HB

336

HOUSE COMMITTEE REPORT

(7)
Date Referred: May 4, 1989 FURTHER REFERRALS: JUDICIARY

Date of Committee Action: 2/8/90

The LABOR & COMMERCE Committee considered: HB 336

HOUSE BILL NO. 336 [MEDICAL MALPRACTICE ADVISORY PANELS]
"An Act relating to medical malpractice advisory panels."

RECOMMENDATIONS:
[ ] be replaced with CS HB336(L&C) [ ] the same title [ ] a new title
[ ] have attached amendment(s)
[✓] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the ________ Committee

ADOPTS: ________ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)
[ ] fiscal impact ________
[ ] zero fiscal note ________
[ ] zero with analysis ________

APPROVES PREVIOUS: (Date/Dept)
[ ] fiscal note(s) ________
[ ] zero fiscal note(s) ________
[ ] zero fn/analysis ________

SIGNING DO PASS:

Dave Donley
(Kelstein) [signature]
[signature] (Gruenberg)

SIGNING: (check approp. column)

	Do Not Pass	No Rec	Amend
(Collins) [signature]	X		
[signature]		X	
[signature]			

Dave Donley
Chairman's Signature

STATE OF ALASKA
1990 LEGISLATIVE SESSION

Bill Version: CS HB 336
Publish Date: 5/4/89

FISCAL NOTE

REQUEST:

Revision Date 2/6/90
Agency Affected: Alaska Court System
Title: An Act relating to medical malprac-tice advisory panels...
BRU: Trial Courts
Sponsor: Labor & Commerce
Components:
Requestor:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL						
REVENUE						

FUNDING (Thousands of Dollars)

General Funds	0.0	0.0	0.0	0.0	0.0	0.0
Federal Funds						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

No fiscal impact.

Prepared by: Jan Strandberg, General Counsel
Phone: 264-8228
Division: Alaska Court System
Date: 02/09/90

Approved by: Arthur H. Snowden, II, Administrative Director
Date: 02/09/90
Agency: Alaska Court System

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management & Budget
Impacted Agency(ies)

STATE OF ALASKA
1990 LEGISLATIVE SESSION

Bill Version: CSHB 336(L&C) No.1
Publish Date: HOUSE 2/12/90

FISCAL NOTE

REQUEST:

Revision Date 2/6/90
Agency Affected: Alaska Court System
Title: An Act relating to medical malprac-tice advisory panels...
BRU: Trial Courts
Sponsor: Labor & Commerce
Components:
Requestor:

EXPENDITURES/REVENUES: (Thousands of Dollars)

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Prepared by: Jan Strandberg, General Counsel
Phone: 264-8228
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Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management & Budget
Impacted Agency(ies)

HOUSE COMMITTEE REPORT

(7)
Date Referred: February 12, 1990 FURTHER REFERRALS:

Date of Committee Action: _____

The JUDICIARY Committee considered: HB 336

HOUSE BILL NO. 336 MEDICAL MALPRACTICE ADVISORY PANELS

"An Act relating to medical malpractice advisory panels."

RECOMMENDATIONS:
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ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)
[ ] fiscal impact_____
[ ] zero fiscal note_____
[ ] zero with analysis_____

APPROVES PREVIOUS: (Date/Dept)
[ ] fiscal note(s) _____
[ ] zero fiscal note(s)_____
[ ] zero fn/analysis _____

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SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend

_____
Chairman's Signature

HOUSE COMMITTEE REPORT

(7)

Date Referred: May 4, 1989 FURTHER REFERRALS: JUDICIARY

Date of Committee Action: 2/8/90

The LABOR & COMMERCE Committee considered: HB 336

HOUSE BILL NO. 336 [MEDICAL MALPRACTICE ADVISORY PANELS]
"An Act relating to medical malpractice advisory panels."

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[ ] fiscal impact_____ [ ] fiscal note(s) _____
[✓] zero fiscal note ~~DOLAC~~ [ ] zero fiscal note(s)_____
[ ] zero with analysis_____ [ ] zero fn/analysis _____

SIGNING DO PASS:

Dave Donley / DONLEY (COLLINS)
(FINKELSTEIN) FINKELSTEIN
GRUENBERG (GRUENBERG)

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend
COLLINS	X		
LEMAN		X	

Dave Donley
Chairman's Signature

6-1316E
Ford
2/6/90

Original sponsor(s): Labor & Commerce Committee

IN THE HOUSE BY THE LABOR & COMMERCE COMMITTEE

CS FOR HOUSE BILL NO. 336 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to medical malpractice advisory panels and amending Alaska Rule of Civil Procedure 72.1."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 09.55.536(a) is amended to read:

(a) In an action for damages due to personal injury or death based upon the provision of professional services by a health care provider when the parties have not agreed to arbitration of the claim under AS 09.55.535, the court shall appoint within 20 days after filing of answer to a summons and complaint a <u>five-person</u> [THREE-PERSON] expert advisory panel unless the court decides that an expert advisory opinion is not necessary for a decision in the case. When the action is filed the court shall, by order, determine the professions or specialties to be represented on the expert advisory panel, giving the parties the opportunity to object or make suggestions. <u>Three members of the panel shall be persons who are not health care providers.</u>

* Sec. 2. AS 09.55.536(b) is repealed and reenacted to read:

(b) The expert advisory panel shall consider only evidence presented by the parties. Under the applicable rules of the Alaska Rules of Civil Procedure, a party may perform discovery, obtain the attendance of witnesses, examine or cross-examine witnesses, obtain a physical examination of the injured person if alive, and obtain the production of all relevant hospital, medical, or other records or

materials relating to the health care provided to the injured person. The parties may attend all hearings of the panel. The panel shall maintain a record of testimony or oral statements of witnesses, and shall keep copies of all written statements it receives.

* Sec. 3. AS 09.55.536(e) is repealed and reenacted to read:

(e) The report of the panel is advisory only and may not be admitted as evidence except the report may be admitted as evidence in determining an award of costs or attorney fees. The members of the panel may not be examined as witnesses on the contents of the report.

* Sec. 4. AS 09.55.536(f) is amended to read:

(f) Discovery [NO DISCOVERY] may be undertaken in a case before [UNTIL] the report of the expert advisory panel is received. [HOWEVER, THE COURT MAY RELAX THIS PROHIBITION UPON A SHOWING OF GOOD CAUSE BY ANY PARTY.] If the panel has not completed its report within the 30-day period prescribed in (c) of this section, the court may, upon application, grant it an additional 30 days.

* Sec. 5. AS 09.55.536(a), as amended in sec. 1 of this Act, has the effect of amending Alaska Rule of Civil Procedure 72.1 by providing that an expert advisory panel consists of five persons, three of which are not health care providers.

* Sec. 6. AS 09.55.536(b), as repealed and reenacted in sec. 2 of this Act, has the effect of amending Alaska Rule of Civil Procedure 72.1 by changing the evidence that the expert advisory panel can consider.

* Sec. 7. AS 09.55.536(f), as amended in sec. 4 of this Act, has the effect of amending Alaska Rule of Civil Procedure 72.1, by allowing discovery before the report of the expert advisory panel is received.

Alaska Action Trust
P.O. Box 102323 • Anchorage, Alaska 99510
Office: 540 L Street, Suite 102 • Anchorage
(907) 258-4040

March 16, 1990

Rep. Peter Goll
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, AK 99811

Dear Rep. Goll,

In the ongoing process of keeping you informed as to current developments relating to the perceived insurance "crisis," the medical malpractice problem and the civil justice system as it deals with that problem, the Alaska Action Trust has prepared this informational packet for your review and consideration.

A. HARVARD MEDICAL PRACTICE STUDY - EXECUTIVE SUMMARY

The Harvard Study, carried out under contract to the State of New York, was designed to inform the policy debate now going on in New York and elsewhere about how society can best deal with its medical injuries and malpractice.

The study had four principal components:

1. A population based measure of the incidence of injuries resulting from medical interventions, called "adverse events," and a determination of the percentage of such events that resulted from fault or negligence of the physician or other provider.

2. A determination of the percentage of adverse events, both negligent and non-negligent, that led to claims and suits. In addition, information about the numbers of claims and suits by patients in whose hospital records no evidence of injury were found.

3. Measures of the costs of medical expenses, lost wages, and lost household production to the victims of medical injuries and to their families, and their compensation for such losses under current legal systems.

4. Estimates of the degree to which variations in the threat of litigation affected the incidence of adverse events.

This study is the most comprehensive analysis yet made of the malpractice issue, and is certain to be used by policy makers nationwide to address one of medicine's most troubling problems. Howard Hiatt of the Harvard School of Public Health, the chief scientist on the study, said its findings broadly reflected the situation in hospitals around the U.S.

Sidney Wolfe, director of the Health Research Group, a Washington consumer advocacy organization, said the study suggests that nationwide 89,890 people die annually because of medical malpractice inside hospitals.

Among the study's other findings:

* 3.7% of patients sustained a disabling injury while they were in the hospital, or about 99,000 out of 2.7 million hospital admissions in 1984.

* 28% of injuries - representing 27,000 patients, or 1% of all admissions - resulted from negligent care Most cases were minor: 57% of patients recovered within a month and 70% within six months. But 14% of patients, or about 14,000, died from injuries.

* About 16 times as many patients suffered an injury from negligent care as received compensation by filing malpractice suits. Only 2% of the patients that suffered a negligent injury actually filed a claim, the study said.

The Trust office has copies of the 1,000 page report. If you are interested in obtaining a copy, please call the Trust office at 258-4040.

B. BACKGROUND INFORMATION ABOUT THE NY STUDY

This information sheet provides a brief overview of the Harvard Study and addresses the issue of a no-fault approach to medical negligence claims, which the Harvard Study advocates.

C. ARTICLE BY RUSS M. HERMAN, PRESIDENT, ASSOCIATION OF TRIAL LAWYERS OF AMERICA

This article demonstrates that escalating medical costs are not due to lawyer action on behalf of injured patients. While the debate on medical negligence has often focused on the number of claims filed or the size of jury verdicts or the cost of the litigation, the real scandal is how much of it actually occurs and the danger it poses to the unwitting health-care-consuming public.

D. STATEMENT BY RUSS M. HERMAN CONCERNING NY STATE MALPRACTICE INCIDENCE

In response to the Harvard Study, Russ Herman provided this statement.

E. "DOCTORS IN DISTRESS"

This 3-part series appeared in the NEW YORK TIMES, February 18 through February 20, 1990. The series illustrates the dramatic changes in medical practice which have shattered the profession, leaving many doctors deeply demoralized; the loss of autonomy and increased regulation which is sapping doctors morale; and a doctor-patient relationship of warmth and caring replaced by distrust and leeriness.

F. NEWS ARTICLE FROM THE WALL STREET JOURNAL - MARCH 1, 1990

The topic of this article is the Harvard Study. It provides an excellent overview of the study. It also includes some brief commentary from members of the health community.

G. "INSURANCE CRISIS AHEAD?" - ANCHORAGE TIMES, FEBRUARY 24, 1990

A U.S. House Energy and Commerce Subcommittee on Oversight and Investigations report on insurance insolvencies portrays the insurance industry as repeating some of the errors of savings and loans companies. The report, titled "Failed Promises," finds no evidence of a crisis immediately threatening the existence of the property/casualty industry. At the same time, "the same early warnings of potential disaster are abundantly evident, as they were five years ago in the thrift industry," the report asserts. "If such warnings are not heeded, the insurance industry and the nation could face a solvency crisis rivaling the savings and loan situation," it states.

The report goes on to point out weaknesses in the present system of state solvency regulation. Frequently used are such terms as "colossal mismanagement," "abandoning ship" and "giving away the underwriting pen."

* Copies of the report "Failed Promises" are now available. If you would like to receive a copy of the report, please call the Alaska Action Trust office at 258-4040.

If you or your staff have any questions about any part of this informational packet, please contact the Alaska Action Trust office at 258-4040.

Sincerely,

Debra Gravo

Debra Gravo
Executive Director
dch/encl.

PATIENTS, DOCTORS, AND LAWYERS:

MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK

A Report By the Harvard Medical Practice Study
To the State of New York

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Chapter

GLOSSARY

ADVERSE EVENT - an unintended injury caused by medical management rather than by the disease process. The injury is sufficiently serious to lead to prolongation of hospitalization or temporary or permanent impairment or disability in the patient. To be judged an AE, there must be a composite AE score of greater than 3.5. Close-call adverse events are cases with scores of 3.0 to 4.0. Low-threshold adverse events are cases with averaged scores greater than 1.0, up to and including 3.5.

CAUSATION - the attribution of a patient's disability to medical management rather than to the disease under treatment. The causation score reflects the reviewer's confidence in his/her judgement that medical management, rather than the disease process, caused the adverse event

CLAIM - a demand by a patient for compensation for injury and financial loss arising out of medical care

IATROGENIC - any adverse condition in a patient resulting from treatment by a physician or surgeon

IBNR CLAIM - an "incurred but not reported" claim. The patient has suffered an injury for which he will eventually file a claim, but the provider has not recognized and reported the incident.

INDEX HOSPITALIZATION - the hospital discharge sampled in the study

NEGLIGENCE - a failure on the part of the physician to provide reasonably careful treatment , i.e. treatment that normally should be expected from the practitioner usually caring for this kind of disease in the particular year in which the care was provided. In the Medical Practice Study, an average score of greater than 3.5

NO-FAULT - provides compensation for all injuries caused by medical management, irrespective of fault

NO-LIABILITY - a system whereby injured patients would pursue redress through the same public and private systems of loss insurance that are available to victims of any other disabling injury.

OBSERVATION or POTENTIAL CLAIM - a physician or hospital report to an insurer or agent that a bad outcome has occurred and might become the subject of litigation

POTENTIALLY COMPENSABLE EVENT - term used by the Medical Insurance Feasibility Study to designate a disability caused by health care management

RELIABILITY - the reproducibility of a judgment. One measure comes from comparing the scores of multiple reviewers of the same medical record.

SELF-WEIGHTING DESIGN - each observation in the sample represents the same number of discharges. Raw rates and ratios calculated for the sample apply to the population.

SUIT - litigation in court

TORT LAW - compensation provided only for those injuries caused by substandard or negligent medical management

TWO-STAGE CLUSTER DESIGN - first, a random selection of hospitals (clusters) and second, a random selection of records within each chosen hospital

UNIVERSITY TEACHING HOSPITAL - 13 facilities in New York State designated by the state's medical schools as their primary clinical centers. Affiliate teaching hospitals are remaining hospitals with a minimum of 5 approved residency programs and 5 specialty hospitals with large numbers of residents on the staff.

VALIDITY - an estimate of the truth in a judgment. Measured by comparing judgments made with two or more methods. Construct validity is assessed by comparing one measurement process to another. The content validity of a process is evaluated by asking xperts to examine it and to comment on its appropriateness.

ACRONYMS

ACOG - American College of Obstetricians and Gynecologists
AEAF - Adverse Event Analysis Form
AHA - American Hospital Association
AMA - American Medical Association
CMA - California Medical Association
DDA - Discharge Data Abstract
DOH - Department of Health
DRG - Diagnostic (or Diagnosis) Related Group
HANYS - Hospital Association of New York State
JCAH - Joint Commission on Accreditation of Hospitals
MDC - Major Diagnostic Category
MLMIC - Medical Liability Mutual Insurance Company
MM - medical management
MMIA - Medical Malpractice Insurance Association
[illegible] - Metropolitan Statistical Area
[illegible] - National Association of Insurance Commissioners
NYHHC - New York City Health and Hospitals Corporation
OPMC - Office of Professional Medical Conduct
PCE - potentially compensable event
PRO - Peer Review Organization
PSU - primary sampling units
SPARCS - Statewide Planning and Research Cooperative System
SU - sampling units
UBF - Uniform Billing Form

February 1990

PREFACE

Concern about the medical malpractice problem and the tort litigation system as it deals with that problem led the then Deans Howard Hiatt of the Harvard School of Public Health and James Vorenberg of the Harvard Law School to bring together certain members of their faculties to form the Harvard Medical Practice Study in 1984. The complexity of the issues confronting legislative and executive bodies of government as well as the courts, physicians, lawyers, and society itself, and the paucity of facts that could illuminate those issues required the participation of members of both faculties and others if a comprehensive research program were to be carried out. An equally important requirement for such work was the sponsorship of a state government prepared to open to investigators hospital records, insurance records, and the participation of administrative units of hospitals, physicians, and several state and municipal agencies.

Benjamin Barnes and Harvey Fineberg of the School of Public Health and Paul Weiler of the Law School were members of the original study group. Weiler, who is also Chief Reporter of the American Law Institute's Tort Reform Project, has continued to serve as a principal architect and investigator. After Fineberg replaced Hiatt as Dean, he asked Hiatt, who is Professor of Medicine and whose background included nine years as Physician-in-Chief at a Harvard teaching hospital, to become a member of the group in 1985.

As the scope of the Study broadened, several colleagues from a range of disciplines joined it. William Hsiao, an economist at the School of Public Health, helped in the planning phase. Russell Localio, a lawyer-statistician, then Director of Research at the Risk Management Foundation, was recruited to manage the project and to work on medical record review design and execution and claims data analysis. Ann Lawthers, a health policy analyst who was at Boston University, was initially administrative director and later

coordinator and designer of the provider studies. Troyen Brennan, a lawyer-physician, member of the Division of General Medicine and Primary Care at Brigham & Women's Hospital, and a Lecturer at the Law School, became a senior member of the physician-reviewer group and a contributor to the provider studies. William G. Johnson, an economist at the Maxwell School of Syracuse University, assumed responsibility for the patient interview phase of the study. Nan Laird, a statistician at the School of Public Health, took charge of statistical design and methodolcgy. Ken Thorpe, an economist at the School of Public Health, joined in the deterrence studies. Sol Fleishman and Howard Frazier, both internists, and Lucian Leape, and Lynn Peterson, both surgeons, were recruited to serve as senior physician reviewers for the record review portion of the study. In 1988, Leape, formerly chairman of the Department of Pediatric Surgery, Tufts Medical School, replaced Barnes as leader of the record review, and Joseph Newhouse, a health economist, formerly Director of the RAND-UCLA Center for Health Financing Studies and the new McArthur Professor and head of Harvard's Division of Health Policy Research and Education, replaced Hsiao as leader of the econometric study. Liesi Hebert, an epidemiologist, joined the research team in 1989.

Consultants to the project included:

Floyd J. Fowler, Jr., Director of the Center for Survey Research, University of Massachusetts, who helped in planning the design of the hospital record survey.

Graham Kalton, Chairman of the Department of Biostatistics at the University of Michigan, who worked on the analysis of the survey sample.

Ruth Kilduff, Risk Manager at New England Medical Center, who helped design the survey on hospital injury prevention activities.

Donald Rubin, Head of the Department of Statistics at Harvard University, Alan Zaslavsky, Lecturer in Statistics, who assisted with the analysis of deterrence, and Theresa Dailey, who provided computational assistance for Chapter 10.

Members of the Medical Practice Study office who provided

invaluable assistance during all phases of the study included: Sybil Carey, who provided administrative direction; Elaine Gebhardt and Steven Marcus, who assisted with computation and data management; Chris Braudaway-Bauman, Wendy Vander Hart, and Robert Chaufornier, who provided secretarial assistance; and Roger Dempsey, who filed endless boxes of adverse event forms.

From the Metropolitan Studies Program, Maxwell School, Syracuse University, the following individuals assisted with the report: Bruce L. Riddle, academic computing specialist; Esther Gray and Martha Bonney, secretaries; Mary C. Daly, graduate research assistant; Linda McCarthy, research assistant; Robert Guell, programmer.

A team from Mathematica Policy Research, Inc, of Princeton, New Jersey, under the leadership of Richard Strouse, carried out the patient interviews -- often under extremely difficult conditions -- very skillfully.

Support for the exploratory stages of the research came from the Klingenstein Fund of New York and a grant from the Risk Management Foundation of the Harvard Medical Institutions.

The relationship with the New York State Legislature and Department of Health under its Commissioner, Dr. David Axelrod, has been especially important. The Department's impartiality and commitment were crucial to that relationship, for the areas of medical malpractice and tort reform have been in urgent need of facts gathered and analyzed with methods that are scientifically sound. Also essential was the State's grant of complete confidentiality of information collected and the protection by New York law against subpoena of data.

Members of our group began with different views of the most promising ways to achieve reform. Some so regarded increased tort litigation, while others favored "no-fault" or other approaches. But as is necessary for every scientific enterprise, all agreed

that our function was to gather the best possible empirical information. We emphasize this point for it has been suggested by some that the Study set out to prove that one approach was better than another. Rather, we believe we have succeeded in our goal--to gather unbiased information which will help inform and elevate the ongoing debate.

EXECUTIVE SUMMARY

Introduction

The Harvard Medical Practice Study, carried out under contract to the State of New York, was designed to inform the policy debate now going on in New York and elsewhere about how society can best deal with its medical injuries and malpractice. To do so, we had to understand and isolate the key issues and assumptions that divide the protagonists of the current tort system, a reformed tort system, and no-fault alternatives. We have not prejudged the feasibility of any such no-fault program for injured patients, nor have we endorsed the criticisms that are made about present day malpractice litigation. Rather, we believe we have provided relevant empirical data that will permit informed judgments and sound policy-making concerning this complex area.

The Study had four principal components:

1. A population based measure of the incidence of injuries resulting from medical interventions, which we called "adverse events," and a determination of the percentage of such events that resulted from fault or negligence of the physician or other provider.

2. A determination of the percentage of adverse events, both negligent and non-negligent, that led to claims and suits. In addition, we obtained information about the numbers of claims and suits by patients in whose hospital records we found no evidence of injury.

3. Measures of the costs of medical expenses, lost wages, and lost household production to the victims of medical injuries and to their families, and their compensation for such losses under current arrangements.

4. Estimates of the degree to which variations in the threat of litigation affected the incidence of adverse events.

The following summarizes some of our methods and major findings.

1. The incidence of adverse events

The hospital medical record review was key to estimating the incidence of adverse events associated with medical management. The record review focused on two critical issues: causation and negligence. We asked, "Was the patient's condition attributable to medical management rather than to the disease under treatment (causation)? Was negligence involved?"

In addition to establishing causation and negligence, we determined where injuries occurred, the types of injury and then the magnitude of disability experienced.

The review was conducted by teams of trained medical record administrators and nurses for the screening phase, and board-certified physicians for the physician-review phase.

Methods were devised to resolve the logistic problems that arose because of the infrequency of adverse events: we found efficient and reliable ways to sift through thousands of medical records to find the few that indicated the patient disability caused by medical management. We also developed ways to deal with the methodologic problems that arose: the medical record administrators had to make valid judgments regarding the presence of screening criteria and physicians had to make valid and reliable judgments about whether a patient's injury resulted at least in part from medical management, and, if so, whether management failed to meet a standard of medical care.

In order to make our results generalizable to the entire population of hospital discharges in New York, we drew a probability sample of more than 31,000 hospital records. Our ability to obtain such a sample was made possible by the

availability of the Statewide Planning and Research Cooperative System (SPARCS) data system. The basic sampling design of the Study was an implicitly stratified, systematic, two-stage cluster sample of discharges. We first selected hospitals with probabilities proportional to the number of non-psychiatric discharges and then secured the cooperation of all 51 hospitals selected. Records within hospitals were selected with three different sampling frequencies determined by patient age and diagnosis-related group (DRG). Using SPARCS information on patient discharges, we drew a sample with a distribution that conformed closely to the population on important hospital and patient characteristics.

We analyzed 30,121 (96%) of the 31,429 records selected for the study sample. After preliminary screening, physicians reviewed 7,743 records, from which a total of 1,133 adverse events were identified that occurred as a result of medical management in the hospital or required hospitalization for treatment. Of this group, 280 were judged to result from negligent care. Weighting these figures according to the sample plan, we estimated the incidence of adverse events for hospitalizations in New York in 1984 to be 3.7%, or a total of 98,609. Of these, 27.6%, 27,179 cases, or 1.0% of all hospital discharges, were due to negligence.

Physician confidence in the judgments of causation of adverse events spanned a broad range, but only 1.3% of all discharges were in the close-call range (defined as a confidence in causation of just under or just over 50-50). An even smaller fraction, 0.7% of discharges were close-call negligent adverse events, but they constituted a larger proportion of total negligent adverse events.

The majority of adverse events (57%) resulted in minimal and transient disability, but 14% of patients died at least in part as a result of their adverse event, and in another 9% the resultant disability lasted longer than 6 months. Based on these

figures, we estimated that about 2,500 cases of permanent total disability resulted from medical injury in New York hospitals in 1984. Further, we found evidence that medical injury contributed at least in part to the deaths of more than 13,000 patients in that year. Many of the deaths occurred in patients who had greatly shortened life expectancies from their underlying diseases, however. Negligent adverse events resulted, overall, in greater disability than did non-negligent events and were associated with 51% of all deaths from medical injury.

Risk factors

The risk of sustaining an adverse event increased with age. When rates were standardized for DRG level, persons over 65 years had twice the chance of sustaining an adverse event of those in the 16-44 years group. Newborns had half the adverse event rate of the 16-44 years group. The percent of adverse events resulting from negligence was increased in elderly patients. We found no gender differences in adverse event or negligence rates. Although the rates were higher in the self-pay group than in the insured categories, the differences were not significant. Blacks had higher rates of adverse events and adverse events resulting from negligence, but these differences overall were not significant. However, higher rates of adverse events and negligent events were found in hospitals that served a higher proportion of minority patients. At hospitals that cared for a mix of white and minority patients, blacks and whites had nearly identical rates.

