the nurse to give a pain shot or pill along with an "I'll see the patient later" (which means if not that night, the next day) -- then the patient becomes seriously injured or dies. Can you imagine being in the intensive care unit where minutes count and no qualified doctor is readily available? You may be told that there is a code call in case of an emergency, and that any doctor in the house will come running. This is a falsity in most cases, as there are not doctors available at all times in the hospital, and many doctors will not answer the call because they don't want to get involved with another doctor's patient. Perhaps, as I have been informed, you may recall a Legislative hearing held year or so ago at which there was testimony about the "Slow Walk" used by doctors in answering emergency calls.

I believe every patient in a major Alaskan hospital is entitled to protective care with a qualified doctor on duty at all times. That doctor would check the critical and post and pre-operative patients himself frequently, and check patients in the intensive care units even more frequently. That doctor should immediately answer a nurse's call when she is concerned over a patient. That doctor, if time allows, should also be required to call the attending physician when needed and require that he come immediately. But the hospital doctor should also be required to give emergency treatment when a patients' life or health is being threatened.

In spite of what you may hear, the five major hospitals do not have doctors on duty at all times to give protective and emergency care to hospital patients as outlined above. The Military and Native hospitals in Anchorage have informed me that they do have the doctors as outlined above on duty at all times, etc.

It is acknowledged that the smaller hospitals in Alaska cannot afford house doctors, and because most of the major operative and critical patients are sent to the major hospitals, there isn't as great a need. The smaller hospitals would be required to have a member of the medical staff on duty at all times or in the near vicinity to answer emergency calls, and that doctor would be required to check on pre and post-operative and critical patients, etc. and perform the other requirements of the doctors in the larger hospitals. It is my understanding that this is already being done in many of the smaller hospitals.

It is inexcusable that the large hospitals do not have a qualified doctor on duty at all times on the premises. Hospitals like Providence in Anchorage with a thousand employees, including administrators (several), public relations officers, carpenter shops, personnel directors, etc., etc., certainly can afford a house doctor. Perhaps it would put a strain on Bartlett Memorial Hospital in Juneau, but I question that.

Even if the State subsidized those hospitals needing help to a reasonable degree, it would be a cheap investment. The additional cost to the State, according to estimates prepared by Bartlett Memorial Hospital last year, would be less than three hundred thousand dollars a year. If the State paid the entire cost for all five major hospitals, it would come to only $1,500,000. I know of no better investment for the State.

You may hear many asinine statements by hospitals and doctors about my involvement: that I am wrought with grief and don't know what I am doing, or that I seek revenge for what I believe happened to my wife, etc. I will always grieve for my June whom many of you knew, but I seek no revenge and I have thoroughly investigated this matter. Senator Stevens has informed me that he also investigated and found no other hospitals in the lower Forty-Eight of over forty beds without doctors on duty as I described above. I have nothing personal to gain by fighting for HB 412, and know I will be attacked for doing so. I only hope that in the name of my wife I can save some one else's life.

I don't think that there are any of you who do not know of a personal experience or the experiences of a friend or relative regarding medical problems in Alaska. It's time that something is done about it.

I have been told that an amended verson of CSHB 412 will never be enacted because the hospitals' and doctors' lobbyists are too powerful and will block it. I cannot

believe that any of you, once you know the story, would succumb to pressures from those lobbyists. But if there are among you those who would take the thirty pieces of silver at the cost of injury or death to Alaskans -- which includes themselves and their loved ones, I can only shake my head in disbelief. I would also remind those who go Outside for medical treatment that emergencies do arise, and like it or not, you can end up in an Alaskan hospital.

I pray that you will support this much-needed and essential legislation in an amended meaningful form.

Respectfully yours,

Cliff Warren

Cliff Warren

PS: You may be interested in my attached comments on the current malpractice statute.

Attachment

From Cliff Warren

Dear ~~Legislator~~: Charlie

As some of you may know, I am presently engaged in a malpractice and wrongful death lawsuit over the maltreatment and death of my wife, June. Although it is too late to help me specifically, perhaps by my letting you know how the present malpractice wrongful death statute has affected me it will hopefully cause you to make changes in the law to prevent the same things from happening to others.

To start out, I will give some examples of what I am talking about.

What would you think of a situation where a policeman or lawyer, etc., through negligence, caused injury and death to someone you loved, and then that policeman or lawyer wrote the official report of the incident causing the injury or death. Then you were required to go to another policeman or lawyer for an opinion to be able to sustain a lawsuit, regardless of the clear evidence you had. If you were lucky, you might find a rare policeman or lawyer to give you an honest opinion for a small fee, but suppose you had the choice of asking for an opinion from a policeman or lawyer to whom you had to pay thousands of dollars or a policeman or lawyer who was a friend or associate of the defendant. What would you do if you did not have the thousands of dollars to pay?

Furthermore, suppose the State enacted a law that you couldn't gather evidence through depositions, etc., prior to filing the lawsuit, to correct erroneous and incomplete records made out by the defendant policeman or lawyer.

Then suppose the State enacted a law that required a three-member advisory panel to be appointed by the judge from a list of policemen or lawyers submitted from the policemen's own police department, or from the lawyer's bar association. Then suppose the judge appointed three members from the policeman's precinct station which was also being sued along with the policeman, or three members of the lawyer's own law firm that was also being sued along with the lawyer. Then one of these groups of three meet and don't call any witnesses, take any statements, affidavits, or honor requests to give testimony, but proceed to give an advisory opinion that will be given to and influence the trial jury, all based only on records prepared by the defendants. Even though those records themselves would show liability, they can be ignored because such an opinion is not given under oath. Then the defendant can try to use that opinion for motions for summary judgment, etc.

Along with the provision in the medical insurance statute that names of doctors found guilty of malpractice cannot be given to the public on request, I would urge the Legislature to revise the present malpractice statute as follows:

(1) That discovery can be made before filing suits.

(2) That the medical advisory panel must be made up of doctors agreed upon by defendants and plaintiffs and funds be provided to bring in impartial doctors not known or associated with either party, etc., if the judge must appoint when there is no agreement between parties regarding Alaskan doctors.

