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ALASKA STATE LEGISLATURE

P. O. Box 770296
Eagle River, Alaska 99577
(907) 694-6623



P. O. Box V
Juneau, Alaska 99811
(907) 465-3720

SAM COTTEN
SPEAKER OF THE HOUSE

MEMORANDUM

TO: Legislative Reference Library
FROM: Speaker Sam Cotten *SC*
DATE: January 2, 1991
RE: Liability Insurance Task Force

Enclosed in the box accompanying this letter are the records of the Liability Insurance Task Force from 1989 through 1990. I am forwarding these items to you for permanent filing.

A. Committee Tapes and Logs as follows:

1. Tapes for October 3-4, 1989, meeting (^{FIVE} ~~four~~ tapes)
2. Tapes and log for March 2, 1990 meeting (three tapes)
3. Tapes and log for March 3, 1990 meeting (five tapes)
4. Tape and log for March 16, 1990 meeting (one tape)

B. Set of 16 volumes of research data and index for same.
Volumes are as follows:

1. Peer Review Panel Results, Etc.
2. Changes in Insurance Services: How the Public is Treated
3. Rand "Three Level" Study and Other Reports
4. Miscellaneous
5. Availability - Affordability Insurance Percentage
6. Availability of Services
7. Alternative Claim Resolution Mechanisms
8. Roles and Mechanisms of State Agencies
9. Claims Information Professional
10. Anti-Trust Suit Status
11. Impacts of U. S. Tort System Changes
12. Rates
13. Self-Regulation Materials
14. Changes in Time in Law of Liability and Damages

15. Comparisons of U. S. Tort System Changes
16. Legislative Research Agency Reports

C. Miscellaneous Handouts Used at 1989 Meetings as follows:

1. April 13, 1989 letter from Center for Study of Responsive Law.
2. MEDICAL ECONOMICS article "Tort Reform: What Works, and What Doesn't"
3. Copies of House Bill 166
4. February 17, 1989 memo from Michael F. Ford, Legislative Counsel, regarding Civil Action - HB 166
5. NATIONAL INSURANCE LAW REVIEW article "The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances"
6. "New Ideas Concerning Organizations: The PIAA Proposal: Establishment of Fault by Either Administrative Review or Normal Adjudication Followed by Indemnification Using a Fixed Benefit Program."
7. August 5, 1988 letter from Milliman & Robertson, Inc.
8. "Who Should Be Liable? A Guide to Policy for Dealing with Risk."
9. "Insurance Rates, Regulation, Commissioner, Initiative Statute"
10. April 27, 1989 memo from Ginger Baim to David Rogers regarding House Bill 166 - pros.
11. September 15, 1989 memo from Rep. Cotten to Liability Insurance Task Force members
12. February 1986 report by the Citizens Coalition for Tort Reform entitled "Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability."
13. March 1987 report by the Tort Policy Working Group entitled "An Update on the Liability Crisis."
14. January 26, 1989 letter, James P. Lynn of Aetna from Ralph Nader and February 8, 1989 response from Aetna.
15. House Research Agency March 15, 1989 report on "Hawaii Court Annexed Arbitration Program."
16. October 1, 1985, "Report of the Governor's Medical Malpractice Insurance Commission."
17. April 25, 1989 statement from J. Robert Hunter, President, National Insurance Consumer Organization.

D. Miscellaneous papers regarding 1990 hearings:

1. March 9, 1990 list of Task Force members and alternates.
2. Memo from David Rogers regarding "Fact Finding Efforts" dated January 19, 1990.
3. Memo from David Rogers regarding "Summary of Data: Almost everything you ever wanted to know about liability issues (and were afraid to ask??)" dated February 22, 1990 and marked "draft".
4. March 2, 1990, Summary of Highlights - Discussion Draft. Prepared by David Rogers for Task Force members.

5. Letters and articles discussed at March hearings:
- a. January 26, 1990 letter from Scott Wetzel Services
 - b. January 26, 1990 letter from Nabors Alaska Petroleum Services
 - c. January 8, 1990 letter from David E. Rogers
 - d. January 31, 1990 letter from Phillips Petroleum Company
 - e. January 31, 1990 letter from NANA Regional Corporation, Inc.
 - f. February 16, 1990 letter from City/Borough of Juneau
 - g. February 16, 1990 letters from Wilton Adjustment Service
 - h. March 1, 1990 letter from Alaska Bar Association
 - i. NEW YORK TIMES articles concerning medical profession
 - j. December 1, 1989 memo from John B. Gaguine, Legislative Counsel, concerning civil jury trials in other countries.
 - (MISSING) → k. February 23, 1990 letter from MICA
 - l. February 27, 1990 letter from National Society of Professional Engineers

6. March 19, 1990 note and draft memo from David Rogers concerning tentative summary of claims experience information.

7. April 2, 1990 memo from Rep. Cotten to Task Force regarding MacNeil Lehrer Report and Harvard Study.

8. April 12, 1990 memo from Rep. Cotten to Task Force concerning Harvard Study materials.

9. June 17, 1990 draft final report.

LIABILITY INSURANCE TASK FORCE MEMBERS

Legislative Members:

Representative Sam Cotten, Chair
Representative Red Boucher
Representative Virginia Collins
Representative Dave Donley
Representative Johnny Ellis
Representative Peter Goll
Representative Max Gruenberg
Representative Ron Larson
Representative Loren Leman
Representative Mike Navarre

Non-legislative Members:

Gary Fye, Gary Fye Company, PO Box 92971, Anchorage 99509, 272-1502
Insurance Investigator

Vince Haneman, University of Alaska, Dean of Engineer, 539 Duckering,
Fairbanks 99775, 474-7330, Educator/Engineer

Russ Huffman, M.D., Past President, Alaska State Medical Association,
701 Stearns Place, Paynesville, MN 56362, (612) 2443-3666,
Physician

Jeff Jefferson, Esq., 215 Fidalgo Street, Kenai 99611, 283-9187,
Attorney

Nancy Lord, PO Box 558, Homer 99603, 235-8252, Consumer

Ames Luce, Esq., Luce & Hensley, 1015 West Seventh Avenue, Anchorage 99501,
272-9403, Attorney

David McGuire, M.D., 4040 Laurel, Anchorage 99508, 562-4142, Physician

Al Parrish, Westmark Hotel, 880 H Street, Anchorage, AK 99501, 272-9403,
Businessman

Mary Pierce, MICA, Aleut Plaza, 4000 Old Seward #203, Anchorage 99503,
563-3414, MICA

Jim Witt, Teamsters, 4300 Boniface #449, Anchorage 99510, 269-4258,
Attorney

Alternates at March 2-3, 1990 Meeting

Bill Brock for Mary Pierce, PO Box 20709, Juneau 99802, 586-3656,
Financial Management Consultant and Chair of MICA

Dan Hensley for Ames Luce, Luce & Hensley, 1015 West Seventh Avenue,
Anchorage 99501, 272-9430, Attorney

Richard Ritter for Vince Haneman, Minch Ritter Voelckers Architects, 800
Glacier Avenue, Juneau 99801, 586-1371, architect

Special Counsel to Task Force

David Rogers, PO Box 33932, Juneau 99803, 586-2366, Lawyer

DAVID E. ROGERS

LAWYER

P.O. Box 33932
JUNEAU, AK 99803

907-586-2366
FAX 907-586-6959

MEMORANDUM

TO: Liability Task Force

FROM: David Rogers 

RE: Fact finding efforts

DATE: January 19, 1990

Our next meeting is set for March 2 (starting at 1:30 p.m.) and March 3 (if necessary; starting at 9:00 a.m.) in Juneau. Attached are materials compiled by my office to date which deal with the various factual matters identified by the Task Force at its first meeting in September. They provide a fairly comprehensive overview of the subjects under discussion although some materials may be dated and/or incomplete. I did not attempt to cover every conceivable angle given limits of time and space, although I did arbitrarily expand the scope of our inquiry into professional liability issues to include Nurses, Dentists and CPA's.

Additional information will be forwarded upon receipt.

If I have missed an issue that you are concerned about or failed to address a question raised at the last meeting please let me know as soon as possible and I will try to respond before our next show. Please note there are some overlaps since several folks responded to my questions in one letter/submittal which cannot be easily divided (note, for example, information regarding dentists and nurses in "Availability/Affordability;Insured Percentage"); certain reports and studies fall into more than one category. There may also be missing or out of order pages, etc. although I have gone through everything pretty carefully to avoid this problem. Each section was stapled if it could be stapled, bound if not, or "rubberbanded" if it couldn't be stapled or bound. All sections have holes for a three ring notebook if you prefer that method of keeping things organized.

I have not attempted to "stack the deck" one way or the other. Generally, I have tried to give you the best available information from "non-partisan" sources

(particularly those identified in the Group #1 and #2 game plans). However, I have also taken the liberty of including what some may consider "partisan" materials (from both sides of the fence) where I felt the information was relevant or helpful in defining a point of view on the many interrelated issues before us. I anticipate that some of the materials contained in this second packet will be rejected by the Task Force for one reason or another when it draws its final conclusions.

You may also want to take a second look at your first packet for other views on the issues.

Additional suggestions are encouraged. If I have left something out which has been recommended by one party or another I am happy to reconsider. It is also quite possible that constructive information in my possession has been lost in the shuffle.

This should not be considered a final product as there are gaps and other problems (some yet to be discovered) which will hopefully be resolved as the process continues. I apologize for the long delay between meetings, but I had to start from scratch and things have arrived in bits and pieces often requiring additional analysis and follow-up; further complicated by last minute realizations that I had missed a piece of the puzzle, endless problems with scheduling our second meeting (Christmas, Session, and busy Task Force members) and other logistical difficulties. After you (and I) have had a chance to start digesting all this and prior to our next meeting, I'll send out a memorandum with my thoughts and observations along with additional materials.

I know there is a lot to review in a fairly short period of time but the subjects addressed are complex and I thought it best to give you as much original data as possible for starters rather than to simply offer a summary of my impressions and conclusions. Fortunately, some of these materials can be skimmed easily.

Just pretend you are a student studying for a mid-term exam.

My thanks and compliments to the many people and organizations who bent over backwards to assist me in this effort without complaint; and a special thanks to Julie Kraft who was always there when I needed her advice and assistance.

Here is a brief discussion of major attachments by topic as set out in the Task Force Group 1 and Group 2 "to do" lists:

1. Insurance Rates: You will find attached rate information (current to this date), including "tail" coverage quotes,

received from the major admitted carriers who have responded to informational requests similar to that contained in the "Claims Survey" section. These surveys were sent to as many admitted carriers as we could identify at the time for each of the target professional groups (Lawyers, Physicians, Hospitals, Architects, Engineers and Land Surveyors). In an effort to broaden the scope of our inquiries, I am also including current rate filings provided by the Division of Insurance for Nurses, Nurse mid-wives, Dentists, and Accountants. No other rates have been included but I am told that the Division of Insurance is developing a comparative analysis of auto and home owner's rates which I will pass along.

Finally, I've attached the MIEC rate filing documents provided by the Division of Insurance for your information. Rates filings for other liability policies of admitted carriers (including MICA, which was to thick to include) are available in my office for anyone who is interested. Please let me know. I am also attempting to nail down rates for those non-professional categories listed as problem areas by the Division of Insurance and/or the Alaska Independent Insurance Agents and Brokers Association; and determine general rate trends for the major professional categories over the last several years. I have not focused on "surplus lines", "purchasing groups" and similar issues because you have to draw a line somewhere but we may want to take a closer look in the future. More on this topic in the analysis memorandum. Stay tuned.

2. Availability of Insurance: Information developed by the Division of Insurance, the Alaska Independent Insurance Agents and Brokers Association, various professional organizations and the Division of Occupational Licensing, along with responses from several of the major admitted carriers (included in the claims survey section) are attached. This is pretty good stuff. Please read these materials carefully. I am told that relevant additional data developed by the Division of Insurance in December concerning surplus lines (which apparently can only be used when there is an admitted carrier availability problem) will be provided in the near future. Information regarding CPA's (and hopefully Day Care facilities) will follow.

3. Percentage of Insured: All available information is included for Doctors, Lawyers, Engineers, Architects, Land Surveyors, Dentists and Nurses. Information regarding CPA's and Day Care Facilities will be forwarded as soon as possible. You will note that with the exception of Doctors, most of the data on this topic is dated, speculative or non-existent. A current survey would be necessary to adequately answer this inquiry. I suspect that most, if not all, of the professional organizations would be willing to conduct such a survey if necessary; but given the effort

required I have not asked them to pending Task Force discussion. However, I have prepared a draft questionnaire which I can share with you upon request. A survey conducted by the Alaska State Medical Association which apparently addresses this issue and perhaps related questions is currently underway with results available by mid-February if all goes according to plan.

4. Availability of Services: This has been hard to pin down since the Task Force provided little guidance on the "other services" category. I have surveyed with a broad brush state and federal agencies, professional and other organizations and individuals who might have something to add to the discussion. All available information received to date is included for target professionals (expanded list). Additional information regarding CPA's is in progress. I'm still working on the "other services" category and waiting for a response from the Department of Health and Social Services; information compiled to date is attached. In addition, I just received word from the Alaska State Medical Association that there are doctor availability problems in the following communities: Haines, Tok, Ketchikan and Dillingham as well as a variety of specialized service gaps (eg. no Ob/Gyn) in other communities. I've also heard that Craig currently has no doctors but this hasn't been confirmed.

Finally and for your information, I am told that it is very difficult for people to find lawyers to represent them in Worker's compensation and certain medical malpractice cases.

5. Who receives what from settlement: See attached "pie chart" from the Rand Corporation contained in the so-called "three-level" study discussed below. Similar information is contained in "Costs and Compensation Paid in Tort Litigation" by Kakalik and Pace also included in that section. Based on my discussions with various interested parties, it appears that no such breakdown has been developed for Alaska, but I suspect that the results would be comparable.

6. Claims experience of Self-insured entities: I also sent a claims survey to target self-insurers in Alaska (all major public entities that we could identify at the time and a couple of private entities); results received to date are included (State of Alaska, Municipality of Anchorage, Anchorage School District and the University of Alaska) along with a couple of letters from hospitals in Cordova and Petersburg. A second, less complicated request went out recently to a wider cross section of self-insured's in an effort to pick up more information since several entities were either unable or unwilling to respond to my naively comprehensive original request. In addition, as I mentioned

above, most of the major players in the Alaska admitted professional liability market have responded as best they could with the exception of National Union (lawyers liability) which has apparently declined to respond.

Please note that this section begins with the heading "Claims Information-Professionals".

7. Roles and Mechanisms of State Agencies: The attached materials summarize the duties of three state agencies which have primary roles in this arena - The Division of Insurance in the Department of Commerce and Economic Development, which regulates insurance activities in the state; the Division of Risk Management in the Department of Administration which is responsible for handling claims against the State of Alaska, a "self-insured" public entity; and the Division of Occupational Licensing within the Department of Commerce and Economic Development which regulates several of the professional groups discussed in the attachments including Doctors, Dentists, Nurses, Architects, Engineers, Land Surveyors, and Certified Public Accountants. I am still waiting for information on State agencies involved in licensing/certification of hospitals, day care facilities, etc. but I should have more on this soon.

8. Status of State Suit against Insurance Companies: See attached memo from Attorney General's office which tells us what has happened to date along with comments from industry representative Tom Slagle.

9. Peer Review Panel Results; Total number of Medical Malpractice cases: As you will see from reading the attached letter from the Alaska Court System much of this information is not readily available. The last document in this section does contain potentially useful information but, ironically, I've lost track of the source. Hopefully, someone out there can help me fill in the blanks. I'm also trying to determine annual costs to the State Court system relating to tort litigation and how long it takes to resolve a typical negligence case from the filing of a complaint to final disposition.

10. Other Solutions Tried Elsewhere; Matrix of State Systems; Federal Actions: I have included information developed by the National Conference of State Legislatures, a New York law firm which tracks these issues and miscellaneous other sources including the Rand Corporation. There is also a separate attachment on "pre-judgement interest" in response to a specific Task Force inquiry. The James Ludlam article ("Battle for Medical Malpractice Reform") while partisan was included because it contains useful information on legislative strategy issues and "tort reform" pros and cons among other things. I've also attached

an NCSL summary of pending 1989 legislation around the country to give you a sense of current thinking on the subject and a copy of an Alaska Attorney General's opinion on the constitutionality of several proposals contained in HB 166; but please note my unsolicited opinion that the conclusions contained in this memorandum are speculative and debatable.

There is duplication in this section but I wanted to give you a choice of formats. Some information may be dated (e.g. Statute of Repose/Limitations) due primarily to the ever present possibility of judicial decisions overturning these laws on constitutional grounds.

At a minimum, I recommend that you read the NCSL narrative and the Wilson, Elser report and take a quick look at what was going on around the country in 1989. An interesting overall view of Federal and State activities is also contained in Chapter 8 of the Winston/Litan book discussed below.

11. Alternate Claims Resolution Systems: I've included a sampling of information on this topic which should give you a pretty good sense of some of the more significant alternatives which are in operation or under consideration. This section includes a 1984 Rand study on state court arbitration, a comparison of three medical liability reform proposals, and discussions of the Hawaii arbitration system and the Virginia Birth Related Neurological Injury Compensation Act. I also direct your attention to Huber who argues direct "first party" insurance (apparently similar to the policies some people purchase before they get on airplanes) and comments contained in the Litan et. al. piece discussed below. Finally, you may want to refer to my original information package for a review of Governor Cowper's "No Fault" medical malpractice proposal.