Adverse event rates varied 10-fold between individual hospitals, when standardized for age and DRG level. Although standardized adverse event and negligence rates for small hospitals (fewer than 8,000 discharges/year) were less than for larger hospitals, these differences were not significant. Hospital ownership (private, non-profit, or government) also was not associated with significantly different rates of adverse

events. The fraction of adverse events due to negligence in government hospitals was 50% higher than in non-profit institutions, however, and three times that in proprietary hospitals. These differences were significant. The standardized rate of adverse events in upstate, non-MSA hospitals was one-third that of upstate metropolitan hospitals and less than one-fourth that in New York City. These differences were highly significant. The percent of adverse events due to negligence was not significantly different across regions. Non-teaching hospitals had half the adverse event rates of university or affiliated teaching hospitals, but university teaching hospitals had rates of negligence that were less than half those of the non-teaching or affiliated hospitals.

The nature of adverse events

Nearly half (47%) of all adverse events occurred in patients undergoing surgery, but the percent caused by negligence was lower than for non-surgical adverse events (17% vs 37%). Adverse events resulting from errors in diagnosis and in non-invasive treatment were judged to be due to negligence in over three-fourths of patients. Falls were considered due to negligence in 45% of instances.

The high rate of adverse events in patients over 65 years occurred in three categories: non-technical postoperative complications, complications of non-invasive therapy, and falls. A larger proportion of adverse events in younger patients was due to surgical failures. The operating room was the site of management for the highest fraction of adverse events, but relatively few of these were negligent. On the other hand, most (70%) adverse events in the emergency room resulted from negligence.

The most common type of error resulting in an adverse event was that involved in performing a procedure, but diagnostic errors and prevention errors were more likely to be judged

negligent, and to result in serious disability.

The more severe the degree of negligence the greater the likelihood of resultant serious disability (moderate impairment with recovery taking more than six months, permanent disability, or death).

2. Litigation data

We estimated that the incidence of malpractice claims filed by patients for the study year was between 2,967 and 3,888. Using these figures, together with the projected statewide number of injuries from medical negligence during the same period, we estimated that eight times as many patients suffered an injury from negligence as filed a malpractice claim in New York State. About 16 times as many patients suffered an injury from negligence as received compensation from the tort liability system.

These aggregate estimates understate the true size of the gap between the frequency of malpractice claims and the incidence of adverse events caused by negligence. When we identified the malpractice claims actually filed by patients in our sample and reviewed the judgments of our physician reviewers, we found that many cases in litigation were brought by patients in whose records we found no evidence of negligence or even of adverse events. Because the legal system has not yet resolved many of these cases, we do not have the information that would permit an assessment of the success of the tort litigation system in screening out claims with no negligence.

Confining our analysis to the adverse events that involved strong or certain evidence of negligence, however, we estimate that 12,859 injuries from medical negligence did not lead to malpractice claims. Of these injuries, 22% (2,833) occurred in patients under age 70 years who suffered moderate or greater incapacity. Our projections suggest that if this group of

patients had litigated, the malpractice claims frequency for year 1984 would have increased by 75%.

3. Economic Consequences of Medical Injury

Having documented from the medical records survey which patients were injured, and from the litigation survey which patients filed tort suits, we used the patient survey to determine from the patients themselves what losses they suffered as a result of these injuries and what compensation they received from non-tort sources. For that purpose we divided our patient sample into five categories -- worker, homemaker, child, retired, and disabled -- and assembled data about lost wages and fringe benefits, medical costs, lost household production, and levels of physical and functional impairment. Our data for that final category have not been analyzed for this Report.

We faced two major difficulties in this survey. First, we had to locate, in 1989, people who had been hospitalized in 1984 in order to interview them about their experience since 1984. In fact, we were successful in finding and interviewing 71% of all injured patients, a response rate which is quite respectable for a survey of this type.

Our second problem was how to disentangle the effects of the adverse event itself from those that were properly attributable to the underlying illness, which itself would naturally be expected to entail considerable medical costs, time off work, and inability to perform normal household tasks. Two different strategies were devised for this purpose. One was to interview a control group of uninjured patients who were matched with our "experimental" group on the relevant dimensions, thus permitting econometric analysis of the precise difference which the iatrogenic injury made in the aggregate economic experience of the two groups. While we have collected all the data for the two groups, we have not completed this analysis for purpose of presentation in this Report.

Instead our primary focus has been on an alternative method -- estimating the compensable losses that might be paid under a hypothetical no-fault plan in which each patient's experience was assessed individually (as would have to be done in a real no-fault program), and then totaled. For that purpose we had to make a number of assumptions about program design: two important ones are noted here. First, all financial losses and compensation received during the first six months from hospital admission were deleted. These short-term losses are likely reimbursed from other sources (e.g., sick pay for time off work). Further, this reduces the number of cases in which disentangling the effect of the injury from the underlying illness may be very difficult. Second, we assumed that a no-fault patient compensation scheme would involve a second insurer, standing behind primary sources of general medical or disability insurance.

Our key findings with respect to these two criteria were that the bulk of disabilities were of short duration -- e.g., 42% of absences from work lasted for less than a month and 76% lasted less than six months. However, the average economic losses were much larger in the smaller number of more serious or fatal disabilities. With respect to these longer-lasting disabilities, more than 85% of the medical bills were covered by some form of health insurance, but only 20% of the lost earnings, and no detectable portion of lost household production.

Our ultimate finding is that the present discounted value of the net compensable losses (past and future) suffered by patients injured in New York hospitals in 1984 amounted to $894 million (in 1989 dollars). These compensable losses consisted of $285 million in lost wages and fringe benefits, $103 million in uninsured medical costs, and $506 million in lost household production (the latter having been valued at the market wages earned by the working women in our patient cohort).

To provide some perspective for these figures, the malpractice premiums paid by New York doctors and hospitals in 1988 amounted to $850 million. When one includes the amount spent by self-insured hospitals and the health care organizations, the total malpractice insurance burden is over $1 billion. However, these tort costs incorporate two major factors not reflected in our estimate. One is damage for pain and suffering, which typically are not compensated under no-fault programs. The other component is administrative and legal expenses which definitely would be a significant factor over and above the patient's economic losses. The administrative share of claims costs in no-fault workers compensation is usually estimated to be around 20%, though we believe it would be somewhat higher for no-fault patient compensation.

Since the sample of injured and interviewed patients in our different categories was rather small despite the relatively large sample of 31,000 hospitalizations, the confidence intervals surrounding our point estimates are large: the figures might be as much as 50% less or 100% more than those presented.. On the other hand, the estimate of net wage losses and medical costs -- these being the items typically covered by a no-fault scheme, and even then not in full fault - totalled just $335 million. Thus, there is considerable room within the current tort "envelope" to adjust even for an outcome at the highly improbable outer limit of these confidence estimates.

4. Malpractice Litigation and Deterrence

We examined the presumed deterrent effects of the tort system in two ways -- a series of physician surveys as well as an econometric study that compared the rates of adverse events and negligent adverse events, on the one hand, with the threat of a claim on the other.

The physician surveys revealed that the overall perceived risk of being sued in a given year was 20%, approximately 3 times the actual risk of being sued. The perceived risk of suit for

negligent care was about 60%, a figure substantially greater than the actual risk of litigation from injuries caused by negligence. Additionally, perceived risk was significantly greater for high-risk specialties such as obstetrics, orthopedics and neurosurgery and for physicians in Nassau and Suffolk counties, lending credence to the responses.

Physicians who perceived themselves to be at greater risk of suit said that in the past ten years they had ordered more tests and procedures and reduced their practice scope more than had their colleagues with perceived risk.

The tort system's deterrence signal to physicians appeared mixed. For example, physicians often considered the severity of punishment to depend on whether a case went to trial or whether the media publicized it. The evidence was not clear, however, on whether the severity of the punishment and the actual transgression were related: most physicians perceived their suits as having arisen from circumstances beyond their control. Many seemed to believe that the threat of the tort system was too broad and lacked specificity.

Although physicians believed they practiced medicine defensively, they did not report long-term changes in their practice patterns as the result of a specific suit. Thus, it was not clear whether defensive medicine resulted from the malpractice environment or from other factors such as advances in the science and technology of medicine, changes in societal expectations as to what constitutes an appropriate level of care, or changes in Peer Review Organization (PRO), state and hospital requirements, or a combination of factors.

Another important finding concerned physician attitudes about iatrogenic injury and negligence. Physicians tended to equate a finding of negligence with a judgment of incompetence. Thus, although willing to admit that all doctors make mistakes, physicians were often unwilling to label substandard care as negligent and were opposed to compensation for iatrogenic injury.

The final part of our study examined the relationship between variations in claims rates and variations in cost and in injury rates in the sample of study hospitals. We found some evidence that total cost per discharge was greater in hospitals that faced higher claims rates, although the relationship that we estimated was sensitive to how we specified the relationship. Even conceding that there is an effect on cost, however, does not tell us whether the effect is good or bad. On the one hand, greater efforts to prevent injuries or ameliorate the consequences of those that occur may well require greater resources. On the other hand, additional resources in response to a greater threat may simply represent wasteful defensive medicine and not contribute to a reduction in patient injuries.

The important test, therefore, is whether hospitals that face higher claims rates actually do exhibit lower injury rates. We find no evidence that they do, but the precision of our estimates is not good, and we cannot rule out the possibility that there are in fact substantially reduced rates of injuries at the hospitals in our sample with higher claims rates. More specifically, the point estimate relating injuries to claims is actually positive in most specifications and never close to significantly negative. However, the confidence intervals around the coefficient include values that would demonstrate substantial deterrence.

We illustrate how our data cannot rule out a substantial deterrent effect by choosing one of the relationships we estimated, that for the probability that an adverse event is negligent, controlling for a number of other hospital characteristics. The point estimate of the claims variable is slightly positive; however, if we reduce the point estimate by approximately one standard error, it shows substantial deterrence. In quantitative terms, the reduced estimate would suggest that, other things equal, hospitals in the highest quartile of claims rates would have about 24% fewer negligent

events (conditional upon an adverse event) as those in the lowest quartile.

Moreover, there may be a bias in our results toward showing no deterrent effect. Our goal was to determine whether there is a negative relationship between claims rates and injuries, but hospitals and physicians that have higher injury rates may have more claims filed against them. This possible positive relationship between injuries and claims would tend to mask any true deterrent effect. We have tested for this bias and do not find any evidence of it, but our test could simply be failing to detect it.

Finally, even if we had been able to conclude that our data ruled out all but a negligible deterrent effect, we could not conclude that abolishing the tort system would have no effect on injury rates. All the hospitals in our sample faced some threat of a claim if an injury occurred, and the most we could hope to learn was the effect on injury rates of variation in that threat. Abolishing the tort system could reduce that threat to zero (depending on what, if anything replaced it), and we cannot learn from our data what the effect of that might be.

February, 1990

BACKGROUND INFORMATION ABOUT THE NY STUDY

Malpractice Incidents/Scope:

Study Year - 1984

Number of Discharges Reviewed - 31,429 discharges selected to represent the state population in terms of race, payer class, age, sex, and type of hospital (urban, rural, teaching and non-teaching, for-profit and not-for-profit, municipal and non-municipal), but limited to acute, short-term care hospitals.

Only 30,195 records were located from the review sample, and another 74 records were not reviewed by physicians and thus the total number of discharges reviewed by the researchers was 30,121.

There were 2,671,863 (rounded to 2.7 million in the report) discharges in N.Y. during 1984, thus the study examined about 1 in 86 of the total discharges in N.Y.

51 hospitals were selected (out of about 270 eligible under the study's criteria) as the sample base from which to review the patient discharge records.

Physicians were used to determine "adverse events" and "negligent adverse events".

The physicians found 1,133 "adverse events" ("AE") after a review of the 30,121 discharge records.

Of the 1,133 AE's', 280 were judged "negligent AE's".

After "weighting these numbers" based on the sample size, the researchers estimated from the study sample that 3.7% of all hospitalizations in NY resulted in AE's, which the Harvard team calculated to be 98,609 adverse events in NY in 1984. Of the 3.7% (98,609) AE estimate, 27.6% of those AE 's (which can also be characterized as 1% of all discharges) were caused by negligence. In raw numbers, the 27.6% (or 1% of all discharges) was calculated to be a total of 27,177 negligent AE's in New York for 1984.

Of the estimated 27,177 negligent AE's, 6985 were deaths and 877 would result in permanent impairment (greater than 50% disability).

Litigation Figures:

The study estimated that a range of 2,967 to 3,888 claims are filed per year in N.Y (n.b., the estimate of negligent AE's was 27,177); claims are not by definition limited exclusively to lawsuits. Only 47 patients in the entire sample filed malpractice claims and eight of those were judged to be among the negligent AE's.

It was estimated that about 1 in eight negligence victims would file a lawsuit and only half of those (about 1 in 16) are likely to receive compensation.

Claims per physician were reported to have declined from 8.4 per 100 physicians in 1975 to 7.3 per 100 in 1984, according to data the Harvard Study team looked at.

Background:

Not all of the Harvard study is positive. The authors are clearly in favor of a no fault approach to medical negligence claims and argue that the tort system is not an effective deterrent.

No Fault/Deterrence

Readers of the report should be aware that the study advocates adoption of a no fault scheme. Its reasoning is that a large number of cases presently do not enter or go uncompensated under the tort system and this, therefore, suggests the need for a broader system like no-fault.

The report rather blithely glosses over what this kind of no fault system would look like or cost, although it says it might cost about what the present tort system costs.

In addition, the report argues that the tort system is not a very strong deterrent, since, in part, insurance ameliorates the impact of negligent behavior to the actor.

Possible Responses to the Report's No Fault Recommendations

Should you be presented with an argument suggesting the adoption of medical malpractice no fault schemes we recommend the following types of response:

1. All cases, small and large, are worthy of compensation. Don't talk about how lawyers can only afford to litigate serious cases under the present system. Nor do you want to sound like you advocate more litigation, although it is clear more victims need to somehow be informed of their rights.

2. Suggest that it is hard to believe a no fault scheme would not cost significantly more than the present tort system. The N.Y. figures show there would be a 7-fold increase in claims and a 15-fold increase in claimants receiving compensation. These claim and compensation estimates assume that a no fault system would be able to easily sort out compensable events, presumably negligent and/or adverse events, from mere bad results, not an easy task. It is quite likely every unanticipated bad occurrence would result in a claim under a true no fault scheme and, therefore, run the cost way above the current tort system.

Possible Responses to the Deterrent Argument

1. The tort system's true deterrent effect must be multiplied through the entire medical community to judge its full impact. Every time an insurer sends out a notice to hospitals or providers about a risk or potential litigation threat, or a review committee adopts new hospital procedures to reduce the risk of negligence, the hidden hand of the tort system is operating in a way no study can easily measure. All these hidden decisions need to be factored in weighing the true deterrent effect of the tort system. To bring in a no fault scheme will increase the incidents of malpractice in that the medical community will eventually lose the incentive to keep developing safer procedures in the hospital or clinical setting. We can not really measure how much more negligence would have occurred had the tort system not been in place.

2. Perhaps an alternative dispute system, such as a mediation plan grafted onto the tort system, can be devised to encourage smaller cases or any other claims which presently do not enter the system, to find their way into the compensation structure with a minimum disruption to the existing legal structures with its well-established rules. Such a plan retains the deterrent effect of the tort system.

President's Page

The Harvard Study *Or* Why the AMA Must Change Its Tune

For many years, the American Medical Association has tried to sing and dance the American people out of the right to trial by jury. The dance takes the form of an old "two-step" to the melody of "Waltz Me Around Again, Willie."

For years, physicians have trilled that medical negligence suits drive up the cost of medical care. However, in recent years many publications have reported that factors other than lawsuits are responsible for the increasing cost of medical care in the United States.

- The January 10, 1990 *Wall Street Journal* reported that the hospital construction boom, which has created thousands of empty hospital beds, has increased medical costs.
- The January 9, 1990 *Financial World* reported that "a truly astonishing percentage of the $650 billion annually spent on health care is wasted, the result of unnecessary surgery, unneeded diagnostic procedures, and puffed up bills."
- The August 13, 1989 *Times-Picayune* reported that doctor-owned labs earn lavish profits. Approximately a quarter of the nation's medical labs are wholly or partly owned by referring doctors.
- The November 7, 1989 *New York Times* reported that the number of surgeons was expanding more rapidly than the number of operations. Dr. John Bunker, a Stanford University anesthesiologist, was reported as saying that with their extra time surgeons "do a certain amount of primary care. They schedule an extra visit. They overtreat."

It is clear that for the last 25 years health-care providers and insurers have lulled state legislators, federal regulators, journalists, and patients into believing that escalating medical costs were due to lawyer action on behalf of injured patients. One wonders whether the editorial staffs of major newspapers and magazines read the objective reports they print in their own publications.

The second step in the two-step is to lead the public to believe that there is actually relatively little medical negligence. In an article in the *American Journal of Law & Medicine* (Vol. 10, No. 2), B. Abbott Goldberg says that the peer review process began as a device to protect physicians from testifying against their will in negligence suits and now this process condones a conspiracy of silence.

The May 26, 1989 *Journal of the American Medical Association* reported a study of doctors at a teaching medical institution in which the researchers tried to determine how honest doctors would be in various circumstances. One question involved a patient who received a fatal dose of medicine—10 times the amount prescribed. Fifty-five percent of the doctors said they would tell the truth about the error; 40 percent said they would stretch the truth by fabricating stories to cover it up (5 percent did not indicate what they would do).

As Dr. Harvey Wachsman said in his August 25, 1989 *New York Times* op-ed piece, "the medical profession is unable to police itself. In 1987, there were 1,700 complaints to the [New York] Office of Professional Medical Conduct. . . . Of these, only five came from the medical societies of New York. The sad fact is that doctors don't report the misconduct of other doctors."

Despite endlessly repeating the refrain about the cost and proliferation of lawsuits, the physician community is now being forced to sing a different tune—"Let's Do the Twist." Recently it has become necessary for the AMA to do a "twist" on the truth.

A just-released study of New York hospitals conducted by physicians at the Harvard University Medical School puts the truth concerning medical negligence in perspective. As reported in the January 29, 1990 *New York Times*, the study found that in 1984 negligence of doctors or hospital staff may have contributed to 7,000 hospital deaths and 29,000 injuries. The study also found that relatively few victims filed lawsuits.

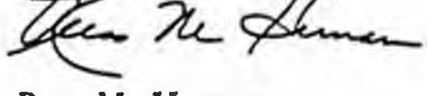
There is no reason to believe that health care in the rest of the United States is much different than in New York. The conspiracy of silence that has accelerated during the last 25 years has been instrumental in keeping information about negligence from victims and surviving relatives. Infectious-disease reports, incident reports of deaths, and peer reviews (when they occur) are sealed not only from the public but also from victims and their families. As a result, these cases are never brought to the attention of the courts.

The AMA's latest ditty is "Please Release Me, Let Me Go." ("Take the Cases Out of the System Completely and Refer 'em to a Panel of Medical Experts"). The AMA intends to deny even the few who find out about negligence in hospitals the right to trial by jury. That number wouldn't be much of a hit with fair-minded, well-informed people.

While the debate on medical negligence has often focused on the number of claims filed or the size of jury verdicts or the costs of the litigation, the real scandal is how much of it actually occurs and the danger it poses to the unwitting health-care-consuming public. The victim has for too long been made the scapegoat in a phony crisis that in the past led physicians to blame lawyers and their clients for the relatively high cost of malpractice insurance.

Physician, Heal Thyself

Based on the new Harvard Study, we call upon the American Medical Association and individual physicians of conscience to speak out, to improve peer review, to oppose the conspiracy of silence, and to afford every American the opportunity to seek justice in a free and open society. But if doctors want to deny their patients and our clients the right to full redress and trial by jury, then ATLA has a ready reply: "I Won't Dance, Don't Ask Me."



Russ M. Herman

STATEMENT BY RUSS M. HERMAN CONCERNING NEW YORK STATE MALPRACTICE INCIDENCE

Harvard University's study reflects a crisis of competence in medical care today. The study dramatically confirms that the numbers of deaths and injuries resulting from medical malpractice are staggering, and that the medical profession is overlooking too many instances of blundering within its ranks. Harvard's study also confirms that the overwhelming majority of malpractice victims never file lawsuits.

Trial lawyers believe that even one case of medical negligence is too many. As a society, we must insist upon the right of every American to safe, trustworthy medical care. We must also undo the legislative obstacles that prevent the innocent victims of malpractice from receiving fair and just compensation through the courts for their injuries and suffering. And we must debunk insurance industry untruths that lawsuits are the cause of outrageously high premiums. The Harvard study clearly shows the incidence of lawsuits to be minimal.

It's time to put the focus where it belongs -- on the health and safety of Americans. The study raises acute concerns about competence in our nation's hospitals. Without a strong civil justice system committed to protecting victims' rights, even greater tragedies would be inflicted on this country's trusting patients.

Russ M. Herman, President
Association of Trial Lawyers of America

Wall Street Journal 3-1-90

Malpractice Study Finds 7,000 Died In New York in 1984 Due to Negligence

By Ron Winslow
Staff Reporter of The Wall Street Journal

NEW YORK—A major new study of medical malpractice found that 7,000 people died in hospitals in New York state in 1984 as a result of negligent care.

The deaths were among 99,000 patients who were injured as a result of their medical care, whether due to negligence or not. Only a handful of patients actually filed malpractice claims or were compensated for their injuries. In addition, researchers found no evidence that the current system of addressing malpractice mainly through the courts has prevented negligent care.

The study is the most comprehensive analysis yet made of the malpractice issue, and is certain to be used by policy makers nationwide to address one of medicine's most troubling problems. Howard Hiatt of the Harvard School of Public Health, the chief scientist on the study, said its findings broadly reflected the situation in hospitals around the U.S.

"One cannot help but conclude that the current system is failing," said David Axelrod, the state commissioner of health. "Without major reform, the system will continue to fail."

Dr. Axelrod indicated the study supports a no-fault medical malpractice system that would pay victims no matter what the cause of their injury. But the state trial lawyers association said the study shows "doctors can virtually ignore" state regulations intended to minimize malpractice, and maintained that the tort system is a deterrent.

Meanwhile, Sidney Wolfe, director of the Health Research Group, a Washington consumer advocacy organization, said the study suggests that nationwide 89,890 people die annually because of medical malpractice inside hospitals. Dr. Wolfe said government should pass laws making it a felony for a doctor to witness medical malpractice and not report it. He also called on physician licensing boards in each state to act more aggressively against dangerous doctors.

Among the study's other findings:

—3.7% of patients sustained a disabling injury while they were in the hospital, or about 99,000 out of 2.7 million hospital admissions in 1984.

—28% of injuries—representing 27,000 patients, or 1% of all admissions—resulted from negligent care. Most cases were minor: 57% of patients recovered within a month and 70% within six months. But 14% of patients, or about 14,000, died from injuries. Researchers said negligence caused or contributed to half the fatalities.

—Patients over age 65 were twice as likely to be injured as those between 16 and 44 years; 70% of in-hospital injuries that occurred in the emergency room were the result of negligence. Hospitals with a high proportion of minority patients had higher rates of negligent injury than those treating more white patients.

—About 16 times as many patients suffered an injury from negligent care as received compensation by filing a malpractice suit. Only 2% of the patients that suffered a negligent injury actually filed a claim, the study said.

Researchers estimated that the injured patients suffered economic losses, measured in lost wages and fringe benefits, uninsured medical costs and what they called household production, equal to $894 million in 1989 dollars. By comparison, they said, the total bill for medical malpractice premiums paid by doctors and hospitals amounted to about $1 billion.

Injuries ranged from falls to allergic reactions to medications to damage in surgery. They also could result from errors in diagnosis.

Kenneth E. Raske, president of the Greater New York Hospital Association, said he was skeptical of the conclusion that 7,000 patients died from negligent care. He also said state hospitals have invested more than $500 million since 1984 in patient safety and quality assurance improvements, though it was too early to tell what impact they are having.

The four-year, $3.1 million study funded by New York State, is based on a review of 31,429 medical records from patients in 51 private, nonprofit and government hospitals.

York Times

New York: Today, sunshine mixing with high clouds. High 35. Tonight, partly cloudy. Low 30. Tomorrow, cloudy, not as cold. High 43. Yesterday: High 58, low 36. Details are on page 45.

NDAY, FEBRUARY 18, 1990

$1.50 beyond 75 miles from New York City, except on Long Island

$1.25

Changes in Medicine Bring Pain to Healing Profession

By LAWRENCE K. ALTMAN with ELISABETH ROSENTHAL

Dramatic changes in medical practice have shattered the profession, leaving many doctors deeply demoralized.

Over the past quarter-century, and especially in the last 10 years, doctors have seen their autonomy eroded, their future earnings potential jeopardized, their prestige reduced and their competence challenged by everyone from oversight boards to hostile, litigious patients.

The image of the dedicated physician toiling long hours for the good of his patients is fading fast, replaced by salaried doctors who work 9 to 5.

An Unrecognized Landscape

Doctors who finished training as late as 1980 look at the field of medicine today and say they do not recognize the landscape.