(3) Require that the medical advisory panel hear all witnesses desiring to testify before it, receive depositions, affidavits, and any evidence any party wishes to present.

(4) That the expert advisory panel file its opinion under oath giving the portions of the records used and why, affidavits, testimony, the medical texts used, etc., and that the panel members did not know any of the defendants or plaintiffs and that the panel's opinion was impartial and honestly arrived at, etc.

(5) That as of now, the advisory panel's opinion cannot be used for summary judgments, and the members are still under obligation to be examined during the trial that should remain if due process is to be maintained.

(6) That an expert advisory panel's opinion can not be used unless the panel is composed of specialists in matters involved in the litigation.

I hope you will give consideration to the above and make other appropriate changes in the law. I will be in Juneau Wednesday through Friday, beginning March 28th. I would be happy to talk with anyone or appear before any Committee then or in the future.

On a personal note, I wish to tell you that when a Catholic priest told me about the powerful forces I would face he was dead right. I'd rather have taken on the Mafia. But those forces are only powerful if the courts and Legislature allow them to be powerful. Part of the battle is fighting off the bunk that is trying to be peddled to Legislators and the court system: that I am obsessed over grief, taking revenge, have no case, that my wife died of cancer, etc.

file copy

POSITION PAPER
ON
CS FOR HOUSE BILL NO. 412

Committee Substitute for House Bill 412 deals with minimum standards for hospital care. The bill requires that acute care hospitals provide for coverage by a hospital attending physician. That physician is responsible for:

1. providing emergency hospital services;

2. monitoring certain hospital patients in acute medical situations at reasonably frequent intervals; and

3. responding to emergency calls for assistance from other medical professionals in the hospital.

The bill mandates acute care hospitals with 40 or more beds to have a hospital attending physician on duty at all times. Smaller acute care hospitals shall have a hospital attending physician on duty or on-call in the near vicinity of the hospital at all times. The bill sets penalties for hospital board of director members or hospital administrators who fail or refuse to provide such services as being guilty of a misdemeanor and punishable by a fine of not more than $1,000 for each day of the offense. The bill also requires hospital board of directors to file complaints and follow-up reports regarding the investigation of the complaints to the State Medical Board regarding failure or refusal of a hospital attending physician to perform these duties. The final section of the bill expands the definition of unprofessional or dishonorable conduct for licensed physicians to include "a willful failure or refusal of a physician" to perform duties of a hospital attending physician when required to do so by a hospital. Unprofessional or dishonorable conduct on the part of a physician may be used by State Medical Board to revoke the offending physician's license.

Discussion Points

1. Requiring acute care hospitals of 40 or more beds to have a physician physically present at all times may be burdensome to some hospitals. Presently five (5) hospitals in the state would be affected by this requirement:

   a. Ketchikan - Ketchikan General Hospital

   b. Juneau - Bartlett Memorial Hospital

   c. Anchorage - Alaska Hospital

   d. Anchorage - Providence Hospital

   e. Fairbanks - Fairbanks Memorial Hospital

The cost of such services particularly Ketchikan and Juneau would be substantial. At present they have an on-call schedule for physicians in the community and in the case of Bartlett Hospital, they only have on emergency room physician on the premises for certain hours of the day but not for the entire period. In March of 1979, Bartlett estimated its cost of implementing this bill to be nearly $300,000 for that hospital alone.

2. The Alaska Council on Emergency Medical Services has been considering standards for hospitals based on size of community. In these draft standards, only the largest communities (defined as serving a community of 150,000 persons or more) would be required to provide a physician in the hospital premises. These draft standards, which have not yet officially been adopted, state that hospitals serving smaller communities should provide 24-hour physician on-call coverage of the emergency room within 15 minutes by a physician trained in emergency medicine. The draft standards also include certain training requirements for emergency room, nurses, and other personnel. The bill presently does not define "on-call" as any specific time limit from the hospital. It may be appropriate to amend the bill to address the time frame issue.

3. Hospitals are already required to meet many types of standards of care. These include standards set by:

   a. Joint Commission on Accreditation of Hospitals

   b. Certification and Licensing by Division of State Health Planning and Development

   c. Risk Management Programs

   d. Medicare/Medicaid

   Placing additional standards will probably impact cost of care to consumers and to the State, when it purchases care through medical assistance programs.

4. The bill does not address the value of coverage of hospitals by nurse practitioners, emergency medical technicians, paramedics, and other allied health professionals. It is possible that these professionals may have more current experience in the emergency medical field, than a physician who does not specialize in this type of medicine.

POSITION PAPER/Department of Health and Social Service

Department's Position

The Department of Health and Social Services recognizes the need for increased availability of emergency medical services. We believe that provisions of the bill may prove burdensome to some hospitals and may raise the cost of hospital care to consumers in the State.

Approved by: _____ 3/25/80
Allen K. Korhonen, Deputy Commissioner (DATE)
Department of Health and Social Services

HB 412 file

Clifford E. Warren
P. O. Box 1124
Anchorage, Alaska 99510

May 12, 1980

Mr. Charlie Parr
Chairman House Judiciary Committee
Pouch V
Juneau, Alaska 99811

Dear Chairman Parr:

Thank you for sending me the Alaska State Hospital Association, Inc.'s comments on H.B. 412. I appreciate having the opportunity to reply to those comments. My reply refers to paragraphs in the Alaska Hospital Association, Inc.'s comments:

Paragraph 2.

It is noted that the Association agrees that the requirements in H.B. 412 for an on-call physician in the near vicinity would not substantially change what is already in use, and would not cause a fiscal hardship.

As to the remarks that <u>if</u> the "<u>voluntary</u>" call schedule broke down and physicians required renumeration, and several hundred thousand dollars <u>might</u> be needed, and a mandated schedule <u>could</u> inhibit recruitment of physicians in small communities, I answer as follows:

First of all, the small hospitals claim they are already doing what H.B. 412 requires; they must feel that what they are doing is necessary to protect the hospital patients. I hope that they also include the checking on critically ill patients, answering a nurse's call, calling the attending physician if time allowed, and giving emergency treatment to save the patient from injury or death not only for emergency patients, but all in-hospital patients.

What do the hospitals want? They acknowledge that such required services are necessary, but apparently want the right to discontinue these services if they feel like it.