12. Impacts of U.S Tort System Changes: This information is hard to come by. I have tried to provide several reasonably credible perspectives on the question, although at first glance the evidence appears to be somewhat contradictory. This section includes information from Rand ("Assessing the Effects of Tort Reform"; "Frequency and Severity of Malpractice Claims"), and actuaries Milliman and Robertson along with several other articles on the subject. Please note that the Danzon report on Frequency and Severity of Claims is often referred to by other civil justice commentators. The Maine report discussed below also addresses these issues.

13. Legislative Research Reports. All reports prepared to date on liability issues are attached.

14. Rand Study-Three Levels: It took awhile to find this study but I am pleased to introduce "Trends in Tort Litigation, The Story Behind the Statistics" by Hensler et. al. I have also included a recent Maine medical malpractice study which you may find interesting along with several other reports (mostly from Rand) which address a number of questions raised by the Task Force; and will be happy to order additional materials in your discretion (see attached Rand Bibliography).

15. Results and Amount of Self-Regulation: Attached are applicable statutes, regulations, current annual reports, national standards, disciplinary statistics, state by state comparisons and observations supplied by various professional organizations and regulators, along with information regarding educational programs and requirements. More will follow as soon as it arrives in my office including the Alaska Bar Association's latest annual report and a general discussion of trends over the last few years.

16. Changes in Time in Law of Liability and Damages: The Huber and Brodeur books (five copies each) just arrived and are available upon request. Call if you want one. I have also included an excellent overall discussion of the issues (including a summary of the kinds of changes which have occurred over the last 30 years) edited by Stephan Litan and Clifford Winston of the Brookings Institute which I urge you to review, particularly the Forward and Chapters 1 and 8. I have talked to Mr. Litan and concluded that he does not appear to have any axes to grind.

17. Changes in Insurance Services; How the Public is Treated: While it is not exactly responsive to this specific question, I have included a report prepared by well known consumer advocate Robert Hunter which hits on a number of topics before us. This also can be considered a partisan effort (which may require a rebuttal from the insurance industry and others), but I feel we have an obligation under the terms of our mandate to review Mr. Hunter's many findings and conclusions since he is considered by many to have a steady and enlightened handle on the issues before us. As I mentioned before, Gary Fye is also willing to discuss the service issue at our next meeting if there is no objection from the group. Otherwise, I am open to additional suggestions on how to further explore this topic and related questions.

18. Insurance Department Report: Jim Jordan, formerly of the Division of Insurance, says there is no such report.

19. Miscellaneous: I have also included several additional attachments which may fall into the "bias" category but are still worth reviewing in my opinion. These include excerpts

from a Tillinghast study on U.S. and World trends, a claim data overview by ISO, Inc., information prepared by Al Tamagni, Senior regarding Alaska Court Rules and related matters, a 1986 report prepared by several state Attorney's General on the causes of the liability insurance situation, A Louis Harris study and others.

Have fun and feel free to call with questions, etc.

Remember, "no pain, no gain".

D.3

DAVID E. ROGERS

LAWYER

P.O. Box 33932
JUNEAU, AK 99803

907-586-2366
FAX 907-586-8959

MEMORANDUM

DRAFT

TO: Liability Task Force

FROM: David Rogers *DR*

DATE: February 22, 1990

RE: Summary of Data; Almost everything you ever wanted to know about liability issues (and were afraid to ask??)

Here is a general summary by category of the highlights contained in my last packet along with occasional editorial commentary as appropriate:

1. RATES: Still working on it.

2. AVAILABILITY/AFFORDABILITY OF INSURANCE: According to the information compiled by the Division of Insurance the market for professional liability insurance is "soft". Their specific findings based on a survey of major brokers placing professional liability are:

* The situation is improving which is to be expected in a soft market;

* Prices are coming down;

* Coverage is generally available but sometimes at high premium or with restrictive conditions. Non-availability appears to occur with home inspection services and any small unseasoned professional;

* Some insurers are now writing as part of a package policy;

* Policies are usually "claims made" with defense within limits and adjustment cost included in any applicable deductible;

* Pollution usually has a \$25,000 deductible;

* Costs are perceived to be prohibitive for testing labs, structural engineers, attorneys doing SEC work, pollution and asbestos work, real estate/developer combinations and computer programmers. They cited the following examples:

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Lloyds- testing lab-\$1/2 million coverage
\$50,000 premium last year; \$1 million coverage
\$25,000 this year.

CNA- mechanical engineer doing some electrical
and survey-\$3 million in billings-\$1 million
coverage, \$25,000 deductible, \$129,000 premium.

* Only Allstate was identified during their survey as providing unlimited Civil Rule 82 coverage on its personal lines coverage. Demand is not there although markets could be found.

The Alaska Independent Insurance Agents and Brokers, Inc. also looked at availability/affordability of other lines of liability insurance based on a survey of members from all areas of the state. They concluded that the following categories have both availability and affordability problems: Day Care Centers, Liquor Liability, Small Specialty and General Contractors, Pollution, and any small business that requires liability coverage only (no supporting property or auto).

These findings are more or less confirmed by responses to our professional liability claims survey discussed below, informal conversations with representatives of insurance companies and in letters contained in this section from representatives of various professional organizations and regulators. Generally, there does not appear to be an availability problem for most professionals. Affordability, as Keith Brown points out, is relative. Note that Dan Rowley estimates that insurance premiums for Alaska Architectural and Engineering firms are approximately 7% of annual gross billings, as compared to the national average of 4.2%; according to the Medical Malpractice Liability Study prepared for the Maine Legislature (see discussion below) nationwide medical malpractice premiums were 6.2% of physicians gross practice income in 1986. I have no comparable statistics for Alaska. Also note that according to Mr. Rowley seven out of eleven carriers nationally have a maximum limit of \$1 million; six of those carriers don't do business in Alaska. Finally, note that in addition to the groups identified by the Division of Insurance rates for certain physicians are very high as we will see in more detail below.

3. PERCENTAGE OF UNINSURED: a) Physicians: Based on a recent survey conducted by the Alaska State Medical Association the total percentage of uninsured is 24% in cities, 12% in towns and 56% in the bush. According to my notes, the study further indicates that OB (44.7%), Family Practice (34%) and Orthopedics (23%) have the largest block of uninsured.

Please note that MICA insures approximately 55% of Alaska insured physicians, MIEC approximately 28% and CNA approximately 7% through group practices that meet CNA criteria; b) Hospitals: Based on a recent survey of 19 hospitals by MICA only two (Cordova Community and Petersburg General) are uninsured. The others are either insured through MICA (most), affiliations with a national chain or the Federal government. MICA also insures twelve health related health care facilities, many of which are "rural" including a skilled nursing facility, clinics, intermediate care facilities and home health services; c) Lawyers: Information on lawyers is based on a survey conducted several years ago when availability was limited and prices had skyrocketed; although market circumstances have changed for the better since then according to Keith Brown, former Chairman of the Alaska Bar Association's Professional Liability Insurance Committee. If I am reading the results correctly, at that time, 275 firms were covered by liability insurance, 120 were not; d) Architects, Engineers, Land Surveyors: There is no statistical information available for Alaska, although nationally 49% of architectural firms do not carry professional liability insurance - 42% of 1-5 person, 17% of 6-10 person and 15 percent of 11-25 person engineering firms are "bare". Rich Ritter of the Alaska Chapter of the American Institute of Architects estimates that 70% of the architect and engineering firms he does business with in Alaska carry professional liability insurance; although he is aware of one major Anchorage firm recently going bare apparently due to the high cost of insurance. Nurses: No numbers are available. Note that Gail McGuill of Occupational Licensing tells us that while nurses typically are covered by their employers' policy increasing numbers are purchasing their own policies to protect themselves further; Dentists: According to Frank Thomas-Mears, writing on behalf of the Alaska Dental Society, approximately 2% of Alaska dentists are uninsured. We have no information for CPA's or other professionals at this time.

Additional survey information developed by the Alaska State Medical Association is not yet available but will be soon and in time for our meeting.

We don't have an answer to the question of how many professionals are going bare (or limiting their practices or getting out of the business altogether) because they can't afford the premiums. A survey conducted by each professional organization is the best way to clarify this issue along with the related question of how many professionals are in fact uninsured.

4. AVAILABILITY OF SERVICES: The information contained in this section is limited. What follows is a discussion of some of the service gaps in Alaska that I have been able to

identify and comments on whether these gaps are attributable to the affordability or availability of liability insurance:

a) Health Care: There are a number of communities in the state (mostly rural) that are having difficulties recruiting and retaining physicians. According to the Health Association of Alaska and the Alaska State Medical Association Haines, Tok, Ketchikan, Dillingham, Wrangell and Petersburg (and possibly Craig) are having doctor availability problems along with other communities with specialized care gaps. In addition, according to a 1988 survey of availability of obstetric care for low income women, fewer than half of the physicians surveyed (93% of the 196 family practice and OB/GYN physicians surveyed responded) are now providing obstetric care; "within two years only slightly more than a third of the surveyed physicians may be offering obstetric services in Alaska." Many attribute this situation to the cost of liability insurance and other health care cost factors. For example the Report of the Governor's Interim Commission on Health Care (September 1988) states that rural providers, especially those providing obstetrical care, have been particularly hard hit by the increase in medical liability insurance: "The cost of medical liability insurance has created a particularly severe problem for pregnant women in rural areas. Non-Native residents of Glenallen, Dillingham, Bethel, and some other communities have lost access to local obstetrical and prenatal care because local providers are either unable or unwilling to pay for the expensive premiums" (at page 57). The report contends that medical liability insurance premiums had more than doubled between 1985 and 1988. See also the comments of Harlan Knudson of the Health Association of Alaska.

For native rural residents the problem, according to Dr. Ward Hurlburt of the Public Health Service, is particularly one of finding money to fund travel costs for diagnostic and treatment services in the larger cities : "As we discussed, as health professionals, we could point to many places in our program where, with added funding, we could do a better job. If I were to select one area, however, to point to where I could see a need related to medical services for rural Alaskans, I would identify the lack of funding for travel...At this time...we are basically paying only for emergency travel. If the State were wanting to identify an area for potential positive impact on the provision of Native services for rural Alaskans, I would suggest consideration of the development of a mechanism for supporting travel costs." The Department of Community and Regional Affairs tells us that this position was echoed in a Resolution passed in November by the North and Northwest Alaska Mayors Conference which proposed an insurance program which will cover both transportation to Anchorage or Fairbanks and services provided by non-Indian Health service facilities in these towns.

There also appears to be a nursing shortage in Alaska. According to Gail McGuill of the state Division of Occupational Licensing : "It has recently been more severe than the cyclical shortage in rural communities and in certain specialty areas of practice. Almost all acute care and long term care facilities in the state have had to utilize "traveling nurses", nurses retained through agencies for short term periods of employment...Of the four main issues discussed in this letter, I view the nursing shortage and the problems it has caused for the health care industry in our state to be the most crucial one. Although, a concentrated effort of agencies in Alaska working together to remedy the shortage has not occurred, individual agencies and organizations have been attempting to alleviate the problem with the resources available to them." There are many cited reasons for this situation including poor pay and benefits, lack of hospital administration support, limited opportunities to further professional education, inadequate staffing, state laws that limit nursing practice, lack of access to child care facilities, insufficient in service education and lack of competent support personnel. The cost (or availability) of liability insurance does not appear to be a significant contributing factor.

b) Legal Services: We have no Alaska specific information. However, from my experience over the years and in talking to others in the profession I can identify several service gaps worth noting - representation of claimants in state and federal workmen's compensation matters; certain medical malpractice claims; low income legal services that cannot be provided by Alaska Legal Services and/or the Alaska Pro Bono program; and general legal services for middle income people who don't qualify for assistance but can't afford standard legal rates for a variety of basic legal services for personal and family matters; a problem I've seen in my own practice many times which may be growing due to the increasing need for some legal services in our society. These gaps do not appear to be due to high liability insurance premiums.

c) Engineering/Architectural/etc Services: We have no Alaska specific information on this but according to Rich Ritter of the Alaska Chapter of the American Institute of Architects there is no apparent availability problem despite the fact that over 50% of Alaska Architects, Engineers and Land Surveyors have left the state in recent years. He feels that "there is still a core group of experienced professionals remaining in Alaska available to provide professional services". It is not clear how much of the attrition is due to the cost of liability insurance versus the dramatic recent economic slump.

d) Dentists: Frank Thomas-Mears tells us that Dental services in rural areas are not impacted by affordability and availability of insurance since a majority of dental practitioners are employed by the Public Health Service and protected under the Federal Tort Claims Act. Of those private practice dentists which either contract with the PHS or native corporations most are insured.

d) Day Care: The only other significant service gap that I have been able to identify to date (other than sewer and water system and similar service needs which are well beyond the scope of our duties) concerns Day Care Facilities. According to the report of the Governor's Interim Commission on Children and Youth parents "often have difficulty finding child care that meets their needs and matches their resources." This is particularly a problem for parents who work rotating shifts, nights or weekends, parents with infants and parents with school age kids who need before and after school supervision: "Too few programs offer flexible hours, overnight care and flexible staffing to ensure safe care for children. Not enough family child care homes exist to accommodate the needs of parents who work a non-traditional or normal schedule. The result is a near crisis in urban and rural Alaska." Recent changes to Federal welfare laws (the Federal Family Support Act of 1988) will exacerbate this problem. It is estimated that the welfare reform work and training requirements will result in the need for day care space for an additional 2400 children statewide.

And child care is expensive. According to the Governor's Interim Commission a recent survey of 600 American families indicates that 40% of their respondents felt they cannot afford their current child care arrangement or the arrangement they would prefer. They add that evidence indicates Alaskans would agree. In March 1987 infant care ranged from \$321 to \$521 per month, pre-school care from \$301 to \$450 per month, school age child care from \$132 to \$215 per month and care for children with special needs from \$600 to \$1,200 per month. The report adds that high quality care may be even more expensive.

A variety of solutions are under discussion including a plan proposed by Virginia Johnson, Dean of the School of Education at the University of Alaska Anchorage, called the Middle School Day Care Center, which would locate day care centers at the six middle schools in the Anchorage area with the curriculum being developed by the Director of the Day Care Centers.

It is difficult to determine if the cost of liability insurance contributes to the day care service gap. It is my understanding based on several informal conversations with people familiar with these issues that affordability and

availability is less of an issue at the present time, even for new facilities. It is interesting to note that current policies exclude liability for molestation/abuse related circumstances and, in some cases, require adult/child ratios that exceed state standards.

5. CLAIMS EXPERIENCE: Still working on it.

6. ROLES AND MECHANISMS OF STATE AGENCIES: The information provided is self-explanatory. However, please note that the Division of Insurance has four primary functions: a) Market Conduct Surveillance (review and approve as appropriate all rate and form filings and perform market conduct examinations on insurance companies or producer licensees to ensure that the consumer is treated fairly in the marketplace); b) Licensing (to license qualified individuals and insurance companies to market insurance in Alaska); c) Financial Surveillance (primarily to ensure solvency - i.e. that the company has sufficient reserves to protect policy holders and pay their claims - and to determine if investments meet statutory requirements and if reinsurance agreements comply with Alaska law); and d) Consumer Complaint and Investigation (to investigate and resolve individual consumer complaints that are filed with the Division. Statistical data that is collected by this section is utilized by the market section as a means to identify licensees or trade practices that warrant further examination.

7. STATUS OF STATE SUIT AGAINST INSURANCE COMPANIES: This lawsuit was filed by 19 states against four major American primary insurance companies and a variety of reinsurance companies alleging anti-trust violations in the form of a pattern of collusion. According to the Attorney General's Office, the allegations are that leading primary insurance companies and reinsurers conspired to withdraw casualty and pollution coverage from the United States market; and that defendants coerced others to take actions which prevented other potential competitors from offering these types of coverage resulting in consumers paying more premium for less coverage than ever before. Tom Slagle of the American Insurance Organization adds that the primary thrust of the lawsuit was that various entities conspired to eliminate the occurrence policy for a claims made policy. In October of 1989, Federal District Court Judge Schwarzer granted defendants' motions to dismiss and entered final judgment against the states. The states have appealed this decision to the Ninth Circuit Court of Appeals; a decision is expected next fall. According to the Attorney General's Office, Alaska has actively participated in this case (against the advice of advice of industry representatives according to Slagle) and intends to continue.

8. PEER REVIEW PANEL RESULTS: With the exception of information concerning the number of professional malpractice cases filed in Alaska state courts since 1987 (177: 90 medical mal.; 56 legal mal.; 31 other), there is no official information available from the court system on peer review panel matters or other issues relating to frequency and severity of claims/judgments; although within the last year or so the court system has started to keep track of how long a case takes from start to finish. The data contained on the last page of this section regarding peer review panel results is interesting but shouldn't be relied on at least until I figure out where it came from. Sorry about that. You may also want to refer to information prepared by Al Tamagni Sr. of Pension Services Ltd. regarding pending civil cases in Anchorage Superior Court.