"My father was a pediatrician and I grew up surrounded by doctors who always seemed to be satisfied, loved medicine and were appreciated by their patients," said Dr. Scott Fox, 39 years old, who practices ear, nose and throat surgery on Cape Cod, Mass. Dr. Fox is president of the Barnstable County Medical Society, but in six months he will put down his scalpel and enter law school.

Many Doctors Dissatisfied

"Two years ago, just before my father died, he encouraged me to apply," Dr. Fox said. "As we talked, we realized the medicine he and I had cherished was finally dead."

The degree of dissatisfaction among doctors is astonishingly high for a profession that is typically regarded as one of the most prestigious, best paid and important in the nation. A survey by Gallup for the American Medical Association last year found that almost 40 percent of the doctors interviewed said that based on what they now knew about medicine as a career they would definitely or probably not enter medical school if they had a career choice to make again.

Many who study the medical profession believe that doctors brought the changes in the profession on themselves, said Prof. Uwe Reinhardt of Princeton, an expert in health care economics. "Physicians have lived like kids in a candy store," he said. "We, the payers, want the key back."

Young Americans pondering career choices apparently have their own reservations; applications to medical school have dropped 25 percent over the past five years.

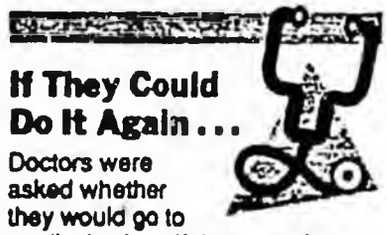
When the A.M.A. newspaper, American Medical News, asked doctors last year to describe how their practices had changed in the 1980's, "The question struck a nerve," the newspaper said. "Dozens of physicians responded with lengthy, heartfelt reflections," many of them expressing frustration with the changes in their profession."

Dr. Richard Short, a pediatrician in

Continued on Page 34, Column 1

Doctors in Distress

First of three articles.



If They Could Do It Again . . .

Doctors were asked whether they would go to medical school if they were in college now, knowing what they now know about medicine.

From a survey of 1,004 doctors interviewed by telephone in January and February 1989. The survey was conducted by the Gallup Organization for the American Medical Association.

The New York Times/Feb. 18, 1990

I.R.S. INVESTIGATING FOREIGN COMPANIES OVER UNITS IN U.S.

LOW TAX PAYMENTS CITED

Officials Say the Prices Used for Internal Transactions Cut Taxes $12 Billion

By ROBERT PEAR

Special to The New York Times

WASHINGTON, Feb. 17 — Bolstered by new auditing powers, Federal tax officials are investigating many American subsidiaries of Japanese companies on the suspicion that they have underpaid corporate income taxes by billions of dollars.

As foreign-owned assets in the United States more than tripled in a decade to $1.8 trillion, the gross income foreign-owned companies made here more than doubled. But the total taxes they paid hardly changed, data compiled by the Internal Revenue Service show. Of the 36,800 foreign-owned companies filing returns in 1986, more than half reported no taxable income.

Tax officials assert that some subsidiaries understate income, thus minimizing tax liability, by manipulating transactions with parent companies. But the I.R.S. has been frustrated in efforts to audit these companies' returns because important financial records are often kept at headquarters abroad, in foreign languages, with much less detail than would be required in the United States.

New Power for the I.R.S.

To aid I.R.S. investigations, Congress has provided an important tool. Under a provision of a law signed by President Bush on Dec. 19, Congress gave the tax agency broad authority to assess taxes on foreign-owned companies that fail to comply promptly with demands for any records or testimony. Those that do not cooperate can be fined up to $10,000 a month, with no limits on the cumulative penalty.

"We don't target a particular country for enforcement," said Charles S. Triplett, deputy associate chief counsel of the tax agency. "Nonetheless, it's pretty clear that the Japanese do a lot

Secretive Nicaraguan Voters

Practice of Medicine Is Undergoing Change, Demoralizing Doctors

Continued From Page 1

San Diego, elaborating on his comments to the A.M.A. in a telephone interview, said: "I enjoy seeing patients and I think I would go into medicine again, but I've had to be very strong to endure the headaches and the hassles. Now it feels more like just a job."

Few doctors are so dissatisfied they are leaving the profession, and in fact the number of doctors has increased faster than the population. But there are many signs that medicine is changing and beginning to lose its appeal.

The days when the doctor alone decided how to treat patients and set fees that patients paid out of their own pockets are long gone. Today, according to the A.M.A., 79 percent of the average physician's payments come from Federal and private health insurance programs, which are demanding increasing accountability from doctors.

The day of the individual practitioner dealing one on one with grateful, adoring patients, is passing. Twenty years ago, most doctors practiced alone. Today, most young doctors favor working in group practices or health maintenance organizations, which provide comprehensive care for a flat fee. Last year, for the first time, more doctors were employees than were self-employed, according to the medical association.

As the number of doctors has greatly increased, so intense competition has resulted in some areas, both for patients and hospital privileges. Many doctors have felt forced to adopt more aggressive marketing tactics.

Physicians, on average, remain very highly paid and their incomes continue to rise faster than their costs, making the medical profession one of the most lucrative. But incomes are now leveling off in some specialties, and the Association of American Medi-

Many experts believe that the regulation of doctors will have to be even more stringent in the 1990's if the nation is to curb its rapidly rising medical costs. But some experts warn that if such oversight is not carried out carefully, it could do more harm than good.

"I am worried about the growing disenchantment of the average doctor," Dr. William Roper, a physician who is deputy director of domestic policy in the White House, said in an interview. "It's a serious problem. It is not as if all the doctors in America are going to move to Australia or something. They just can't do that economically.

"But neither should we treat them as if we can abuse them and think we have lost nothing by it. I fear that the loss of faith by doctors will make them less caring and compassionate."

Private Practice

Costs and Trials Of Going It Alone

Last year, more than half the country's doctors were salaried employees. Among physicians over 45 years old, 75 percent are self-employed, but for those under 35 the figure drops to less than 40 percent, according to the medical association's statistics.

Experts say the costs of starting a private practice are prohibitively expensive for most doctors emerging from medical training, who may owe $50,000 or more.

Equipping the simplest doctor's office may cost $30,000 to $40,000 and for more complicated specialties, like ophthalmology, equipment can cost $100,000, said George Conomikes, whose firm in Los Angeles advises doctors starting to practice. On top of that, the doctors will be facing annual malpractice premiums that can sometimes exceed $30,000.

In some regions, especially rural areas, even established self-employed doctors say they are no longer able to make ends meet.

Dr. Short, the San Diego pediatrician, who grew up in the 1960's and went into medicine to "make a difference," said in the interview that he closed down his busy pediatrics office in rural Oregon to take a salaried job with a large group in San Diego after office expenses and [illegible] problems rose dramatically. During one two-month period he received no Medicaid payments because the state was out of money for the health care program for the poor. He said a $30,000 bank loan failed to keep the practice afloat.

"I really felt I helped people, but I couldn't afford it emotionally or financially," Dr. Short said.

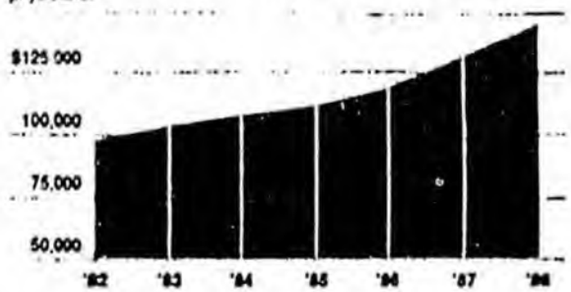
Government Bonus Plan

In an effort to slow the exodus of doctors

Illustrations by Javier Romero

INCOME

Average annual net income after expenses and before taxes for all physicians



Averages for self-employed physicians. Slightly less than half of all physicians are self-employed.

BY SPECIALTY

Average income after expenses and before taxes, in thousands for 1988.

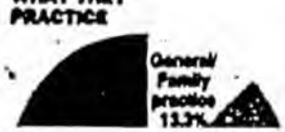
Surgery	$307.8
Anesthesiology	$194.5
Obstetrics/Gynecology	$180.7
[illegible]	$144.7
Pathology	$131.0
Internal medicine	$130.9
General/Family practice	$94.6

Sources: American Medical Association (all physicians, specialties); American Medical News (self-employed physicians)

SPECIALTY

Figures for the 521,328 active, classified physicians with known addresses that the American Medical Association tracked at the beginning of 1988.

WHAT THEY PRACTICE



WHERE THEY PRACTICE

The New York Times/Jeff Sperm

Dr. Scott Fox

Ear, nose and throat surgeon

"My father was a pediatrician and I grew up surrounded by doctors who always seemed to be satisfied, loved medicine and were appreciated by their patients."

cal Colleges now warns all applicants for medical school, "Physicians need to lower their income targets and their expectations for autonomy and independent decision making."

In five years, there has been a drop of 8,000 in the annual number of applicants for medical school, although the number of applicants rose slightly last year.

Medicine is heading toward a demographic revolution of major proportions, in which the traditional dominance of white male doctors is yielding to an influx of women and minority members that could radically change how medicine is practiced. Women, for example, are often more interested in the specialties that treat the primary medical needs of patients, and they have lower income expectations than highly paid specialties like surgery.

Little Sympathy for Complaints

The rising volume of complaints from doctors wins little sympathy from governmental leaders and private organizations that are trying to slow the rise in medical costs, which are largely determined by physicians' decisions. Until the explosion of technology made medicine far more powerful, and far more expensive, physicians were seldom challenged about the therapies they chose and the fees they charged.

But today, with health care accounting for about 12 percent of the gross national product, about double what it was when Medicare was enacted in 1965, many private and government groups argue that the country can no longer afford to give its doctors a blank check.

Companies "are applying to health care the same methodologies that they use for their products," said Dr. Paul A. Ebert, head of the American College of Surgeons. "They are asking for the same type of assurances that they are getting what they paid for."

More Stringent Oversight Is Seen

Dr. Louis W. Sullivan, Secretary of Health and Human Services, said in an interview that changes had been forced on the medical profession because it had not acted itself to meet society's needs, both in terms of the rising cost of medical care and imbalances doctors that leave many areas lacking enough doctors. "We've known for 15 years that we've had rising costs and that if things were not done to bring them under control there would come a day when there would be a reaction," he said. "We've reached that point."

"I really felt I helped people, but I couldn't afford it emotionally or financially," Dr. Short said.

Government Bonus Plan

In an effort to slow the exodus of doctors from areas that desperately need them, the Federal Government will add a 10 percent bonus next year to all Medicare and Medicaid payments made to doctors in areas that are short of health manpower, 73 percent of which are in rural areas.

The increasingly complicated paperwork required by government regulators and insurance companies often prove too burdensome for a private doctor to handle, or too expensive if he pays someone to do it for him. For example, on Cape Cod, Dr. Fox has one employee who spends all day doing paperwork, including completing Medicare and Medicaid forms, which in a growing number of states must be filed by the doctor, not the patient.

Dr. J. Gary Grant, an internist in Pacific Grove, Calif., who was among those who conveyed their feelings to the A.M.A. newspaper, said in an interview: "Many people decide it's not worth the hassle and get a salaried job at an H.M.O. Frankly those salaried positions sound pretty good."

But he added that he would not leave his practice, which he called "a family of 2,000 to 3,000 patients who depend on me."

The Money

Lucrative Still, But Not for All

Medicine remains a very lucrative calling. Most doctors make comfortable salaries, and their average net income continues to rise. But experts predict that as the government moves more vigorously to control costs in the 1990's, medicine will no longer be the gold mine it once was for some specialists.

Young doctors already face mixed salary prospects. Some big employers like the Kaiser health plans in California and the Health Insurance Plan in New York report that they are having trouble finding young doctors and have thus been forced, repeatedly, to raise the salaries they offer to these doctors. But according to a survey of 470 group practices by the American Group Practice Association, starting salaries for about 1,000 doctors finishing their training dropped almost 5 percent in 1988, the first drop since the association began keeping records in 1980.

Average Salary of $144,700

In 1988, the American Medical Association's annual survey found that the average practicing physician earned $144,700, but the range is wide and often based on a doctor's specialty or location. While a quarter of all physicians earned more than $100,000, another quarter earned less than $80,000.

The survey reported that the average annual income for doctors in the Middle Atlantic states, which it defined as New York, New Jersey and Pennsylvania, was $134,000, while the average in the New England states was $123,000.

The disparities are a cause for friction in the profession. Dr. Ronald A. Arky, who heads the department of medicine at Mount Auburn Hospital, a Harvard affiliate, in Cambridge, Mass, talks of cardiologists, gastroenterologists and eye doctors who earn 5 to 10

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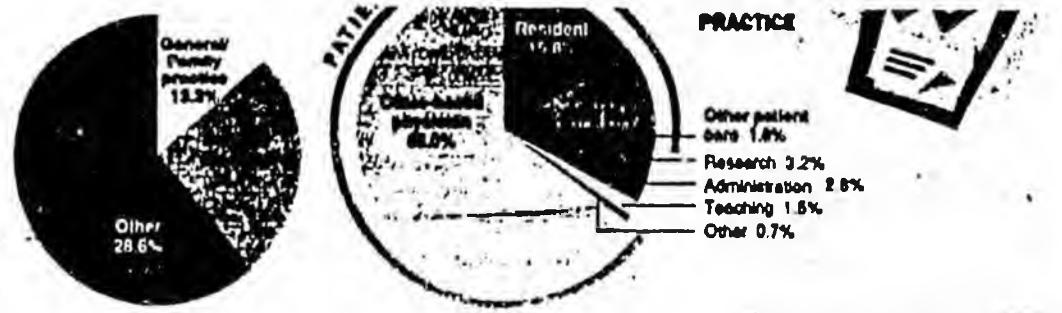
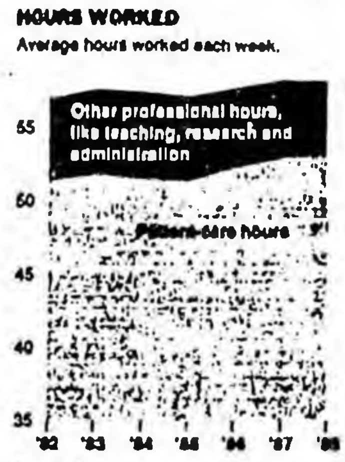


Source for both charts: American Medical Association

PRACTICE

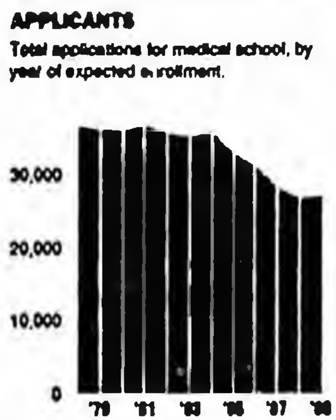
Source: American Medical Association (U.S. figures), World Health Organization (foreign figures)

Source: American Medical Association

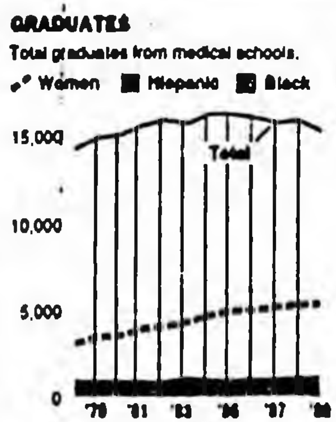


Source: American Medical Association

MEDICAL SCHOOL



Source: Association of American Medical Colleges



Sources: Association of American Medical Colleges (racial breakdown), National Resident Matching Program (women)

Source: Association of American Medical Colleges Graduate Questionnaire. For the most recent figure, 11,178 senior medical students were surveyed in the spring of 1989

Image of Doctor Toiling All Hours Yields to One of a 9-to-5 Practitioner

Women have been entering the medical profession in increasing numbers. Above, Dr. Edwin Wheeler, examining a patient, leads medical students, interns and residents at Massachusetts General Hospital in Boston.

Cont'd From Preceding Page

times the pay of internists, family practitioners and pediatricians who practice next door. Young doctors become cynical, he said, when they see a primary care doctor spend days preparing a patient for a brief surgical procedure, only to have the surgeon earn many many times what the primary care doctor earned.

The income inequalities between specialties can be traced largely to the evolution of health insurance reimbursement policies, which have long paid higher fees for operations and procedures and much lower ones for the hours primary care doctors spend making a diagnosis or determining the most effective drugs for patients with chronic ailments.

'I'm Going to Miss the Income'

Last year, Congress moved to redress the disparity by mandating a new Medicare payment schedule, effective Jan. 1, 1992, that will

patients, established doctors are keeping these cases, he said.

Particularly worrisome to some physicians has been the infusion of aggressive business tactics. Many health maintenance organizations do extensive telephone and mail solicitation of the elderly, sometimes spending 20 percent of their budgets on advertising and promotion.

Dr. Michael D. Myers of Los Alamitos, Calif., a family practitioner, said in an interview that he had to get a court injunction in 1987 to keep a local H.M.O. from what he termed interference with his mail and telephone service and harassment of his patients as they entered his office.

Some physicians successfully incorporate advertising and financing into their own practices. Although Dr. Christ's plastic surgery practice thrived in the oil boom of the early 80's, he said he was in "desperate circumstances" by 1988, when he says he rethought his position on advertising.

"I had thought that advertising was not the cool thing to do," he said. "Not quite unethical, but certainly to be frowned upon." But a limited advertising campaign turned his practice around, he said, and he now advertises on billboards, in magazines and on the radio. He also offers financing plans to patients.

"If recent trends continue," wrote Dr. Ar-

thing for the next 10 years of my life," adding, "It wasn't something I wanted to commit that much of myself to."

The Future

White Male Image Gives Way to Diversity

The white male image of medicine is changing as the entering levels of the profession. Indeed, many medical schools would have been in trouble, experts agree, had it not been for the great increase in women and minority members among their students. The number of male applicants to medical school has dropped almost 50 percent since the mid-1970's; in 1988-1989, the medical schools would have been unable to fill their first-year classes if they took only males, even taking every male who applied. For the first time ever, white men last year made up less than half the first-year class.

ISSUES

Demographics

Black and Hispanic doctors make up less than 1 percent of American physicians, but the percentage of female physicians has risen rapidly. In 1966, roughly 1 in every 6 American doctors was a woman. Men and women have been applying to medical school in smaller numbers in recent years. Male applicants have dropped 50 percent since the mid-1970's.

Incomes of Male and Female Doctors

Female doctors continue to earn far less than their male counterparts at all age and all experience levels, despite a slight narrowing of the gap in recent years. In 1987, male doctors practicing 20 years or more earned an average of $127,200. Comparable women doctors earned $72,800. Among doctors practicing four years or less, men earned $110,600 and women earned $74,000.

What the Patient Pays

The average fees paid to physicians for an office visit have risen steadily for the past decade, particularly for relatively new patients. The average charge for an office visit for the newer patients, who have been with their doctor only a few years, jumped to $63.51 in 1988, from $25.38 in 1978. For patients with a longer-established relationship with their doctor, the charge for an office visit rose to $33.91 in 1988 from $15.26 10 years earlier.

Rural Physicians

The long-standing dearth of doctors willing to practice in rural areas was slowly being mitigated from 1975 to 1985, when the number of rural doctors increased by 14.2 percent, still far below the number deemed necessary by the National Rural Health Association. But the modest gains may be in jeopardy. A 1988 survey of doctors in sparsely populated counties found that while 71 percent said they were satisfied or very satisfied with their practices, 25 percent said they were either dissatisfied or very dissatisfied and were planning to leave rural practice within five years.

Respect From Patients

The public's respect for physicians has eroded over the past decade, in the opinion of both doctors and patients. A poll in 1989 found that 72 percent of doctors felt that the public had less respect for doctors than they did 10 years ago. Only 1 percent of the doctors felt their profession got more respect. When the public was polled on a similar question, 26 percent said they has less respect for doctors than they did a decade ago; 14 percent said they had more respect.

The American Medical Association

Membership in the American Medical Association, the nation's largest professional society for doctors, has increased over the past decade, reaching nearly 300,000 last year. But because the number of doctors in the country has been expanding far more rapidly, the percentage of doctors enrolled in the A.M.A. has been declining, to 47 percent at latest count. That has reduced its potential impact as the voice for American medicine. Many doctors are joining medical specialty societies, such as the American College of Surgeons, without joining the A.M.A.

The New York Times/[illegible]

Dr. Richard Short
Pediatrician

"I enjoy seeing patients and I think I would go into medicine again, but I've had to be very strong to endure the headaches and hassles."

increase Medicare payments for evaluation and management of patients while reducing those for invasive and imaging procedures. Even some physicians who will be hurt by the change acknowledge that the change was overdue.

"I'm going to miss the income," said Dr. Carl J. Newman, a urologist in rural Kansas, one of those who responded to the medical association's survey.

"It's always nice to be overcompensated in your work," Dr. Newman said in an interview. "And I think you can argue that I have been."

He is closing his rural urology practice to take an academic position this fall.

Competition

Now the Doctor Will Call You

The gentlemanly atmosphere that once reigned in the profession has been replaced with what many doctors call a savage competition for patients, caused largely by a great increase in the number of doctors and the rise of health maintenance organizations.

The number of physicians in the United States today is nearly double that in 1963; 586,000 versus 290,000. The ratio of physicians for every 100,000 people has risen to 237 from 148 in the same period.

Aggressive Business Tactics

Younger doctors say they can no longer count on referrals from older colleagues. "In the good old days," said Dr. John Christ, a Houston plastic surgeon, "you paid your dues and earned your living by doing the cases the old boys didn't want to do," like bedsores and

[illegible]

cal, but certainly to be frowned upon." But a limited advertising campaign turned his practice around, he said, and he now advertises on billboards, in magazines and on the radio. He also offers financing plans to patients whose health insurance does not cover cosmetic operations.

Hernia Operation Packages

In New Jersey, two surgeons adopted other tactics to carve out a market share: They began performing hernia operations exclusively. The surgeons, Dr. Ira Rutkow and Dr. Alan W. Robbins, operate the Hernia Center (dial 1-800-HERNIAS), offering all-inclusive hernia operation packages. Dr. Rutkow said their high volume and specialization allowed them to deliver good care at a low cost.

Many physicians continue to look askance at such practices. "As a general statement, I think the more a doctor advertises, the less good he is," said Dr Grant.

Dr. Christ is convinced that his untraditional marketing strategy has cost him the regard of some colleagues and membership in at least one professional society.

The Training

No Clamor At Schools' Doors

Competition, regulation, malpractice worries and the disparaging things that doctors themselves say about their profession, combined with the rapidly rising costs of medical education, have produced a sharp drop in medical school applications.

"A lot of students are being told by practicing physicians that the profession ain't what it used to be," said David A. Nunnally, a biology professor who advised pre-medical students at Vanderbilt until last year. "There are more and more burned-out doctors for whom the profession is changing rapidly in ways they don't like."

Drew Rebilie of Dallas, a senior at Stanford, changed his mind about medical school the summer after his freshman year, when he worked as an orderly in the trauma center of a Memphis hospital. "It was a great job," he said, "but all the red tape we had to go through to do anything was unbelievable." The resident doctors he met there advised him against medicine as a career, he said, and he is now an English major.

Five years ago, 35,944 college students applied to medical school. Although enrollment has been relatively steady, only 28,913 applied for the 1988-89 freshman class. Fifteen years ago, 1 of every 2.8 applicants was accepted, but today the applicant-to-acceptance ratio is 1.6 to 1.

Some Schools Recruit

A few medical schools are now recruiting students in advertisements in college newspapers.

At the University of Massachusetts at Amherst, the number of seniors applying to medical school dropped to 100 in 1988-89 from 200 five years ago. The high cost of medical school, along with "horror stories" about malpractice suits and the grueling lives of doctors played a part, said W. Brian O'Connor, a zoology professor who advises pre-medical students.

"It's not very attractive," he said. "They have to go to school for four years, and three years of residency, and then the 60- to 80-hour work weeks they associate with a physician — it doesn't leave much for personal and family life."

Mr. Rebilie said he realized that if he went [illegible]

[illegible]

every male who applied. For the first time ever, white men that year made up less than half the first-year class.

"If recent trends continue," wrote Dr. Arnold S. Relman, editor in chief of The New England Journal of Medicine, "the medical profession in the United States, which not long ago was composed almost entirely of white men, will soon have a majority consisting of men from racial minorities and women."

Too Little Progress

But Dr. Russell L. Miller, vice president for health affairs at Howard University College of Medicine in Washington, wrote in a pamphlet published by the Association of American Medical Colleges, that over all "too little progress has been made" in increasing minority enrollment in medical schools. Blacks, for example, make up 12 percent of the nation's population but only 6 percent of medical students and 3 percent of practicing physicians.

Dr. Joyce Davidson, a psychiatrist at the Menninger Clinic in Topeka, Kan., who specializes in the issue of women in medicine, said women as doctors earn an average of 30 percent less than their male counterparts and often face subtle biases. For example, Dr. Davidson says that when she calls a colleague's office and identifies herself as "Dr. Davidson," the receptionists often assume she is Dr. Davidson's secretary rather than Dr. Davidson.

More Stress for Women

Medicine is particularly stressful for women, said Dr. Davidson. In addition to the biases, there are the added pressures of the family and the home, she said. Studies show that 75 percent of married female doctors perform all their household work. More than half of female physicians suffer a major depression sometime during their career and the divorce rate for the group is 40 percent higher than that of women in general, Dr. Davidson said.

On the bright side, Dr. Davidson said, the presence of women has "softened the profession a bit," encouraging the development of alternatives to the customary 24-hour-a-day, seven-day-a-week medical grind, made feasible originally by the self-sacrificing wives many doctors had at home.