Every Alaskan has a right to demand the protection required in H.B. 412 and any hospital that admits patients without those required protections is not a hospital, but a first aid station, and is guilty of the most gross criminal negligence. H.B. 412 makes sure that these hospitals always have the necessary

protections for the inhospital and emergency patients.

As to the remarks that physicians may demand renumeration if they are required to do what they are allegedly already doing and that recruitment of physicians in small communities may become difficult if H.B. 412 mandated the services, etc., is a bunch of bunk with no foundation in fact, but only "if's", "might's" and "could's".

Every small community hospital is a monopoly with only the physicians allowed to practice in that hospital (whether public or private) being the ones admitted to practice by the medical staff of the hospital.

Any physician now a member of that medical staff or as a member of that medical staff in the future, could, would, or should be removed from the medical staff and deprived of his right to practice in that hospital if he refused to perform in turn the duties of H.B. 412. The present so-called volunteer system reminds me of the army when the sargeant points to the private and says you just volunteered. The fact is the medical staffs in these small hospitals require that their members take their turns serving as on-call physicians. Anyone refusing to serve shouldn't be on the medical staff.

As to influencing recruitment of new physicians, any physician not wanting to take his turn as an on-call physician should not be on the medical staff of the hospital, and the community is better off without him. The truth is that recruitment of new physicians (with rare exceptions) is a matter of economics. That physician goes there to make money and stays there if he is making money.

In summary, the small community hospitals have no legitimate complaint against H.B. 412.

Paragraph 3

The Association's comments are that at this time it would be very difficult to develop a fiscal impact figure. It would be difficult for major hospitals to locate and contract in-house physicians.

Emergency Room physicians are on duty 24 hours a day, who, for patients, are in a life threatening situation or require prompt attention. Patients are not routinely visited by other physicians under the care of attending physicians. Areas with critical patients are monitered by specially trained nurses and other technical staff, etc. more qualified than contracted physicians who

might check patients. Physicians in intensive care units are available by phone or have designated alternates to be contacted if assistance is required. Phone directions are frequently more effective than having a non-attending attempt to become involved with the patient during a crises. Usually standing orders are left by the attending physicians which allows for life saving efforts to be initiated even before a physician becomes present on the scene.

The answers to the Association's comments are: It should not be any harder to locate in-house physicians for Alaskan hospitals than any other hospital. Alaska has no shortage of physicians and there are more than a sufficient amount available in the south 48. But it is not necessary to hire in-house physicians as a member of the hospital medical staff can take a turn as an in-house physician.

Certainly with the large medical staffs of the large hospitals an indiviudal doctor's turn would come up only a few times a year. These hospitals can have sleeping quarters for these doctors. Again, if the hospitals have physicians on duty in the emergency rooms 24 hours a day, then these physicians can perform the duties as prescribed under H.B. 412.

It's ridiculous to say that these hospitals, that have several administrators, maintain shops and crews, public relations officers, etc., etc., cannot afford an in-house doctor.

Cut some of the unneeded fat and give the protections a hospital is supposed to give, that is give full protection and care of its patients.

Bartlett Hospital had no trouble arriving at a cost figure, and it shouldn't take any time to fifgure the cost for in-house doctors <u>if needed</u>.

As I have stated before, the percentage of overall cost of operating a hospital with a thousand employees or less would increase insignificantly because of hiring in-house doctors.

Most people I have talked with would be happy to pay a little more for the protection. Emergency room physicians (if there are any) are not always called or not called at all for a regular patient's emergency, and these emergency physicians are not checking critically ill patients. Any in-house patient can become critical for a multitude of reasons.

The Association admits that critically ill patients are not routinely checked by physicians other than the attending physician. <u>It is time this is done.</u> The Association speaks of critical

patients being monitored by specially trained nurses, etc., who are more qualified than the in-house physician.

Nurses are not physicians nor are they trained as such, nor can nurses or technicians take all the medical actions that may be needed to prevent injury or death, as only a physician is authorized to take the actions needed.

Patients in intensive care units are very critical and minutes count. You don't always have time to contact an attending physician and get him to the patient in time.

Psychic medicine over the telephone doesn't always work as a patient may develop a condition only a physician can tell by being present and then give the treatment necessary.

Standing orders aren't worth a dam if the patient developes a condition the standing orders don't cover. The Association attempts to mislead by inferring an in-house doctor is always going to give treatment during a crisis. H.B. 412 is very clear that the in-house physicians contacts the attending physician and orders him to attend the patient if he feels it is necessary and time allows. An in-house doctor can take the steps needed which only a doctor can take, after discussion with the attending physician, and the patient is not being injured or dies waiting for the attending physician to show up.

There is nothing in H.B. 412 that prevents the nurse from also calling the attending physician. If time does not allow a wait for the attending physician to show up and a patient is threatened with immediate injury or death, then and only then is the in-house physician forced to act. How many people have died waiting for the attending physician to get there or because psychic telephone medical treatment was not adequate or the physician refused to attend the patient. Any decent doctor should welcome the assistance of an in-house physician, not only to give his patient needed protection, but saving him unneeded emergency calls to the hospital. There is no requirement in H.B. 412 as amended that is not vital if Alaskans are to receive the protections they are entitled to. Any patient even the non-critical patients can develop crises, many caused by conditions not known by the attending physician. Telephone diagnosis and treatment is morally and ethically wrong.

Paragraph 4.

The Association is concerned about malpractice and malpractice insurance rates. With all the reasons given, to oppose H.B. 412, this is the main underlying reason. The in-house doctor wouldn't be responsible if he carried out the attending physician's orders.

Yes, the hospital would be responsible for malpractice if the in-house physician was grossly negligent with an in-house patient the same as he would be for being grossly negligent with an emergency room patient.

It is and always will be the responsibility of a hospital to have qualified doctors whether in-house or on the medical staff. When a hospital opens its doors and accepts patients the risk of malpractice is always there. A hospital is responsible for the protection and care of its patients and to see that qualified medical staff is available. I remind you that the State makes available malpractice insurance for hospitals. A hospital trying to shirk that responsibility has no business operating as a hospital. I wonder how many people have been injured or died because a nurse had to stand by and couldn't save the patient's life or a doctor wouldn't give treatment. It is time that this is put to a stop.