9. RESULTS AND AMOUNT OF SELF-REGULATION: Given the large amount of information contained in this section, I will only attempt to set out several general observations about the subject:

a. With the exception of lawyers, all target professionals (doctors, architects, engineers, land surveyors, dentists and nurses) are regulated by the Division of Occupational Licensing within the Department of Commerce and Economic Development through various regulatory Boards. Lawyers are governed by the Alaska Bar Association (and its Board of Governors) created by statute as an "instrumentality of the State". All groups also have independent professional organizations (e.g. The Alaska Dental Society, the Alaska State Medical Association, The Alaska State Nurses Association, The Alaska Chapter of the American Institute of Architects, the Juneau Bar Association, etc.)

b. All target groups are subject to a variety of admission and licensing requirements, grievance procedures, and disciplinary sanctions for improper conduct; along with certain peer review procedures, sometimes required as a condition of membership in their respective professional associations. Note that lawyers are subject to rules promulgated by the Alaska Supreme Court.

c. Only Physicians, Nurses and Dentists have mandatory continuing education requirements. For example, physicians are required to complete at least 17 continuing medical education hour per year to retain a medical license provided through hospitals, the Alaska State Medical Association, local medical societies and physician specialty associations. Lawyers have an extensive optional continuing legal education program. Architects, Engineers and Land Surveyors have no continuing legal education requirements or voluntary programs.

d. Based on information gathered to date, it is difficult to determine if, in fact, a relatively small number of professionals cause a relatively large percentage of complaints but some statistics included in this section suggest that is the case. The Alaska Bar Association tells us that since 1982 there were 1505 complaints against 710 attorneys. 57% of the attorneys had only one complaint against them which accounted for 27% of the complaint volume. 18% of the attorneys had two complaints against them which accounted for 17% of the complaint volume. The remaining 25% of the attorneys had three or more complaints against them and were responsible for 56% of the complaint volume.

Certainly, the number of disciplinary actions taken annually appear to represent a relatively small percentage of total professionals in several of the target groups. Please note that according to the Alaska Bar Association, there has been a marked increase in informal requests for ethics opinions from Bar Counsel which suggests that lawyers are attempting to practice preventative medicine, so to speak.

e. All target groups are subject to specific statutory or regulatory provisions regarding unprofessional conduct. In addition, Physicians apparently follow the American Medical Association "Principles of Medical Ethics", as a condition of membership in the Alaska State Medical Association; Nurses apparently follow the Code of Ethics of the American Nurses Association; Lawyers are subject to a Code of Professional Responsibility promulgated by the Alaska Supreme Court; Dentists who belong to the Alaska Dental Society (2/3 of all Alaska dentists) agree to adhere to a Dental Code of Ethics (along with agreeing to be subject to peer review and mediation procedures); same with Architects, Engineers and Land Surveyors who each have separate codes adherence to which is a condition of membership to their respective professional organizations.

f. As to a specific task force question regarding Alaska physician disciplinary actions compared to other states, the information provided by the Public Citizen Health Research Group ranks Alaska #2 (per capita) in Doctor discipline for 1987; up from 19 in 1986 (Pam Ventgen tells us that in 1981 there was 1 disciplinary action; 0 in 1982; 4 in 1983; 2 in 1984; 1 in 1985; 2 in 1986; 5 in 1987; 5 in 1988 and 7 in 1989. She also points out that HB 70, passed in 1987 provided for a full time investigator and an executive secretary for the medical board which may help explain these numbers) The recommendations contained in this report are also worth noting: Increase license fees to \$500 per year and use all money to finance doctor disciplinary actions; Require periodic re-certification of doctors based on written exams and audits of doctor performance such as medical record review; Grant subpoena power to state

licensing boards to go after evidence necessary to evaluate doctors; Grant state boards emergency powers to suspend a doctor's license to practice, pending investigation, when continued practice is considered to constitute a hazard to public safety; Require all hospitals to have a risk management program designed to prevent injury to patients (according to the American Hospital Association only 60 percent of hospitals have such programs and only half of these are excellent programs); Require all insurance companies to experience-rate doctors with sub-specialties, whereby doctors with the best records pay the lowest premiums, and multiple malpractice "loser" doctors pay the most; Require insurance companies to immediately disclose and forward to the state licensing board the filing of malpractice claims, as well as the results of all malpractice settlements and adjudications (see HB 146 now in House HESS); Require hospitals or other institutions taking disciplinary actions against doctors to publicly disclose and forward to the state licensing board the details of such actions; Provide immunity and confidentiality to all those reporting doctor malpractice, incompetence, substance abuse or fraud to state medical boards (see HB 146); Provide strong consumer representation on state medical boards; Do not allow the state medical society to control membership on the boards; Officials should make strong, public statements indicating a commitment to strong doctor discipline and protection of patient's safety. It is my understanding that several of these suggestions have already been adopted in Alaska.

10. MATRIX OF STATE SYSTEMS; FEDERAL ACTIVITY: It is difficult to briefly summarize this material but several general observations can be made;

a) Legislative responses to the increasing cost and availability of insurance and apparent claim trends can be broadly categorized into civil justice- or tort reform - measures, insurance regulatory reform measures and risk management measures. According to Patricia Young formerly of the Legislative Research Agency from information provided by the National Conference of State Legislatures (NCSL), in 1986 the emphasis was on civil justice reform. The legislative focus in 1987 turned to immunities- from sovereign immunity extended to counties, cities and towns, to immunity from personal liability extended to groups of public employees and volunteers. More recently however legislative activity in civil justice reform has declined and the focus has shifted to regulation of the insurance industry, including the anti-trust suit discussed above. In 1989, the majority of legislative activity regarding liability dealt with regulation of the automobile insurance industry, including California's proposition 103 and similar measures introduced in other states.

b) The significant "tort reform" measures enacted over the years include laws relating to limits on recovery (caps) of damages; abolition or modification of Joint and Several Liability; reduction of compensatory awards by collateral sources, or at least notification to the jury of such sources; limits on attorney's contingency fees; limits on punitive damages; periodic payment of awards; penalties for frivolous suits; settlement incentives; limits on prejudgment interest; and establishment of statutes of limitation and repose. Proposals concerning alternative systems and similar issues will be discussed below. I have little "easy to read" summary information on the status of proposals regarding regulation of the insurance industry, professional competency laws and similar approaches to the problem.

c) According to the recent report by the New York law firm of Wilson, Elser, Moskowitz, Edelman and Dicker (Wilson) contained in this section, a majority of the states have considered or enacted "tort reform" laws as described above in various forms. The constitutionality of many of these measures has been challenged in state and federal courts with mixed results; some upheld, some not for a variety of reasons. See also the Alaska Attorney General's opinion for a discussion of some of these cases including the recent decision by the Washington Supreme Court on their cap mentioned below.

d) According to the Wilson Report, in 1989, the most significant activity concerning Civil Justice reform occurred in the courts rather than the Legislatures. In 1986 thirty-six state (36) legislatures passed tort reform (varying in degree and significance). In 1989 only seven (7) states enacted reforms; although many measures were pending (see NCSL 1989 pending legislation summary). NCSL tells us that four state courts rendered decisions in litigation questioning the constitutionality of damages caps. In Maryland, the cap on non-economic damages in all civil suits was upheld; in Kansas, a \$100,000 cap on such damages in wrongful death actions was upheld; the Virginia Court upheld a cap on total damages in medical malpractice cases; but in Washington, the cap on all non-economic damages was ruled unconstitutional (letter from Brenda Trolin dated December 23, 1989).

e) According to the Wilson Report, states which have enacted the most extensive reforms include Alaska, Washington, Hawaii, Colorado, New Hampshire, New York, California, Florida and Illinois (See Wilson starting on page 1 of the Introduction for a detailed breakdown of how many states enacted various reform measures in 1986 and 1987; and for a discussion of 1989 tort reform enactments).

f) Alaska in 1986 enacted a series of civil justice changes including: Modified joint and several liability; caps on non-economic damages (\$500,000 except damages relating to disfigurement or severe physical impairment); increased burden of proof for establishing punitive damages; limits on a person's ability to recover damages sustained while that person was committing a felony; detailed provisions on damage award requirements; limited liability for certain directors and officers of non-profit corporations, non-profit hospitals (including hospital citizen advisory boards) and members of school boards and school districts and members of governing bodies, commissions and citizen's advisory committees of a municipality; and provisions on contributory fault, collateral benefits, apportionment of damages, offers of judgement, costs and attorneys, including pre-judgment interest, and the effects of a release. This legislation has been characterized by tort reform advocates as a "patch work quilt" of necessary compromises, and, in their view, did not go far enough toward making Alaska's civil justice system fair and predictable. As you know, Alaska also has a medical malpractice claims system created during the 1970's.

g) On the automobile insurance front, California's Proposition 103 is the biggest news. This reform measure narrowly adopted by California voters in November 1988 included a one year 20% roll back in most property/casualty "insurance charges" from November 1987 levels; a 20% automobile insurance discount for "good drivers", as defined as those with no more than one moving violation in three years; a requirement of advance state approval for insurance rate increases after November 1989; and election, instead of appointment, of the State Insurance Commissioner starting in 1990. Prop 103 also requires the Insurance Commissioner publish for consumers a list of rate comparisons, and compels insurance companies to notify their customers of the right to join an "independent, non-profit corporation which shall advocate the interests of insurance consumers in any forum." The California Supreme Court upheld all of 103's long term restrictions on insurance rates and practices, but struck down the provision that would require insurers to be "substantially threatened with insolvency" before they could receive relief from rollback. The Court held that insurers may charge rates above the rollback level whenever insurers can justify them as not being excessive.

Many states are also considering "No-fault" automobile insurance proposals in response to escalating auto insurance costs. Note that according to NCSL at least 20 states already have no-fault legislation in many different forms particularly on issues relating to restrictions on the right to sue, conditions necessary to sue for pain and suffering and first party coverage.

h) The Wilson Report concludes as to state activity: "In general, although state legislatures have reviewed thousands of bills addressing the Civil Justice System and insurance regulation, disputes persist as to what precisely are the problem areas, and solutions to the perceived problem areas remain elusive. It is likely that state legislative activity will continue in the area of civil justice reform and the courts will be entertaining arguments relative to the interpretation and validity of these reforms for some time." See Wilson at page 7.

i) Federal activity in this area has confined itself primarily to products liability. For the past several years Congress has seriously considered proposals to federalize products liability law. Detailed discussions of current proposals are contained in the Wilson materials at pps. 77 and 93. In addition, Congress is considering a variety of proposals to modify the McCarren-Ferguson Act, a 1945 law that provides limited anti-trust immunity to insurers and continues the authority of the state to serve as the primary regulators of the insurance industry. A proposal to modify the doctrine of Joint and Several liability also is pending in the Senate according to my sources.

j) Two final notes. On the question of "pre-judgement interest", according to a 1983 Rand Note prepared by Stephan Carrol (which hasn't been updated according to Carrol) at least 26 states had pre-judgement interest laws on the books. The Note also suggests that juries implicitly provide pre-judgement interest at a rate equal to the underlying inflation rate plus 3.7 per cent per year in addition to any applicable statutory pre-judgement interest rate.

As to contingency fees, commentators argue that limiting those fees will potentially increase the amount of compensation paid to claimants, increase the likelihood that a case is dropped, decrease the likelihood of litigation to verdict and deter frivolous suits by placing the plaintiff's lawyer at financial risk; but will also preclude some victims with legitimate claims from obtaining representation. It is not clear whether the presence of contingency fee arrangements increases the total number of claims (See Frank Sloan "State Responses to the Malpractice Insurance "Crisis" of the 1970's: An Empirical Assessment"-Vanderbilt University, 1985). One study also concludes that in modest cases contingent fee lawyers spend less time on a case than hourly fee lawyers; but there is no statistically significant evidence of a differential in effort for larger cases, although there is an indication that if there is an effect is in the opposite direction (see Rand, "The Impact of Fee Arrangement on Lawyer Effort" by Kritznier et. al.) For detailed discussions of these issues see "Rand Three Level Study and Other Reports" and various references to the subject contained in "Impact of U.S. Tort System Changes".

Note that Danzon suggests that contingency fee limits reduce the amount of settlements by 9%, reduced the number of cases litigated to verdict by 1.5%, and the number of cases dropped by 5% (See Maine Malpractice Study at page 36).

11. ALTERNATIVE PROPOSALS: Here is a summary of some of the more significant alternatives I have been able to identify that are either in effect or under consideration today:

a) Arbitration and Screening Panels: According to the Rand article by Deborah Hensler entitled "Reforming the Civil Justice Process, How Court Arbitration May Help" arbitration programs may be established by state statute or by rule of a state supreme court or a local court. Typically, under these programs the Court is authorized to compel arbitration for cases that fall within certain limits (Rand says \$25,000 is the typical cutoff); with certain exceptions. However, any of the parties to a suit may reject an arbitration award and request that the case be calendered "de novo" (without regard to the arbitration verdict). This appeal option is generally considered necessary to ensure that the litigants right to a trial is not abrogated. In 1984, Rand's Institute for Civil Justice estimated that arbitration programs are operating in more than 100 trial courts around the country and estimated that over 100,000 cases are arbitrated annually through this process. Apparently, there also are voluntary, binding program options.

Typically in court annexed arbitration programs cases are heard by private attorneys or retired judges who volunteer to serve as arbitrators and, according to Rand, receive only a small honorarium for their efforts. Arbitration hearings usually are private, informal and often brief. After giving the parties an opportunity to settle, the facts of the case are heard with the litigants often appearing as witnesses. If accepted, an arbitrator's award is entered as a judgement and is enforceable. As a disincentive for frivolous appeals, some programs require applicants who request a trial de novo to reimburse the court for arbitrator's fees; in some programs court costs and attorneys fees may be levied on unsuccessful appellants, or applicants who do not improve their position (e.g. Hawaii-if the court does not alter the award by at least 15% in favor of the appealing party; see Patricia Young memo in this section). Note that such programs also are required by some carriers

Does it work? The reason for these programs is to reduce congestion, costs and delay. According to Rand preliminary information derived from two studies of a new program in California and an older program in Pennsylvania arbitration can and does contribute significantly to reducing congestion, costs and delay. These findings are confirmed by the Hawaii and North Carolina experiences discussed in this

attachment. For example, reviewers from the University of Hawaii of the Hawaii program which covers all tort cases with a probable jury award of \$150,000 or less concluded in January of 1989 that: "Hawaii's Court Annexed Arbitration Program appears to be meeting its goals of reducing litigant costs, increasing pace, and maintaining the satisfaction of participants..." "To our knowledge no other arbitration program in the country claims to be reducing litigation costs; Hawaii leads the nation in this area." Similarly, a 1989 evaluation of the North Carolina program by the University of North Carolina concludes that the program: disposed of cases faster than standard procedures; reduced trials and out of court settlements replacing them with "promptly scheduled adversarial hearings in a courtroom before specially trained arbitrators"; and improved litigants satisfaction with the outcome and procedure used in their cases. The study also notes that attorneys were satisfied with the program and, in a survey, voted strongly in favor of continuing it.

However, the Rand study cautions that program design and implementation are critical factors in determining success. Some of the design issues that must be considered include: setting jurisdictional limits of the program, establishing procedures for determining case eligibility, adopting guidelines and procedures for selecting arbitrators and deciding how many arbitrators will hear each case, where the hearings will take place and whether there will be financial disincentives for appealing.

Please be advised that the American Medical Association, The American Hospital Association and the Physician Insurers Association of America each have proposed versions of alternative systems apparently involving arbitration or a form of administrative adjudication with various limitations on recovery. I do not have sufficient first hand information on these proposals at this time to go into specific differences but you may want to refer to the analysis prepared for MICA by Jerry Cogan. The State Alternative version of the PIAA proposal is also included for your information. Also note that the AHA calls for a study of a Medical Indemnity Fund as a supplemental method for compensating medical malpractice victims financed by assessments or surcharges levied on medical malpractice insurers and the self-insured.

In Alaska, voluntary arbitration and mandatory peer review systems applicable to medical malpractice (AS 9.55.535 and 536) and court ordered small claims arbitration procedures (AS 9.43.190-220) are available. In addition, state law recognizes certain contractual arbitration agreements (AS 43.010-180; Uniform Arbitration Act). I have no other information on the latter two options.

b) The No-Fault Alternative to Tort recovery: James Ludlam ("The Battle for Medical Malpractice Tort Reform: A Report From the Front Lines" prepared for the Annual Meeting of the American Academy of Hospital Attorney's, June 1989) tells us that in the 1970's and 1980's there was much discussion of possible no-fault alternatives to compensating plaintiffs for catastrophic injuries including "trip insurance" under which a patient bought his own coverage, or a system for which there would be payment without fault on the basis of a worker's compensation type schedule (similar to that proposed by Governor discussed in my introductory memo to the Task Force dated September 15, 1989). There was little or no action on these proposals. In fact, the California Medical Association and the California Hospital Association concluded that these systems would be more expensive than the existing tort system based on a study of over 25,000 charts and dropped the whole idea.

Then, in 1987 North Carolina and Virginia adopted no fault programs followed by Florida in 1988. The North Carolina program was restricted to vaccine related injuries which were compensated for out of a fund consisting of state appropriations with a limit of \$300,000. Damages only can be awarded under this system to the person receiving the vaccine.

The Virginia Birth-Related Neurological Injury Compensation Act, mentioned at our first Task Force meeting, apparently was adopted to meet a crisis in the availability of insurance for physicians practicing obstetrics (according to Ludlam, it was expected that 25% of the OB/GYN's were going to lose coverage by the end of 1987). The Act applies only to patients of physicians and hospitals that have voluntarily participated in the program by payment of \$50 per delivery with a \$150,000 maximum by a hospital and a \$5,000 fee for a physician doing obstetrics. These payments are voluntary. In addition, all other physicians are assessed a fee of \$250 as a condition of licensing. If the fund falls short there is an annual premium tax on all liability carriers in the state. The purpose of the fund is to assure lifetime care of infants with severe neurological injuries sustained during labor, delivery and resuscitation, and to be the sole and exclusive remedy for those who participate. The fund is administered by the Industrial Commission of Virginia with the assistance of an expert panel of three physicians. Compensation is limited to actual and necessary medical and related expenses, loss of earnings from age 18-65 based on a discounted formula and reasonable expenses incurred in connection with filing the claim including attorney's fees.