Health Groups Attract Women

"Most women will not be 100 percent devoted to their career," Dr. Davidson said of female doctors, noting that they wanted time to devote to their personal lives. She said that jobs like 9-to-5 salaried positions at health maintenance organizations "work out well for women who need relatively strict hours for their families" and that a disproportionate number accept these positions.

Dr. Wendy Levinson, an internist in Portland, Ore., who has written on women in medicine, said that in the future the most successful medical practice groups would be those that adjust to meet the needs of female doctors.

Dr. Relman said the demographic changes might well help medicine meet its social obligations more effectively. "A changing younger profession, more broadly representative of American society, with more moderate income expectations and a greater commitment to the primary care specialties, will be in a better position to meet the needs for health care in the next century," he wrote in The New England Journal of Medicine last November.

NEXT: The loss of autonomy.

its potential impact as the voice for American medicine. Many doctors are joining medical specialty societies, such as the American College of Surgeons, without joining the A.M.A."

Sources: Census Bureau (demographics), American Medical Association, National Rural Health Association

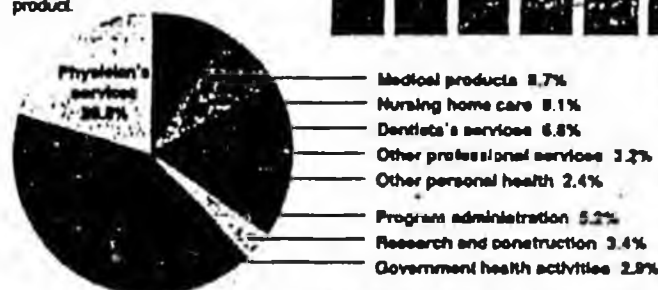
THE NATION'S BILL

ITS GROWING SHARE OF THE G.N.P.

National health expenditures as a percentage of the gross national product each year.

WHERE IT GOES

Figures for total health spending in 1987. The total that year was $500.3 billion; 11.1 percent of the gross national product.



Sources: Department of Health and Human Services (share of g.n.p.), American Medical Association [illegible]

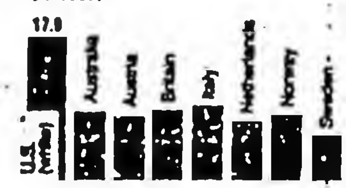
BAROMETERS OF HEALTH

INFANT MORTALITY RATE

Deaths of infants under 1 year per 1,000 live births.

IN COMPARISON

Deaths of infants under 1 year per 1,000 live births in 1988. U.S. breakdowns are from 1987.



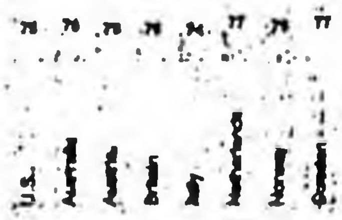
LIFE EXPECTANCY

At birth, in years   Men   Women

Source: American Medical Association

IN COMPARISON

Averages for both sexes in 1988



Source: Compiled by the Population Reference Bureau

Charts by Anne Cronin

"All the News That's Fit to Print"

The New Yor

VOL. CXXXIX . . . . No. 48,151 NEW YORK, MONDAY, FEBRUA

Many in Medicine See Rules Sapping Profession's Morale

By LISA BELKIN

Even the most staid audience of doctors applauds with vigor when Dr. Arthur Caplan gets to the part about Gulliver and the Lilliputians.

In speeches around the country, Dr. Caplan compares Gulliver, the mythical traveler, to today's doctors, who have awoken to find themselves pinned to the ground by hundreds of 6-inch-tall Lilliputians.

In his modern parable the Lilliputians are not imaginary islanders but the growing number of official and unofficial regulators — insurance companies, government agencies, malpractice lawyers and employers — that make the doctor feel trapped.

Chained by 'Munchkins'

"They love that analogy," said Dr. Caplan, the director of the Center for Biomedical Ethics at the University of Minnesota. "They applaud. They resonate. They come up to me and say, 'That's exactly what it's like out there, we're chained down by munchkins.'"

This feeling of being shackled by rules and overseers is nearly universal among doctors today, experts inside and outside the profession say. Doctors say they are overwhelmed by paperwork, prohibited by insurance companies from doing procedures and subjected to scrutiny by group employers like health maintenance organizations that can even include scheduling of restroom breaks.

Doctors In Distress

Second of three articles.

There is a seemingly endless debate over whether all the supervision is necessary, with regulators saying doctors refuse to police themselves and doctors saying the level of policing is extreme. But both sides agree that it is taking its toll on the morale of the medical profession.

A poll taken last year by the Gallup Organization for the American Medical Association found that nearly 40 percent of all doctors probably or definitely would not go to medical school if they were in college today. The most common reason was government or insurance regulations that "interfere with doing my job" and cause a "lack of autonomy," which was cited by 27 percent of the respondents.

"I've become irrelevant," said Dr. Joseph J. Merigo, a Boston doctor who bought a laundromat and is looking for a small restaurant to buy so he can close his medical practice. The last straw, he said, was when he had to send a patient home without treatment for several days because a new state rule required tests before the treatment and the insurance company refused to pay for them without a second opinion.

"Medicine is not really the profession that it was," he said. "The

Continued on Page A13, Column 1

A protester using an iron rod to break a window at t

In Pretoria, Last Throes Of Marxism?

By CHRISTOPHER S. WREN

Special to The New York Times

JOHANNESBURG, Feb. 17 — The winds of change battering Marxism around the world have hit the South African Communist Party, which has endured by making itself synonymous in many blacks' minds with the struggle of the majority to free itself of domination by the nation's white minority.

The party finds itself defending an

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New York State's Budget Troubles Are Rising, Approaching a Crisis

Many Doctors Seeing Increase of Regulation As Professional Malaise

Continued From Page A1

regulators make up a formula, and they don't include the doctor in that formula. We no longer make important clinical judgments."

These feelings are causing some concern but little alarm among those who regulate and study the medical profession.

"Accountants leave, lawyers leave, businessmen walk away from their jobs," said Bruce C. Vladeck, the president of the United Hospital Fund, a philanthropic and research organization in New York City that specializes in health-care matters. "The fact that a 36-year-old guy who's been doing well decides he doesn't want to buck the bureaucracy anymore, that's to be expected."

Many observers believe that "doctors brought this on themselves," in the words of Prof. Uwe Reinhardt of Princeton University, an expert in health-care economics. In 1965 when Medicare was formulated, he said, doctors refused to accept limits on the amount they could charge patients, so they ended up with limits on the clinical procedures for which they would be paid.

"The regulations that rain down on physicians are largely of their own doing," he said. "If they had accepted a fee schedule their lives would be much easier."

Medicine is, in fact, more regulated than ever before, a change that can be traced to 1965, when Medicare began. Since then, the yearly cost of health care in the United States has risen more than tenfold, to $550 billion or 11.1 percent of the gross national product in

unnecessary procedures at hospitals having high rates.

Although it may seem to some doctors that the rules were designed only to harass them, the real purpose is to allow payers to exert some control over sky-rocketing medical costs, at a time when state and Federal government budgets are hard pressed and the well-publicized abuses of some doctors add to those costs by doing unnecessary procedures.

"There are certainly doctors whose attitude is 'well, the insurance company is paying,'" said Dr. Cary Sennett, who now works for an insurance company. "We do have a responsibility to guard against that."

Two years ago, Dr. Betty Halpern, an internist in Houston, volunteered to serve on the utilization review board of the The Travelers Companies, which reviews doctor bills that the insurance company considers excessive. She said she joined the group expecting to be outraged at the restrictive decisions of the insurance company.

Instead, she found, that while her group approved many of the disputed charges "there were also physicians who would do things repetitively that were inappropriate. Certain specialties were worse than others," she said, "and you could see who had taken a course on how to code their charges to be maximally reimbursed. I saw a need for some control."

Who Decides?

Doctors Debating The Insurers

Of all these external influences, those that second-guess the doctors' care seem to chafe the most. "They don't allow you to make your own decisions, they expect you to follow theirs," said Dr. Michael Rosenthal, who specializes in internal medicine and gastroenterology in Branford, Conn. near New Haven. "I was trained to practice medicine, not debate with insurance companies."

Dr. Rosenthal is currently debating with Medicare about $2,800 in care for a patient last spring. The elderly man was admitted to the hospital with a broken hip and then suffered numerous complications, including pneumonia and an instance of cardiac arrest.

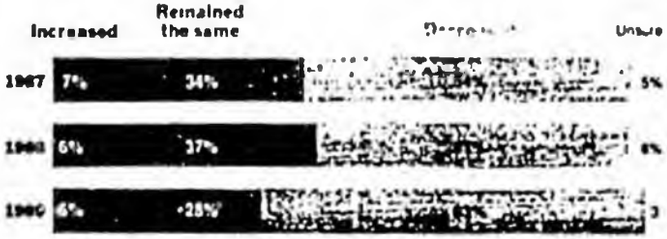
The hospitalization lasted three months, and Dr. Rosenthal said he saw the patient every day. But Medicare payment was disallowed for a number of those days, after the Government said the patient did not need to be visited then. Recently Dr. Rosenthal spent several hours at the hospital reviewing the patient's chart and preparing a detailed memorandum to justify the visits that were questioned.

The Government and insurers are com[illegible] frequently stipulate minimum requirements for certain operations: for example, in some states a patient's airway must be 80 percent

Dr. Dennis Wagner, left, and Dr. Robert Wagner, brothers who have been practicing medicine in Shiner, Tex., for nearly 30 years. They say they no longer enjoy their work, in part because they spend 40 percent of their time on paperwork.

Feeling a Loss of Control

Doctors were asked whether they thought their control over patient treatment decisions had increased, decreased, or remained about the same in the last several years.



Based on three Gallup surveys sponsored by the American Medical Association. The 1989 figures are based on responses from 1,004 doctors interviewed by telephone in January and February.

Having Some Second Thoughts

Doctors were asked whether they would go to medical school if they were in

system to handle their insurance forms. The computer "doesn't eliminate the paperwork," Dr. Robert Wagner said. "It just makes it neater."

One Boston internist estimates he is 300 hours behind on his paperwork, and the thought of adding catch-up hours to his already overloaded schedule exhausts him. "I'm afraid I'm going to burn out at the ripe old age of 35," he said. "I know a lot of happy doctors, but none of them take care of patients. For $72,000 a year, this isn't worth it."

The Consequences

Many Are Leaving In Frustration

In fact, many doctors are leaving medicine entirely. Dr. Michael McCarthy, who works in an emergency room in Seattle, is trying to become a journalist, specializing in medical writing. "I like the emotional side of medicine," he said. "But this isn't about emotion anymore. It's a business. I'm not a businessman."

Dr. Sennett graduated from Yale Medical

The New York Times/[illegible]

Dr. Cary Sennett
Aetna Life and Casualty, Middletown, Conn.
"A lot of doctors I meet at parties, and who know nothing about me, don't like me because I work for Aetna."

1987, and nearly all the new rules have been aimed at controlling costs.

The autonomy of doctors eroded slowly for nearly two decades, but after 1983 the pace increased when the Government adopted a system that broke down all known diagnoses into 467 subgroups and set a price that Medicare would pay for each. The price for each type of care in these Diagnostic Related Groups is based on the expected average cost in the region for the care. Regardless of what the care really costs, that is all a doctor or a hospital will receive from Medicare.

In a poll conducted for the American Medical Association last year, 81 percent of the doctors surveyed said that D.R.G.'s had "a significant impact on medical practice" and two-thirds of those felt the impact was "primarily negative."

Soon private insurance companies were following the Government's lead. Most companies now require doctors to ask permission, in effect, for major, non-emergency hospitalization and procedures. If the company does not approve the care in advance, it will not pay. The extra paperwork is annoying, doctors say, but even worse, companies occasionally refuse to authorize treatment that a doctor thinks to be necessary.

These changes, and others, have led to more sophisticated, and more public, ways to rate the performance of hospitals and individual doctors. In March 1986, the Federal Government for the first time released the mortality rates of Medicaid patients in hospitals nationwide. Last year, New York State began compiling statistics on the rates of Caesarean sections at hospitals and trying to reduce the number of the expensive and often

patient a [illegible] memorandum to justify the visits that were questioned.

The Government and insurance companies frequently stipulate minimum requirements for certain operations: for example, in some states a patient's airway must be 80 percent obstructed to warrant a tonsillectomy. Surgeons must often obtain approval from insurance companies or Government agencies before starting a case.

Dr. Ralph Bard, a 42-year-old general surgeon in Tullahoma, Tenn., told the American Medical News, the newspaper of the American Medical Association, that medicine had been "a big disappointment." In an interview, he said he performed emergency surgery last year on a young boy with heavy intestinal bleeding. Because he did not call before starting the operation, Medicaid payment of his fee was refused.

"The last thing on my mind as I prepared the child for surgery was calling Medicaid," he said. "But now before I do any procedure, I phone my office manager and ask: Can I go ahead?" Dr. Bard said he plans to leave medicine. "I wouldn't do it over again, and I tell others not to," he said.

The H.M.O.'s

Controls Within the Profession

While most of the wrath of today's doctors is directed at outside regulators from the Government and private insurers, they also complain of internal controls. Health maintenance organizations, which are groups of doctors who accept a yearly fee from an employer or individual in exchange for nearly unlimited health care, are becoming more numerous and more complicated. In 1970 there were 37 H.M.O.'s enrolling 3 million people. This January, there were 607 serving 32.5 million, or nearly 13 percent of the population.

H.M.O.'s regularly issue lists comparing their physicians for the time spent with patients and the amount of medications prescribed — with the clear message that those highest on the list are a financial drain on the group. All care beyond the flat fee paid for a patient is absorbed by the organization, while all unused fees are profit.

Dr. Halpern, the Houston internist who is now in private practice, left two H.M.O.'s in the last five years. "They're trying to make rules for disease, which doesn't follow rules," she said.

Her decision to leave was due in part to the fact that one organization went so far as to schedule her restroom breaks. More important, she said, she was tired of the monthly lists showing how many lab tests, X-rays and consultations each doctor in the group had ordered and frustrated at being urged to spend as little time on each patient as possible.

"I would be confronted by my bosses on how long it would take me to do a physical," Dr. Halpern said. "Why wasn't I more like Doctor X, who does it faster? The system doesn't reward people for being competent or good or up to date. It rewards them for being superficial."

Having Some Second Thoughts

Doctors were asked whether they would go to medical school if they were in college now, knowing what they now know about medicine.

From a survey of 1,004 doctors interviewed by telephone in January and February 1989. The survey was conducted by the Gallup Organization for the American Medical Association.

Why Not?

Government and third-party payer regulations interfere with doing my job; lack of autonomy	27%
Rewards are not great for effort, time, risks, overhead	12%
Too much like business, too much paperwork, administration	8%
Malpractice suits; legalities	8%
Too much pressure, stress	6%
Doctors do not get the same respect as they did in the past	5%
It is no longer fun, satisfying	5%
Other	29%

The New York Times/Feb. [illegible] 1989; Illustration by [illegible]

The Bureaucracy

The Paperwork Grows Rapidly

Both a cause and a consequence of the growing number of players in the health industry is a growing number of administrators. An American Hospital Association booklet lists 200 health-care careers, and 52 of those are administrative. Similarly, a study by the Journal of Internal Medicine found that the numbers of health administrators increased nearly fourfold between 1970 and 1986, while the number of doctors increased by half.

Doctors tend to see these administrators as another obstacle to what needs to be done and another cap on their authority. Dr. Sally Faith Dorfman, is a New York gynecologist and now, as Commissioner of Health for Orange County, she is an administrator. She recalls the time she spent as the medical director of a clinic in the Bronx.

Dr. Dorfman still sees patients once a week "to keep me from being an ivory-tower bureaucrat." And she speaks for many doctors when she questions the effectiveness of administrators who have never been doctors.

Some, but not all, administrators, she says "are frustrated physicians, who, for whatever reason, family, finances, grades, didn't go to medical school, and these people now have the power to regulate doctors. Some might even admit say they always wanted to be a doctor. I think some may delight in being able to tell doctors what to do and not necessarily for the right reasons."

The growing bureaucracy also brings more paperwork, another source of frustration. Dr. Robert and Dr. Dennis Wagner are brothers and have been practicing in Shiner, Tex., with a population of 2,500 for nearly 30 years. They say they no longer enjoy it and spending 40 percent of their time on paperwork is one of the reasons why.

They recently bought a $75,000 computer

[illegible] man."

Dr. Sennett graduated from Yale Medical School in 1983, worked as a doctor briefly, then joined Aetna Life and Casualty in Middletown, Conn., in July. "I did my residency at a time when Medicare D.R.G.'s were being implemented," he said. "I saw doctors under increasing obligation to justify their decisions to people who didn't understand and certainly were not interested in learning."

He hopes that by "working within the system," he can "make the policy more rational," but says that "a lot of doctors I meet at parties, and who know nothing about me, don't like me because I work for Aetna."

Other frustrated doctors are staying, some because they cannot afford to leave. One 31-year-old New York-area obstetrician says she has soured on her profession because "the Government and the malpractice lawyers are always looking over your shoulder."

She has thought of such alternatives as starting her own medical-transcription service, pursuing a business degree or becoming a professional musician. But if she does any of these things she will have to pay about $70,000 for a "malpractice tail" to keep her covered until the statute of limitations runs out on claims over cases she has handled.

As New York State Health Commissioner, Dr. David Axelrod has been responsible for such policies as the regulations on resident hours, the publishing of statistics on Caesarean sections and the proposed universal health insurance for the state. He complains that doctors have failed to police themselves.

"Laissez-faire has not been successful," he said. "The regulatory process has stepped into a void. Physicians are going to have to recognize that if there is to be less regulation there has to be a more effective level of peer review."

Others have reached the same conclusion. In their book "Quality Health Care," published last summer by the American College of Physicians, the editors Dr. Norbert Goldfield and Dr. David B. Nash warn that in the near future regulators will cross the line from monitoring performance to rewarding and punishing on the basis of that performance.

Already, they said an H.M.O. in Pennsylvania planned to pay physicians bonuses based partly on their performances in quality measurement scales. And the Health Care Financing Administration, which watches over Medicare, is proposing to rate individual physicians, as it does individual hospitals, and make the results public.

"Physicians have to take the lead and be responsible for themselves," Dr. Nash, an administrator at Thomas Jefferson University Hospital in Philadelphia, said in an interview. "I would rather have other doctors doing this than someone more pernicious. It's inevitable."

Said Dr. Axelrod: "I suspect that in the future the pendulum will swing away from the extraordinarily high level of regulation. I think the medical community's begun to recognize that if there is to be less regulation there has to be a change in attitude."

But if that change comes, it will be too late for some.

"So many of the people you most want to go into practice have already been driven out of it," said Dr. Sennett of Aetna. "Many of my patients told me they were very sorry that I was leaving. I took that as very flattering. But I couldn't plan a career in private practice as I saw the world shaping up."

NEXT: A changing relationship

Some Point to Massachusetts as Extreme of Regulation

By ELISABETH ROSENTHAL

In 49 states, grumbling private doctors are consoled by the fact that the regulation could be worse: they could be practicing in Massachusetts. In the name of controlling costs and improving access to medical care, that state has led the nation in enacting strict laws to govern doctors' practices and limit their fees.

But many say the good intentions have backfired. The American Medical Association estimates that more than 10 percent of doctors in private practice have left the state since 1985; the figure may be as high as 30 percent in some specialties, although a special state commission says the figures are difficult to determine.

Doctors say three laws make practice in Massachusetts financially difficult.

¶Limits on doctors' bills. Doctors have to accept as payment whatever an insurer, in-[illegible]

¶Forced Medicare participation. To be licensed, physicians have to accept all Medicare patients.

¶Retroactive malpractice payments. The state's Joint Underwriting Association lost money through much of the 1970's and early 1980's, and doctors are paying extra premiums to make up for these losses. According to Medical Economics magazine, a urologist was charged $16,000 for 1989 insurance and $15,000 in retroactive premiums.

With doctors' incomes in Massachusetts running 13 percent below the national average, many doctors are leaving.

At Dr. Scott Fox's ear, nose and throat office in Falmouth on Cape Cod, one of the areas hardest hit, one doctor retired, another moved to New York and Dr. Fox is the only ear, nose and throat doctor at his hospital. Departures by doctors have left the hospital emergency room without a general surgeon

cial Physician Supply Commission to study the problem. That was in part to respond to legislators' claims that constituents in some areas were having trouble finding doctors and to claims by hospitals in some parts of the state that they could not fill their staffs, said Matthew Fishman, Massachusetts Assistant Secretary for Health and Welfare.

Because of data problems, the report the commission issued in July, reserved judgment about whether the number of doctors practicing in Massachusetts was dwindling but acknowledged that "there was significant room for improvement" in the supply of doctors, especially on Cape Cod and in the western part of the state, Mr. Fishman said.

Among the commission's recommendations were incentives to practice in areas with few doctors and a pilot project to allow some doctors' bills to exceed insurance payments. The report "did a lot of consciousness raising in the Legislature and let them know that doctors here were really angry."

go up, the costs of paying for an apartment go up. And when costs go up, values tend to sink.

"People are seeing their property values shot out from under them," said Dan Baumol, a former Finance Department official who helped draft the city's property tax procedures.

The increase in assessments is not the result of any decision by the city to

[illegible] homes to 6 percent a year or 20 percent over five years, while allowing much larger increases on co-ops, condominiums and rental buildings.

State officials say the approach has created many inequities, even among the owners of small houses protected

Continued on Page B3, Column 1

Wariness Is Replacing Trust Between Healer and Patient

By GINA KOLATA

Doctor-patient relationships are becoming a distorted version of the rosy image so many Americans have long held dear.

Both doctors and patients tell of communication gone awry and of warmth and caring replaced by distrust and leeriness.

The widow of a Connecticut cancer patient, embittered by her experiences with what she felt were cold, uncaring doctors, said that what has happened to medical care is "hideous and grotesque."

'Mos' Doctors Mean Well'

A Washington doctor, beaten down by what she sees as increasingly hostile patients, complained that more and more people "think that doctors are the enemy," and added: "Trusting is considered naive and inappropriate. Why is it that society cannot permit itself to accept the fact that most doctors mean well?"

Although there are still devoted doctors who cherish life-long relationships with loyal, trusting patients, such doctors and such patients appear to be a diminishing breed.

"I think there is no question that doctor-patient relationships have changed and changed dramatically," said Dr. Elliot Leiter, a urologist in private practice in New York. "The major problem is that there's an adversarial relationship that wasn't there before."

Opinion polls indicate that doctors

Doctors in Distress

Last of three articles.

feel they are losing the public's esteem, that they believe patients have unrealistic expectations of what medicine can do and that they think patients are demanding more services than are necessary.

Patients, in turn, express dissatisfaction with their doctors in opinion polls. Sixty-seven percent of 1,500 people questioned in a Gallup poll last year for the American Medical Association said

Continued on Page D15, Column 1

Over Lack of Quick Help, Bonn Is Criticized by East German

By HENRY KAMM

Special to The New York Times

EAST BERLIN, Feb. 19 — Prime Minister Hans Modrow bitterly criticized the Government of Chancellor Helmut Kohl of West Germany today for not providing immediate financial help to the East German economy.

Since his return from last week's meetings in Bonn with Mr. Kohl, Mr. Modrow has let it be known that he is angry and disappointed that an expected aid package of 15 billion marks, or about $9 billion, has not been put forth.

The Kohl Government has decided to extend cash aid only to the government that will emerge after East Germany's first free parliamentary elections, to be held on March 18.

No Longer Brothers?

"I can understand the disappointment of many citizens of the German Democratic Republic who ask themselves whether they are no longer brothers and sisters after all," Mr. Modrow said, alluding ironically to years of West German insistence that the people of East Germany are their kin.

He was speaking to the "round table" of 16 political groupings here,

East Germany's m[illegible] political forum in u[illegible] democratically ele[illegible] after the fall of the [illegible] nists last year.

"But my Govern[illegible] more than to contin[illegible] fort," Mr. Modrow sa[illegible] on bended knees for [illegible] contribution."

Commitment W[illegible]

In the first meeting [illegible] man leaders last ye[illegible] assistance was discus[illegible] row Government as[illegible] Kohl had committed [illegible] darity contribution.

In the Kohl Gover[illegible] offer of a rapid econo[illegible] union, not immediat[illegible] East Germany, consti[illegible] fective material assi[illegible] can provide.

But Mr. Modrow [illegible] against hasty steps t[illegible] because of serious leg[illegible]

In his speech, Mr. [illegible] that East Germany

Continued on Page

Romanian Leader Warns of Tough New Measures Against Demonstr[illegible]

President Ion Iliescu vowed that demonstrators would be "severely punished" if Sunday night's takeover of Government headquarters were repeated. In Bucharest yesterday, soldiers arr[illegible] suspected of leading the takeover. Ab[illegible] pects were arrested, a source said. Page

INSIDE

Physicians and ... Are Frequently Sharing Mistrust and Wariness

Continued From Page A1

that doctors are too interested in making money, and 57 percent agreed that "doctors don't care about people as much as they used to." Three-quarters said that doctors "keep patients waiting too long."

The poll also found that 76 percent of Americans say they respect doctors less now than they did 10 years ago. The most frequent reasons they cited were that doctors were "in it for the money" or lacked concern for their patients.