Paragraph 5.

The Association states that what is presently being done at the Alaska hospitals under an effective voluntary system based on moral and ethical considerations complies with the intent of H.B. 412.

I have previously given the knowledge that I have known of personally and have obtained from nurses, doctors, etc. It is interesting to note that none of my charges have been denied.

There may be those who may think it is ethical and moral for a patient to have a crisis where immediate injury or death is threatened, and have to depend on a nurse who is not a physician to decide whether there is a crisis, or not, and if the nurse does feel there is a crisis and calls the attending physician only to have him raise hell with her for bothering him or having the attending physician practice psychic diagnostic medicine over the telephone, saying as an example, give the pain shot; I'll see the patient tomorrow, then having the nurse standing by helpless with the patient suffering, being injured or dying.

There may be those who think it is ethical and moral for a patient in intensive care not to have a doctor readily available, but have only nurses who not being physicians may or may not know of a crisis, or those nurses having to call the attending physician and catch hell for bothering him, or maybe he will practice psychic medicine and give orders for a little oxygen, etc., etc., and again the nurse having to stand by while the patient suffers, is injured or dies, because the attending physician wouldn't attend the patient, or took too long to get to the patient.

Certainly the present system works to a certain degree. As one prominent member of the medical establishment told me, "The system works pretty good; of course, like anything else, it breaks down once in a while." We are talking about human beings and we don't want a system that breaks down.

Every Alaskan is entitled to the protections given by H.B. 412.

Debra Behr asked me what I thought about specially trained nurses taking over certain hospital duties. My answer is that nurses of this nature would improve health care, but they are not doctors and cannot perform the acts a doctor can to protect and save patients.

I ask that your committee pass out H.B. 412 so that Alaskans can receive the protection and care that they deserve and have a right to demand.

Sincerely,

Cliff Warren

Clifford E. Warren

P.S.

In conjunction with the tape I sent you about trauma teams and the need for all hospitals to be trained in trauma treatment, etc., I would urge you to obtain the video tape from the A.B.C.'s 20/20 Program on the subject, that was shown in Anchorage last week.

It is very dramatic, and tells of the vast differences in the death rates between hospitals with trained personnel and those without, and it urges the training of all hospitals in trauma care and treatment.

HB 412 file

BARTLETT MEMORIAL HOSPITAL

P. O. BOX 3-3000 • JUNEAU, ALASKA • TELEPHONE (907) 586-2611
MILE 3 — GLACIER HIGHWAY

April 7, 1980

Representative Charles Parr
House of Representatives
Alaska State Legislature
Pouch V
Juneau AK 99811

HB 412 - MINIMUM STANDARDS OF CARE

This bill will affect only 3 hospitals in Alaska:
Bartlett Memorial Hospital
Fairbanks Memorial Hospital
Ketchikan General Hospital

Alaska Hospital and Providence Hospital now have physicians on duty 24 hours per day. All of the hospitals under 40 beds now have physicians on call.

Fairbanks Memorial and Bartlett Memorial have physicians on duty for 12 hours per day and on call for 12 hours per day. Ketchikan has physicians on call for 24 hours per day.

Bartlett Memorial Hospital's Board of Directors approved a one year trial of 12 hour physician on duty coverage. The trial period is to see if this service will be self-supporting. The first two months of coverage, January & February 1980, showed a loss of $1300. However, we are confident that the summer months will offset the losses.

Prior to starting this service, we did several studies on use of our emergency room. tached is a graph showing the distribution of patient visits by the time of day. We put our physicians on a 12 hour schedule (10 AM to 10 PM) because 80% of the patient visits come between those hours. We are now averaging 26 visits per day with 19 visits between 10 AM and 10 PM. This leaves only five patients in the other 12 hours of the day. That is too few to support the service or to keep a doctor busy.

We are currently paying $25 per hour. (physicians are getting up to $50 per hour in the lower 48). This adds up to $109,500 per year and this year's malpractice insurance costs us $20,108. The additional 12 hours would cost us another $109,500 with very little income to offset this expense.

This financial burden would have to be passed on to the patients unless the State of Alaska wishes to fund the cost at the three hospitals.

We respectfully request that you give this legislation a "do not pass".