Following in the footsteps of Virginia, the Florida legislature passed a comprehensive malpractice reform package in 1988. Part of the package was a no-fault state

run fund to provide for the care and treatment of babies born with permanent, severe disabilities due to mechanical failure or malpractice. The Fund, administered by the State Worker's Compensation Division, is to be financed by an annual payment of \$5,000 per year by each participating physician. The parents may recover the cost of care and rehabilitation and up to \$100,000 for non-economic damages. As an aside, the total Florida legislation (114 pages) also included caps for other cases, arbitration options, a new watchdog unit called the Medical Quality Assurance Division, hospital reporting requirements of malpractice cases involving doctors and other provisions designed to provide notice of certain events. It is interesting to note that there are no caps if both parties refuse arbitration.

One final note on alternative systems. Peter Huber ("Liability-The Legal Revolution and its Consequences") calls for a return to contract principles in the form of direct first party insurance.

Other miscellaneous procedures to provide faster and less expensive ways to resolve disputes include: "fast tracks" for certain types of cases; dismissal of inactive cases; penalties for last minute settlements made after the trial is underway; procedures designed to limit filing of motions and pleadings; procedures limiting discovery; and procedures which set firm trial dates.

12. THE RAND THREE LEVEL STUDY AND OTHER REPORTS: "Trends in Tort Litigation- The Story behind the Statistics" by Deborah R. Hensler, Mary E. Vaiana, James S. Kakalik, and Mark A. Peterson attempts to set the record straight on many of the underlying issues that we too are attempting to sort out. They start by reminding of us of how all this began:

"Over the past two years, manufacturers, physicians, consumer advocates and trial attorneys have vigorously debated the costs and benefits of the tort system as a mechanism for compensating and deterring injuries. The debate began with a perceived "insurance crisis". Liability insurance premiums, particularly for medical malpractice and commercial lines, increased sharply and insurance for some kinds of activities became unavailable at any price. While there is broad consensus that obtaining and paying for insurance was a pressing problem, there was little agreement about the cause or its solution. On the one hand, insurers linked rising rates and unavailability to trends in tort litigation, thus focusing attention on the legal system. In many states and at the federal level, insurers, manufacturers, health care professionals and local government officials formed coalitions to support substantive changes in tort law. On the other hand, trial attorneys and consumer groups generally opposed these

changes arguing that what needed reform was not the tort law but poor management practices in the insurance industry."

The authors go on to say that not only did these groups hold different positions on these issues they also held sharply different views of reality (and presented contradictory statistical data to support their claims):

"Proponents of change argued that there has been an explosion of liability lawsuits in the past five years, that recent verdicts demonstrate that civil juries are "out of control" and that the monetary benefits delivered by the tort system to injured parties are overshadowed by the enormous costs of administering the system. Tort reform was needed to counteract these trends. Opponents of tort reform argued that the litigation explosion is a myth, that jury awards have been basically stable for 25 years, and that the transactions costs of the system are acceptable, given the systems twin objectives of compensation and deterrence. Tort reform was not only unnecessary - it might be harmful to those whom the system is intended to serve."

In the author's words, "Where does the truth lie?" In an effort to resolve these apparent contradictions and put the issues in perspective for policy makers this report attempts to answer three questions - How much litigation is there? Are jury awards stable? How much does litigation cost, and who gets the money? A summary of their basic conclusions follows:

a) One of the reasons for confusion is that there is not a single tort system. Instead, there are at least three types of tort litigation, each with its own distinct class of litigants, attorneys and legal dynamics. The FIRST is the world of routine personal injury torts, exemplified by auto suits. They occur frequently and usually involve modest injuries and relatively low financial stakes. Settled law and routine procedures lend an air of stability to this world. The SECOND is the world of high-stakes personal injury suits such as product liability, malpractice and business torts. Here the litigation itself is newer, the law is still evolving, and the stakes per case are larger and increasingly uncertain. The THIRD is the world of mass latent injury cases, such as asbestos litigation, Dalkon Shield cases and other suits arising from mass exposure to drugs, chemicals or toxic substances. The lack of "fit" between traditional tort law and the facts of these cases leads many to view them as problematic.

b) How much tort litigation is there? Based on data compiled from the Administrative Office of the U.S. Courts, the National Center for State Courts and the Rand Institute for Civil Justice they have concluded that: accident cases are a steady or declining percentage of court action; non-auto

personal injury cases such as malpractice and product liability are growing moderately in state courts and more dramatically in federal courts; and mass latent injury cases have the potential for explosive growth as new evidence of harms is developed.

c) Are jury awards stable or out of control? Based primarily on data compiled by Rand from Cook County, Illinois and San Francisco, California between 1960 and 1984 (only data available in the U.S that can be used to discuss long term trends) they have concluded that: Plaintiffs in auto cases involving modest injuries and expense continue to obtain modest awards and, at least in recent years, these awards generally hold after trial; Plaintiffs in product liability and malpractice cases are winning more frequently and obtaining higher awards; Deep pocket defendants in product liability cases ultimately pay much, if not all the awards against them, even after post-trial adjustments; Jury behavior seems more unpredictable, but this may simply be because we do not have a very good sense of why juries make the decisions they do. The authors suggest that these trends may hold nationwide because of the similarities between the jurisdictions studied.

d) Litigation costs - How much, to whom? Based on Rand studies of litigation costs the authors state: "Our snapshot of litigation shows that the costs of litigation consumed about half of the \$29 to \$36 billion dollars that were spent on litigation. When we disaggregate these costs, we see that in more complex cases (non-auto torts) the costs of litigation were higher. In the case of asbestos claims, the only mass latent injury cases for which these data have been assembled, litigation costs constituted almost two-thirds of the total per-claim expenditure." Their specific breakdown in percentage of totals: Auto - 19% in Defendant legal fees and expenses, 26% in Plaintiff legal fees and expenses and 52% to Plaintiff; Non-auto- 30%, 24% and 43% respectively; Asbestos- 37%, 26% and 37%. See also pie charts contained on pages 27 and 28 of the report and the Tillinghast cost breakdown contained in Miscellaneous on page 15.

e) What is the story behind the statistics? Here is the authors' summary of their findings: Routine personal injury torts such as auto cases are growing slowly in frequency and costs, and their outcomes-inflation adjusted- have not changed much over the last 25 years; Higher stakes torts such as malpractice and product liability are growing faster in frequency and costs, and their outcomes have increased dramatically over the past 25 years in the jurisdictions observed intensively, and substantially in the shorter five year period for which they had national data; Mass latent injury torts, once identified, tend to explode in number, carry high transaction costs and have highly uncertain outcomes.

Unfortunately, this report does not resolve the nagging underlying question of why have we had significant affordability and availability problems that have lead to considerable debate of these issues. Is it industry practice, increased claims loss experiences, or both? I have found no study or analysis which settles this question in my mind.

The Medical Malpractice Liability Study by the Public Health Resource Group, Inc. for the Maine Legislature submitted in June 1989 is also worth noting in some detail. Here are their general findings:

a) Premium rates for Maine Physicians have been rising to "record proportions" over the last ten years.

b) Frequency, severity and losses as a percentage of income do not indicate that the liability insurance problem in Maine is out of control. It does suggest that more efficient methods of estimating reserves, reinsuring and obtaining legal services could reduce the price of premiums for policy holders while continuing to provide high quality coverage. These are areas where policy changes could achieve savings to the insurance industry and ultimately the rate payers.

c) Maine is experiencing a steady decline in physicians who provide obstetrical services; although the decline appears limited primarily to urban areas. The principal reasons reported by physicians for this decline are the price of medical malpractice insurance and fear of a malpractice suit.

d) It is not clear whether tort reforms actually have succeeded in reducing the price of insurance or the frequency or severity of claims, or whether they will succeed in reducing or stabilizing premiums or claims in the future; although it is far easier to estimate the effect of certain reforms on the frequency and severity of claims than on the price of insurance or the willingness of physicians to practice high risk specialties. For example, caps on awards have potential to reduce the dollar amount of high stakes claims and limits on attorneys fees may increase compensation to plaintiffs (while also leaving some victims with smaller claims without representation, they add). Nor is it known if these parameters would have increased more than they have in the absence of reforms. Moreover, many state reform statutes have not been in operation long enough to have a clearly measurable effect. For these and other reasons, new tort reforms at this time are questionable policy options to reduce insurance premiums and to insure medical care availability. Ongoing studies to be completed within the next two years may provide a clearer picture. If reforms are contemplated, the legislature might consider

designing them to expire after a certain period of time if availability and affordability of insurance and medical services does not improve by some measure acceptable to policymakers.

e) Alternative systems are appealing because they may help reduce inefficiencies and costs of the current tort system. Unfortunately, no state has implemented an exclusive alternative and it will be years before any evidence is available on the impact of such approaches. Please note the report indicates that the Vermont Legislature is considering the AMA fault based administrative system discussed briefly above.

f) A principal goal of the government in a regulated industry like insurance is to get insurers to manage their business as efficiently as possible and provide a quality product to consumers at a reasonable price and at a fair return on investment. Accordingly, the Insurance Regulator should be directed to promulgate an investment income model and require insurers to demonstrate an effective cost control program. The report also suggests that the State could authorize insurance regulators to spread rate changes over three years and implement a merit rate system and/or system of deductibles which would have the effect of spreading the risk of claims payments and resulting rate increases to those policy holders responsible.

g) To keep professionals on their toes, the state could require investigations by the medical board of physicians who have three or more claims over a ten-year period which resulted in a payment; create an ombudsman within the board to defuse potential complaints before they are elevated to a claim; and require the board to collect additional information on the voluntary or involuntary loss of hospital privileges in or outside the state. They also suggest that the Legislature take a look at "care standards" that have been proposed by a variety of entities.

h) They conclude: "There are many approaches to controlling the rising and unstable malpractice liability premiums in Maine and their effect on access to care. These include changes in the tort system, the insurance regulatory system and the medical care delivery system. To target one while ignoring the other will create disequilibrium and lead to policies likely to fall far short of the mark. Each has some merit and some drawbacks. Each needs to be addressed with a realistic understanding of what will be gained and what will be lost. It was no surprise to many experts that the St. Paul Companies decided to lower their premiums due in part to a reduction in expected reserve demand for outstanding claims. Considering past history, however, the medical malpractice issue is likely to revisit Maine in a very few

years. The severity of the problem will depend on how comprehensive an approach the Legislature takes now."

13. IMPACTS OF U.S TORT SYSTEM CHANGES: (Frequency, Severity and Rates - this section does not attempt to discuss impacts of tort reform on victim rights and related issues, but see pros and cons discussions contained in your first information packet along with the James Ludlam article discussed above): While tort reform measures do appear to affect the frequency and severity of claims there is no solid proof to date that they also have a direct effect the cost or availability of insurance.

Patricia Danzon of the University of Pennsylvania in a series of Rand articles (including in particular "Frequency and Severity of Malpractice Claims-New Evidence"- 1986) appears to have produced the most credible contemporary analysis of the relationship between certain tort reform provisions and the frequency and severity of medical malpractice claims. Although her study is restricted to medical malpractice claims her conclusions are worth examining in some detail:

a) Malpractice claim severity has risen roughly twice as fast as the Consumer Price Index. Nevertheless, the tort reforms enacted since the mid-1970's malpractice "crisis" affected the frequency and severity of malpractice claims over the decade from 1975-1984 in a manner broadly consistent with economic theory and previous evidence. Although claim frequency and severity have continued to rise despite reforms this trend does not indicate that the tort changes have had no effect.

b) For example, states that enacted shorter statutes of limitations and set outer limits on discovery rules have had less growth in claim frequency than states with statutes more lenient to plaintiffs. On the average, cutting one year off the statute of limitations for adults reduces claim frequency by eight percent. The effect would presumably be greater for a reduction from, say, four to three years than from ten to nine years.

c) Statutes permitting or mandating the offset of collateral benefits have apparently reduced malpractice claim severity by eleven to eighteen percent and claim frequency by fourteen percent relative to comparable states without collateral source offset. One of the reasons for this is that collateral source offsets often reduce the potential for recovery for a large number of claims, thereby reducing incentives to file.

d) Caps on awards have reduced severity by twenty-three percent. This percentage represents the average impact of the various forms of cap, over the period of 1975 and 1984,

during which time some statutes were still under challenge. If the dollar thresholds are not revised periodically to keep pace with inflation, the future effect will presumably be greater, unless juries find ways of implicitly circumventing the limits by increasing allowances for uncapped components of the award.

e) Arbitration statutes apparently increased claim frequency, but reduced overall average severity. Disaggregated data would be necessary to determine whether the reduction in observed average severity results from a reduction in awards per case or simply reflects the filing of more small claims. The net effect appears to be an increase in total claim costs, but compensation of more claimants.

f) None of the other reforms analyzed, including screening panels and limits on contingency fees, appears to have had any systematic impact on claim frequency or severity.

g) Urban areas have a particularly high frequency of non-meritorious claims (those closed without payment) and claims filed more than two years after the alleged injury. Per capita income, the unemployment rate, and the number of attorneys per capita have no statistically significant effects. The surgery rate in a state increases claim frequency, and the ratio of surgeons to medical specialists increases claims severity.

h) On average, severity of malpractice claims has increased at almost twice the rate of inflation of consumer prices over the last decade.

i) The above analysis on claim frequency and severity should not automatically be translated into an effect on premiums (a subject beyond the scope of this paper) for several reasons: First, the net potential impact on premiums also depends on litigation expenses and changes in the timing of disbursement of loss reserves, and hence investment income. Second, reforms that reduce the uncertainty in estimating malpractice claims costs- namely caps on awards, periodic payment of amounts for future damages and shorter statutes of limitation/repose- may be expected to reduce premiums by a modest amount over and above the reduction in mean expected losses. This result can be expected because of the reduction in the insurer's risk. Perhaps more importantly, she adds, by reducing uncertainty, such reforms should reduce the volatility in price and availability of malpractice insurance, which is a major inefficiency of the present malpractice system.

Please note that Danzon's claim severity conclusions are more or less confirmed by actuaries Milliman and Roberston, Inc. in their August 5, 1988 letter to MICA.

While this potential positive impact on insurance costs is theoretically possible and there is evidence that the experience in California (which has had time to test the theory) and perhaps other states bears this out (the informal opinion of Ray Bacon of the California Department of Insurance and Ron Neupauer of MIEC who feels strongly that California tort reform measures have had a significant impact on rates which currently are increasing less than inflation; although he agrees that other factors also come into play), as well as evidence to the contrary, I have found no study that definitively concludes this has been the case. And I suspect no such study exists. See "Insuring Our Future: Report of the Governor's Advisory Commission on Liability Insurance," New York, 1986- "no research currently available quantifies the linkage or even irrefutably establishes that such a linkage exists." In fact, according to Franklin Nutter, president of the Alliance of American Insurers (quoted in the attached article from Public Citizen, "The Impact of Tort Changes on Insurance Rates"), "It is clearly impossible to say that if you adopt a certain tort reform, you will get 'X' reductions in premiums." Similarly, the Frank Sloan article entitled "State Responses to the Malpractice Insurance 'Crisis' of the 1970's: an Empirical Assessment" states: "The empirical results of the study presented here give no indication that individual state legislative actions, or actions taken collectively, had their intended effects on premiums." One last comment. When evaluating the significance of the California experience, it is useful to keep in mind that 90% of the insurance is provided by doctor owned companies which have a significant incentive to keep rates down.

Perhaps the most recent and detailed analysis of this issue in the context of medical liability and obstetrical care is contained in the 1989 report of the National Academy of Science Institute of Medicine's Committee to Study Medical Professional Liability and the Delivery of Obstetrical Care which has just been brought to my attention by a Task Force Member. While I have not had time to review this report in any detail, I would like to bring to your attention their conclusions on the question of "tort reform". According to the study's Preface, the Institute of Medicine appointed a "distinguished interdisciplinary committee" (see attached list of participants) to evaluate the data relating to the effects of medical professional liability issues on access and delivery of obstetrical care. The preface continues that this study was a response to an inquiry of the American Academy of Pediatrics along with several other groups who believed that more attention to professional liability issues was "urgently" required. Here are there general findings on the basic question of legislative solutions to the problem:

a) Every state but West Virginia has enacted legislation modifying common-law tort doctrine that is intended to relieve the medical liability crisis; many are discussing additional reforms.

b) After evaluating these reforms (and reviewing the Danzon analyses, a 1987 Report of the General Accounting Office and others) the committee concluded that only a modest reduction in medical malpractice claim frequency and size of awards has been achieved. The committee also concluded that "the many deleterious side effects of the tort system for resolving obstetrical claims - resulting in distortions of health care delivery patterns - have not been reduced by those tort reforms." (See Attachment to follow, Volume I page 127).

c) The committee believes that the problems created by the medical professional liability issues in obstetrics represent a serious threat to the delivery of obstetrical care in this nation. However, although some of the tort reforms already in place have merit, they do not appear sufficient to stem the exodus of obstetrical providers from the profession or to solve the attendant problems caused by the current professional liability climate in obstetrics.

d) On the basis of its findings - that the costs of the current system in terms of impaired obstetrical care are great, that tort reforms are so far largely ineffective, and that data evaluating the merits of proposed alternatives to the tort system are lacking- the committee concludes that state legislatures should not focus on further reform efforts within the existing tort system but should instead redirect their energies toward developing alternatives to the traditional tort system for resolving medical malpractice claims and toward implementing these alternatives in certain circumstances.

e) The committee recommends that states consider three proposals for additional research and implementation on a limited basis: the no-fault designated compensable events scheme (including those variants enacted in Virginia and Florida discussed above), the AMA-Specialty Society's fault based administrative system, and legislation authorizing the use of contractually determined legal relationships governing medical professional liability between providers and patients. The committee also recommends that the Federal Government provide grant funds to finance studies of proposed legislation and to begin pilot projects for limited implementation of various solutions.