Fourteen percent, in contrast, said they respected doctors more now, the most frequent reasons being that doctors were more educated and more knowledgeable or that the respondents were older and needed doctors more.

In interviews, many patients complained that doctors were acting more and more like aloof business people. To insure good treatment, some patients say, they have to learn all they can about their disease and take charge of their own treatment.

The Causes

Distrust at 2 Ends Of the Stethoscope

The fraying of doctor patient relationships stems from many causes. The fear of malpractice suits has led some doctors to mistrust patients, the consumer movement has led some patients to mistrust their doctors and feel they have to decide for themselves

last year for the American Medical Association, half the doctors surveyed said patients are demanding more services from them than are necessary.

"You start off with what is a good trend, that people should be aware of what their problems are and that they should understand their bodies and understand what's wrong," Dr. Leiter said. "Then comes a whole trend that supposes that with appropriate explanations people can have the kind of understanding without the background. That they can understand all the nuances and that they have the ability to evaluate the data without having lived through the development of the data and seen trends come and go or seen conflicting manuscripts and reports."

Patient Pressure for Tests

Dr. Stephen Brenner, an internist in private practice in New Haven, Conn., said he is often pressured by patients who demand unnecessary tests and procedures. For example, he said, patients with lower back pain will demand a computerized tomography, or C.T. scan. He said the scan would be "clearly very inappropriate" because it would not necessarily show what was wrong and would be an unjustified use of a very expensive technology. Dr. Brenner said that he has to "delicately negotiate" with such patients. "To flatly say no often loses patients," he said.

Dr. Brenner said he has been dismayed to find some of his patients even ordering their own laboratory tests. "I just saw a woman who had been having dizzy spells," he said. "When her lab tests came back, they included a cholesterol test, her blood group and her blood type. That was clearly off the wall. When I called her and asked how those tests got done, she said she asked for them because she was curious."

Although, in theory, laboratories are supposed to have the doctor's authorization before doing tests, in practice, technicians sometimes do tests at a patient's request, Dr. Brenner said.

Masterminding the Treatment

But many patients say they do not fully trust their doctors and feel obliged to mastermind their own treatment.

Barbara Sikes, a freelance photographer who lives in Midland, Tex., said she became cynical and disillusioned during a three-year quest to become pregnant. "I thought you go in and tell them what's wrong and they will fix it," she said of her initial response to the medical profession. But she said the doctor she initially consulted suggested treatments that Ms. Sikes later learned were considered inappropriate.

The doctor "wanted to do some very drastic things," she said, adding, "I went to the library and got books on infertility and I bought a few books." She ended up going to Dallas and waiting six months for an appointment with a highly regarded endocrinologist.

"You Can't Depend on Doctors"

"I learned that I have to get other opinions, do research, and then make my own informed decisions," she said. "You can't de-

The New York Times/Rick Friedman

Dr. Brendan Magauran stitching an accident victim's head in the emergency room at Parkwood Hospital in New Bedford, Mass. When Dr. Magauran entered practice he thought he would have long-lasting relationships with his patients. But after discovering that, in general surgery programs, he would be on 24-hour call, he switched to emergency room practice.

Dr. Ross said he will now put off calling patients until after he has gone running or after he has returned from watching his daughter's soccer practice.

Thinking About Free Time

Young doctors, too, say they are thinking more and more about how they will live and what sort of free time they will have when they plan their careers. Dr. Brendan Magauran, a 28-year-old emergency room doctor at St. Luke's Hospital in New Bedford, Mass., said he became a doctor thinking he would have close, time-consuming, long-lasting relationships with his patients, like his father, a general practitioner.

"My Dad was always available," Dr. Magauran said. "You could call him on Christmas Day and he'd be available. I saw him form lifelong relationships with patients. I saw how happy he was. I saw the rewards he got out of his work. I thought that's what I would like."

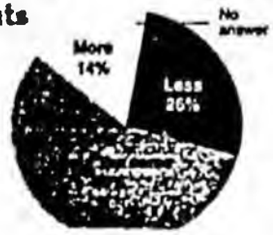
Dr. Magauran was accepted in a general surgery program, but he dropped out, deciding that he could not remain in a field where "you have to be available 24 hours a day." He said, "I felt it fundamentally had come down to a choice of saying, 'What is more important, your family or your work?'"

Working in an emergency room, Dr. Magauran will not have personal relationships with his patients. But he said, "The nice thing about it is that when your shift is over, your shift is over."

The Results

The Public Image

Percentage of respondents agreeing with each statement.



The Respect of Patients

Percentage saying they respected doctors more, less or about the same as they did 10 years ago.

Respondents were then asked why they

Dr. Stephen Brenner
Internist, New Haven, Conn.

"I just saw a woman who had been having dizzy spells. When her lab tests came back, they included a cholesterol test, her blood group and her blood type. That was clearly off the wall."

what treatments they need. The growth of prepaid medical plans meant that more and more people are not able to choose their doctors and are encouraged to consider doctors as interchangeable technicians.

Discouraged by the current climate, many doctors are saying they need time for themselves and that they are unwilling to be available 24 hours a day. And doctors who are feeling an economic crunch have tended to overschedule their patients or give each one less time and attention, in order to maintain their income level.

The disintegrating relationship is seen most vividly in doctors' reactions to the threat of malpractice litigation. St. Paul Companies of St. Paul, Minn., a group that claims to be the nation's largest medical malpractice insurer, recorded 13 malpractice claims for each 100 doctors in 1988, a figure that, although it has fluctuated throughout the 1980's, is still about 30 percent higher than it was a decade ago.

Doctors complain that patients no longer trust them and are always ready to sue.

Suits Emotionally Devastating

Even if they win, malpractice suits can be emotionally devastating, said Dr. Michael A. Ross, a gynecologist who practices in McLean, Va.

When a patient decides to sue, "it becomes a hatred, a vindictive thing," Dr. Ross said. Doctors feel that the patients suing want vengeance as much as retribution, he added. "It's a matter of, 'You should rot in hell and all your family members should rot with you,'" Dr. Ross said.

Dr. Ross said a friend who also is a doctor was sued recently, and although he was vindicated, the suit permanently affected him and his partners. It "turned a very well-educated, happy-go-lucky bunch of guys into people who are always nervous, looking over their shoulders," Dr. Ross said, "and it took a tremendous amount out of their families."

Dr. Devra Marcus, an internist in private practice in Washington, said: "What's happened is that we have antennas out for patients who might sue us. That didn't happen 10 years ago."

Dr. Marcus said she found this posture particularly disheartening because she went into medicine thinking it was "a noble profession."

Patients have changed in other ways too, doctors assert. They say that the growing consumer movement has led patients to think they can decide for themselves what care is needed, leading them to treat doctors as technicians rather than as healers.

Patients hear about medical advances on television or by reading newspapers and magazines and then challenge their doctors, the doctors say. In a Gallup poll conducted

tic things," she said, adding, "I went to the library and got books on infertility and I bought a few books." She ended up going to Dallas and waiting six months for an appointment with a highly regarded endocrinologist.

'You Can't Depend on Doctors'

"I learned that I have to get other opinions, do research, and then make my own informed decisions," she said. "You can't depend on the doctors to do it for you. If you're not a desperate person and aggressive and well educated, you will have trouble. If you trust doctors blindly, you're going to lose. You need brains and money and a little bit of pushiness. That, to me, is frightening."

Increasingly, many patients with serious diseases like AIDS say they feel that they have to make themselves at least as informed as their doctors to be sure they get the best treatment. Peter Staley, a New Yorker with the AIDS virus, said that when he learned he was infected in October 1985, he immediately got his own subscription to The New England Journal of Medicine and the Morbidity and Mortality Weekly Report, a publication of the Federal Centers for Disease Control in Atlanta.

"My doctor was another resource for me, like a medical journal," Mr. Staley said.

Mr. Staley added, "There are certainly huge numbers of AIDS patients who let the doctor control the entire show, but I consider that dangerous since most doctors in this country are terrible AIDS doctors."

The Loss

Relationships Are Impersonal

Doctor-patient relationships are often increasingly impersonal in prepaid health plans, like health maintenance organizations, according to both doctors and patients.

Dr. Paul Bearman, the director of urgent care at Park Nicollet Medical Center in Minneapolis, which cares for patients served by H.M.O.'s, said that doctor in these groups "have to deal with patients more rapidly than is comfortable."

"The ability to have the same kind of caring relationship, I think that's gone," he said. "There is the feeling that you could just replace one physician with another and that's unfortunate. A lot of the really good doctors feel bad."

Long Relationships Are Rare

Dr. John J. Barton, a professor and the chairman of the department of obstetrics and gynecology at Illinois Masonic Hospital in Chicago, said that prepaid medical plans "severed the doctor-patient relationship." Because long-term relationships with patients are becoming increasingly rare, many doctors say that they are becoming acutely conscious of their own needs to have free time for themselves and to spend with their families. Some are increasingly reluctant to make themselves routinely available to patients.

Dr. Ross said he recently gave up the practice of obstetrics because he wanted more of a personal life. Although he is embittered by the malpractice crisis in obstetrics, he insisted that that alone would not have driven him out of the business of delivering babies.

"When I look back at what I did before, I say, 'How did I ever live like that?'" he said. "People respect my evenings now. Before, no matter how educated my patients were, if they had a little problem they did not feel bad about bothering you."

[illegible] Magauran will not have personal relationships with his patients. But he said, "The nice thing about it is that when your shift is over, your shift is over."

The Results

Image of Medicine As Just a Business

Medical ethicists say that advertising by individual doctors has reinforced the impression that the practice of medicine has become just another business. The American Medical Association reports that 18 percent of doctors are advertising for patients and that more than 20 percent of doctors in general and family practice are doing so.

Advertising "is undermining the doctor-patient relationship," said Dr. Lawrence J. Nelson, an ethicist with the Bioethics Consultation Group in Berkeley, Calif., who has studied physician advertising. Buying medical care begins to look like "going out and buying a new or used car rather than going to a physician and being sure that he or she is there for your best interests," Dr. Nelson said.

Like Finding an Auto Repair Shop

In such a setting, "it is quite reasonable at times for prospective patients to wonder if the doctor is trying to run up the meter," he said.

Some doctors, like Dr. Ross, readily admit that the practice of medicine is becoming much more of a business. Patients look at finding a doctor like they look at finding an automobile repair shop, he said. "You'll go to a car dealer until he scratches your car and then you'll find another," he said.

But patients say they are increasingly concerned and bitter about what they see as doctors' excessive interest in the bottom line. They resent it when doctors ask for payment before they will do an expensive procedure, like a magnetic resonance imaging scan. They also resent the time they spend waiting in doctors' offices so that the doctor can be assured that no income is lost through failure to schedule a patient.

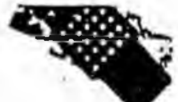
Lila Bucklin, a Connecticut woman who has spent the past two years struggling with doctors to get the care she wanted for her husband, who recently died of cancer, is especially bitter about the monetary aspect of the doctor-patient relationship. She felt that the doctors did not seem to care about her husband. The doctors "never call you and ask how is he doing," she said.

'Realm of a Medical Industry'

"You have to dog them around for days sometimes," to get answers to questions, Ms. Bucklin said. "It's gotten into the realm of a medical industry or business rather than dealing with human life."

At one point, Ms. Bucklin said, she had to arrange and pay a round trip fee of $300 for an ambulance to take her husband a half a mile down the road to a doctor who needed to do a simple procedure that took five minutes. The doctor refused to come to see her husband at home, Ms. Bucklin said, adding: "It's so inhumane. You feel like a commodity, like a way for doctors to make a living."

Physicians like the Washington internist Dr. Marcus, who say they went into medicine to have long-term personal realtionships with patients, are chilled by the turn that doctor-patient relationships have taken. "When you start out as idealistic as I was, it's hard not to be disillusioned," Dr. Marcus said.



Percentage saying they respected doctors more, less or about the same as they did 10 years ago.

Respondents were then asked why they respected doctors more or less than they used to.

Less Respect Because . . .

They are in it for the money	26%
They lack rapport/concern/interest	17%
They don't take time for patients	15%
I have had a bad personal experience	13%

More Respect Because . . .

They are more educated/knowledgeable	20%
I'm older/I need them more now	15%
They are doing a good/better job	13%
They have more pressures/challenges	11%

Based on telephone interviews with 1,500 adults nationwide during January and February 1989, conducted by Gallup for the American Medical Association.

A.M.A. Is Splintered by Challenges

By LAWRENCE K. ALTMAN

The American Medical Association, the leading voice of American doctors, remains one of the nation's most powerful political lobbies. But in recent years the political influence of organized medicine has been ebbing as it is challenged by consumer groups and fragmented by rivalries between medical specialties.

For much of its 143-year history, the A.M.A. spoke for American doctors. But the Chicago-based organization has been competing with a growing chorus of voices representing medical specialties, many of which have competing interests.

The medical association enrolled more than 75 percent of the nation's 292,000 physicians in the United States in 1965, but today more doctors are joining specialty groups without joining the A.M.A. Only 47 percent of the 586,000 physicians now belong to the association.

The organization remains "something of an 800-pound gorilla because of its money, campaign contributions and ability to call on its network of physicians at the grassroots to work their will on Congressmen," said John K. Igelhart, editor of Health Affairs, a journal of health policy.

The A.M.A. said its political arm, the American Medical political action committee, gave $3.6 million to Congressional candidates in 1987-1988, the third highest among all political action committees.

But "when the A.M.A. gets into a fight with the Congress and state legislatures over big issues, the legislators don't have to pay as much attention to the A.M.A. as they did 20 years ago," said Dr. Robert J. Blendon, who heads the health policy and management department at the Harvard School of Public Health in Boston.

When Truman pushed a national health insurance program in the 1950's, the medical association opposed it as government interference with medicine. The proposal died.

But last year, when Congress was debating a revised Medicare payment system for physicians, organized medicine did not speak with one voice.

The American College of Surgeons, whose 51,000 members stood to lose income from the system, opposed it from the outset. On the other side were those who would be paid more, the doctors who deliver primary care. In fact, the whole idea was initiated by the American Society of Internal Medicine, a group of internal medicine specialists. The American Academy of Family Physicians also endorsed it wholeheartedly. These doctors will gain under the newly adopted system.

General Support for the Plan

The association supported the system in general.

Dr. James S. Todd, the medical association's senior deputy executive vice president, cited a survey of senior Congressional staff members, conducted by the Wirthlin Group in McLean, Va., that rated the A.M.A. among the five most effective lobbying groups. "The perception that the A.M.A.'s power is waning is the sheer magnitude of more diverse issues that makes it impossible to have equal impact on all of them," Dr. Todd said.

Dr. William L. Roper, deputy director of domestic policy in the Bush Administration and a former head of the Health Care Financing Administration, agreed. "The A.M.A. is still the player on the field," he said. "What has changed is not their losing power but the specialty societies have gained power."

Insurance crisis ahead?

Times 2/24/90

House panel sees S&L-like warning signs, urges better regulation of industry

By JANET ASCHKENASY
Journal of Commerce

A House subcommittee report on insurance insolvencies, a pet project of Rep. John Dingell, D-Mich., portrays the insurance industry as repeating some of the errors of savings and loan companies.

The report, titled "Failed Promises," finds no evidence of a crisis immediately threatening the existence of the property/casualty industry.

At the same time, "the same early warnings of potential disaster are abundantly evident, as they were five years ago in the thrift industry," the report asserts.

"If such warnings are not heeded, the insurance industry and the nation could face a solvency crisis rivaling the savings and loan situation," it states. The report goes on to point out weaknesses in the present system of state solvency regulation.

The 76-page report is the product of the House Energy and Commerce Subcommittee on Oversight and Investigations, chaired by Dingell. It is a strongly worded document that becomes particularly biting in dealing with such insolvencies as Mission Insurance Co., Integrity Insurance Co., Transit Casualty and Anglo-American Insurance Co.

Frequently used are such terms as "colossal mismanagement," "abandoning ship" and "giving away the (underwriting) pen."

David Farmer, vice president for federal affairs at The Alliance of American Insurers, Washington, said Friday that while he had yet to see the document, "my understanding is that this is a study of four insolvencies. You can't really paint the state solvency mechanism with such a broad brush."

"The number of insurance insolvencies is quite small compared to the number of S&Ls that have gone under," added Alliance official Tom O'Day. "The magnitude of the two problems are just like night and day."

Still, the Dingell report targets an April 1989 study by the National Association of Independent Insurers, Des Plaines, Ill., showing that the number of companies designated for regulatory attention by insurance commissioners more than quadrupled in the past 10 years.

Nearly half the nation's 150 insurance insolvencies since 1969 occurred within the past five years, it says. And nearly half the $2.2 billion in insurance company assessments used to cover those costs through state guarantee funds from 1969 to 1987 was assessed in 1987 alone.

The Dingell report makes no recommendations as to how the problem of failing insurers should be addressed, but hearings have been scheduled March 12 and 19 to continue the fact-finding process, according to Jack Chesson, counsel to the House oversight subcommittee.

Judiciary

MICA Medical Indemnity Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503
(907) 563-3414

February 13, 1990

Representative Dave Donley, Chairman
Labor and Commerce Committee
House of Representatives
State of Alaska
PO Box V
Juneau, Alaska 99811

Dear Chairman Donley:

I testified in front of the House Labor and Commerce Committee and was requested to submit my comments in writing. Please share this written testimony with the other committee members.

Chairman Donley and Committee members, I am Mary Pierce, Executive Director of MICA.

* CSHB334 - Requiring insurance of outstanding judgement.

We wanted to make a few brief informational comments on this bill. We, like all insurance companies, have underwriting requirements to write physicians. We do gather previous claims experience and our Underwriting Manager and the Underwriting Committee may not cover an applicant based upon that experience. In other words, we do not offer insurance coverage to all applicants. If this bill is passed we wanted the committee to know that physicians with an outstanding judgement may not be able to procure coverage and therefore not able to practice.

* CSHB336 - Medical Malpractice Advisory Panels.

We feel strongly that if current Medical Malpractice Advisory panels are to work they need to be comprised of experts, more importantly specialists who can understand the technical medical procedures and make assessments that offer the judge and both parties accurate medical conclusions.

We fight now to obtain the appropriate physicians specialist on a panel. It does no good whatsoever to have a family practitioner on a panel where we have technical complications involving an orthopedic procedure. We feel that adding lay people to this panel would not make it any better. In fact, the time the panel would need to review a case would increase as the physicians would have to educate the lay people.

We ask you to not further dilute the credibility of the panel but in fact maintain it as an "expert" advisory panel membered with medical experts. We suggest that lay people have a place in the system and that is on the jury. If you must put a lay person on the panel to make sure the doctors play straight then please make them non-voting members on these highly technical issues.

Medical Indemnity Corporation of Alaska

* CSHB337 - Mandatory insurance requirements for hospitals.

Our comments here are similar to HB334. We do have underwriting requirements for hospitals. We are concerned since we are the only company offering coverage in the state to the rural hospitals that we may not chose to underwrite a hospital. We want the committee to understand that we are unwilling to compromise our standards because the strength and stability of those standards allow us to continue in business. We are not interested in becoming a substandard market or acquiring risks that may lead to our insolvency. It is our commitment to be here to write malpractice for the majority.

HB349 - Money from Medical Malpractice Revolving Loan Fund.

This fund was established to fund the operations of MICA. We have borrowed from it twice and have an outstanding balance of $2,402,286 on the first note and $800,000 on the second note. This fund has been important to us both in our original capitalization and also as surplus. This surplus is critical when being reviewed by reinsurers because it helps add stability to our small company. Needless to say, we are concerned about any depletion to the fund.

HB350 - Matching Fund.

We are certainly supportive of the concept of a matching fund. We do have some questions regarding this in legislation.

First of all, I believe I understand the intent of the formula but for the life of me, I can't get it to work. Perhaps someone can explain it to me.

We are also curious as to a definition of the term "rural" as it applies to the bill.

Finally, we have some concerns if we are to administer this fund.

1) The first is a potential restraint of trade problem that might occur by a physician with another carrier being denied access to the fund. It is at the very least a potential conflict of interest.

2) Secondly, if we do administer it we are concerned with the increase in administrative costs to us. Our question is therefore one of developing a budget and receiving compensation to administer the fund.

Again, we don't disagree in concept to the idea of a matching fund but do have questions regarding the mechanics.

Thank you for your time. I will be happy to answer any questions.

Sincerely,

Mary A. Pierce

Mary A. Pierce
Executive Director

HB336

HOUSE LABOR AND COMMERCE COMMITTEE

ALASKA STATE LEGISLATURE P.O. BOX Y, JUNEAU 99811
(907) 465-3892

February 6, 1990

M E M O R A N D U M

To: Members, House Labor and Commerce Committee

From: Representative Dave Donley, Chair
House Labor and Commerce Committee

Re: Proposed CS for HB 336
Work Order # 6-1316E, by Ford, dated 2/6/90

The proposed CS for HB 336 makes the report of the medical malpractice advisory panel adivsory only, prohibiting it from being admitted as evidence except for determining an award of costs or attorney fees. The CS further provides that members of the panel may not be examined as witnesses on the contents of the report.

Arguments in support of the proposed CS are outlined in a letter in members files from attorney Dan Hensley and in testimony offered during the November 30, 1989 hearing on HB 336 in Anchorage.

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HB336

LAW OFFICES
Luce & Hensley
A PROFESSIONAL CORPORATION
1015 WEST SEVENTH AVENUE
ANCHORAGE, ALASKA 99501

L. AMES LUCE
DAN A. HENSLEY

TELEPHONE (907) 276-1191
FAX:(907) 277-4864

February 5, 1990

Via Fax

Rep. Dave Donley, Chairman
Labor and Commerce Committee
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, Alaska 99511

Re: House Bill Nos. 334, 336, 337, 349 and 350

Dear Representative Donley:

I have reviewed several bills pending in the Labor and Commerce Committee which address issues concerning medical malpractice insurance and medical malpractice litigation. As an attorney who represents plaintiffs in medical negligence cases, I am very pleased to see that your committee is taking steps to address the real problems involved in the medical insurance "crisis" -- that is, availability of insurance and access to the justice system. What a refreshing approach when compared to some prior legislative attempts to solve these problems by reducing or eliminating the rights of injured victims of negligence.

I do have some minor suggestions concerning some portions of the bills which are addressed below. However, please understand that I wholeheartedly support the intent of this legislative package.

House Bill 334, which requires professionals to obtain malpractice insurance, is a step in the right direction in my view. However, I am concerned that the bill, as presently drafted, does not require liability insurance unless the professional has had a judgment entered against him or her. This exception raises two questions.

First, a professional who holds himself out to the public as competent in an area should back that representation with insurance, regardless of whether he or she has been the subject of a negligence judgment. Second, although this exception was apparently designed to focus on the professional with a "track record" of negligence, it does not appear to apply to the professional who may have settled a series of negligence claims short of trial to avoid a negligence judgment. Despite these concerns, I strongly urge the passage of some legislation requiring mandatory liability insurance for professionals.

House Bill 336 makes changes in the medical malpractice advisory panel law presently on the books. The important modifications are the increase in the size of the panel, the addition of non-health care providers to the panel, and a change in the prohibition on discovery in litigation presently written in the law.

There is an additional, significant problem with the panel statute which is not addressed by this bill. That problem is the use to which a panel report may be made in court. Several physicians who testified at the recent committee hearings believe that the role of the panel is only to address "biological" issues, without regard to the important legal-medical issues raised in the litigation. Moreover, many physicians with whom I have spoken personally believe that their role as panel members is to "educate the judge" rather than to prepare a report for use by the trial jury in deciding the case.

Nevertheless, under present law, a panel report may be introduced into evidence at trial <u>without</u> the members of the panel actually testifying. In addition, the Alaska Supreme Court has held that an expert advisory panel report may be used as the basis for summary judgment against a party. <u>Kendall v. State</u>, 692 P.2d 953, 955 (Alaska 1984). Finally, under present administrative rules, although the court appoints the expert advisory panel, often over the objection of a party, a party who wishes to have a member of the panel testify at trial (either to support the panel report or to expose fallacies in the report) must pay for that physician's deposition and appearance at trial.

If the purpose of the panel proceeding is to provide "screening" of cases, it is superfluous. Competent plaintiff's lawyers screen difficult medical negligence cases prior to filing them. The high costs of pursuing a medical negligence case act as a deterrent to filing a non-meritorious case. There are existing court rules for addressing frivolous claims (Rule 82 awards to the prevailing party; Rule 11 sanctions).

If the panel is to remain a part of Alaska's medical negligence law, its role should be clearly defined. I suggest that House Bill 336 be amended to add the following:

> A.S. 09.55.536(e) is repealed and re-enacted to provide: The panel's report is advisory only. It may not be introduced into evidence at trial and its members may not be called as witnesses. In awarding costs and attorneys' fees at the conclusion of litigation, the trial court may consider the panel report.

Finally, House Bill 350, concerning creating the Alaska Medical Malpractice Matching Fund, is an extremely important piece of legislation. The passage of this bill will do much to alleviate the problems faced by rural physicians in obtaining insurance, without forcing rural Alaskans to settle for second rate medical care.

Thank you for the opportunity to comment on these legislative proposals. If I can answer any questions or provide additional information, I will be happy to do so.

Sincerely yours,

LAW OFFICES OF LUCE & HENSLEY, P.C.