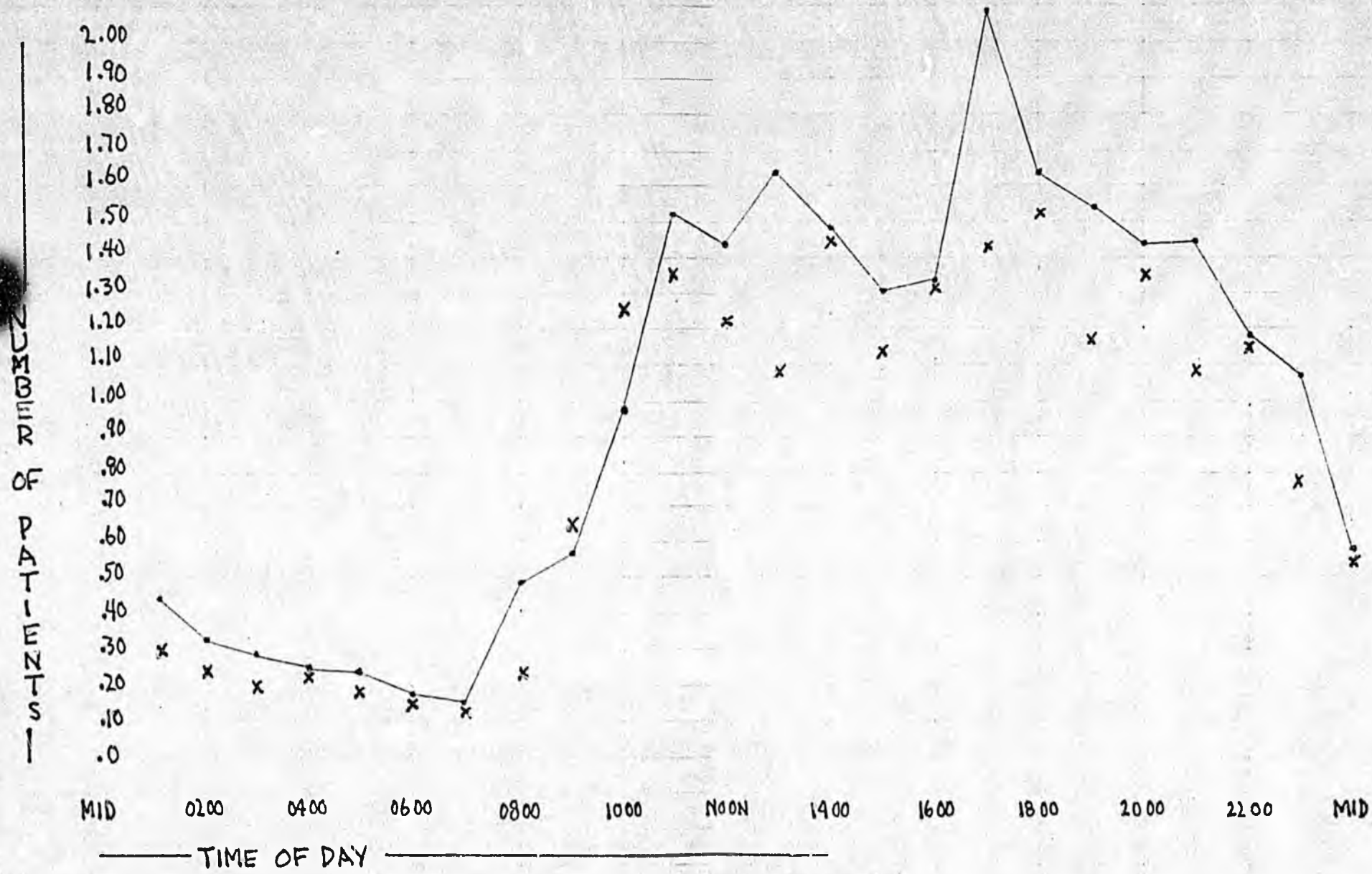
James R Burns

JAMES R. BURNS, ADMINISTRATOR

cc: Tom Mingen - Fairbanks Memorial Hospital
Sister Barbara Hasse - Ketchikan General Hospital
Alaska State Hospital Association

ER VISITS BY TIME OF DAY

BARTLETT MEMORIAL HOSPITAL



Fairbanks Memorial Hospital

1650 Cowles St.
FAIRBANKS, ALASKA 99701

OPERATED BY
LUTHERAN HOSPITALS AND HOMES SOCIETY
FARGO, NORTH DAKOTA 58102

April 2, 1980

Representative Charles Parr
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Mr. Parr:

I thought I would send my comments regarding two bills which your committee is considering.

House Bill 412 relating to a minimum standard for hospitals will substantially increase the cost to the patients in Fairbanks. We currently have 12 hours of physician coverage in the emergency room but do not have 24-hour coverage. We understand that this bill will mandate 24-hour physician coverage in the hospital. At this time our hospital cannot justify from a needs standpoint the coverage which this bill requires. Therefore, other patients will be required to pick up a portion of the cost which this hospital has to incur. As you can tell, I am very much opposed to this bill and would appreciate your effort in doing anything to stop the passage of this bill as it now stands.

House Bill 974-75 relating to increased revenue sharing in hospitals has our support. We do feel that the minimums should be changed to give hospitals with 10-30 beds $175,000 a year in revenue sharing, hospitals with 30-100 beds $200,000 a year and hospitals with greater than 100 beds $225,000 a year. I think that we both recognize that smaller hospitals in the state are in much greater need of this money than some of the larger facilities that enjoy higher occupancy, but I also believe that hospitals should be given some credit for their size. I believe that the formula which I am submitting could be very workable for all hospitals in the state.

I would appreciate your comments on these bills.

Sincerely,

Tom Mingen
Administrator
452-8181

TM/mw

HB 412 file

BARTLETT MEMORIAL HOSPITAL

P. O. BOX 3-3000 • JUNEAU, ALASKA • TELEPHONE (907) 586-2611
MILE 3 — GLACIER HIGHWAY

March 28, 1980

House Judiciary Committee
Alaska State Legislature
Juneau, Alaska

HB 412 - MINIMUM STANDARDS FOR HOSPITAL CARE

The Board of Directors of Bartlett Memorial Hospital (Juneau) went on record in March, 1979 as opposed to HB 412 because of "cost", "professional conflict" and "shortage of physicians in small communities."

1. COST: As one of only five (5) hospitals in Alaska with 40 or more beds, we would be required to provide "a hospital attending physician on duty at all times." We are currently providing an emergency room physician on duty from 10 A.M. to 10 P.M., and the income is not yet sufficient to cover this expense. There are not enough ER patients to support the cost of 24 hour coverage. The remaining 12 hours are covered by physicians on our Active Medical Staff on an "on-call" basis. This legislation would require us to provide the additional 12 hours of coverage at a loss of about $110,000 per year. This loss would have to be added to patient charges or subsidized by the State of Alaska. The Board of Directors is opposed to increasing rates.

2. PROFESSIONAL CONFLICT: All patients have their own physician. To have another physician "monitoring" the patient can only lead to problems for patients and doctors.

3. SHORTAGE OF PHYSICIANS: The smaller community hospitals do not have sufficient physicians now. The physicians cover emergencies now on a voluntary basis as best they can. To make it mandatory through legislation would justify a demand for remuneration and assistance. Where will the money and additional physicans come from?

We agree with the concept of 24 hour emergency coverage and suggest that the State of Alaska appropriate the funds and recruit the physicians to make this possible. In the absence of such funding, we respectfully request your opposition to HB 412.