Despite these findings, keep in mind that some commentators still feel that it may be too soon to draw any definite conclusions about the impacts of tort reform measures. According to Brenda Trolin of the NCSL a minimum of five

years is needed before cases processed under previous systems clear the courts. Several additional years must pass before a sufficient number of cases have been processed through systems to determine whether changes have had the desired consequences.

And Patricia Young formerly of the Legislative Research Agency reminds us : "Because of the variations in state constitutions and laws regarding tort reform, identical reform measures may have dissimilar impacts in each state. Thus, even those reform measures which appear promising require careful consideration in the context of an individual states circumstances to determine potential ramifications. Opponents frequently argue that constitutional rights-including equal protection, access to courts, and trial by jury- are violated by certain reform measures. Also, reform measures can encourage or discourage lawsuits. Although some measures may facilitate and expedite resolution, they may also encourage claims which would not otherwise be made."

One of the keys to better understanding of this issue is more and better information. Most agree that this general lack of statistical data is a problem. According to Stephan Carroll ("Assessing the Effects of Tort Reforms, 1987 at viii): "The kinds of data needed to assess the effects of reform are generally not now available... Three types of new data collection systems need to be considered: 1) systematic efforts to obtain data from insurers and self-insured defendants on the aggregate outcomes of liability claims; 2) special surveys of claimants, the bar, and insurers to obtain the detailed individual claim information needed to identify reform's winners and losers; and 3) systems for collecting information both on the other factors that impinge on the behavior of participants in the tort system, and therefore have to be controlled for, and on economic outcomes and injuries".

14. ROBERT HUNTER ("CHANGES IN INSURANCE SERVICES; HOW THE PUBLIC IS TREATED"): Given limits of time and space I will only summarize in "bullet" form Hunter's many recommendations contained in the publication called "How to Tame the Insurance Industry Cycle and Make the Legal System More Efficient- A Suggested Legislative Agenda for 1987" by Robert Hunter and Jay Angoff. Hunter's central premise is that limiting the ability of severely injured people to sue and be compensated for their injuries does not bring down insurance rates (see above for additional discussion of this issue). He proposes many reforms including: Requiring disclosure by insurance companies of data on actual income and payouts on different types of insurance; permit group insurance/risk-retention group programs; allow banks to write liability insurance; establish joint underwriting

insurance in the voluntary market; establish state reinsurance programs which would authorize self-insureds to pay the state a premium in return for which the state would agree to pay all claims above a certain specified amount; establish state run insurance companies; establish interstate compacts for interstate reinsurance programs; prohibit arbitrary cancellations of policies; require experience rating where good risks pay less than those who are bad risks; to allow the market to work competitively despite the McCarren-Ferguson Act, establish flex-rating which would allow insurance companies to raise or reduce rates without insurance commissioner approval within a "zone of reasonableness"; beef up enforcement by properly funding and staffing state insurance agencies; close the "revolving door" by discouraging or limiting the practice of hiring industry people to regulate the industry; establish an office of Insurance Consumer Advocate which would represent the consumer point of view at rate hearings and ensure that the insurance regulators do not rubber stamp insurance company rate requests; prohibit the pass through of lobbying expenses; require risk management by insurance purchasers and self-insureds which should reduce the frequency and severity of claims; allocate medical malpractice insurance costs more equitably. For example, doctors in high risk specialties pay for the risks that should be shared by others, doctors are broken down by insurance companies into too many categories with too few doctors in some categories, doctors pay for malpractice that could be more easily be borne by hospitals, and doctors are not experienced rated; insurance companies should disclose names of doctors involved in claims and the amount of those claims. This information should be made available to various organizations and the public in general; limit lawyers fees on both sides. Hunter focuses on defense costs and contends that defense legal fees have doubled in ten years. States could limit defense fees by disapproving any rate that included within it more than a certain percentage (he suggests 25%) for defense costs which would force the insurer to keep an eye on fees insuring that a greater percentage of the money flowing through the system would end up in the hands of the injured person; penalize frivolous actions on both sides including frivolous motions and objections by defendants lawyers who charge by the hour; to encourage accountability to the public, prohibit secrecy agreements which prevent disclosure of the details of a settlement and other information about the case; encourage offensive collateral estoppel which prevents re-litigation of certain facts (i.e. once a fact is established it can be used in future cases); pass back collateral source benefits by requiring the defendant to pay the full amount of a verdict but excuse the source of collateral benefits from paying such benefits to the extent they are already included in the jury verdict and then require the source of the collateral benefits to reduce the cost of those benefits

across the board based on these savings; create incentives to settle including penalizing defendants for refusing to make reasonable offers to settle, and penalizing plaintiffs for making unreasonable demands; and last but not least, establish alternatives to the tort system including no-fault systems (particularly for relatively minor injuries), arbitration, mediation, mini-trials, and other dispute resolutions systems. However, Hunter is careful to point out that cases involving defective products should be subject to common law principles without any limits on either compensatory or punitive damages: "The stories of A.H. Robins and the Dalkon Shield, Ford and the Pinto gas tank, Richardson-Merrell and MER-29, and Johns-Manville and asbestos are just a few of the scandals unearthed as a result of tort litigation. And it was only the fear of more litigation, and of large awards for both compensatory and punitive damages, which finally forces these and other dangerous products off the market and encourages the development of less dangerous substitutes."

15. CHANGES IN TIME IN THE LAW OF LIABILITY AND DAMAGES: "Liability, Perspectives and Policy" edited by Robert E. Litan and Clifford Winston of the Brookings Institution in Washington, D.C. (1988) provides insight not only into the question of how tort law has evolved over the last thirty years but also presents an excellent overview and summary of the many issues we have attempted to review in this memorandum and related attachments. Here are the key findings:

a) Tort law is largely based not on statutes but on common law, a body of legal principles developed case by case by judges, primarily those in state courts. It is difficult to generalize about the status of tort law in all jurisdictions but certain important changes in doctrines have occurred in the past several decades, all of which have expanded the system's function in spreading losses:

- * Whether by applying the negligence test in a flexible fashion or by imposing liability on parties whose behavior is causally related to accidents but who are not necessarily negligent (so-called strict liability) the courts have increased manufacturer's liability for defective products. Certain courts have held that a product can be defective even if it conforms to prevailing regulatory standards and if the manufacturer had no knowledge at the time of design or production that it would entail the risks later attributed to it in litigation.

- * The negligence standard itself has been extended through litigation to impose liability on a wide class of service providers not previously accustomed to being sued. Day care centers, ski lift, ice rink, and amusement park operators, tavern and restaurants, and not-for-profit organizations

have all been taken to court for failures to warn of certain dangers and for the careless conduct of their employees. The exposure of these defendants to liability claims has been widened by the doctrine of joint and several liability, which allows prevailing plaintiffs to recover up to the full amount of a total damage award from any single defendant if the other defendants are unable to pay, and by the collateral source rule, which prohibited juries from reducing damages by subtracting insurance monies or other compensation plaintiffs receive from other sources.

* The concept of contributory negligence has been relaxed in many states so that negligent plaintiffs are no longer totally barred from recovery. Instead, they find their damages reduced by the proportion by which their negligence contributed to their injury. In addition, beginning with the Federal Tort Claims Act of 1946, which waived the federal government's sovereign immunity, courts have made state and local governments liable for tort suits.

* Courts have relaxed the standards the plaintiffs must satisfy in proving, under either the negligence or strict liability doctrine, that defendants have caused their injuries. This trend has been manifested primarily in product liability and so-called toxic tort cases, which have frequently required courts to decide whether plaintiffs' injuries have been caused by their exposure, often over long periods of their lives, to substances recently discovered to be associated with the development of cancer or other serious diseases. Courts have adopted a long range of rules to determine causation in such cases. Some have placed liability on the first or last source to which plaintiffs can establish they were exposed; others have made all manufacturers of the substance jointly and severally liable. In one noted case involving the exposure of Vietnam veterans to the chemical Agent Orange, a federal court actively encouraged a \$180 million settlement even though no hard scientific evidence had been uncovered that linked the chemical to the medical infirmities claimed by the plaintiffs.

* Finally, courts in certain jurisdictions have liberally interpreted statutes of limitation, which bar plaintiffs from recovering if they wait too long after suffering injury to file suit. In many toxic tort, product liability and medical malpractice cases it is difficult to determine when injury actually occurs. It could develop decades later when the symptoms of disease become observable. Although jurisdictions differ widely on this issue, the trend has been for courts not to invoke the statute of limitations to bar suits involving long-latent injuries.

These observations appear to be more or less consistent with the more detailed and critical analysis of these trends

contained in Peter Huber's book "Liability, the Legal Revolution and Its Consequences" (1988).

b) The calls for reforming the civil justice system are less urgent now (1988) than they were in "recent months". As in previous insurance cycles, increases in premiums have moderated. In some instances, coverage that was withdrawn has reappeared. In 1986 the property and casualty industry earned 11.6 percent on its equity, a return lower than the manufacturing sector average of 13 percent during the past decade but still considerably better than the disappointing performance of the previous two years.

c) The issues raised by the most recent crisis will not disappear. If nothing else, the dramatic increases in premiums and curtailments of coverage have called greater attention to the nation's civil justice system - whether it is working satisfactorily, and if not why - then at any point in recent memory. Moreover, interest in these issues will intensify if and when the underwriting cycle reverses course and turns against the industry once again. Chances are that it will in five to ten years.

d) Injuries pose three different and potentially conflicting challenges for all societies. One is to efficiently deter behavior that cause injuries. A second and related objective is to exact retribution against those responsible (the criminal law is a key component of this function). The third challenge is to compensate victims for their injuries. Compensation may be supplied by the government or the private sector (through insurance), and may or may not be linked to specific injuries or types of accidents. Tort law-rules allowing accident victims to seek compensation through the judicial system from the parties responsible - can be considered a mechanism for meeting all three of these challenges.

e) Of the millions of insurance claims filed each year, typically only 2% are resolved through litigation. Of cases brought to court, less than 5% are tried to verdict; the rest are settled.

f) The amounts actually received by successful plaintiffs are often much smaller than those originally awarded by juries due to trial judge and appellate overrides and/or the inability of some defendants to satisfy the judgement. In one study of 198 tort verdicts between 1984 and 1985 that resulted in awards of 1 million or more the final distributions to plaintiffs were on average 30% less than the original award. Successful plaintiffs received the jury award in only 51 cases.

g) As Rand noted average awards in tort cases in San Francisco and Cook County increased sharply, considerably

faster that growth in real GNP and real prices of medical services.

h) Awards in medical malpractice cases and products liability cases were significantly higher and increased at a faster pace than those for personal injury cases generally.

i) Much of the Cook County and San Francisco increases are due to "explosive growth" in jury awards of \$1 million or more (Cook County-Two verdicts between 1960 to 1964 accounting for 4% of all personal injury awards; 67 verdicts between 1980 to 1984 accounting for 85% of awards; San Francisco- only 3.8 % of all personal injury case produced \$1 million plus awards which accounted for half of the total amounts awarded).

j) From the liability insurers point of view these statistics cause problems - Insurers can only remain profitable if they set their premiums to cover total expected claim costs, and large dollar claims increase uncertainty about the range of possible losses.

k) The greater frequency of large dollar awards can be partly explained by increases in non-economic damages - pain and suffering - as well as increases in punitive awards in certain cases. One commentator (George Priest, see page 10) finds that non-economic damages generally account for 30% to 40% of all tort damage awards and for even higher proportions of very large awards. Patricia Danzon draws similar conclusions according to Litan/Winston.

l) There are gaps in existing compensation programs and devices. For example, more than 30 million people in this country remain uninsured for medical purposes at any given time, and perhaps more than 20 million are uninsured throughout a given calendar year. In addition, many of those with insurance have limited coverage, especially for the catastrophic medical expenses often associated with major tort litigation. Gaps also exist in programs designed to compensate for income losses, although such coverage (provided through public and private disability programs) probably has increased over time. There is little evidence that expanded tort liability has efficiently filled in the gaps left by public and private the network of compensation plans. In fact, it may be undermining the compensation objective by inducing private insurers to withdraw coverage and raise premiums at the expense of low income consumers.

m) While they have broadened the availability of compensation, more liberal liability doctrines and larger damage awards and settlement may have overdeterred, forcing socially worthwhile products, services and activities to be curtailed, withdrawn from the market or eliminated. (A classic example of this phenomenon is the loss of physicians

willing to perform obstetrics, as discussed in this memorandum under "Availability of Services" above and in the Danzon article contained in chapter 4 of this book. Similar effects are observed by Peter Huber in chapter 5 regarding hazardous waste facilities.)

n) Delivering compensation through the tort system is very expensive. According to Rand the United States spent between \$29 million and \$36 million in 1985. Of that amount less than half the total (\$14 billion to \$16 billion) was paid to plaintiffs as damage awards; the rest went to lawyers and court administrators. Researchers at New York University, using a variety of methodologies, have arrived at similar estimates for administrative costs.

o) Because these costs are so high, interest has grown in supplementing or replacing the tort system with alternative means of compensation similar to the worker's compensation system. Most suggestions would place some sort of cap on total compensation - especially for pain and suffering - in return for automatic eligibility. More ambitious proposals envision separate funds, financed by taxes on employees or employers or both, to pay compensation awarded to victims of medical malpractice or exposure to toxic substances. But the limited experience with alternative compensation programs in the United States has not been encouraging. The federal black lung program, was established in 1969 to provide temporary compensation for an estimated 100,000 miners with pneumoconiosis. But due to broadened eligibility provisions by Congress, 542,000 miners, spouses and dependents have received benefits under the program by the end of 1981. Because of this experience, future proposals to establish compensation programs are unlikely to be given serious consideration by Congress or state legislatures unless they are accompanied by convincing demonstrations that their costs can be contained. The New Zealand experience, which does not cover disease or sickness, has not been evaluated comprehensively; and is of probable limited value in the United States which is larger and has a more heterogeneous population. In short, we simply do not know whether society would be better off if the process of identifying risks and hazards were further centralized by replacing the tort system with more intensive regulation.

p) Nevertheless, the most effective way of avoiding much of the transaction cost would be to provide ways of compensating injured parties that do not require the high fact-finding expenses characteristic of tort litigation. This suggests a tradeoff: relaxed standards for eligibility but limits on compensation, especially for non-economic damages. The Product Liability Reform Act of 1986 (S. 2760) offers the tradeoff within the tort system itself by giving plaintiffs incentives to accept manufacturers settlement offers that limited non-economic damages components. This

approach could be generalized to all types of tort cases; although it is not clear whether an expedited settlement process would result in net savings.

q) Stiffer regulation of liability insurance rates or policies will not solve the liability crisis and conceivably could be counterproductive. Tighter regulations by some states will only induce some carriers in those states to reduce coverage they offer or even withdraw entirely. The only way in which regulation of the property-casualty industry might be significantly improved is to strengthen solvency regulation by state insurance agencies. At the Federal level, it is unclear whether repeal of the McCarran-Ferguson Act would have a significant impact on insurers.

r) Virtually all tort reform measures would reduce compensation available through the system. In fact, there is evidence, at least for medical malpractice cases, that tort reforms have already reduced the frequency of claims and the growth rate of insurance premiums (he cites the 1987 update of the Tort Policy Working Group under the Reagan Administration contained in your first packet). But deterring injury is also an objective of tort law, and reducing compensation could weaken deterrence. The problem facing policymakers is that relatively little empirical information is available to indicate how tort compensation could be modified without compromising deterrence.

s) Judges should encourage juries to evaluate the costs and benefits of the behavior of both plaintiffs and defendants in tort cases in deciding which parties should bear the loss from the accident at issue.

t) The search for cost effective reforms should focus on modifications of the tort system to reduce uncertainty and eliminate inappropriate levels of compensation while retaining a fault-based rule of liability (which while costly and inefficient is probably less expensive than no-fault systems). Accordingly, there is a strong case for limiting non-economic damages in tort cases (as well as for more restrictive statutes of limitation and periodic payment of future damages, according to Danzon) but only in a way that takes into account the age of the injured party and the severity of the injury. By reducing non-diversifiable risk, such changes would also reduce the volatility of insurance premiums.

u) Finally, while some may be disappointed by the failure of Congress to enact comprehensive tort reform legislation, the experiments now being conducted by the states may prove more useful in the long run. Given the uncertainties about economic effects of different legal rules, we may one day be grateful that reform proceeded in the relatively uncoordinated fashion that it has in recent years. Today we

simply know too little to be confident that any major overhaul of the U.S. tort system would produce more benefit than harm.

March 2, 1990

SUMMARY OF HIGHLIGHTS

Discussion Draft

I. AVAILABILITY AND AFFORDABILITY OF INSURANCE.

A. Availability has improved. Based on information received by the Task Force to date, there appear to be no significant availability problems for most professionals with certain limited exceptions. According to the Alaska Independent Insurance Agents and Broker's Association there are some availability problems for non-professional categories like day care centers, liquor liability, small specialty and general contractors, pollution and any small business that requires liability coverage only.

B. Generally, rates appear to have stabilized within the last year or so although costs are still perceived as prohibitive and/or unreasonable for some categories, most notably testing labs, structural engineers, attorneys doing SEC work, pollution and asbestos work, real estate developer combinations, computer programmers and certain physician categories including but not limited to OB/GYN. Many experts tell us that this is a cyclical business and anticipate another round of availability/affordability problems in the future.