Dan A. Hensley

DAH:fs
off.dah.let.rep.dav.don.1

HOUSE LABOR AND COMMERCE COMMITTEE

ALASKA STATE LEGISLATURE P.O. BOX Y, JUNEAU 99811

(907) 465-3892

November 23, 1989

M E M O R A N D U M

To: Members, House Labor and Commerce Committee

From: Representative Dave Donley, Chair
House Labor and Commerce Committee

Re: HB 336 - Medical Review Panels

HB 336 amends Alaska's statute establishing an expert advisory panel to review medical malpractice cases where parties have not agreed to arbitration of the claim to:

1. Change from a panel comprised of three health care providers to a panel of five, three of which shall not be health care providers. (Over thirty states have medical malpractice pre-screening panels. Alaska has the only one without non-physician members).

2. Allow the parties to control the presentation of evidence. (Done in all states with pre-screening panels except Alaska, Kansas, and Nevada).

3. Obtain attendance and allow cross examination of witnesses. (Done in all states with pre-screening panels except Alaska, Kansas, and Nevada).

4. Permit pre-trial discovery. (All states with pre-screening panels except Alaska, Hawaii, Idaho, Kansas, Montana, Nevada, New Mexico, Utah and Wyoming).

5. Permit parties to attend all panel hearings. (In all states with pre-screening panels except Alaska, Kansas and Nevada).

HB 336 does not change provisions under Alaska's current law allowing the advisory panel's report to be admissible as evidence at trial, a provision we share with half the states that have pre-screening panels. Only in Puerto Rico are the findings of the advisory panel binding.

dd/gbi89
b/hb336

Appendix "A"

A Comparative Analysis of Various Medical Malpractice Screening Panel Statutes

STATE	Parties Control Pres. of Evidence	Cross-Exam. Permit	Pre-Trial Disc. Permit	Parties Attend Hearing	Non-Physician Members	Report Admissible as Evidence at Trial	Statute Number
ALABAMA	YES	YES	YES	YES	YES	YES	§6-5-480
ALASKA	NO	NO	NO	NO	NO	YES	§09.55.560
ARIZONA	YES	YES	YES	YES	YES	YES	§12-566
CONNECTICUT	YES	YES	NO	YES	YES	YES	§38.19a
DELAWARE	YES	YES	YES	YES	YES	YES	18§6903
FLORIDA	YES	YES	YES	YES	YES	NO	TIT45§768.57
HAWAII	YES	YES	NO	YES	YES	NO	§671
IDAHO	YES	YES	NO	YES	YES	NO	§6-1001
INDIANA	YES	YES	YES	YES	YES	YES	§16-9.5-9-1
KANSAS	NO	NO	NO	NO	YES	NO **	§65-4901
LOUISANA	YES	YES	YES	YES	YES	YES	§1299.47
MAINE	YES	YES	YES	YES	YES	NO	§2801
MARYLAND	YES	YES	YES	YES	YES	YES	§3-2A-02
MASS	YES	YES	YES	YES	YES	YES	TIT.231§60B
MICHIGAN	YES	YES	YES	YES	YES	NO	§600.5040
MONTANA	YES	YES	NO	YES	YES	NO	§27-6-101
NEBRASKA	YES	YES	YES	YES	YES	YES	§44-2840
NEVADA	NO	NO	NO	NO	YES	YES	§41A.003
NEW HAMP.	YES	YES	YES	YES	YES	YES	§519-A:1
NEW JERSEY	YES	YES	YES	YES	YES	YES	§4:21-1
NEW MEXICO	YES	YES	NO	YES	YES	NO	§41-5-14
NEW YORK	YES	YES	YES	YES	YES	YES	§148-a
OHIO	YES	YES	YES	YES	YES	YES	§2711.22
PENN.	YES	YES	YES	YES	YES	YES	40P.S.§1264
TENNESSEE	YES	YES	YES	YES	YES	YES	§29-26-101
UTAH	YES	YES	NO	YES	YES	NO	§78-14-12
VERMONT	YES	YES	YES	YES	YES	NO	§7001
VIRGINIA	YES	YES	YES	YES	YES	YES	§8.01-581.1
WISCONSIN	YES	YES	YES	YES	YES	YES	§655.02
WYOMING	YES	YES	NO	YES	YES	NO	§9-2-1501
PUERTO RICO	YES	YES	YES	YES	YES	BINDING	[illegible]

HB336

HOUSE LABOR AND COMMERCE COMMITTEE

ALASKA STATE LEGISLATURE P.O. BOX Y, JUNEAU 99811
(907) 465-3892

April 20, 1989

MEMORANDUM

To: Tam Cook, Director
LAA Legal Services

From: Representative Dave Donley, Chair
House Labor and Commerce Committee

Re: Bill drafting requests

I need several bill drafts, for introduction by the House Labor and Commerce Committee, as described below:

1. Prepare a draft bill (see attached analysis of various state statutes governing medical malpractice screening panels) repealing and reenacting the statutes governing Alaska's medical malpractice screening panel to provide for five (5) members, three of which shall be non medical providers, to permit parties to control the presentation of evidence, to permit cross examination, pretrial discovery, parties to attend hearings and to allow the report as admissible evidence at trial. Please refer to statutes in the highlighted states for guidance.

2. Prepare a draft bill that requires any professional licensed by the state to carry professional malpractice insurance (or errors and omissions, or whatever their particular professional liability insurance is called) if they have an outstanding judgement against them for professional malpractice until they have payed ofr the judgement or have reached a satisfactory settlement with the plaintiff.

3. Prepare a draft resolution (see attached) regarding the Alaska Bar.

4. Prepare a draft bill giving a private cause of action to a person when an insurer has acted in bad faith, entitling the injured party to sue for actual damages, not just policy limits.

5. Prepare a draft bill providing that when a plaintiff moves their case from small claims court and they loose, the court may require them to pay actual court costs and attorney fees.

6. Draft a bill amending Rule 68 to provide that if the defendant makes an offer that the plaintiff turned down and the plaintiff is ultimately awarded less than the offer, the plaintiff may be held liable for the defendants attorney fees and if the plaintiff makes an offer that the defendant denies and the judgement is more than than the offer

the plaintiff made, the defendant may be liable for the plaintiff's attorney fees.

7. Draft a bill requiring that all medical malpractice policies sold in Alaska must name any hospital that a medical provider practices at as an "also insured".

Please call Ginger Baim at 4954 if you have any questions or need additional information. I would like these drafts as soon as possible.

be conducted in accordance with procedures established by any rules of court which may be adopted and according to provisions of AS 09.55.540 — 09.55.548 and AS 09.55.554 — 09.55.560, and AS 09.65.090. (§ 33 ch 102 SLA 1976; am § 22 ch 177 SLA 1978)

Cross references. — For purpose of 1978 Act, see § 1, ch. 177, SLA 1978, as amended by § 8, ch. 46, SLA 1982, in the Temporary and Special Acts.

Collateral references. — Arbitration of medical malpractice claims, 84 ALR3d 375.

Sec. 09.55.536. Expert advisory panel. (a) In an action for damages due to personal injury or death based upon the provision of professional services by a health care provider when the parties have not agreed to arbitration of the claim under AS 09.55.535, the court shall appoint within 20 days after filing of answer to a summons and complaint a three-person expert advisory panel unless the court decides that an expert advisory opinion is not necessary for a decision in the case. When the action is filed the court shall, by order, determine the professions or specialties to be represented on the expert advisory panel, giving the parties the opportunity to object or make suggestions.

(b) The expert advisory panel may compel the attendance of witnesses, interview the parties, physically examine the injured person if alive, consult with the specialists or learned works they consider appropriate, and compel the production of and examine all relevant hospital, medical, or other records or materials relating to the health care in issue. The panel may meet in camera, but shall maintain a record of any testimony or oral statements of witnesses, and shall keep copies of all written statements it receives.

(c) Not more than 30 days after selection of the panel, it shall make a written report to the parties and to the court, answering the following questions and other questions submitted to the panel by the court:

(1) What was the disorder for which the plaintiff came to medical care?

(2) What would have been the probable outcome without medical care?

(3) Was the treatment selected appropriate for the case?

(4) Did an injury arise from the medical care?

(5) What is the nature and extent of the medical injury?

(6) What specifically caused the medical injury?

(7) Was the medical injury caused by unskillful care?

(8) If a medical injury had not occurred, how would the plaintiff's condition differ from the plaintiff's present condition?

(d) In any case in which the answer to one or more of the questions submitted to the panel depends upon the resolution of factual questions which are not the proper subject of expert opinion, the report shall so state and may answer questions based upon hypothetical facts that are fully set out in the opinion. The report shall include copies of all written

statements, opinions, or records relied upon by the panel and either a transcription or other record of any oral statements or opinions; shall specify any medical or scientific authority relied upon by the panel; and shall include the results of any physical or mental examination performed on the plaintiff. Each member shall sign the report and the signature constitutes the member's adoption of all statements and opinions contained in it; however, a member may, instead of signing the report, submit a concurring or dissenting report which complies with the requirements of this subsection. A member may not attest to any portion of the report as to which the member is not qualified to give expert testimony.

(e) The report of the panel with any dissenting or concurring opinion is admissible in evidence to the same extent as though its contents were orally testified to by the person or persons preparing it. The court shall delete any portion that would not be admissible because of lack of foundation for opinion testimony, or otherwise. Either party may submit testimony to support or refute the report. The jury shall be instructed in general terms that the report shall be considered and evaluated in the same manner as any other expert testimony. Any member of the panel may be called by any party and may be cross-examined as to the contents of the report or of that member's dissenting or concurring opinion.

(f) No discovery may be undertaken in a case until the report of the expert advisory panel is received. However, the court may relax this prohibition upon a showing of good cause by any party. If the panel has not completed its report within the 30-day period prescribed in (b) of this section, the court may, upon application, grant it an additional 30 days.

(g) Members of a panel are entitled to travel expenses and per diem in accordance with state law pertaining to members of boards and commissions for all time spent in preparing its report. If a panel member is called upon as a witness at trial or upon deposition, the member is entitled to payment of an expert witness fee, which may not exceed $150 per day. All expenses incurred by the panel shall be paid by the court. However, in any case in which the court determines that a party has made a patently frivolous claim or a patently frivolous denial of liability, it shall order that all costs of the expert advisory panel be borne by the party making that claim or denial.

(h) Parties to the case and their counsel may not initiate communication out of court with members of the panel on the subject matter of its inquiry and report or cause or solicit others to do so, except through ordinary discovery proceedings. (§ 33 ch 102 SLA 1976; am § 23 ch 177 SLA 1978)

NOTES TO DECISIONS

Chapter 102, SLA 1976, enacted in violation of Alas. Const., art. II, § 14. — Where the free conference committee recommended adoption of a version of ch. 102, SLA 1976, that differed in many respects from the version originally passed by the house; the free conference committee's bill was passed by the senate by a recorded vote; but in the house there was no roll call or recorded vote and the free conference committee bill was passed there by a simultaneous voice vote, this voice vote constituted "final passage" of ch. 102, SLA 1976, and thus violated the recorded vote requirement of Alas. Const., art. II, § 14. Plumley v. George E. Hale, M.D., Inc., Sup. Ct. Op. No. 1847 (File Nos. 4014, 4017), 594 P.2d 497 (1979).

But this holding is to be applied prospectively. — Although the supreme court held that ch. 102, SLA 1976, was enacted in violation of the recorded vote requirement of Alas. Const., art. II, § 14, the supreme court held that its holding in this case should be applied prospectively in light of its conclusions that its decision was one of first impression, that substantial reliance had followed from the legislature's alternative interpretation of law, that undue hardship would have resulted from retroactive application of its holding, and that the rationale of the holding did not compel retroactivity. Plumley v. George E. Hale, M.D., Inc., Sup. Ct. Op. No. 1847 (File Nos. 4014, 4017), 594 P.2d 497 (1979).

Therefore, this section was not invalidated. — Since neither ch. 102, SLA 1976, nor any other bill previously enacted into law by voice vote, will be overturned by its interpretation of Alas. Const., art. II, § 14, the supreme court did not invalidate this section. However, in order to effectuate the goals of fairness and intelligent advocacy, the supreme court held that this section would not be applicable in the malpractice actions consolidated for this appeal. Plumley v. George E. Hale, M.D., Inc., Sup. Ct. Op. No. 1847 (File Nos. 4014, 4017), 594 P.2d 497 (1979).

Collateral references. — Validity and construction of state statutory provision relating to limitations on amount of recovery in medical malpractice claim and submission of such claim to pretrial panel, 80 A.L.R.3d 583.

Sec. 09.55.540. Burden of proof. (a) In a malpractice action based on the negligence or wilful misconduct of a health care provider, the plaintiff has the burden of proving by a preponderance of the evidence

(1) the degree of knowledge or skill possessed or the degree of care ordinarily exercised under the circumstances, at the time of the act complained of, by health care providers in the field or specialty in which the defendant is practicing;

(2) that the defendant either lacked this degree of knowledge or skill or failed to exercise this degree of care; and

(3) that as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

(b) In malpractice actions there is no presumption of negligence on the part of the defendant. (§ 1 ch 49 SLA 1967; am § 34 ch 102 SLA 1976)

NOTES TO DECISIONS

The language of this section is so clear and unambiguous that the supreme court is foreclosed from broadening the standard contained therein through judicial construction. Poulin v. Zartman, Sup. Ct. Op. No. 1204 (File Nos. 2120, 2127), 542 P.2d 251 (1975), unmodified on rehearing, 548 P.2d 1299 (1976).

Optometrists were not included in this section prior to 1976. Steele v. United States, 463 F. Supp. 321 (D. Alaska 1978).

Requirements of surgeon's report. — It is incumbent upon a surgeon to describe accurately and fully in his report of an operation everything of consequence that he did and which his trained eye observed during an operation. Patrick v. Sedwick, Sup. Ct. Op. No. 206 (File No. 314), 391 P.2d 453 (1964).

To have maximum probative force, the report should be dictated immediately after the operation. Patrick v. Sedwick, Sup. Ct. Op. No. 206 (File No. 314), 391 P.2d 453 (1964).

Informing patient of hazards of operation. — There is good law in support of the argument that a doctor need not inform the patient of all the hazards involved in an operation; that doctors frequently tailor the extent of their preoperative warnings to the particular patient to avoid the unnecessary anxiety and apprehension which such appraisal might arouse in the mind of the patient. Patrick v. Sedwick, Sup. Ct. Op. No. 206 (File No. 314), 391 P.2d 453 (1964).

Absence of surgeon's personal recollection or of recorded facts not defense. — Under the circumstances of the instant case, the court would not permit the absence of a surgeon's personal recollection or of recorded facts to serve as a defense in an action for malpractice. Patrick v. Sedwick, Sup. Ct. Op. No. 206 (File No. 314), 391 P.2d 453 (1964).

Prima facie case of negligence. — See Patrick v. Sedwick, Sup. Ct. Op. No. 206 (File No. 314), 391 P.2d 453 (1964).

Failure of trial court to make finding of lack of informed consent was not clearly erroneous. Patrick v. Sedwick, Sup. Ct. Op. No. 206 (File No. 314), 391 P.2d 453 (1964).

"Similar communities" instruction did not convey a standard of conduct more lenient than a national standard instruction. Priest v. Lindig, Sup. Ct. Op. No. 1660 (File No. 3016), 583 P.2d 173 (1978), remanded on other grounds, Sup. Ct. Op. No. 1812, 591 P.2d 1299 (1979).

Cited in Baker v. Werner, Sup. Ct. Op. No. 2541 (File No. 5753), 648 P.2d 980 (1982).

Collateral references. — Qualification of medical expert witness, 33 Am. Jur. PDF2d, pp. 179-210.

Proximate cause, 13 ALR2d 11.

Aggravation of injuries as mitigating damages in action against physician or surgeon for malpractice, 50 ALR2d 1055.

Necessity of expert evidence to support an action for malpractice against a physician or surgeon, 81 ALR2d 597.

Competency of physician or surgeon of school of practice other than that to which defendant belongs to testify in malpractice case, 85 ALR2d 1022.

Standard of skill and care required of specialist, 21 ALR3d 953.

Competency of general practitioner to testify as expert witness in action against specialist for medical malpractice, 31 ALR3d 1163.

Competence of physician or surgeon from one locality to testify, in malpractice case, as to standard of care required of defendant practicing in another locality, 37 ALR3d 420.

Necessity and sufficiency of showing of medical witness' familiarity with particular medical or surgical technique involved in suit, 46 ALR3d 275.

Patient's failure to return, as directed, for examination or treatment as contributory negligence, 100 ALR3d 723.

Propriety, in medical malpractice case, of admitting testimony regarding physician's usual custom or habit in order to establish nonliability, 10 ALR4th 1243.

Standard of care owed to patient by medical specialist as determined by local "like community," state, national, or other standards, 18 ALR4th 603.

Sec. 09.55.546. Advance payments. In an action to recover damages under AS 09.55.530 — 09.55.560, no advance payment made by the defendant health care provider or the professional liability insurer of the defendant to or on behalf of the plaintiff is admissible as evidence or may be construed as an admission of liability for injuries or damages suffered by the plaintiff; however, a final award in favor of the plaintiff shall be reduced to the extent of any advance payment. The advance payment shall inure to the exclusive benefit of the defendant or the insurer making the payment. (§ 35 ch 102 SLA 1976)

Sec. 09.55.547. Pleading of damages. In a cause of action against a health care provider for malpractice, the complaint or any other pleadings may not contain an ad damnum clause or monetary amount claimed against the defendant health care provider, except as necessary for jurisdictional purposes. (§ 35 ch 102 SLA 1976)

Sec. 09.55.548. Awards, collateral source. (a) Damages shall be awarded in accordance with principles of the common law. The fact finder in a malpractice action shall render any award for damages by category of loss. The court may enter a judgment that future damages be paid in whole or in part by periodic payments rather than by a lump-sum payment; the judgment shall include, if necessary, other provisions to assure that funds are available as periodic payments become due. Insurance from an authorized insurer as defined in AS 21.90.080 or from the Medical Indemnity Corporation of Alaska is sufficient assurance that funds will be available. Any part of the award which is paid on a periodic basis shall be adjusted annually according to changes in the consumer price index in the community where the claimant resides. In this subsection, future damages includes damages for future medical treatment, care or custody, loss of future earnings, or loss of bodily function of the claimant.

(b) Except when the collateral source is a federal program which by law must seek subrogation and except death benefits paid under life insurance, a claimant may only recover damages from the defendant which exceed amounts received by the claimant as compensation for the injuries from collateral sources, whether private, group or governmental, and whether contributory or noncontributory. Evidence of collateral sources, other than a federal program which must by law seek subrogation and the death benefit paid under life insurance, is admissible after the fact finder has rendered an award. The court may take into account the value of claimant's rights to coverage exhausted or depleted by payment of these collateral benefits by adding back a reasonable estimate of their probable value, or by earmarking and holding for possible periodic payment under (a) of this section that amount of the award that would otherwise have been deducted, to see if the impairment of claimant's rights actually takes place in the future. (§ 35 ch 102 SLA 1976)

Submitted by Dr. Ross Bi

November 17, 1989

The information requested concerning statistics dealing with the expert advisory panel process and the medical malpractice suits follows:

Total number of claims processed since the inception of AS 09.55.536:
338 claims

Annual number of claims:

1977	12
1978	6
1979	15
1980	12
1981	16
1982	27
1983	32
1984	37
1985	55
1986	31
1987	37
1988	29
1989	29 to date
TOTAL	338 to date*

Avg. 26/yr.

Information concerning the decision of the expert advisory panel is not complete, since records have not been supplied by the court. Although the court sends notices of dismissals of cases, data concerning the status of the case at this point is unavailable, therefore a determination can't be made concerning fault or no fault on dismissed cases.

The following information might be helpful concerning the final results of some of the cases:
Dismissed cases: 27
Dropped cases: 10
Excused expert advisory panel members: 2[illegible]nels
Panel ruled fault and jury ruled against plaintiff: 1
Plaintiff ordered to pay settlement: 2

Expert Advisory Panel determination:
Defendant -- No Fault: 138 or 73% of the total cases
Defendant -- Fault: 40 or 21% of the total cases
No report available: 93

The number of judgements entered in favor of the plaintiff is unknown.

Submitted by Dr Ross

P.O. Box 210616
Auke Bay, AK 99821
November 21, 1989

Rav Schalow
Alaska State Medical Association
4107 Laurel Street
Anchorage, AK 99508

Dear Mr. Schalow,

This letter is in response to your requests for comments on HB336. Here are a few of my thoughts.

Increasing the number of members on the advisory panel will complicate the process unnecessarily. It will make it less likely to have reports in 30 to 60 days. Going to a five member panel may make this process so awkward that it will undermine the purpose of the panel and lead to stronger sentiments to disband it altogether.

Alaska is the only state listed in Exhibit "A" that has only physician members. In Section 1, paragraph a, line 16 to 19, the court is given the power to determine the professions or specialties to be represented on the expert advisory panel. Stipulating later in Section 1 that three out of five members not be health care providers unnecessarily restricts the courts ability to choose the most appropriate experts for the advisory panel. Why not let the court decide in each case whether there should be one or no non-health care provider on an individual panel?

The discovery issue is confusing, since I don't know how Section 2 originally read. Am I correctly interpreting the information presented when I conclude that as the law now stands, the panel can perform discovery but the respective parties cannot? Does this hinder the process, or would more information be available to the panel if discovery were allowed prior to and during the expert advisory panel report? Would allowing discovery delay the report? The discovery process certainly can be used to generate legal fees--is this more of what the lawyers amending this law are after?

If there are no serious problems with the law as it now stands, will changing it benefit the personal injury lawyers, the court, the injured parties being represented, or the physicians on the panel? Except to possibly allow an non-health care provider on the panel when the court might deem it appropriate, I cannot find any reason the law should be amended.

Sincerely,

Marcia A. Liberatore, M.D.

submitted by Dr. Ross

RODMAN WILSON, M.D.
FELLOW OF AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE
6234 TANAINA DRIVE, ANCHORAGE, ALASKA 99502, U.S.A.
(907) 243-5583

November 28, 1989

Representative Dave Donley, Chairman
Labor & Commerce Committee
Alaska House of Representatives
P.O.Box V
Juneau, AK 99811

Re: HB 336: "An Act relating to medical malpractice advisory panels."

Dear Representative Donley:

I am writing as a physician who served on the Governor's Commission on Medical Malpractice Insurance in 1975 that devised the three-person expert advisory panel system to assist the courts in adjudicating medical malpractice lawsuits. For 12 years after that I served as chairman of the Medico-Legal Committee of the Alaska State Medical Association. My committee's principal task was to recruit physicians, and occasionally other experts, for nomination to the court for service on panels and to assist panels administratively in doing their job. Thus I am in a position of knowledge concerning the origins of the panel system and how they have worked. Unfortunately there has not been a systematic, complete analysis of panel performance, although I have worked on this to some extent in past years.

HB 336 will emasculate or destroy the expert advisory panel system. This apparently is the purpose of the bill.

The prime reason for the panel, as it was created in AS 09.55.536, is to **explain the biology** of the case to the court-to explain the nature and natural march of disease as altered in most cases by medical intervention. The purpose is **not to apply the law** to cases or to answer the question as to whether medical malpractice occurred.

HB 336 would completely change this because only two at most of the panelists would be physicians. It is even possible that at some times none of the panelists would be physicians. How could a panel with a minority of members being "expert" in the biological issue at hand be "expert"? Who other than attorneys would presume to be qualified to be non-medical experts on the committee? The entire nature of the exercise would be altered and would be then, in my opinion, useless.

Further, under Sec. 2, the panel would no longer be able, among other things, to do two valuable functions of present panels, namely, physically examine patients (claimants) and adduce other expert opinion from current medical literature. Both of these facets of the present system are eminently pertinent

to the medical exegesis of the case and should not be so lightly discarded.

It has been very difficult to guage whether or not the panel system is socially constructive or not, i.e., whether lawsuits are handled in a way that is fairer, quicker, and operationally cheaper than the system without amicus curiae panels. It may well be that the panels are too ponderous and have outlived whatever usefulness they originally had. If so after thorough scrutiny, they should be abolished (not vitiated as in HB 336) but this, I submit, should be a part of elaborate tort reform that would replace a hoary system no longer serving the public well.

Respectfully,

Rodman Wilson

Rodman Wilson, M.D.

Submitted by DR Ross.

December 8, 1981

ALASKA'S MEDICAL PANEL REVIEW

OF

MALPRACTICE CASES

1978-1981

(draft - not completed or published)

Alaska's Medical Advisory Panel System

for

Malpractice Lawsuits

by

Rodman Wilson, M.D.
and
Martha MacDermaid, A 3, ?

The singular feature of Alaska's system for pre-trial review of legal actions alleging medical malpractice is that the three-person expert advisory panel is all medical. Although the statute (appendix) in 1976 which created the panels allows any person expert in the matter at hand to sit on a panel, in practice the courts have appointed only physicians or other medical professionals such as dentists, nurses, and optometrists.

The panel scrutinizes the medical records, interviews whomever it wants to interview, examines the patient if it wishes, answers eight cardinal statutory questions, expands on its answers if it desires, and within 30 days, or 60 if extension is requested and granted, reports to the court.

The key statutory question is number 4: "Did an injury arise from the medical care?" If the answer is yes, question number 7 is also salient: "Was the medical injury caused by unskillful care?"