James R Burns

JAMES R BURNS, ADMINISTRATOR

Attachment: "A PERSPECTIVE OF ALASKA'S HOSPITALS

A PERSPECTIVE OF ALASKA'S HOSPITALS

1980

* * * ALL HOSPITALS * * *

There are 1459 general hospital beds in 11 federal hospitals and 17 "open to the public" hospitals. The beds are distributed as follows:

FEDERAL	LOCAL GOV'T	PRIVATE
7 USPHS - 381 beds	5 owned/operated - 125 beds	6 - 595 beds
4 Military 202 beds	6 owned/other op. 156 beds	
583 beds	281 beds	
40% of total	19% of total	41% of total

* * * GENERAL PUBLIC HOSPITALS * * *

A further breakdown of the 17 hospitals and 876 beds open to the public show:

(the number in parentheses is nursing home beds)

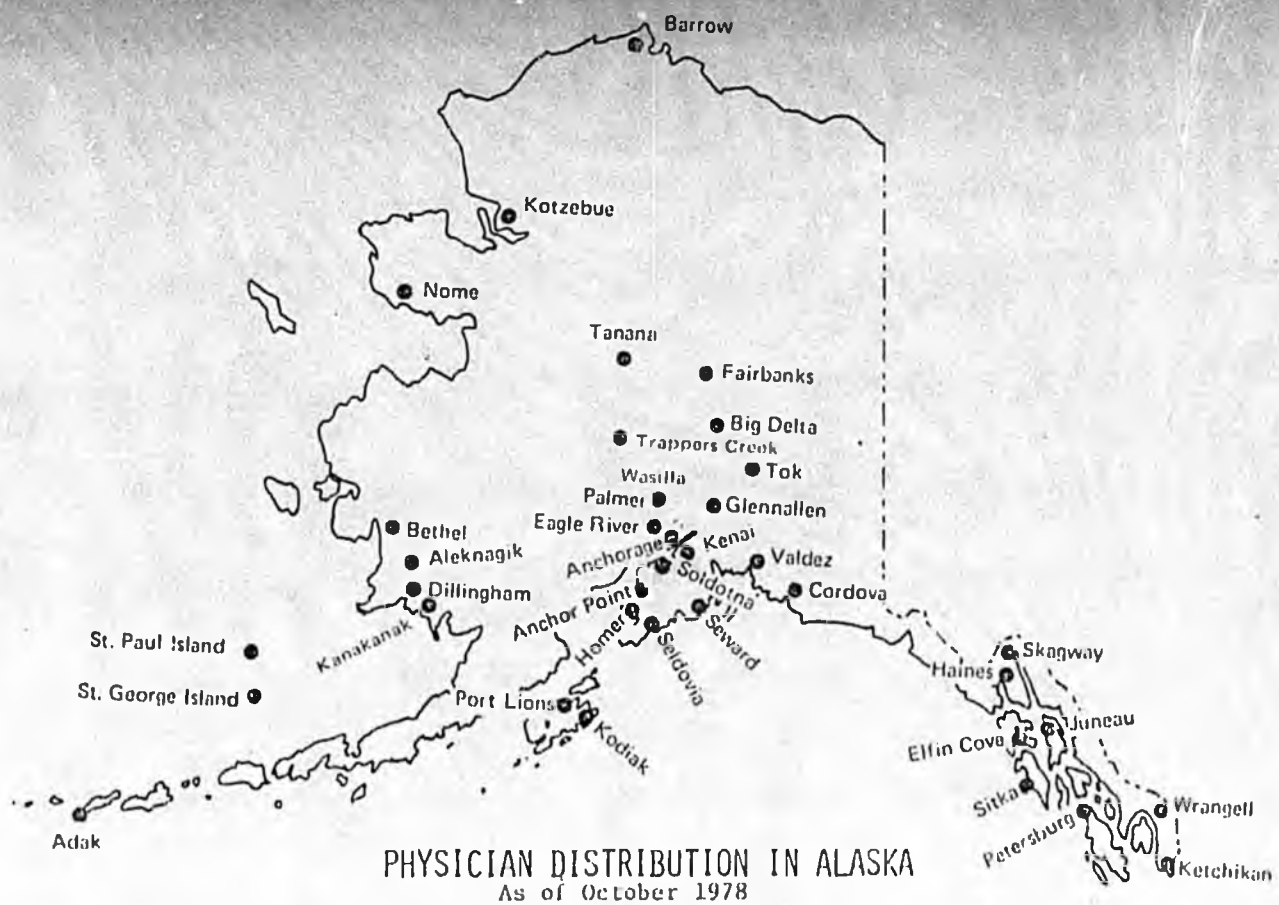
Under 20 beds		20 to 30 beds		31 to 100 beds		Over 100 beds	
Glenallen	6	Sitka	24	Ketchikan	44 (48)	Alaska	154
Wrangell	9 (14)	Kodiak	25(19)	Juneau	67	Fairbanks	155
Cordova	12 (8)	Seward	29		111 (48)	Providence	250
Homer	13 (4)	Soldotna	30				559
Nome	13 (6)		108 (19))				
Petersburg	13 (12)						
Valdez	15						
Palmer	17 (6)						
	98 (50)						
Hospitals	47%		23%		12%		18%
Beds	11%		12%		13%		64%

* * * NURSING HOMES * * *

There are 644 nursing home beds in Alaska. As noted above, there are 8 hospitals with 117 nursing home beds (18% of the total beds). There are 5 "free-standing" nursing homes;

St Ann's	Juneau	45 beds
Wesleyan	Seward	64 beds
Careage	Anchorage	101 beds
Careage N.	Fairbanks	101 beds
Nakoyia	Anchorage	216 beds
		527 beds

The State of Alaska operates 4 Pioneer Homes with 170 beds. There are plans to build in Ketchikan in direct competition with the beds already in existence.



PHYSICIAN DISTRIBUTION IN ALASKA

As of October 1978

Towns	Private Practice	USPHS	Military	Federal	Municipal State	Total
Adak			1			1
Aleknagik	1					1
Anchor Point	1					1
Anchorage	212	55	43	5	13	328
Barrow		3				3
Bethel		8		1		9
Cordova	3					3
Dillingham	1					1
Eagle River	2					2
Elfin Cove	1					1
Fairbanks	76	3	24		3	106
Glennallen	1					1
Haines	2					2
Homer	5					5
Indian	1					1
Juneau	18	4		1	5	28
Kanakanak		3				3
Kenai	1					1
Ketchikan	13	4	1	1		19
Kodiak	5		3			8
Kotzebue		5				5
Nome				5		5
Palmer	5					5
Petersburg	2					2
Port Lions	1					1
Seldovia	1					1
Seward	2					2
Sitka	5	7				12
Soldotna	8					8
St. Paul Island		1				1
Tanana		2				2
Valdez	2					2
Wasilla	3					3
Wrangell	2					2
Total	374	95	72	13	21	575
	65%	17%	12%	2%	4%	

HB 412 file

Clifford E. Warren
P. O. Box 1124
Anchorage, Alaska 99510

April 23, 1980

Mr. Charles Paar
Chairman
House Judiciary Committee
Pouch V
Juneau, Alaska 99811

Dear Chairman Paar:

Apparently the Alaska State Medical Association has not filed with you their comments on HB 412 as requested by you, as I have not received a copy which I could answer. Under these circumstances, I will proceed to answer some of the questions raised at the recent judiciary hearing held before you in Juneau.