C. Affordability is relative; the greater percentage of income represented by insurance premiums, the greater the concern. It is interesting to note that nationwide, medical malpractice premiums were 6.2% of physician's gross income in 1986; the national average for Architects and Engineers is 4.2% - it is estimated that in Alaska the average is 7%. We have no comparable information for lawyers. Results of a recent survey of Alaska physicians by the Alaska State Medical Association may shed further light on this subject.

II. PERCENTAGE OF UNINSURED.

A. Based on a recent survey by the Alaska State Medical Association the total percentage of uninsured physicians in Alaska is 24% in cities, 12% in towns and 56% in the Bush. The study further indicates that OB/GYN (44.7%), Family Practice (34%) and Orthopedics (23%) have the largest block of uninsured. The more recent survey by the Medical Association mentioned above may provide additional information.

B. Only two out of 19 hospitals surveyed by MICA are uninsured.

C. Only 2% of Dentists are uninsured.

D. There are no current and reliable Alaska statistics for lawyers, nurses, architects and engineers; although nationally it is estimated that 49% of Architectural firms do not carry liability insurance; 42% of 1-5 person engineering firms, 17% of 6-10 person firms and 15% of 11-25 person firms are "bare".

E. We simply do not know the answer to the question of how many professionals are uninsured (or limiting their practices, getting out of the business altogether or significantly limiting coverage) because of the cost of insurance. A survey conducted by the various professional organizations is the best way to clarify this issue along with the related question of how many other professionals are uninsured.

III. AVAILABILITY OF SERVICES.

A. There are a variety of service gaps that we have been able to identify including: significant doctor availability problems in several communities particularly relating to obstetrical and pre-natal care, day care service needs, certain legal services gaps (worker's compensation cases, medical malpractice, low and middle income legal services), nursing shortages, and the need for travel funds to transport rural residents to urban areas for diagnosis and treatment.

B. With the exception of physicians (and possibly Day Care providers), the cost or availability of liability insurance does not appear to be a major contributing factor to these service gaps.

IV. PEER REVIEW PANEL RESULTS AND RELATED STATISTICS.

A. There is little useful information readily available from the Court System regarding peer review panel results, the frequency and severity of liability actions, the length of time it takes to process an average case and/or the costs of litigation to the court system or the parties. However, we do know that since 1987, 177 malpractice cases have been filed in Alaska State Courts: 90 Medical Mal.; 56 Legal Mal.; and 31 "Other". And information provided by an unidentified source indicates that have been 338 medical malpractice claims processed since the current system was established in the 1970's.

B. This information gap appears to be common throughout the United States and consistently has been identified as a problem in attempting to understand and resolve issues relating to reform of the civil justice system.

V. RESULTS AND AMOUNT OF SELF-REGULATION.

A. Based on information provided to date, it is difficult to tell if a relatively small number of professionals (repeat offenders) cause a relatively large percentage of complaints and/or disciplinary actions. Certainly, the number of disciplinary actions taken annually appear to represent a relatively small percentage of the total number of professionals. Please note that only Physicians, Nurses and Dentists have mandatory continuing education requirements. Lawyers have an extensive optional program.

B. Comprehensive risk management programs (including peer review, quality assurance and education) by regulators, professional associations and insurance carriers appear to be the modern trend.

C. In response to a specific Task Force question, Alaska was ranked #2 per capita in the nation in Doctor Discipline for 1987 by the Public Citizen Health Research Group (a Ralph Nader organization); up from 19 in 1986.

VI. STATE AND FEDERAL LEGISLATIVE ACTIVITY.

A. Most states have adopted "tort reform" legislation in one form or another over the years including, for example, measures relating to limits on recovery (e.g. caps), statutes of limitation and repose, modification of joint and several liability, periodic payments of awards, reduction of compensation by collateral sources and limits on attorney contingency fees. The constitutionality of many of these measures has been challenged in state and federal courts; some upheld, some not for a variety of reasons. The most comprehensive reforms have been enacted in Alaska, Washington, Hawaii, Colorado, New Hampshire, New York, Florida, Illinois and California.

B. During the 1980's, legislative activity on these issues peaked in 1986 when 36 state legislatures passed tort reform laws. In 1989, only seven legislatures enacted such laws, although many measures were pending. The focus of state activity appears to have shifted to regulation of the insurance industry and auto insurance matters, including "Proposition 103" and "no fault" proposals.

C. At the Federal level, Congress is most concerned with products liability issues and changes to the McCarran-Ferguson Act which, among other things, provides limited anti-trust immunity to insurers.

VII. ALTERNATIVE PROPOSALS.

A. There are a variety of alternative systems in place or under consideration which may provide some relief; although most commentators agree that more analysis is required. These include: 1) court annexed mandatory arbitration programs (with "de novo" appeal rights) for cases which fall within certain limits and other administrative arbitration and/or adjudication proposals including pre-trial peer review screening panels; 2) "No-fault" alternatives like the Virginia Birth-Related Neurological Injury Compensation Act which establishes a fund financed by voluntary payments from physicians and hospitals to cover actual and necessary medical and related expenses, loss of earnings from age 18-65 based on a discounted formula and reasonable expenses incurred in connection with filing the claim including attorney's fees. A similar program is operated in Florida which also allows recovery of up to \$100,000 in non-economic damages. Also note that Governor Cowper has proposed a general medical malpractice "no-fault" system; and 3) a variety of other proposals including use of direct "first party" insurance and state subsidization of certain insurance premiums for qualified applicants (see, for example, HB 449 and 450 by Donley and Gruenberg).

B. Reviewers of the Hawaii and other court annexed arbitration programs have found that they seem to achieve their goals of reducing litigation costs, increasing pace and maintaining the satisfaction of participants. The Rand study indicates similar attitudes about the California and Pennsylvania programs.

VIII. THE RAND THREE-LEVEL STUDY.

A. This study, "Trends in Tort Litigation - The Story Behind the Statistics" by Deborah R. Hensler, Mary E. Viana, James Kakalik, and Mark A. Peterson, attempts to settle three highly controversial issues which dominate discussions about the need to reform our civil justice system: How much litigation is there? Are jury awards stable? How much does litigation cost and who gets the money?

B. The authors tell us that one of the reasons for confusion is that there is not a single tort system. Instead, there are at least three types of tort litigation, each with its own distinct class of litigants, attorneys and legal dynamics - 1) the world of routine personal injury torts, exemplified by auto suits. These occur frequently and usually involve modest injuries and relatively low financial stakes. Settled law and routine procedures lend an air of stability to this world; 2) the world of high stakes personal injury suits such as products liability, malpractice and business torts. Here the litigation is

newer, the law increasingly uncertain; and 3) the world of mass latent injury cases, such as asbestos litigation, Dalkon Shield cases and other suits arising from mass exposure to drugs, chemicals or toxic substances. The lack of "fit" between traditional tort law and the facts of these cases lead many to view them as problematic.

C. What is the story behind the statistics? The author's found that: Routine personal injury torts such as auto cases are growing slowly in frequency and costs, and their outcomes -inflation adjusted - have not changed much over the last 25 years; Higher stakes torts such as malpractice and product liability are growing faster in frequency and costs, and their outcomes have increased dramatically over the past 25 years in the jurisdictions observed intensively, and substantially in the shorter five year period for which they had national data; Mass latent injury torts, once identified, tend to explode in number, carry high transaction costs and have highly uncertain outcomes.

D. In response to a specific Task Force question about "who gets what" the authors tell us that: for auto cases 19% of total litigation dollars go to the defendant's lawyers for legal fees and expenses, 26% are for plaintiffs legal fees and expenses, with 52% left for the plaintiff; Non-Auto- 30%, 24% and 43% respectively; Asbestos, etc.- 37%, 26% and 37%. We have no Alaska specific numbers on this question.

IX. IMPACTS OF U.S TORT SYSTEM CHANGES- FREQUENCY, SEVERITY AND RATES.

A. While malpractice claim severity has risen roughly twice as fast as the Consumer Price Index, Patricia Danzon in a study prepared for the Rand Corporation ("Frequency and Severity of Malpractice Claims-New Evidence") tells us that certain tort reforms - particularly caps on awards, periodic payment of future damage provisions and shorter statutes of limitation/repose - appear to reduce the frequency and severity of medical malpractice claims as compared to what would have happened if the law had not been enacted. This conclusion is more or less confirmed in other studies contained in our information packet including the recent National Academy of Sciences Study (which acknowledges a "modest" reduction in medical malpractice claim frequency and severity), the 1988 Winston/Litan anthology by the Brookings Institute and the 1989 study done for the Maine Legislature by the Public Health Resource Group, Inc. (but there is disagreement over the significance of this impact).

B. However, there appears to be no definitive evidence that any reduction in claim frequency and severity effects the cost or availability of insurance; although the experience in California suggests that certain tort reform measures may at least contribute to stability (in the context of doctor

owned insurance companies at any rate); and Danzon argues that certain reforms that reduce the uncertainty in estimating malpractice claim costs "may be expected to reduce premiums by a modest amount over and above the reduction in mean expected losses" (although she also mentions other factors such as litigation expenses and "changes in the timing of disbursement of loss reserves, and hence investment income").

C. The jury is still out on this one. More time may tell.

X. WHAT SHOULD THE LEGISLATURE DO?

A. The four primary commentators relied on (Rand, Brookings, National Academy of Sciences and the Maine Legislative Study by the Public Health Resource Group, Inc.) agree that sweeping alternatives to the existing system are intriguing but require more study. It is less clear how they feel about partial alternatives like the Hawaii arbitration program.

B. In the meantime, Winston/Litan et al. argue that in terms of reducing uncertainty and eliminating inappropriate levels of compensation, there is a strong case for limiting non-economic damages in tort cases but only in a way that takes into account the age of the injured party and the severity of the injury. In the same report, Patricia Danzon also argues for more restrictive statutes of limitation and provisions requiring periodic payment of future damages. The authors oppose stiffer regulation of insurance rates and support greater solvency regulation by state regulators.

C. On the other hand, the Maine group concludes that new tort reforms at this time are questionable policy options to reduce insurance premiums and to insure medical care availability pending more information that should be available within the next two years. If reforms are pursued they further suggest that they be designed to expire after a period of time if the price of insurance and availability of essential medical services do not improve by some measure satisfactory to the legislature. In any event, the report cautions that you cannot just target one set of issues. Instead, Legislatures should develop a carefully balanced mix of changes to the tort, regulatory (for example, they suggest requiring rate changes to be spread over time and requiring insurer's to demonstrate effective cost control programs) and medical care delivery systems (they suggest investigations of multi-claim physicians, greater efforts to diffuse potential complaints, information collection requirements and, possibly, adoption of "care standards") based on a considered understanding of what will be gained and what will be lost.

D. The National Academy of Sciences, which focuses on the issue of medical liability and obstetrical care, takes a

different tack. On the basis of its findings - that the costs of the current system in terms of impaired obstetrical care are great, that tort reforms are so far largely ineffective, and that data evaluating the merits of proposed alternatives to the tort system are lacking - the report concludes that state legislatures should not focus on further reform efforts within the existing tort system but should instead redirect their energies toward developing alternatives to the traditional tort system for resolving medical malpractice claims and towards implementing these alternatives in certain circumstances.

E. Other commentators on the issues before us, like Robert Hunter, advocate various forms of insurance regulatory reform; risk management and disclosure requirements; certain tort reforms like limiting attorney's fees for both sides (although he focuses on defense fees), penalties for frivolous actions and settlement incentives; and increased use of alternative systems except in defective products and similar cases which Hunter feels should be subject to common law principles without damage limits as a necessary deterrence measure.

Finally, you may want to keep in mind the words of Gustave H. Shubert, Director of the Institute for Civil Justice of the Rand Corporation, who observed in 1986: "I think underlying all our problems with the civil justice system is the inability of this country to decide whether it wants to have a pure compensatory system or whether it wants to have a fault based liability system. We can't decide whether everybody should be compensated for every injury no matter what its cause, or whether we want compensation to be limited in a strict way, in a comparative way, or in a contributory way to those who have caused the injury. My personal assessment is that we are experiencing the disadvantages of trying to operate both systems in tandem, the worst of both worlds. We are attempting to compensate everyone with a fault-based system and we are incurring huge social overhead costs by attempting to do so. I believe it is time to focus on that overall choice and to be rational in doing so".

SCOTT WETZEL
SERVICES, INC.

Risk Management Planning and Support

D.5a

JANUARY 26, 1990

DAVID E. ROGERS, Esq.
P.O. Box 33932
JUNEAU, ALASKA 99803

Re: LIABILITY TASK FORCE QUESTIONNAIRE
CARR-GOTTSTEIN CORPORATION

DEAR MR. ROGERS:

THE CARR-GOTTSTEIN RISK MANAGER HAS FORWARDED YOUR JANUARY 8TH LETTER REGARDING THE REVISED QUESTIONNAIRE FOR LOSS RECORDS OF CARRS' CLAIMS HISTORY.

WE ADMINISTER THE GENERAL/AUTO LIABILITY SEGMENT OF THEIR SELF-INSURANCE PROGRAM, AND IT'S OUR DESIRE, ALONG WITH CARRS', TO ASSIST HOUSE SPEAKER COTTEN IN HIS SURVEY, ANTICIPATING THE POSSIBILITY SOMETHING POSITIVE MAY RESULT FROM THE TASK FORCE.

THE INFORMATION REQUESTED, HOWEVER, IS NOT READILY AVAILABLE, AND WOULD REQUIRE A CONSIDERABLE AMOUNT OF TIME AND EXPENSE TO RESPOND ACCURATELY TO YOUR LETTER. FROM 1985 TO 1988 CARRS AVERAGED APPROXIMATELY \$167,000 PAID OUT ANNUALLY ON TORT CLAIMS. MOST OF THESE WERE SLIP AND FALL ACCIDENTS IN THE CARRS STORES, WHICH REPRESENTED MINOR INJURIES TO CUSTOMERS. VERY FEW, IF ANY, WERE OVER \$50,000 OR \$100,000.

FREQUENTLY, A CLAIMANT IS REPRESENTED BY COUNSEL, BUT THE CLAIM IS SETTLED WITHOUT SUIT BEING FILED AND, THEREFORE, RARELY IS A JUDGMENT ENTERED AGAINST CARRS.

BECAUSE ALL CLAIMS ARE DEFENDED BY AN "IN-HOUSE" COUNSEL AT THE CORPORATION, IT WOULD BE DIFFICULT TO ESTIMATE WHAT PORTION OF THE LEGAL STAFF'S TIME AND EXPENSES ARE ALLOCATED TO TORT CLAIMS.

I RECOGNIZE THE PRECEDING IS NOT PRECISELY WHAT YOU ASKED FOR, BUT DO HOPE IT IS OF SOME ASSISTANCE IN THE SURVEY. LET ME KNOW IF YOU HAVE ANY SPECIFIC QUESTIONS, OR IF WE CAN BE OF FURTHER SERVICE.

SINCERELY,

SCOTT WETZEL SERVICES, INC.



E.T. WALSH
LIABILITY CLAIMS MANAGER

ETW/cf

cc: ERIC TOLLEFSON/CARRS



**Nabors Alaska
Petroleum Services**
A NABORS INDUSTRIES Company

D.5b
Nabors Alaska
Petroleum Services, Inc.
4300 B Street
Anchorage, Alaska 99503
907-561-4448

January 26, 1990

David E. Rogers
P.O. Box 33932
Juneau, AK 99803

RE: Response to Task Force request

Dear Mr. Rogers:

We have received your request of January 8, 1990, a copy of which is enclosed, and we wish to advise you that Nabors Alaska Petroleum Services, Inc. (formerly known as Anglo Alaska Petroleum Services, Inc.) and its subsidiaries are self-insured only with respect to their workers' compensation program. Accordingly, while we are uncertain, we do not believe that we are part of the group of companies targeted in your January 8, 1990 correspondence. Therefore, we are not providing any claims information.

Please contact us if additional information is required.

Very truly yours,

Mark L. Lindsey
Vice President - Finance

MLL:te

D.5c

DAVID E. ROGERS

LAWYER

P.O. Box 33932
JUNEAU, AK 99803

907-586-2366
FAX 907-586-6958

January 8, 1990

To whom it may concern:

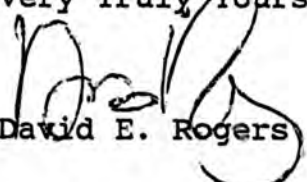
I am writing on behalf of House Speaker Cotten who is Chair of the House Liability Task Force. This Task Force was created last session to look into various issues relating to liability insurance in Alaska. Our first job is to develop a common factual basis for our deliberations, including a better understanding of the claims experiences of the various public and private "self-insured" entities in Alaska.

A previous claims survey effort undertaken several months ago by the Task Force with selected self insured entities was only partially successful; apparently because it was too detailed. As a result, Rep. Cotten has asked me to try again using a less complicated format. We would appreciate answers, at your earliest and preferably by February 15, to the following questions concerning your liability claims experience (not including worker's compensation) for as long a period as possible without going through heroic efforts to comply. Please contact me if you have any questions or concerns about this request. If you have already responded to our prior questionnaire with similar information please disregard this letter and thanks for your previous submittal:

1. By year, what is the percentage range of payments in the following categories: 0-\$50,000; over \$50,000 under \$100,000; and over \$100,000;
2. How many of the above claims were settled without legal action? How many were settled after an action was filed? How many went to judgement?
3. What were your claim defense costs over this time period, per year, if possible; or better yet per claim?

Thanks very much for your time. If for any reason you cannot answer these questions please let me know why in writing.