Notice that neither of these crucial questions, nor any other, precisely asks the panel to determine whether or not "malpractice" occurred, a matter, as in most jurisdictions, having to do with proximity, standard of care, and the like. The distinction is important, for it allows the panelists to confine their opinion to medical rather than legal questions. Panelists are thus comfortable as a rule in their role as medical consultants to the court.

Other states have created screening panels of varying size and composition but usually including attorneys and lay persons. The closest parallel is the panel in Louisiana where three physicians, observed by an attorney, review cases. By and large they have been cumbersome, costly, and unconstitutional. Panels in Florida, Illinois, Missouri, Nevada, North Dakota, Pennsylvania, Rhode Island, and Tennessee have either been repealed or have fallen to court challenge. Panels persist

in 20 states including Alaska. Alaska's panel system was upheld by the Alaska Supreme Court, albeit obliquely. Plumby vs Hale pointed out that the final vote on the 1976 statute in the State Senate was by voice rather than roll call. The State Constitution calls for roll call votes on final adoption of statutes. The Alaska Supreme Court agreed that the vote was procedurally irregular but let the statute stand, throwing the complaining party a bone by allowing the pleader to proceed with two cases without expert advisory panels.

APPOINTMENT OF PANELS

Sixty-three medical malpractice lawsuits were filed in state courts in Alaska in the four-year period 1978-1981. ~~One case was subsequently transferred to federal court jurisdiction.~~ Most cases were filed in the Third Judicial District (3JD) in Anchorage where approximately one-half of the state's 460,000 people live. Most actions named more than one physician. One complaint listed 13 physicians. Ten physicians were named more than once. Dental cases invariably named only one dentist. One dentist was named twice. An action against an optometrist named his five colleagues and their corporation. Suits against physicians often named their associates, their clinic, and the hospital where the aggrieved had lain. An action solely against a hospital did occur. A total of 99 health professionals, including 78 physicians, and 33 institutions were named (Tables 1 and 2). Not included in the tables were many "John Doe's" and "XYZ Corporations."

Categories of allegations among 63 lawsuits are arrayed in Table 3. Faulty surgery or avoidable complications of surgery was claimed in 16 cases (25%); no two cases were alike. Mishandling of fracture was alleged in 14 cases (22%): fracture was missed according to the complaint in four instances (cervical vertebra, scapula, wrist, pelvis); angulation of the tibia after healing was specified three times. Faulty dentistry was the issue in 11 cases (17%): six involved oral or facial complaints

after extraction; four involved dissatisfaction with root-canal procedures. The accusation was faulty obstetrical or gynecologic care in eight lawsuits (13%): there were two claims of pregnancy after tubal ligation; two claims alleged damage from forceps delivery with death in one instance and cerebral palsy in another. Missed diagnosis, cancer twice and myocardial infarction twice, was specified in eight actions (13%). Six patients or their survivors (10%) were dissatisfied with management of medical problems; no two cases were alike.

Although the statute ordering expert advisory panels and at the same time creating a state-sponsored medical professional liability insurance company, initially mandatory for physicians but amended in 1977 to be optional, and working minor tort law alterations was enacted in June 1976, the first panel was not appointed until October 1978 — partly because of institutional inertias and partly because few complaints were brought in the wake of the new law while attorneys pondered its meaning and because of uncertainty as to whether physicians were insured or not. Most were not for a three-to-four-year period from 1975 to 1978.

In five instances among 62 cases in state courts panels were not appointed. In these five panels were not appointed because certain judges misunderstood the intent of the law, because the cases were dropped after the complaints were answered, or because, in one instance, a charge was defended successfully before a jury and an appeal on the issue of the statute of limitations before the medical issue was considered.

Nineteen judges appointed 57 expert advisory panels. In three cases lawsuits were dismissed before the panels convened. In a fourth case settlement out of court in an amount of $142,500 was made when a

newborn infant died from damage to the head during forceps delivery without using the panel.

Fifty-three panels completed their work by filing reports at the court. Forty-eight of these were available to the authors for review and the opinions as to fault or no fault are known in the five reports which were not in hand.

PROCESS

In 3JD the time line for lawsuits from filing to panel report is shown in the figure. The system is designed to complete this phase in 100 to 130 days.

Nominations for panel seats in 3JD cases were made by arrangement between the court and the Alaska State Medical Association (ASMA) or in a dental case the Alaska Dental Association (ADA). As a rule nine names were submitted together with suggestions as to appropriate specialty representation. Sometimes nine names could not be mustered when, for example, specialists, uninvolved in the case, in a small field like neurosurgery or otolaryngology were scarce.

Nominations were made by ASMA or ADA merely upon a reading of the complaint or occasionally in addition from having wind otherwise of the matter. For example, in a complaint about an infected compound fracture naming an orthopedic surgeon, the ASMA might submit the names of six orthopedic surgeons and three internists especially knowledgeable about infectious disease. None of the nine, of course, would have been

involved in the care of the patient. Or in a case against a dentist alleging mandibular nerve damage after molar extraction, the ADA and the ASMA together might suggest to the court the names of three dentists, three oral surgeons, and three neurologists.

Nominees usually, but not invariably, lived within the same judicial district in which the complaint had been entered, but sometimes out-of-city panelists were deliberately proposed, for example, physicians from Fairbanks to study a Kenai Peninsula case where physicians are few.

In 3JD the court allowed the ASMA or ADA 30 days to make nominations. In the 54 cases under study it took 2 to 41 days (median 14) for the ASMA to do this and from 2 to 30 days (median 10) for the ADA.

0762
0758
1617

The judge hearing the case then selected any three of the nine nominees, usually adhering to the specialty distribution proposed. In other judicial districts judges selected panels in their own manner, listening in some instances to counsel for each side or perhaps even to the judge's personal physician's recommendations. Unsolicited nominations were sometimes offered by the ASMA in judicial districts other than 3JD. In one case a First Judicial District judge allowed the plaintiff to name 2 persons and the defendant to name 1. The plaintiff chose a podiatrist and a non-physician professor of anatomy; the defendant chose a professor of orthopedic surgery. The case was dropped after the all Seattle panel agreed that there was no-fault in the manner in which the Alaska orthopedic surgeon handled Morton's neuroma of the foot (use 36).

There were an average of 385 physicians and 192 dentists in private practice in Alaska during the years 1978-1981. Nominations for panel

positions were made almost exclusively from these pools. Nurses and optometrists were sometimes proposed. In all 243 individuals were nominated from around the state, 95 once, 64 twice, 28 thrice, 27 four times, 15 five times, and 14 six or more times. Forty-two percent of the average physician-dentist pool thus were nominated at least once during the period.

Fifty-six panels were appointed, comprising 168 persons, all but four of whom were physicians or dentists. Make-up of the panels by specialty is shown in Table 4. Except in dental cases it was uncommon for panels to consist of individuals all practicing the same specialty but there were four panels entirely of obstetrician-gynecologists, three of orthopedic surgeons, two of internists, and one each solely of radiologists, otolaryngologists, or ophthalmologists. It was common for an internist to be on a panel involving a complication of surgery, and he was often chosen chairman (Table 5).

Thirty-three individuals were appointed twice, 14 thrice, 4 four times, 1 five times, and 2 six times. A few grumbled when designated again, but no one refused to serve unless he discovered that he had been involved in the care of the patient after all, was ill, or was on an extended holiday.

Modus Operandi of Panels

The statute compels production of all relative medical records and other materials for use by the medical panel. Copies of records were usually provided to the court by the plaintiff, often in triplicate, and were forwarded to the panel. Records, however, were frequently incomplete or copies illegible especially on margins. Laboratory reports were

sometimes copied overlain, only names and dates showing. Accordingly, panelists, having chosen a chairman (two typically fingering one) usually first individually inspected the original hospital chart if the case had occurred in their community, next studied x-rays and other materials, then met informally, sometimes by telephone, to decide how to proceed. This usually involved interviewing the defending physician or dentist, questioning nurses or other persons having first-hand knowledge of the matter, and arranging to examine or at least interview the injured person if still alive. If he had left the state, interviewing was sometimes done by a long-distance conference call.

A murky area has been in the matter of what records to keep and whether to allow representation at hearings and physician examinations. Justices in 3JD have generally been supportive of informality in these areas, leaving it to the panel chairman whether to suffer attorneys and whether to muzzle them or not.

Likewise the court has not insisted upon recorded or written testimony and proceedings so long as a list of the names of those interviewed and documents or other resources used was attached to the report. The statute, however, specifies that the panel "shall maintain a record of any testimony or oral statements of witnesses". Tape recordings of hearings were made by some panels, but as a rule these were not transcribed or submitted.

Physicians understandably felt most at ease when working approximately as they do when consulting, that is to say, investigating the case however they chose. A salient difference between a consultation and this modality, of course, is that it is a three-person consultation, an exercise not customarily practiced by physicians, but on the other hand

not that strange.

After delays for receipt and persual of further records, search of medical writings on the topic, re-interviewing and mulling, often leading to a request for the statutorially permitted 30-day extention of time, and sometimes after prodding from ASDE and ADA, panelists typically met in camera to discuss the case, to decide on their answers to the eight questions, and to draft, or delegate the chairman to draft, further paragraphs or pages of exegesis. When this had been reviewed, revised, and signed by each participant, it was delivered to the court, which promptly distributed it to all parties.[3]

Reports have varied in length from extremely brief answers to the fixed questions to lengthy elaborations running to eight to ten pages. Most have been two to three pages in length and have included a list of materials scrutinized, persons queried, and references consulted. Most reports have been direct and specific, covering each point in the complaint however trivial. Some have been very imaginative. One panel polled twelve general surgeons on the question of what each would do in a hypothetic case like the one before the panel. They used the results of the poll to support their opinion.

It took from 23 to 308 days for panels to complete their work from day of appointment to day of delivery of the report to the court. Average and median times in 1978-1979 was 121 and 104 days respectively, and in 1980-1981, 80 and 63 days respectively (Table 6). As physicians and dentists have become accustomed to the task, work has been done faster but still, as a rule, not quite within the 30-60 day period specified by the statute, and some panels have been extraordinarily slow in completing their chore.

Panel members are entitled by the law to payment for time spent and travel, but pay for time is the State's per diem rate[4] for members of boards and commissions. As panel work has been done an hour here, a quarter hour there, it has been a bother for doctors and dentists to compute bills, and since the State considers per diem as payment for an eight-hour day, or at least a four or five-hour day of duty, most physicians and dentists have not deigned to bill. The amounts authorized do not adequately compensate them for the many hours expended and the gravity of the task. Pay, however, has not been an issue of importance to doctors and dentists thus far. Even counting administrative court costs, the expert advisory panel system has been inexpensive to the public to say the least.

Findings of Panels and Outcomes of Cases

The study will now focus on the 54 instances in which the expert advisory panels finished their work. Outcomes both legal and medical have been traced for at least eighteen months in almost every case. Some dollar data are estimates rather than exact amounts but represent figures as close as the authors could obtain. Amounts of out-of-court settlements and personal legal expenses are, as a rule, private information and hard to get. Valves recorded are probably accurate to within 20 percent.

A. Cases in Which Panels Found Fault

Twelve expert advisory panels (22%) found that injury arose from unskillful care. Table 7 presents features of these 12 cases.

In five instances surgery was deemed to be faulty by reason of mistakes at surgery in three instances and because of postoperative complications in two. In Case 16 the panel thought that a surgeon had severed a trunk of the brachial plexus in performing a scalene anticus operation, but he was fully exonerated by a jury. On appeal, however, the case was remanded when later surgery else where showed that, indeed, the trunk had been severed. An out-of-court settlement in an amount of approximately $250,000 was made. In Case 44 a surgeon cut the femoral artery in the course of a herniorrhaphy on a woman. The vessel was subsequently repaired with a prosthesis at further surgery. There is presently no

evidence of vascular insufficiency in the limb. Final settlement has not been made. In Case 49 a general surgeon of great experience but scant formal training in plastic and reconstructive surgery performed prophylactic simple mastectomy and insertion of a prosthesis on the left after modified radical mastectomy for carcinoma of the right breast. Necrosis of the skin and permanent disfigurement occurred on the left. Originally the surgeon, the hospital, the credentials committee, and the chief of surgery who allowed him to do "plastic" surgery were all named, but the credentials committee and chief of surgery were subsequently dropped from the action. The panelists all agreed that there was some degree of fault on the part of the surgeon, but their report hedged. Jury trial ensued and awarded the plaintiff $220,000. This included a portion of the woman's costs and pre-judgment interest.[5] In Case 13 infection complicated replacement of a knee joint with an artificial device. Ankylosis ensued. The panel did not believe that the orthopedic surgeon was sufficiently trained and experienced to have undertaken the prosthetic procedure. Settlement in the amount of $85,000 was made. In Case 56 glaucoma occurred soon after cataract surgery. Vitreous material extruded through the iris into the anterior chamber. Although vision was not lost, the panel felt that the patient was at risk for future trouble in the eye. Settlement has not yet been made.

In three instances diagnosis was missed to the detriment of the patient in the opinion of panels. In Case 28 an optometrist failed to appreciate that a patient's complaint of sudden loss of vision was due to retinal detachment. Referral to an ophthalmologist was delayed for several days by which time a substantial amount of vision was irretrievably lost. A panel comprised of two ophthalmologists and one optometrist serving as chairman thought that while an optometrist cannot be considered competent

to diagnose retinal detachment, this one should have been alert enough even on a Friday afternoon to suspect from the complaint that something dire was happening and should have referred the patient on an emergency basis to an ophthalmologist. Settlement in an amount of $240,000 followed receipt of the panel report even though the attorney for the defendent protested that the case was still defensible on several grounds.

Case 9 was settled out-of-court for $110,000. The expert advisory panel thought that a family practitioner should have heeded a radiologist's suggestion that more x-rays be taken in a case of injury to the neck. Fracture of the cervical vertebra with partial loss of sensation and strength in the left side of the body occurred, but the patient ambulates satisfactorily with a cane.

In the third case of missed diagnosis the panel blamed an internist for death of a patient due to delay in diagnosing and removing carcinoma of the cecum. Settlement in an amount of $400,000 was entertained until another physician acting as a consultant to the defense reconstructed the case to demonstrate convincingly that death had occurred not from the carcinoma of the cecum but from a second primary adenocarcinoma of the lung. Physicians, in another state (and not named in the suit) caring for the patient at this time had missed this second tumor. When it was finally found, they pretended that it was metastatic spread from the carcinoma of the cecum. The liver was uninvolved. Final settlement was $225,000.

Panels found fault in the way physicians handled two non-surgical cases. A woman had mild viral pneumonia (Case 7) during pregnancy and suffered chest pain and anxiety when one after another of six physicians attended

her during several days of hospitalization including some days on the delivery ward even though she was not in labor. She recovered from the pneumonia and subsequently gave birth to a normal baby. The panel found fault with the handling of the patient, specifically blaming the physicians for inept communication with the woman, thus contributing to her anxiety. An out-of-court settlement in a small amount was made. A panel faulted a part-time jail physician for not consulting a previous physician before re-ordering an oral estrogen preparation (Case 37). The female prisoner claimed injurious, transient galactorrhea. The panel agreed, though precisely what significant injury had occurred, if any, was far from clear in the panel report. The case was settled for $7,000 by the insurance company on behalf of The State of Alaska which insured the jail physician.

Two dental cases (34,35) involving root canal procedures, both done by the same dentist, were poorly handled in the opinion of panels of dentists. Out-of-court settlement in an amount of approximately $15,000 was made in Case 34. Settlement in an unknown amount was reached in Case 35.

B. Cases in Which Panels Did Not Find Fault

Forty-two (78%) of expert advisory panels did not find that injury arose from medical care.[6] Table 8 displays selected features of these 42 actions.

In 25 ± cases the lawsuit was dropped, dismissed, or summarily dismissed soon after the panel report. In 2 ± instances the judge awarded partial costs to the defendant.

It appeared to the panels that many times there was simply confusion on the part of the plaintiff about the nature of his disorder and about the sequence of medical events. Often he did not seem to appreciate what was inevitable and unalterable or what the outcome would have been without medical intervention. Likewise there was misunderstanding about what disease and what was treatment, about decision points in treatment, and about what complications are common and not necessarily to be ascribed to shoddy care. Although lawsuit might well have been averted in many instances had the physician carefully explained these matters to the patient or to loved-ones, yet panelists did not find generally that the injuries claimed were produced by lack of proper explanation. An exception was Case 7 (Table 7 and text).

Fracture outcomes illustrate these points. Everyone wants a "straight", strong bone again no matter how complex the original break. If outcome is less than expected, disappointment ensues. The risks and complications of orthopedic restoration are not often understood and sometimes not fully explained to an injured person or if explained, not heard. Once a panel set out the details and sequence of decision points, perspective usually improved. Indeed there were no instances among this material where fracture treatment was found to be at fault except in Case 9 (Table 7 and text) where cervical fracture was missed.

The value of the all-medical panel in sifting through the intracacies of certain cases is illustrated by an instance of quick death from unrecognized bacteremic pneumococcal pneumonia (Case 32) in which the panel of internists made the fine but telling point, annotating it carefully, that mortality during the first three days of this disease is not altered by penicillin therapy. The case was thereupon dropped, but

the trial lawyer exacted a promise from the defendant that he would not countersue him for bringing the action.

In Case 54 action was brought against a family practitioner 11 years after the birth of a child with cerebral palsy. Prgenancy in 1970 had been uneventful until membranes ruptured at 36 weeks. The doctor ordered an intravenous drip of posterior pituitary extract three days later to stimulate labor. When varying fetal heart rate and meconium staining were noted, the physician came to the hospital and extracted a flaccid infant by low forceps technique. The child remains brain damaged. The panel was able to show from its accurate knowledge of the standards of practice in Anchorage in 1970 (before sophisticated fetal monitoring) that the family practitioner had not strayed from accepted practice of the day.

In another instance (Case 33) a panel succinctly explained that salpingitis and sterility were not necessarily produced by an intra-uterine device placed by a family practitioner but could have just as well been associated with two episodes of sexually transmitted infection.

Twice (Cases 18, 22) family practitioners were excused by panels from not recognizing acute myocardial infarction, eventually fatal, in emergency rooms in small communities. In one instance (Case 22) the patient was seen initally by a physician's assistant on behalf of the physician. He was quite unaware that myocardial infarction could occur in a 30-year-old women who was neither hypertensive, diabetic, or obese. She did smoke and was on birth control pills but these details were not known to the PA. The case was eventually dismissed. The other case (Case 18) went to trial. A family practitioner, a medical student, and a hospital

were blamed for allowing a man who earlier in the day had had chest pain leave an emergency room. In the ER he had been asymptomatic and the electrocardiogram was either normal or close to normal (later interpretations varied). He died a few hours afterwards on a flight to Seattle. The medical student was dropped from the case shortly before trial began. The jury exonerated the physician and the hospital.

In 16 ± of 38 instances suits progressed toward trial despite exonerating panel opinions. In one case (Case 2) two of three panel members were deposed.[9] A neurologist and an orthopedic surgeon reiterated their stance that a neursurgeon was not culpable for footdrop caused by damage at reoperation of an already compromised lumbar nerve. Nonetheless the neurosurgeon, on advice from his insurer, settled out-of-court for $50,000.

In the 15 ± other cases (table 8) 8 ± out-of-court settlements were reached ranging from $10,000 to $80,000 ± (average $40,000 ±, median $25,000 ±). Seven ± cases are pending but only 2+ are ever likely to reach a jury???

Suits against clinics and hospitals were generally settled or otherwise disposed of soon after the panel decided about the doctor. In no case has an action against a clinic or hospital progressed alone to trial.

C. Cases Without Expert Advisory Panel Action

Table 9 lists lawsuits in which medical advisory panels were either

not appointed for one reason or another or, if appointed, did not finish their work before the case was settled. In one important case (Case) in 1978 a judge misunderstood the intent of the statute and granted a motion by the plaintiff to proceed without a panel in a case of suicide by drug and alcohol. The defense was able to convince the jury that a family practitioner and a hospital were not responsible for the death and the jury decision was narrowly sustained on appeal. The cost of defending the doctors and the hospital was $150,000. In two instances (Cases) referred to earlier the plaintiff was excused from having panel scrutiny because of an irregularity in the way in which the legislature voted on the statute creating the panels. This ruling did not apply to other cases.

In several other cases panels were appointed but hardly began their work before the case was dropped, dismissed, or settled out-of-court. In ? instances panel reports have still not been received.

In another First Judicial District case a panel still had not been appointed one year after filing of the suit. The case went to trial without panel findings and found

Acceptance

(1) The courts in Alaska have generally been helpful in implementing the panel mechanism. In 3JD the presiding justice, the court administrator and his assistants, defense and trial attorneys, and representatives of ASMA met several times to work out orders and schedules for panel appointment and operation.

Although the statute allows attorneys "to object or make suggestions" concerning panelists, the presiding justice of 3JD has not permitted objections to be pre-emptory. Judges have almost invariably followed the recommendations of ASMA for specialty distribution.

The courts have let panels proceed informally and have left it to the panel chairmen whether to allow attorneys at hearings. The courts have ordered that reports be on time, but these dates have sometimes slipped anyway. Judges have distributed the opinions to all parties promptly but not before reading them, for in one instance (Case 15) a judge considered a panel report to be so brief and so poorly prepared that he sealed it, allowing the action to proceed without panel report.

(2) Attorneys understandably do not welcome onto their turf new players who can truncate their cherished jousting. To a man trial lawyers object to the expert advisory panel system. Defense attorneys by-and-large do too, though some see merit in the system, particularly in the authority of some of the more scholarly reports. Both trial and defense lawyers have commented on the speed and specificity with which physicians bore in upon what actually injured or bothered a plaintiff. They have also been surprised at how effectively doctors can locate records or other important material of which they were unaware. Panels thus have abetted discovery. On the other hand some panels have not looked beyond materials provided by the court.

To date there has not been much to suggest that otiose attorneys are using panels to work up a case for them to see if a quick, favorable opinion and three expert witnesses can be suddenly accrued. The court has the power under the law to assess costs if it determines that a

claim or a denial of liability is "patently frivolous". Moreover, some of the costs of defense are recoverable if there is summary dismissal of the case under Alaska Court Rule 82.[10]

(3) Insurance companies, returning to the field after the 1976 act, have been uneasy about the panels. There is no way that they can legitimately influence a panel.[11] Thus they feel a loss of control of the case. If a panel does not find fault, the carrier is in a good, though not unassailable, position. If the panel finds fault, capitulation is likely even if there remain possible defenses since at least two and usually three Alaska physicians have opined that their insured was unskillful[12] and can be led into court to say so to a jury.

Despite their misgivings, and perhaps heartened by the fact that there has never been an award or settlement in excess of $500,000 for medical malpractice in Alaska, insurance companies have watched the panel system with interest[13] and have from time to time even made helpful general suggestions, in particular warning that panels should not gratuitously enlarge a case.

(4) Physicians for their part have mixed feelings about the panels, though there feelings are more favorable than not. From a desperate time in 1975 when professional liability insurance was available to a few psychiatrists and to almost no one else in Alaska to the present when at least three companies, including the one created by the state in the 1976 law, underwrite coverage at rates slightly less than those in Northern California, some order and ease of mind has at least been restored. Some doctors choose to remain uninsured, feeling among other things that insurance invites claims. These, in particular, like the

panels for they give quick determinations without high legal fees or interferring advice from carrier attorneys. For insured doctors, pari passu, costs can also be less. This should eventually make insurance cheaper.

Physicians have been outstandingly tractable, though newcomers are unfamiliar with the system and occasionally seem not to take it seriously. No one has wanted to be on a panel because the task is difficult, even painful. More often than not in this sparsely populated state, a panelist is judging someone he knows and with whom he may even share cases. But no one has refused to serve.

(5) There has been no way to tell what the public thinks about the expert advisory panel system. It has had no publicity since enactment. Inasmuch as a majority of panel reports favor defendants, there are undoubtedly many disgruntled plaintiffs. But this hardly measures public sentiment. Legislators, surfeited with the issue in 1975-1977, have paid the matter no attention since.

Discussion

During the deliberations in 1975 of the Governor's Commission on Medical Malpractice Insurance physicians insisted that a major defect in malpractice actions was that the medical story was not laid out early and in proper

clinical perspective. Even at trial this is sometimes not done.

The expert advisory panel mechanism was fashioned from the Commission's recommendations to do this. The aim was to provide both parties soon after filing and while further costly discovery was stayed an explanation by three knowledgeable persons of the biology of the case and how the natural process in question had been altered by medical intervention. The eight statutory questions were to provide the matrix for the response. Further explanation was also invited.

A special feature of the law allows panel members the opportunity to examine physically the aggrieved person, if alive, to help determine for themselves the nature and extent of injury. Physicians have not availed themselves enough of this unusual privilege, perhaps because the situation is awkward. They have tended to depend entirely upon review of records and interviews.

Detailed questioning (medical history) is a powerful tool in the hands of physicians for determining "truth", just as interrogatories and cross-examination are for attorneys. Physicians, however, are more gullible than lawyers in accepting what a person says as fact, for in the usual doctor-patient relationship there is little incentive to exaggerate or deceive.

In the malpractice setting, however, a part of the game seems, at least to physicians, to be exaggeration or even mendacity. Doctors may fall prey to this by believing everything a plaintiff says. Perspicacious physicians on a panel, however, have been able to detect hyperbole and prevarication, recognizing it sometimes as behavioral sickness or neurosis.

Still they should seek more often to corroborate what the plaintiff avers by careful physical examination of their own.