First of all, HB 412 is not a bill that necessarily requires the hiring of new doctors. Most of the five major hospitals in Alaska have someone on duty at all times in the emergency rooms.

In those cases, the bill requires that house doctors check the critically ill patients, intensive care patients, etc. and perform the other duties prescribed under HB 412. Extra doctors may or may not be required to perform the duties outlined in HB 412. It would depend on the individual hospital. It is also to be noted that the hospitals can use medical staff members rather than hire a hospital doctor.

The smaller hospitals where HB 412 requires a doctor on duty at all times in the near vicinity, don't require any additional doctors, as most if not all such hospitals have doctors on call in the near vicinity for emergency treatment.

HB 412 spells out the vital duties that those doctors must perform. Those duties are not time consuming and should not put any strain on these doctors, and in some cases are already being performed. If additional doctors are needed, and there are additional costs that cannot be absorbed, hospitals can be judged as to their needs, and financial help given by the state as necessary.

Most people I have talked to wouldn't mind paying a little more of their hospital costs for the protection of a hospital doctor.

If state money is needed by them, it is one of the best investments the state could make. Too many times patients have suffered, been injured, or died because there was not a doctor available to check critically ill patients, the intensive care units, etc., and call and require the attending doctor to come if time allowed and to take emergency measures if time did not allow, to stop injury or death. Too many times nurses have not called the attending doctor because the nurse, not being a doctor, did not know of the seriousness of the patient's condition.

Too many times attending physicians have refused to answer a nurse's call, because the doctor practiced psychic medicine over the telephone, and raised hell with the nurse for bothering him, or prescribed an aspirin and he'd see the patient the next day. Too many times nurses have had to stand by and watch a patient suffer, be injured or die because there was no doctor, and she didn't dare do what was necessary to save the patient from suffering, injury or death. Too many times doctors have not answered the emergency code call, or gave the slow walk because they didn't want to get involved with another doctor's patient.

The medical opponents of HB 412 have stated that the bill interferes with the doctor-patient relationship. "Bull!" The attending doctor would be called and required to attend his patient, if called by the hospital doctor. That requirement does not interfere with a doctor-patient relationship.

As to emergency treatment by a hospital doctor interfereing with the doctor-patient relationship, I say to hell with such relationship. I wonder how many Alaskans have died because of this relationship. Any hospital patient is entitled to emergency treatment to save him serious injury or death, and I am sure you won't find many people not wanting such treatment. As an old timer who has been around the horn a few times, I recognize that ~~that~~ the medical profession is trying to kill HB 412 by many means, one being to incite the legislators from the small communities to believe that HB 412 will raise the medical costs or ruin their hospitals.

This is bunk as the costs would not rise or the hospitals be ruined. I have explained that above. I cannot believe that any legislator from a small community would vote against HB 412, when that bill is to protect and/or save the lives of his constituents as well as himself and loved ones.

It has been brought up that the board members of a hospital, like Glenallen, would be subject to fines if there was not a doctor in the near vicinity at all times. It was explained that substitute doctors took over when the community doctor left.

If there is no doctor available for this hospital, it is nothing but a first aid station.

Any hospital board of directors who operated a hospital and admitted patients without doctors available not only should be fined, but criminal charges should be placed against them. Certainly they would be subject to malpractice actions. There is nothing in HB 412, when amended as suggested, that is not needed if Alaskans are to receive the care and protections they have a right to demand. I wish to emphasize that for the bill to be effective, the suggested amendments are vital.

If there are other questions to be answered, I would appreciate having the opportunity to answer them before you act on the bill.

On a personal note, which I hope is not misunderstood, I wish to state as follows. For years Alaskans have known of the problems with the medical treatment in Alaska, with many Alaskans going outside for treatment or correction of Alaskan maltreatment. We have all stood by and let these happenings take place, year after year, without doing anything about it. I had to learn the hard way, and will now do what I can to change things.

I still alive.

I have attempted to work with the medical profession, but have received the cold shoulder. The medical profession will not or cannot clean up their industry, so now it is time the citizens and the state government accept their responsibility and do so.

There are two ways to do it. One is for me as an old bird to raise up from the ashes of my life, and do battle in the

public and political arena with petitions, etc., etc. This I was prepared to do, and started to do. I stopped not only because of my personal problems, but because I did not wish to harm the good doctors in Alaska, or the hospitals, and above all I did not wish to unduly cause worry or upset to those Alaskans who are in or going to be in the Alaska hospitals.

I can assure you that the medical situation in the rest of the country, as well as Alaska, is an explosive issue. You cannot talk to a person without hearing a horror story about medical treatment, in particular treatment in Alaska. I can assure you, people I have talked to get quite upset when they find they do not have the protections afforded by HB 412, as amended.

Secondly, I can come to the legislature, as I have done, and without fanfare, (at least until after the bill becomes law, you can give the fanfare) explain the importance and seriousness of the situation and urge passage of HB 412, as amended.

I respectfully request your committee to pass HB 412, as amended, with a recommendation of do pass. I also urge the Senate committee to do the same.

I urge both the members of the House and Senate to realize the vital need for HB 412, as amended, and to give their support and vote.

Sincerely yours,

Cliff Warren

Cliff Warren

P. S.

Please find enclosed a public information program tape where prominent doctors are talking about the need for specially trained doctors and nurses for emergency rooms and how these people are used for in-patient treatment. Most significant is the huge discrepancy between hospitals' mortality rate for trauma victims where one hospital has special trained personnel and the other has not. I would urge support of the Department of Health in their endeavors to send teams to train all state hospital personnel in emergency treatment.