Very Truly Yours,


David E. Rogers

OFFICES LOCATED IN THE COURT PLAZA BUILDING
240 MAIN ST., SUITE 602, JUNEAU, ALASKA

D.5d



PHILLIPS PETROLEUM COMPANY

BARTLESVILLE, OKLAHOMA 74004 918 601-6600

PROPERTY TAXES, REAL ESTATE AND CLAIMS

January 31, 1990

Mr. David E. Rogers
Attorney at Law
P.O. Box 33932
Juneau, AK 99803

Dear Mr. Rogers:

Your letter of January 8, 1990, has been passed to me for response. We are pleased to cooperate with the Alaska House Liability Task Force and respond to your survey questions.

I will begin by clarifying a technical point of insurance coverage for our program in Alaska. Phillips Petroleum Company and subsidiaries are self-insured for general liability purposes. Our automobile liability program for the subject periods was underwritten by an insurance policy issued through Employers Casualty Company. By arrangement with that Company we administered all claims activity contemplated under the policies and made any required direct payments. We were acting, in a manner of speaking, as our own third party administrator for the purpose of automobile claims. In responding to your questions, we will draw on data for the calendar years 1987, 1988, and 1989.

Our automobile liability for those 3 years is as follows:

	1987	1988	1989
Number of Claims:	-0-	1	1

All automobile claims involved payments of less than \$50,000. All automobile claims were settled without legal action. We had no legal defense costs involved in our automobile program for the 3 years.

	1987	1988	1989
General Liability			
Number of Claims:	1	1	-0-

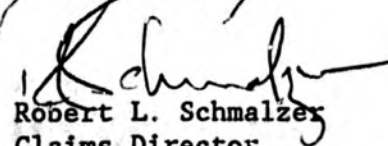
Both claims appear to arise out of work-place injuries to sub-contractor employees. No direct claim by either injured employee has been made against Phillips Petroleum Company or any subsidiary. No payments were made on either claim and we maintain zero dollar reserves in each case. House counsel was assigned on one claim, but no action was ever filed nor do we anticipate any action to be filed. No outside legal costs were incurred.

David E. Rogers, 1/31/90

2

We would be pleased to provide detailed information concerning all above-referenced claims if such is required by yourself. If there is anything further we can do in connection with your survey, please feel free to call or write to me directly.

Very truly yours,



Robert L. Schmalzer
Claims Director

Property Taxes, Real Estate & Claims
536 Phillips Bldg. Annex
Bartlesville, OK 74004
Telephone: 918 661-5680

RLS:bjw

cc: M. D. Kemp

NANA REGIONAL CORPORATION, INC.

4706 HARDING DRIVE, ANCHORAGE, ALASKA 99517
TELEPHONE (907) 248-3030
FAX (907) 248-3779



January 31, 1990

Mr. David E. Rogers
P. O. Box 33932
Juneau, Alaska 99803

Dear Mr. Rogers:

This letter is in response to your letter of January 8, 1990, which requested information on general liability claim losses by self insured entities in Alaska. As the chief financial officer for NANA, I also serve in that capacity for Alaska United Drilling, Inc. and the NANA/Marriott Joint Venture. Combined, these entities employ approximately 650 people on a regular basis and generate revenues of about \$70 million a year.

I have been with NANA for a little over 5 years, so this letter will cover activity during that time period including any cases that were in process when I arrived here in October of 1984. Fortunately, NANA and its affiliates have had a very good record as far as general liability exposures are concerned, especially if you eliminate liability cases which actually resulted from injuries to employees of NANA and its affiliates or our customers or vendors as I will discuss later in this letter.

I will not go into any detail in this letter about the three or four minor traffic accidents which NANA's or its affiliate's vehicles have been involved in which have resulted only in property damage .

We only have two cases open at the present time, both of which we would expect to ultimately resolve for less than \$50,000, with one probably settling for \$10,000 or under.

To my recollection there have been five cases which have been concluded, with all but one having been settled before conclusion of a trial. Two resulted in payments in excess of \$100,000, two were in the range of \$50,000 to \$100,000, and one settled for less than \$20,000.



Member Villages: Ambler, Buckland, Candle, Deering, Kiana, Kivalina, Kobuk, Kotzebue, Noatak, Noorvik, Selawik, Shungnak



Mr. David E. Rogers

January 31, 1990

Page 2

Both of the large cases and the small case were situations where an employee of one of our investee companies took action against another of our affiliates. This resulted from our having a situation where our oil drilling rigs were owned by a partnership (primarily for income tax purposes) but were being operated by a sister corporation. The employees took the position that they were injured because of problems with the rig and that thus they were not restricted to the sole remedy of workers compensation. The employees used this to get higher benefits than are provided by the workers compensation statutes.

Two of the smaller cases were employees of other organizations who were injured in their normal line of work in connection with their employers providing services to us. Again, they were attempting to get a larger settlement through a liability case than was being provided through their workers compensation benefits.

One of the open cases is one of our employees who has sued our customer, maintaining that it was the customer's fault that he was injured while working for us (a housekeeper who slipped on a wet floor). Again it appears that he is looking for a higher benefit than he received from his workers compensation coverage. As you are probably aware, some large companies in Alaska will generally not enter into a contract to purchase services unless the contractor agrees to indemnify the customer for any and all liabilities of the customer that are in any way connected with the service being provided by the contractor. Thus we are the real defendant in this case even though the plaintiff is our employee.

While we have not had any real large problems with this type of contractual liability, we are constantly exposed to it and therefore must buy large amounts of umbrella excess insurance coverage to provide for the fact that if our customer ever caused serious injury or death to a number of our employees, even though it was through gross negligence of the customer, the customer would be able to force us to reimburse it for all costs which it incurred in its defense and any damage payments or settlements to the injured parties.



Mr. David E. Rogers

January 31, 1990

Page 3

Because we were requested to hold our customer and others harmless on one large and complex contract, our liability insurance was about 9% of our revenues on that contract. I might also note that the waiver of subrogation clauses and the hold harmless clauses which we must provide in our insurance policies in favor of certain customers cause our insurance carriers to charge us higher premiums. The waiver of subrogation charge on workers compensation policies alone is 3% of the premium.

In answer to your question No. 2, all of the cases discussed above (with the exception of the minor automobile situations) resulted from legal action actually filed against us. Only one of the cases ever actually went to completion of a trial, and that was one of the \$50,000 to \$100,000 cases.

As to your question #3, unfortunately I do not have any information readily available to tell you our claim defense costs. Fortunately, NANA is very active in managing its litigation cost and while the amounts involved have certainly been substantial, we do not believe that they were excessive. Legal fees can easily run \$10,000 to more than \$200,000 in liability cases.

If House Speaker Cotten, as Chair of the House Liability Task Force, is interested in recommendations for issues that need to be looked into, we would suggest the following:

1. That consideration be given to expanding the exclusivity of workers compensation coverage, especially for related business organizations. Additionally, some exclusivity provisions might also be appropriate in conjunction with injuries related to the employer's customers or vendors, except perhaps where gross negligence was involved.
2. Although we are not aware of any cases where contractors have lost large sums of money, the policy of major purchases of services in Alaska demanding total hold harmless clauses from their vendors appears not to be in keeping with the public interest because it relieves the large customers from their responsibilities, even for gross negligence. Consequently, we would suggest that the task force look into this situation and perhaps consider legislation which would prevent all companies from dealing with their contractors in this manner.



Mr. David E. Rogers
January 19, 1990
Page 4

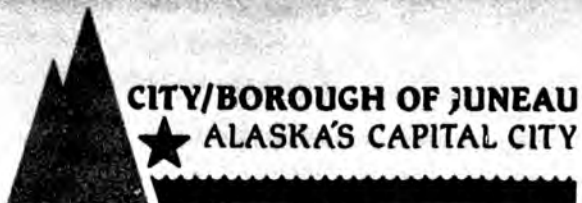
We certainly appreciate the interest of House Speaker Cotton in this situation because it is one which gives NANA great concern. Insurance, claims and claim management costs for our organizations normally run approximately 5% percent of our gross revenues, and that is after using self insured retentions of \$500,000 for general liability and up to \$300,000 for workers compensation. Considering the slim margins on work available in Alaska in these tight business times, this makes it very difficult to turn a profit.

If you would like additional information or if I can be of further assistance in this matter, please feel free to contact me at your convenience.

Very truly yours,

William H. Miller
Vice President, Finance

WHM/mak/54



February 16, 1990

The Honorable Sam Cotton
Chairman, House Liability Task Force
Alaska State Legislature
P.O. Box V, State Capital
Juneau, Alaska 99801

Dear Representative Cotton:

RE: Your request for information about the City & Borough
of Juneau Self-Insurance Program.

I am sorry about the delay in my response to your request. As I told Mr. Rogers on the telephone recently, I was attempting to obtain a comprehensive report on the CBJ historical claims activity from our contract adjusting firm. It now appears that the requested report is not going to be forthcoming in a timely manner, so I will provide you with as much information as I can from my files. Please keep in mind our program is not automated.

The City and Borough of Juneau established its self-insurance program in 1976 under ordinance No. 76-8. I have enclosed a copy for your information. In the early years, the program was administered as a collateral duty of the Assistant City Manager. In 1984, a Safety and Risk Management Officer position was established; and in 1986 during our last insurance crisis, the Risk Management Division was established.

The Risk Management Division is staffed by a Risk Manager, a Safety Officer, a Risk Management Technician, and a clerical support position. We are responsible for risk management, safety, loss control, workers' compensation, claims management, health benefits, life insurance, property and casualty excess insurance, and the in-house self-insurance programs. We employ contract claims adjusters, insurance brokers, a number of local

The Honorable Sam Cotton
Chairman, House Liability Task Force
Alaska State Legislature
February 16, 1990
Page Two

law firms, and from time-to-time an independent risk management consulting firm.

Currently we are self-insured for the first million dollars of auto and general liability, the first million dollars of property loss and the first 750 thousand dollars of workers' compensations claims annually. We carry excess insurance above our self-insured retention (SIR), as well as, specialty policies for medical/hospital malpractice, docks and marinas, the ski area and the airport. Our program also covers the Juneau School District. I am enclosing insurance schedules for the past ten years.

I will also be sending as actuarial study of our claims history as of June 30, 1988, a set of our most recent liability claims reports from our adjusting firm "GAB Business Services;" a copy of our most recent budget book which describes our program, and a copy of our most recent financial statement which will show details of the CBJ insurance fund.

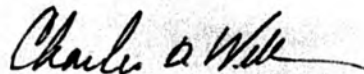
We only have an average of twenty-eight (28) liability claims a year. Less than a dozen of those requires the services of an attorney. The vast majority are in the 0-\$50,000 category. In the past, five and one half (5 1/2) years since I have been with the city, only two claims have gone to judgment, and both of those were for incidents that took place before I was hired. Our total paid-out auto and general liability costs over a thirteen (13) year history is only \$830,629. I don't know exactly how much of that was in attorney fees. During the years since I have been here, we have been including attorney fees as one of the administrative costs of adjudicating claims.

I hope this information helps you with your task. I know that it is not everything that you requested in some cases, and probably more in others. At this time, this is the best we can do under the circumstances. In some future year when we are able to convert to an automated system, we will be able to store and more easily provide the kind of detailed information you originally requested.

The Honorable Sam Cotton
Chairman, House Liability Task Force
Alaska State Legislature
February 16, 1990
Page Three

In the meanwhile if there is anything further I can do to assist you, please do not hesitate to contact me. My office telephone number is 586-5302.

Sincerely,


Charles D. Williams
Risk Manager

Enclosures
CDW:els

D5g
WAS

Wilton Adjustment Service

P.O. Box 70244
Fairbanks, Alaska 99707
(907) 456-4342
(907) 436-4949 (FAX)

February 16, 1990

David E. Rogers
Attorney at Law
P. O. Box 33932
Juneau, AK 99803

RE: Fairbanks North Star Borough
Fairbanks North Star Borough School District

Dear Mr. Rogers:

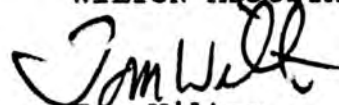
This will acknowledge receipt of your January 8, 1990 letter, which was recently mailed from Juneau and received in our office February 12, 1990. We have been handling the liability claims for the Fairbanks North Star Borough and Fairbanks North Star Borough School District since February of 1987, or over the past three years. I am rushing this information to you but, it is generally based upon our experience as the adjuster and not from the actual loss runs themselves.

1. 100% of the claims have been in the \$0 to \$50,000 range.
2. Approximately 90% of the claims have been settled without legal action. 10% settled after an action was filed and, none of them have gone to judgment.
3. I would estimate liability claims costs to be averaging around \$50,000 per year. This would be approximately \$10,000 per claim with about five claims going into litigation per year.

Again, if I can be of any further assistance do not hesitate to contact me.

Sincerely yours,

WILTON ADJUSTMENT SERVICE



Tom Wilton
Owner/General Manager

TW/mk

WAS

Wilton Adjustment Service

P.O. Box 70244
Fairbanks, Alaska 99707
(907) 456-4342
(907) 456-4949 (FAX)

February 16, 1990

David E. Rogers
Attorney at Law
P. O. Box 33932
Juneau, AK 99803

RE: City of Fairbanks

Dear Mr. Rogers:

This will acknowledge receipt of your January 8, 1990 letter, which was not mailed until February 8, 1990 from Juneau and received in our office February 12, 1990. I note you want a response by February 22, so we are rushing this information to you.

We have been handling the liability claims for the City of Fairbanks since February of 1987 or, over the past three years. The following response is basically a composite of that information over the past three years. This response is not based upon any specific data other than the fact that I am aware of all the claims that we have had and, I can give accurate information based upon the liability activity over the past three years.

1. I would say that 97% of the claims against the City of Fairbanks are in the \$0 to \$50,000 range. 2% are in the \$50,000 to \$100,000 range and 1% over \$100,000.
2. Again, over the past three years 97% would have been settled without legal action. The other 3% were settled after an action was filed and, on my recollection, none have gone to judgment.
3. The few claims that have gone to litigation have averaged less than \$10,000 in defense costs. It is a very rare claim and, perhaps one every two or three years that incurs litigation expense in excess of that \$10,000 figure.

Again, please note that this is information supplied without

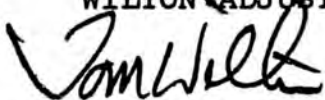
David E. Rogers
February 16, 1990
Page 2

benefit of going into heavy research from the computerized loss runs but, simply based upon the knowledge of the adjusting service who has actually handled the claims over the past three years.

If I can be of any further assistance, do not hesitate to contact me.

Sincerely yours,

WILTON ADJUSTMENT SERVICE

A handwritten signature in cursive script, appearing to read "Tom Wilton", is written over the typed name.

Tom Wilton
Owner/General Manager

TW/mk

D5K

ALASKA BAR

ASSOCIATION

March 1, 1990

Representative Sam Cotton
Alaska State Legislature
Box 33932
Juneau, AK 99803

Attention: David Rogers, Esq.

RE: Attorney Discipline Dispositions

Dear Mr. Cotton,

Last Tuesday, David Rogers asked if we could provide you with additional information concerning the disposition of the disciplinary complaints which we reported to you in Jeff Feldman's letter of October 26, 1989. In addition, Mr. Rogers asked if we could identify how many attorneys were repeat offenders.

In the October 26, 1989 letter, we reported on a study of 1505 complaints against 710 attorneys. A one case correction was needed in the search group, so the following tables reflect a study of 1504 cases.

In answer to the first question, Table 1 reflects the number of cases in each category of disposition along with the percentage of all cases each category represents. For example, 158 cases (or 10.5% of all cases) were resolved by private admonition by bar counsel.

The clearest way to answer the second question is to analyze the data by category of disposition (Table 2) and by considering all the disposition categories together (Table 3). For each type of disposition, Table 2 reflects the percentage of time discipline was imposed on attorneys for one incident, two incidents, or three or more incidents. For example, of the 158 cases resolved by private admonition by bar counsel, 70% of the admonitions were issued to one attorney for one incident. 20% of the admonitions went to attorneys who either already had one admonition or were receiving two admonitions for separate incidents at the same time. Finally, 10% of the admonitions went to attorneys who either had two admonitions previously or were receiving multiple admonitions at the same time.

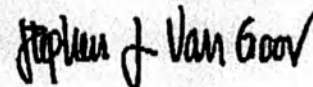
Representative Sam Cotton
March 1, 1990
Page 2 of 2

Finally, Table 3 combines all discipline imposed by the Supreme Court, the Disciplinary Board and Bar Counsel into one figure and shows the percentage of time discipline was imposed on attorneys for one incident, two incidents, or for three or more incidents. Table 3 also shows comparable figures for cases closed by dismissal or not accepted for investigation.

I hope this information is of assistance to you and the Liability Insurance Task Force. Please feel free to contact me with any questions you may have or if we may provide you with further information.