It had been feared by many that bias would be so strong that panel reports would regularly whitewash defendants. Some attorneys continue to assert this. But the overriding afflatus of panel work has been professionalism rather than animus toward attorneys. Too much is at stake in terms of credibility as a specialist or simply as a physician to risk shading an opinion for the benefit of a colleague. The fact that three work in concert helps. Each keeps the others true.

Contrariwise there has been little to suggest conspiracy to hurt a physician. Not that there is not internecine strife among doctors; there is, but panels have not been a battleground for extraneous issues.

It should surprise no one that a large majority of panels, 78% in this experience, have, so to speak, found for defendants. Approximately 80% of malpractice claims across the nation prove to be without merit. The surprise rather may be that professionals have adjudged professionals unskillful 24% of the time. Doctors may prove to be harsher judges of their bretheren than juries. It has not always been easy to continue to practice in a community where one has declared a colleague at fault.

On the other hand physicians may measure the extent of an injury (question 5) less than a jury might, for they eschew quantifying unquantifiable things such as pain, suffering, and loss of consortium. Fortunately, the statute does not call upon the panel actually to rate impairment or disability and certainly not to transmute disability into gold.

Panel performance has been uneven in quality, some of it poor, some adequate, some brilliant. Although competent to do consultations, physicians are not accustomed to working by threes and not attuned in consultation work to answering interrogatories, even the disarmingly straightforward questions in the statute. But there is reason to believe that Alaskan physicians are learning how to do this chore. More thoroughgoing, balanced, well-documented reports are now flowing to court.

Problems remain: (1) Complaints are frequently vague and filled with errors of fact. It may not be of much importance legally at that stage of the action, but it does make it difficult at times to tell what the medical problem may be and therefore hard to advise the court what specialists should be impaneled.

(2) Copies of all the medical records are supposed to be delivered to the panel upon appointment. It has sometimes been difficult for the court to get these from plaintiff's attorney. Delay comes when the panel chairman has to commandeer records himself.

(3) Expansion of a case by a zealous panel, as mentioned above, may prove to be troublesome. Blame not posited by the plaintiff may be fixed. Rattlesnakes thus aroused may be hard to shoot.

(4) In this and other regards, can the substance of a lawsuit be amended after receiving a panel report? If so, does the panel reconvene to ponder the revised charge? When would such cycles terminate? What about discovery of important medical material after the report of the panel has been filed? These are questions of legal procedure which may require definition.

(5) Physicians up to now have been entirely cooperative. Will they maintain this attitude, particularly when the state is parsimonious in paying them for their labor? Most have not minded, indeed have not even billed. But is is a proper question to ask how long physicians will continue to do grave, unpleasant work for a fraction of what they customarily fetch for their time.[15]

(6) A more important question is will physicians tire? Will their work on panels deteriorate? Overall it has been far from perfect. The better trial attorneys virtually ignore overly terse, obscure, or fence-sitting[16] reports. If the load of malpractice actions increases, physicians in certain specialties like obstetrics-gynecology, neurosurgery, otolaryngology, and oral surgery will be overused. Practicing physicians concentrate enormous energy and attention upon their patients. Nothing else, except matters in their personal lives, can repeatedly command that much focus. There is also a problem with new physicians, perhaps attracted to Alaska in part by relatively low medical malpractice insurance rates. They did not know the wrenching days of the mid-1970's and have little or no familiarity with the panel mechanism. How well will they perform on a panel? Thus there is a possibility that the panel device will wither by default on the part of physicians.

In sum, then, what of the expert advisory panel system? Is it worthwhile? Is it socially constructive? It is too early to say. The courts and medical professionals are still learning how to use it. Attorneys and insurance companies are still learning how to live with it. More experience is needed.

In the final analysis the panel mechanism should be measured by whether it is fairer, quicker, and operationally cheaper than the previous

system. Perhaps the only way to determine this with scientific certainty would be to randomize or alternate cases prospectively over a four or five-year period, then compare the two groups. It is unlikely, however, that the court or the Legislature would allow such rationality. Someone would surely appeal his draw.

Summary

Expert advisory panels composed of three medical professionals found among 54 malpractice actions in Alaska that defendants had not caused injury by unskillful care in 42 cases (78%) and that they had in 12 instances (22%). Panel opinions appear to have led to early settlement of suits in many instances, but it is premature to conclude that the new system is fairer, quicker, and cheaper than traditional ways of handling medical malpractice lawsuits.

Acknowledgment

Many people gathered data for this study. We thank particularly the members of the Judiciary Committee of the Alaska State Medical Association. We also especially thank The Honorable Ralph A. Moody, Presiding Justice, Third Judicial District, Alaska for helping to make the medical panel

system work.

appendix: The statute 09 55 036

Footnotes

1. AS 09.55.536 does not absolutely require a panel "if the court decides that an expert advisory opinion is not necessary for a decision in the case." It was, however, clearly the recommendation of the Governor's Commission on Medical Malpractice Insurance in 1975 and clearly the intention of the Legislature which incorporated most of the Commission's recommendations into law in 1976 that a panel be seated in every case. The courts have now adopted this practice.

2. One United States Public Health Service physician and one state-employed physician were nominated but not selected. One USPHS optometrist was named to a panel and was chairman.

3. AS 09.55.536 allows concurring or dissenting reports. So far no dissenting report has been submitted. Two concurring opinions were offered.

4. Fifty-five dollars per day.

5. As allows awards to be increased by an amount of interest computed from the day to filing to the day of payment. The interest rate is

6. When the answer to question number 4 was "no", the remaining questions were left unanswered or were marked "N/A."

7. Alaska law, AS 09.55.510, allows "the circumstances at the time of the act complained of" to be considered in measuring the standard of care.

8. Panel reports are admissible.

9. Panelists may be called to court.

10. In addition at least one countersuit against an attorney for allegedly bringing action falsely is under way in Alaska.

11. Parties to a case and their counsel are enjoined by the statute from initiating communication out-of-court with an expert advisory panel.

12. The word "unskillful" was chosen with great care in drafting question 7, "Was the medical injury caused by unskillful care?" A physician above all all else is supposed to be skillful. If he is not, he is no more than a "man on the street." Lay persons have difficult in distinguishing skill from lack of skill, but physicians do not and tend to scorn ineptitude. This is the quintessential talent of the all-medical professional panel and largely explains why there has not been dissent amoung panelists.

13. Tacit approval of the panel design by one insurance company came when it began to appoint its own paid expert advisory panels of local doctors to interpret claims, even using the eight-qyestion format of the new law. This initially created confusion among physicians and others. The company is now more discreet and calls its physician-investigators something other than "expert advisory panels."

14. One panel did reconvene several months after submitting its report when a subsequent operation added information, but the panelists opinion about the case did not change.

15. A flat, worthwhile stipend (plus travel expenses, if any) however simple or convoluted the case, would be preferable to the present perdiem allowance. It would also be easier for the court pay clerk than piecing together as now snatches of time here and there into one perdiem unit. The matter f who pays for deposition subsequent to the panel report is also confusing, although the statute clearly specifies that a panelist will be paid up to $150 per day for appearance in court as an expert witness. Panelists feel harrassed when they are deposed at low fees to repeat what they have already said. Perhaps requiring the party deposing a panelist to pay the physician at his customary or an agreed upon fee would solve this problem.

16. Such as when the answer to question 4 is "no", but expository paragraphs say "maybe".

17. And constitutional (see page 1).

June 4, 1986

Closed Cases

No Fault Found by Expert Advisory Panel

Case	Description	Legal Outcome	Cost of Defense
1	Infected laminectomy	dropped	
2	Footdrop after disc surgery	settled $50,000	
3	Lacerated uterus at colposcopy	dismissed	
4	malaligned wrist fx	dismissed	
5	missed wrist fx	dismissed	1,500
8	post-op adhesions	dismissed	15-20,000
10	angulated leg fx	dismissed	
12d	facial paresis after extraction	dismissed	
15	angulated fx femur	dismissed	
18	missed myo infarction	exonerated by jury	91,717
20	pg after tubal ligation	dismissed	10,000
22	missed myo infarction	dropped	
23d	root canal	settled 11,000	
24	missed sickle cell anemia	dismissed	
25	unnecessary rib biopsy	dropped	
27	mgmt carcinoid	dropped	5-10,000 x 4 (?)
30	malfunctioning defibrillator	settled 45,000	83,666
31	tinnitus p ear surgery	dismissed	8,000
32	missed pneumonia	dropped	
33	IUD complications	dismissed	
36	Morton's neuroma foot	dropped	5,843
38	ankle fx surgery	exonerated by jury	45,000
39	non-union fx femur	dismissed	6,000
40	cast phlebitis	dropped	3,000
41	K-wire hand	dropped	
42	T & A sore throat	dropped	5,000 +
45d	numb face p extractions	settled 15,000	
47	missed Hodgkin's breast	dropped	
48	pg after ligation	settle 5,000	
54	cerebral palsy forceps	settled 1,300,000	
61	stillborn	settled 60,000	
64	cast phlebitis	dropped	
66	dissatisfied about gastroplasty	dropped	5,000
68d	multiple tooth extractions without written consent	settled 30,000	
70d	unsatisfactory orthodontics	dismissed	6-7,000
74	herniorraphy atrophy testis	jury award 50,000	
75	hung self at hospital	settled 780,000 (?)	
85	bladder torn at surgery	dropped	
90	missed pn child	dismissed	12,000

May 20, 1986

Closed Cases

No Expert Advisory Panel

Case	Description	Legal Outcome	Cost of Defense
11	ovary removed s consent	dismissed	
17	nerve damage p shoulder disloc	dropped	
19	hypoparathyroidism p surg	settled 35,000	<20,000
26	missed diverticulitis	settled 600,000	
43	fx ankle surgery	dismissed	
46d	numb face p extractions	dismissed	
50	severed tendons	not served	
51	forceps crushed head	settled 142,000	
55	Hodgkins staging surgery	dismissed	
57	hematoma p groin surgery	dismissed	
58	missed stress fx femur	dismissed	1,000
59	missed fx scapula	dismissed	6,394
62n	infection after Bl inj	not served	
63pa	delay in dx head inj	not served	
92	negligent rx craniotomy	not served	
94	Darvon suicide	exonerated by jury	150,000
95	alteration of records	statute of limitations	15,000
96	drowning resusitation child	jury award 1,175,000	
97	IV infiltration arm child	settled 250,000	

SETTLED 3.69 MILLION

MAC NEIL/LEHRER NEWSHOUR

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ANCHORS	ROBERT MAC NEIL
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CORRESPONDENT:	KWAME HOLMAN, NEWS MAKER (Interview with Defeated Pres. Ortega)
FOCUS - EXXON - FACING CHARGES:	ROBERT ADLER, Environmental Lawyer
	RICHARD SAMP, Washington Legal Foundation
FOCUS - NEGLIGENT TREATMENT: (Medical Malpractice Debate)	DR. DAVID AXELROD, New York Health Commissioner
	DR. HARVEY WACHSMAN, Malpractice Lawyer

TRANSCRIPT BY:

"STRICTLY BUSINESS"
P.O. BOX 12361
OVERLAND PARK, KANSAS 66212
913-649-6381

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MR. ADLER: What worries me is that despite many years of civil enforcement of environmental laws we still have widespread non-compliance. Let me give you an example. According to the General Accounting Office, a recent study, four out of every ten industries who discharge toxic waste into the nation's sewer systems are violating their discharge permits despite civil compliance. Obviously, we don't have enough deterrence, and without this sort of action corporate America is not getting the message that it has to comply with environmental laws.

MR. LEHRER: Do you think this sends the new message though on those kinds of cases as well?

MR. ADLER: I think it does to all corporations who are responsible for complying with pollution laws if pursued aggressively.

MR. LEHRER: Your concern, Mr. Samp, is that it sends a double message, it may send a message to the bad guys, but it also sends the wrong message to the good guys as well?

MR. SAMP: Exactly, and it seems to me that, as I stated before, that this is not a reasonable environment in order to allow business to thrive in this country, that I would certainly agree that there are appropriate circumstances under which criminal law should be enforced. For example, it seems to me that any company that goes out in the middle night and takes drums full of toxic waste and dumps them in a park and does so knowingly and intentionally, that sort of corporation ought to be indicted. But we're not talking about that kind of case here. We're talking about a corporation which had no intention of spilling any oil, did so, perhaps through its own negligence, and now they're finding themselves in a criminal court.

MR. LEHRER: All right. Mr. Samp, Mr. Adler, thank you both for being with us.

MR. ADLER: Thank you.

MR. SAMP: Thank you.

FOCUS - NEGLIGENT TREATMENT

MR. MAC NEIL: Next tonight new facts and the new debate about medical malpractice. A major study released today found that thousands of hospital deaths and tens of thousands of injuries each year are the result of negligence but that relatively few victims ever file malpractice claims in courts. The study conducted by Harvard researchers examined one state, New York, that drew conclusions with implications for a malpractice insurance system nationally. The study was based on New York hospital patients in 1984. It found more than 27,000 patients were treated negligently in hospital, 6,630 deaths were due in part to negligence, but only one in eight of the patients injured by negligence actually sought compensation and filed malpractice claims. These figures fuel an already heated debate over what can be done to cut malpractice insurance costs and improve medical care. Pres. Bush spoke last week to doctors at Johns Hopkins University about the impact of malpractice lawsuits on medical care.

PRES. BUSH: (February 22) And I ask you today to avoid the understandable urge to practice defensive medicine, where doctors fearing litigation too often dictate treatment that is unnecessary, where the threat of lawsuits threatens the very research that is so desperately needed to save lives, and in return, we've got to restore common sense and fairness to America's medical malpractice system.

MR. MAC NEIL: Restoring common sense to the system is the subject of a proposal in this week's New England Journal of Medicine. The article calls for implementing a no fault malpractice insurance system. The no fault system would take cases out of courtrooms and set up expert panels to compensate victims. We turn now to reaction to today's study and a debate over the no fault solution proposal. Dr. David Axelrod is the New York State Commissioner of Health. He

commissioned the Harvard Report today and is one of the leading proponents of the no fault insurance solution. Harvey Wachsman is a physician and practicing lawyer. He is president of the American Board of Professional Liability Attorneys. He's on the faculty of Brooklyn Law School and the University of South Florida College of Medicine.
Dr. Axelrod, what is the surprising finding in your study, the large amount of negligence, or the small amount of claims?

DR. DAVID AXELROD, New York Health Commissioner: I think it was rather the small amount of claims. A previous study done at Stanford approximately 10 years ago identified roughly the same percentage of adverse events, that is injuries to patients that occurred that would lead us to have believed at least that the number would be approximately the same. There is a concern I have with the data that are being presented and that is that this is an extrapolation from the review of some 30,000 charts to over 2.7 million discharges in 1984. So to say that numbers of thousands of individuals who are identified as having died represents an extrapolation from 1,100 cases in which injury was identified in the Harvard study.

MR. MAC NEIL: I see. It's like a poll. In other words, you've taken a sample and you're saying that represents that reality?

DR. AXELROD: That is correct.

MR. MAC NEIL: Right, like a blood sample.

DR. AXELROD: Yes.

MR. MAC NEIL: Okay. Why do you believe there are so few malpractice claims arising out of so many cases of negligence?

DR. AXELROD: I think in many instances, the patient is not aware of the fact that any negligence has been committed. I think there are difficulties in accessing what is otherwise identified as an officious system with respect to the individual person. I don't think that the average person thinks that there is much chance of success. An individual who comes from a lower socii-economic background may not feel that he has the wherewithal or she has the wherewithal to purse a malpractice suit. There is no clear indication that our system is geared to one of social responsibility with respect to payment for medical injury and it leads more to an event that looks like entering a lottery with respect to a return with a medical malpractice suit.

MR. MAC NEIL: Do you share Pres. Bush's belief that fear of malpractice claims, that doctors hold of malpractice claims, is distorting the medical delivery system?

DR. AXELROD: Yes, I believe that there is a distortion which is occurring. I think it's occurring in a number of different areas. The most important of them may, in fact, be the unwillingness of physicians to participate in peer review of their own colleagues. That fear I think has removed an important element of maintaining the quality of healthcare within our institutions. Without full participation of physicians, it is not going to be possible to have a full review of what happens and the manifestation of quality that we would like to have. I do believe there is a cost impact associated with the practice of defensive medicine. I don't know what it is. It's been estimated to be 5 percent or 10 percent or 15 percent in various studies.

MR. MAC NEIL: How does that come about?

DR. AXELROD: Doctors because of their concern for their ultimate testimony in the event that they should be faced with a malpractice suit attempt to go to the nth degree with respect to the ruling out of diseases. There is an error of commission in many instances with respect to reaching the 99.9 percentile in terms of likelihood of a given disease by some very expensive tests. We have a broad armamentarium of diagnostic tests, valuative procedures that are available to the valuative

procedures that are available to the medical profession, and the physician may choose to utilize one or many of them or all of them in an effort to assure himself that he is not going to be subject to litigation by virtue of his failure to have done a single test.

MR. MAC NEIL: Okay. We'll come back in a moment.
Dr. Wachsman, do you dispute the findings of the survey?

DR. HARVEY WACHSMAN, Malpractice Lawyer: I think the survey's findings of enormous of amount of malpractice in this country is true. I think that there are numbers of physicians who are alcoholics, drug addicts, psychiatrically impaired. According to the AMA 7 to 9 percent, or thirty to forty thousand physicians in this country are impaired. Obviously, that would cause an enormous amount of malpractice which does cut across this country, and you extrapolate those numbers, that comes out to about 100,000 people a year die because of malpractice in hospitals alone. This was a study of hospitals, not even doctors' offices, and hundreds of thousands of people are injured. The reason for the great disparity between the numbers of lawsuits and the numbers of malpractice is clear. It's due to deception and fraud practiced by physicians and hospitals in this country, misleading patients, so that they do not know, and they are misrepresented to in a wholesale manner by physicians so that they cannot find out what exactly occurred. There's also changing of records, forgery that goes on on a national level, that's as significant as well.

MR. MAC NEIL: But for those patients who do find out and do know or suspect there's been malpractice, Dr. Axelrod said they don't claim because they think they're throwing themselves into a lottery.

DR. WACHSMAN: It's not so. First of all, those people who are significantly injured or, in fact, were injured, they win the cases because they're meritorious. In our office, we just heard before from Dr. Axelrod, there's very few wins by patients, not so. In our office, more than 90 percent of the patients who come to us, who we actually bring a lawsuit for, we win, and although we only take about 3 percent of those patients who actually call or contact our office in order to bring a suit.

MR. MAC NEIL: Do you agree with Dr. Axelrod and the President that doctors fearing malpractice are practicing defensive medicine and that that is raising the cost of healthcare?

DR. WACHSMAN: That's absolutely untrue. That's something that has been propagated by medicine and also obviously misled the President into thinking that there is so much defensive medicine going on. There is none essentially, because no test that does not help a patient or at least find the diagnosis or help elucidate the diagnosis for that patient in no way assists the physician in defending himself. And the truth of the matter is, that most malpractice is not due to the 99 percentile test but is due to three things, one, the physician not showing up, two, I'm talking about seeing the patient and evaluating him rather than over the phone or showing up some other time, two, is not taking a proper history, which takes time to evaluate a patient and 80 percent of diagnosis is made on history, and three, is not doing a proper, a physical examination. 70 percent of all malpractice cases across this country are due to a physician not showing up, not taking a proper history, examining, and if you look at that, I think any patient is entitled to those things and not due to some test that somehow he didn't do. Those cases we have wide experience, we've written three volumes in the area, it's not so.

MR. MAC NEIL: You say it's not so, but you wouldn't agree with the cartoon, with the sort of folk wisdom that's in the cartoon in the New Yorker recently where a doctor is saying to a patient, well, I think it's just a common cold, but let's run a full battery of tests just to be sure?

DR. WACHSMAN: No, because that's just not true. Again that's misrepresentation. There have been a lot of things in history, as you're aware of, that have occurred and knowledge that's pushed around and stated when, in fact, it's not true. The truth is that there is no great defensive medicine. The only defensive medicine that does exist, which I do agree with, is when a physician spends

more time with his patient, talks him and examines him over a longer period of time, and, therefore, can see less patients per hour and therefore, there's a cost to that physician because he can't make as much money. But it's certainly not due to tests.

MR. MAC NEIL: Two quite different points of view on this. Now, you are in favor of replacing the present system with a no fault system. Can you explain briefly how that would work and why it would improve things, in your view?

DR. AXELROD: I think the first difficulty is that you've been talking about the Harvard study dealing with medical malpractice. The Harvard study did not deal with medical malpractice. The Harvard study dealt with medical injury and the nature of that injury and the extent to which negligence was responsible for that injury. Only 1 percent of the cases that were reviewed by the Harvard study demonstrated negligence, so that what we have tried to do is to define our terms a little bit better. We are concerned with a social system which provides justice to those who are injured by virtue of their contact with the healthcare system. Our concern is that the medical care system is a hazardous one in terms of your entry into that system because of the nature of the interventions, and that there is a distinct possibility for injury. The no fault system which we are proposing would have a mechanism by which individuals would be paid on the basis of the nature of that injury if there was causality established, rather than fault assigned to a given physician. It would not be necessary for an individual to become a plaintiff within an adversarial system in order to be compensated for the injury which occurred.

MR. MAC NEIL: Well, who would decide whether they were at fault, the office or hospital --

DR. AXELROD: It would presumably be a panel of individuals who would be expert with respect to the nature of those injuries, it would work similar to worker's compensation where those who make decisions with respect to occupational health would make a judgment.

MR. MAC NEIL: Why would that be an improvement over the system now?

DR. AXELROD: Because as it currently stands, the Harvard study demonstrates that only 1 in 10, approximately 1 in 10 individuals, who have been injured as a result of negligence ever receive any kind of compensation. There is nothing to suggest that there is any equity, that it's an effective system with respect to compensation for medical injury. I think what we have to do is to separate what it is we're trying to do. Are we simply trying to provide a small number of individuals that has no relationship to the nature of the injury?

MR. MAC NEIL: In other words, big awards, millions of dollars?

DR. AXELROD: Big awards as opposed to providing everyone who suffers an injury that is significant with a level of compensation that is relevant to the nature of that injury.

MR. MAC NEIL: Why wouldn't that be an improvement on this system?

DR. WACHSMAN: I think first of all, all it does is grant immunity and that's what they're really interested in. The whole purpose of the study was not to see to it how they can compensate people better but to gain immunity. I can point to Virginia and New Zealand which has no fault. In New Zealand, since January 1, 1988, they have a brain damaged baby circumstance --

MR. MAC NEIL: No fault --

DR. WACHSMAN: -- no fault system, and they're going to compensate all these children, the total number of children in two years and two months that have been compensated is zero. In New Zealand, there's no fault system where a patient has to prove their case to an official of the government. That just doesn't occur, because they can't do it. One little comment that Dr. Axelrod mentioned in passing was the word "causation". The word "causation" means proximate cause under

the law. That is the most difficult thing for a malpractice lawyer who's capable to prove in any case. No patient will ever be able to prove it by themselves.

MR. MAC NEIL: In other words, this is just giving the doctors immunity because you'll never pay anybody because the doctors will never admit if they review themselves or a committee reviews them, they'll never admit that there was malpractice.

DR. AXELROD: But we've confused two very different things. We've confused physician discipline and deterrence with an equitable system for compensation for medical injury. Both Dr. Wachsman and I would agree that there needs to be a better disciplinary system. I do not believe that there is any data that would suggest that the existing malpractice system represents an effective deterrent. That was one of the elements of the Harvard study and I think that there is, if any presence of deterrence, it's very limited.

MR. MAC NEIL: But his point is that the system you're proposing would represent no deterrence at all.

DR. AXELROD: Oh, no, oh, no, hardly.

MR. MAC NEIL: I mean, he instances no compensation for birth damaged babies under the Virginia's no fault system and the inability of patients in New Zealand under their system to gain any admission of malpractice.

DR. AXELROD: Well, there's, I don't want to get into other systems, because I think that there are complexities about the New Zealand system which has been in place for 15 years that, in fact, has not had an effective deterrent system. The Virginia system has been in place for one year in which there has been any experience, and I don't know that that is an appropriate time frame in which to judge the effectiveness of the program. What I think you have to do is identify the fact that we have not been as good as we think we have been with respect to oversight of physicians. I think that there needs to be a whole new arena in which we evaluate the effectiveness of the oversight of government, the failures of the existing physician peer review process, the failures of the hospital review process, but I think that the most important thing of all that will challenge the effectiveness of any malpractice system, any no fault system even, will be the new information that is emerging. One of the major revolutions that has occurred is the availability of information with respect to outcome, with respect to procedures within institutions, procedures done by physicians. I am firmly convinced that it is the public, it is the advocacy of the public, it is the public requesting information that is going to change the medical practice in the most imaginative way possible.

MR. MAC NEIL: I'm sorry, gentlemen, but that is the end of our time. Thank you both for joining us.

RECAP

MR. LEHRER: Again, the major stories of this Wednesday, Nicaragua's Sandinista government declared a unilateral cease-fire in the war against the contras. On the Newshour, Pres. Ortega said if the contras refuse to disband, he will do what is needed to defend his nation. And after five previous attempts, NASA successfully launched the space shuttle Atlantis.
Good night, Robin.

MR. MAC NEIL: Good night, Jim.
That's the Newshour tonight and we will be back tomorrow night. I'm Robert MacNeil. Good night.