P.P.S.
We have given the health providers malpractice insurance & a protective malpractice law.
Lets give the people some protection.

ALASKA STATE HOSPITAL ASSOCIATION INC.
5401 CORDOVA STREET
PHONE: 277-1633
ANCHORAGE, ALASKA 99503

April

Debra Behr
Special Assistant Designee
Department of Health and Social Services
Pouch H-01
Juneau, Alaska 99811

Dear Miss Behr:

I wanted to follow up our recent telephone conversation with written documention concerning H.B. 412 which is now under consideration. I would like to express our appreciation for involving our Association in the fiscal research on this proposed legislation, an infrequent but welcomed invitation from the Department of Health and Social Services.

We polled our membership on the basis of institutions with 40 beds or less and those with more than 40 beds. The smaller institutions generally did not feel the requirement for an "on call" physician would substantially change the voluntary call schedule physicians in their communities are already using. A mandated schedule was distasteful in concept, but did not appear to cause a fiscal hardship to the hospitals. If the present "voluntary" call schedule broke down and physicians required remuneration from the institution as well as the patients they treated, there would be a serious fiscal problem however, estimated to be several hundred thousand dollars annually. A mandated schedule, if carried to its ultimate, could inhibit recruitment of physicians in the smaller communities as well. I would encourage the removal of a mandated "on call" requirement as long as the voluntary scheduling is successful.

Hospitals with more than 40 beds, who would be required to have "in house" coverage beyond their present level of E.R. coverage indicated that it would be very difficult to develop a fiscal impact figure at this time, primarily due to the short notice and the detail that would be required in breaking out the information. A nonfiscal comment was that it would be very difficult for our major hospitals to locate and contract with "in house" physicians to comply with H.B. 412. Emergency Room physicians are on 24 hour coverage for patients who are in a life threatening situation or require prompt attention. Patients in the hospital are under the care of attending physicians and are not routinely visited by other physicians, contracted or not. Areas with critical patients are monitored and observed by specially trained nursing and other technical staff who are probably more qualified to make treatment judgements than most contracted physicians who might periodically check on the patient. Most physicians with patients in intensive care situtions are availible by phone or have designated alternates for the hospital staff to contact immediately if assistance is

required. Phone directions to highly trained staff by the attending physician is frequently more effective than having a non-attending physician attempt to become involved with that patient during a crisis. Usually standing orders by the attending physician allows life saving efforts to be initiated even before a physician becomes present on the scene.

Aside from any direct impact related to contracted physicians to provide "in house" coverage is the question of how this concept would affect hospital malpractice insurance rates. An alledged malpractice incident might involve a hospital employed physician as well as the attending physician, particulary if the hospital based physician initiated a change in treatment.

I hope this information has been helpful, and while it does not develop identifiable direct costs it does demonstrate that the intent of the bill is being met under an effective voluntary system based on ethical and moral considerations. It also identified that it would be inflationary and an unnecessary expense to have a contracted physician do what a highly skilled and well trained intensive care team is already doing.

Sincerely,

Max Kersbergen
Executive Director

MK/ic

APR 23 1980

The Honorable Joe McKinnon
House of Representatives
Pouch V
Juneau, Alaska 99811

Document# 84-80

Dear Representative McKinnon:

I asked Mark Johnson, Coordinator for the Emergency Medical Services Program for the State of Alaska, to contact the affected hospitals with 40 beds or more. We based our calculations on the assumption that no monies would be included for smaller hospitals to cover costs for physicians on call, as this is the current practice. Since the Anchorage hospitals already have the level of service required on CSHB412, the only remaining hospitals to be contacted were Bartlett Memorial, Fairbanks Memorial, and Ketchikan General. The total costs of implementing CSHB412 were estimated by these three hospitals to be $612,000. (Mark Johnson's memorandum detailing a cost break-down is attached for your reference). The Department has some concerns regarding Fairbanks estimate being high, as that hospital already has part-time physician coverage.

If you need any additional information on this topic, please do not hesitate to contact me at 465-3030.

Sincerely,

Deborah Behr
Special Assistant to the
Commissioner

MEMORANDUM State of Alaska

TO: Deborah Behr, Special Assistant for Legislative Affairs
Dept. of Health & Social Services

DATE: April 22, 1980

FILE NO:

Thru: Dean Tirador, M.D., Director
Division of Public Health

TELEPHONE NO: 465-3027

FROM: Mark Johnson, Coordinator
Emergency Medical Services

SUBJECT: Fiscal note for CS/HB412

This is a response to your request for information on the increased costs which will be incurred by those hospitals affected by CS for House Bill 412. Since both Alaska and Providence Hospitals in Anchorage already provide 24 hour-a-day in-house physician coverage, only Fairbanks Memorial, Ketchikan General, and Bartlett Memorial Hospitals would be affected by this bill. Also, the assumption is made that no fee would be paid for physicians on call, as this is the current practice.

Unfortunately, the affected hospitals could not agree on a standard formula for computing additional costs, so the additional cost figures listed are estimates provided by each of the hospital administrators.

Hospital	Additional Costs for Full-Time ER Coverage Per CS/HB412	
Fairbanks Memorial	$250,000	
Bartlett Memorial	110,000	(minimum)
Ketchikan General	252,000	(minimum)
TOTAL	$612,000	

The cost estimates for Bartlett Memorial and Ketchikan General were based on an estimate of $25 per hour plus malpractice insurance at $7,000 per physician per year. According to some physicians, this would be the absolute minimum. Bartlett Memorial already has 12 hour per day in-house physician coverage (10 A.M. - 10 P.M.), but Ketchikan General currently relies on on-call Physician coverage for all emergency services.

Fairbanks Memorial estimates that two additional full-time physicians would be required at $80,000 per year each, plus malpractice insurance. FMH also estimates that other indirect costs would be incurred as a result of this requirement. However, Tom Mingen, the Hospital Administrator, did not elaborate on what these additional costs would include.

If you need any additional information, I'll be happy to do what I can.