Sincerely,

ALASKA BAR ASSOCIATION



Stephen J. Van Goor
Bar Counsel

cc: Jeffrey M. Feldman, President
Deborah O'Regan, Executive Director

BC108/RF

TABLE 1

<u>Disposition:</u>	<u>Cases:</u>	<u>Percentage:</u>
Disbarment by Supreme Court	17	1.1%
Suspension by Supreme Court	26	1.7%
Probation by Supreme Court completed by attorney	4	.3%
Public Censure by Supreme Court	10	.7%
Public Reprimand by Disciplinary Board	1	.1%
Private Reprimand by Disciplinary Board	32	2.1%
Private Admonition by Bar Counsel	158	10.5%
Dismissed by Bar Counsel	729	48.4%
Not Accepted for Investigation	527	35.0%
TOTAL:	1504	100.0%

TABLE 2

<u>Disposition:</u>	<u>1 Incident:</u>	<u>2 Incidents:</u>	<u>3 or more:</u>
Disbarment by Supreme Court (17 Cases)	47%	--	53%
Suspension by Supreme Court (26 Cases)	54%	23%	23%
Probation by Supreme Court completed by attorney (4 Cases)	--	--	100%
Public Censure by Supreme Court (10 Cases)	80%	20%	--
Public Reprimand by Disciplinary Board (1 Case)	100%	--	--
Private Reprimand by Disciplinary Board (32 Cases)	66%	19%	15%
Private Admonition by Bar Counsel (158 Cases)	70%	20%	10%
Dismissed by Bar Counsel (729 Cases)	41%	19%	40%
Not Accepted for Investigation (527 Cases)	47%	30%	23%

25

TABLE 3

<u>Disposition:</u>	<u>1 Incident:</u>	<u>2 Incidents:</u>	<u>3 or more:</u>
Discipline Imposed By Supreme Court, Board or Bar Counsel (248 Cases)	65%	19%	16%
Dismissed or Not Accepted for Investigation (1256 Cases)	43%	24%	33%

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ALASKA STATE LIBRARY

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 eco-

Doctors in Distress

First of three articles.

nomics. "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.

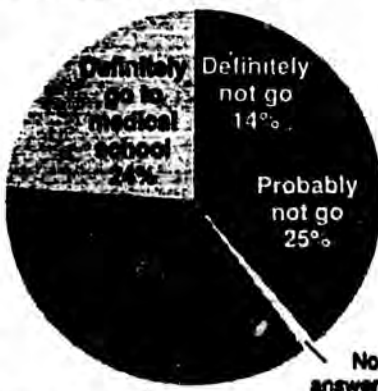
When the A.M.A. newspaper, American Medical News, asked doctors last year to describe how their practices had changed in the 1980's, "The question struck a nerve," the newspaper said. "Dozens of physicians responded with lengthy, heartfelt reflections," many of them expressing frustration with the changes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

Dr. Richard Short, a pediatrician in

Continued on Page 34, Column 1

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 of business here and have many U.S.

Secretive Nicaraguan Voters

Practice of Medicine Is Undergoing Change, Demoralizing Doctors

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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, an 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 \$20,000 to \$40,000 and for more complicated specialties, like ophthalmology, equipment can cost \$100,000, said George Conomikos, 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 reimbursement 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 \$20,000 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.

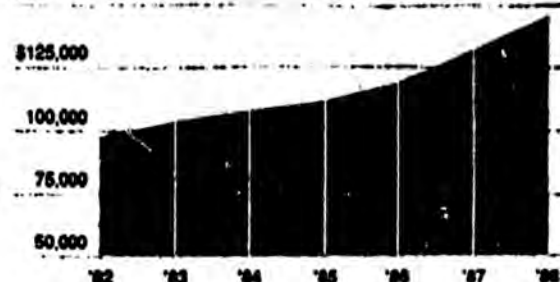
Government Bonus Plan
In an effort to slow the exodus of doctors



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
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 1989.

WHAT THEY PRACTICE



WHERE THEY PRACTICE





The New York Times/Jack Ryan

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 warn 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 1966.

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 was wide and often based on a doctor's specialty or location. While a quarter of all physicians earned more than \$180,000, 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 \$134,900, while the average in the New England states was \$133,000.

The disparities are a cause for friction in the profession. Dr. Kenneth 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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PRACTICE

Source for both charts: American Medical Association

PRACTICE

NUMBER OF DOCTORS

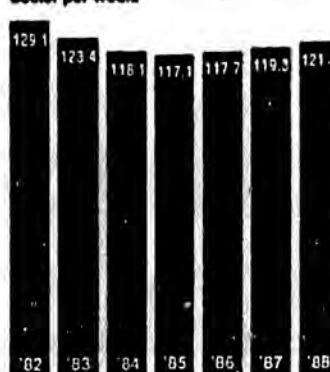
Number of physicians per 100,000 population. Foreign figures are for 1986.



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

PATIENT VISITS

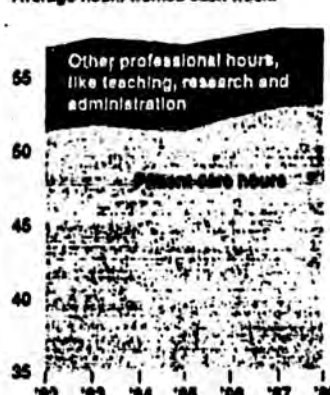
Average number of patient visits per doctor per week.



Source: American Medical Association

HOURS WORKED

Average hours worked each week.



Source: American Medical Association

MEDICAL SCHOOL

APPLICANTS

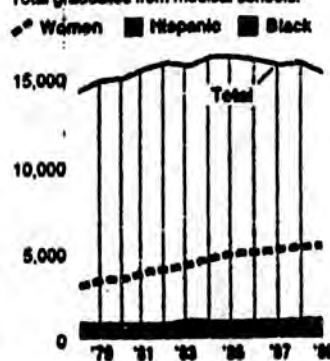
Total applications for medical school, by year of expected enrollment.



Source: Association of American Medical Colleges

GRADUATES

Total graduates from medical schools.



Sources: Association of American Medical Colleges (total enrollment), National Resident Matching Program (women)

DEBT

Mean debt of indebted medical graduates upon graduation, including student debt incurred before medical school, in thousands of dollars. Figure for 1987 was not available. About 80 percent of all graduates are indebted.



Source: Association of American Medical Colleges Graduate Questionnaire. For the most recent figure, 11,175 senior medical students were surveyed in the spring of 1988.

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 pa-

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 at 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 1985-1986, 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 that year made up less than half the first-year class.

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

ISSUES

BLACK 3.3% HISPANIC 4.7%



Demographics

Black and Hispanic doctors make up less than 1 percent of American physicians, but the percentage of female physicians has risen rapidly. In 1988, 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 ages 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 had 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.



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 1965: 506,000 versus 298,000. 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 bedouins and

code thing to tell, and some of the things that can't, 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-HERNIA), 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. Chris 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 Robillo 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 26,915 applied for the 1989-90 freshman class. Fifteen years ago, 1 of every 2.8 applicants was accepted, but today the applicant-to-acceptance ratio is 1.8 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 109 in 1989-90 from 269 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 80- to 85-hour work weeks they associate with a physician — it doesn't leave much for personal and family life."

Mr. Robillo said he realized that if he went to medical school "it would be the primary

reason for 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. Reiman, 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."

The 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 48 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. Reiman 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 (where it goes)

BAROMETERS OF HEALTH

INFANT MORTALITY RATE



IN COMPARISON

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

LIFE EXPECTANCY

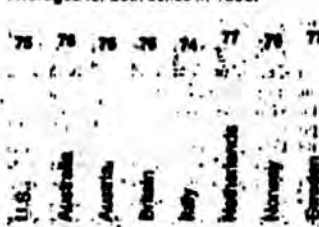
At birth, in years. Men Women



Sources: American Medical Association

IN COMPARISON

Averages for both sexes in 1988.



Sources: Compiled by the Population Reference Bureau

Charts by Anna Cronin

"All the News
That's Fit to Print"

The New York Times

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NEW YORK, MONDAY, FEBRUARY

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 the pr

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 ideology that is collapsing across East-

Jeering R To Demo

BUCHAREST, Romania — Protesters demanding President Ion Iliescu's provisional government ters this evening, rough of the new leaders, to party manuals to the c shouting for a complete nism.

Soldiers on the steps hundreds of demonstr into the ornate Foreign ing after hours of win

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

By ELIZABETH KOLBERT

STATE LIBRARY

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. Viadeck, 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 56-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 Reischardt 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 procedure.

"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 \$2,000 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 his 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.

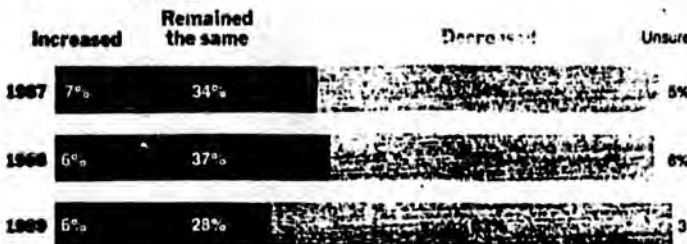
The Government and insurance companies frequently stipulate minimum requirements for certain operations: for example, in some states a patient's airway must be 80 percent



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 1969 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 college now. Some doctors who

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





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."

1967, and nearly all the new rules have been aimed at controlling costs.

The autonomy of doctors eroded slowly for nearly two decades, but after 1963 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 1968, 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 Cesarean sections at hospitals and trying to reduce the number of the expensive and often

DELIVER & CARE & COSTS
memorandum to justify the visits that were questioned.

The Government and insurance companies frequently stipulate minimum requirements for certain operations: for example, to see a state a patient's airway must be 90 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

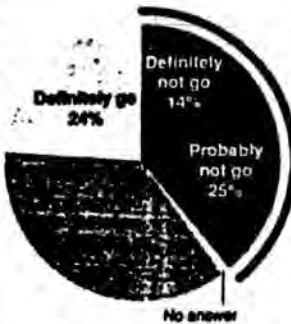
Controls Within the Profession

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 907 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

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 1968. 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. 16, 1968. Illustration by Jovon Samuels

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."

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 1968, 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, 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 2,360 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

they say they no longer enjoy it and spending 40 percent of their time on paperwork is one of the reasons why.

Dr. Sennett graduated from Yale Medical School in 1963, 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 26-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 \$78,000 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 Cesarean 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."

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 1965; 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:

1. Limits on doctors' bills. Doctors have to accept as payment whatever an insurer, including Medicare or a private insurance company, will pay and cannot bill patients for

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

3. Retroactive malpractice payments. This 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 1969 insurance and \$15,000 in retroactive premiums.

With doctors' incomes in Massachusetts running 15 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 to cover one night in five.

Last year Massachusetts convened a special

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," Mr. Fishman said.

NEXT: A changing relationship

COMPLIMENTS OF THE
STATE LIBRARY

As the costs of paying for the 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

assessments on the 10 percent of homes to 8 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 leanness.

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."

'Most 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 naïve 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

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 most recent political forum in the traditionally democratically elected assembly after the fall of the hard-line last year.

"But my Government more than to continue to fort," Mr. Modrow said. "I on bended knees for such contribution."

Commitment Was An

In the first meeting between man leaders last year, such assistance was discussed, a row Government assume Kohl had committed himself to a contribution.

In the Kohl Government offer of a rapid economic union, not immediately a East Germany, constitutes effective material assistance can provide.

But Mr. Modrow cautioned against hasty steps to economic union because of serious legal issues.

In his speech, Mr. Modrow that East Germany could

Continued on Page A10, C



INSIDE

New Bishop for Brooklyn

Bishop Thomas V. Daily of Palm Beach, Fla. will be the next head of the Brooklyn diocese, according to a Roman Catholic official. Page B1.

Selma Still Smolders

Blacks and whites mingle and seem to tolerate one another in Selma, Ala., but the divisions that surfaced 25 years ago still exist. Page A12.

Airlines Bet on Expansion

Higher fuel prices and slower passenger growth in recent months have not deterred the nation's largest airlines from ambitious plans. Page D1.

Heart Surgery and the Mind

Romanian Leader Warns of Tough New Measures Against Demonstrators

President Ion Iliescu vowed that demonstrators would be "severely punished" if Sunday night's takeover of Government headquarters were repeated.

In Bucharest yesterday, soldiers arrested suspected of leading the takeover. About 100 suspects were arrested, a source said. Page A10.

Business Taps the East Bloc's Intellectual Resources

Physicians and Patients 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 26 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 is wrong," Dr. Letter 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. Brenda 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

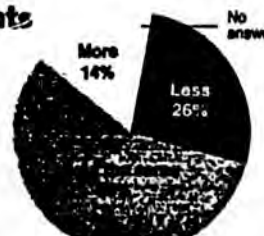
Percentage of respondents agreeing with each statement.

Most doctors spend enough time with their patients	29%
Doctors usually explain things well to their patients	43%
Doctors are usually up to date on the latest advances in medicine	61%
Doctors keep patients waiting too long	75%
Doctors are too interested in making money	67%
Doctors don't care about people as much as they used to	57%



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 respected doctors more or less than they used to.



Dr. Stephen Brommer
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, who 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."

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 he is 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 relationships 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	25%
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.

The New York Times/Feb. 28, 1989; Illustrations by Jovier Ramon

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 in the field," he said. "What has changed is not their losing power but that specialty societies have gained power."

D5j

M E M O R A N D U M

December 1, 1989

SUBJECT: Civil jury trials in other countries
(Work Order No. 6-1753)

TO: Representative Sam Cotten

FROM: John B. Gaguine
Legislative Counsel

You have asked whether the United States is the only, or one of the only, countries in the world that allow for jury trials in civil cases. While I have not been able to get a definitive answer, it appears that the United States and Canada are about the only two that have civil jury trials on a regular basis.

Civil law countries (constituting virtually every country without an English common law tradition) have always given judges a far more prominent role than juries. Therefore, according to Francis, How to Serve on a Jury at p. 6 (1979), jury trials in non-English speaking countries are usually limited to criminal cases. Even in England, according to the 1988 edition of the Encyclopedia Americana (Vol. 16, Jury, at p. 240), the jury has virtually disappeared from all but criminal trials. Similarly, Hans and Vidmar, Judging the Jury at p. 31 (1986) note that outside of North America the civil jury has all but disappeared.

I spoke to a researcher at the Center for Jury Studies of the National Center for State Courts, in Washington, DC, who indicated that Canada allows civil jury trials to about the same extent as the United States. The researcher did not have a country-by-country list of availability of civil jury trials, but he seemed to think that such a list would likely find the United States and Canada to be the only two.

Of course, as you are no doubt aware, Article I, Section 16 provides that in civil cases where the amount in controversy exceeds \$250, "the right of trial by a jury of twelve is preserved to the same extent as it existed at common law."

Representative Sam Cotten
Page 2
December 1, 1989

(In "courts not of record" - the district courts of the state - this section allows the legislature to authorize six-person juries; AS 22.15.150 accordingly states that all trial juries in the district courts will consist of six jurors.) The Seventh Amendment to the U.S. constitution, similar to Article I, Section 16, has been held by the U.S. Supreme Court not to apply to the states.

Incidentally, the Center for Jury Studies researcher indicated that at least one American state, Colorado, does not have a civil jury trial guarantee. Colorado allows civil jury trials, but makes the litigants pay the considerable costs incurred by a jury trial, rather than a court trial. The state uses the moneys it obtains this way to pay for criminal juries.

If I may be of further assistance, please advise.

JBG:lmb
L8/074

D52

NATIONAL SOCIETY OF PROFESSIONAL ENGINEERS



February 27, 1990

Rep. Sam Cotten
Speaker of the House
of Representatives
Alaska State Legislature
Box V
State Capitol
Juno, Alaska 99811

Dear Mr. Speaker:

The National Society of Professional Engineers feels strongly about the need to educate the engineering community regarding an engineer's professional liability exposure. As part of that commitment, our Sustaining University Program has developed the enclosed Presentation Guide for engineering students, to be used with a videotape on professional liability produced by our consulting engineers division (Professional Engineers in Private Practice).

I am sending this to you on the request of Vincent S. Haneman, Jr., P.E., Dean of Engineering, University of Alaska-Fairbanks.

Sincerely,

Margaret E. Bayers
Director
Professional Engineers in Education

enclosures

cc Vincent S. Haneman, Jr., P.E.

RETURN TO: _____



GLOSSARY OF INSURANCE TERMS

Insurance, including professional liability insurance, is an important business consideration for design professionals. Questions such as what kinds of insurance to carry, what do professional liability policies cover, and under what conditions are claims covered are constantly raised by architectural and engineering firms' management.

In an effort to aid architects and engineers in understanding professional liability insurance, and in making business decisions associated with insurance, this Glossary of Insurance Terms has been compiled to define basic terms used in regard to insurance. It also will be helpful as a reference source to more fully comprehend articles dealing with insurance.

GLOSSARY

Calendar/Accident Year

A calendar year during which policy premiums are earned and claims are reported.

Capacity

The maximum amount of insurance that a company is willing to write.

Case Estimates (Reserves)

The insurance company's estimate of its anticipated indemnity and expense payments on a claim subject to coverage by the policy.

Claim Expense

As defined in the insurance policy, the costs associated with the handling of a claim. This often includes defense attorney fees, investigation costs and expert witnesses. Not included normally are the salaries of insurance company employees and direct expenses which they may incur in performing their duties.

Claims-made Insurance

A type of insurance whereby the claim has to be made while the insurance policy is in force for coverage to apply. A claims-made policy without retroactive coverage does not cover claims arising out of services performed prior to a date stated in the policy that defines

when the coverage commences. (See Retroactive Coverage.)

Closed Without Payment (CWP)

A claim closed without indemnity payment by the insurance company and for which expense payments may or may not have been made.

Combined Ratio

The sum of an insurance company's incurred loss and expense divided by its earned premium.

Compensatory Damages

Those losses which can readily be proven to have been sustained, and for which the injured party should be compensated as a matter of right.

Earned Premium

For each day a one-year policy is in force, the insurance company earns 1/365 of the premium.

Excess of Loss Reinsurance

A form of reinsurance which indemnifies an insurance company for losses incurred above an agreed upon amount of underlying insurance coverage. (See Reinsurance)

Exclusions

Risks, perils or other exposures that are not covered by an insurance policy.

Expense Only Claim

A claim which only results in claim expenses being incurred by the insurance company, but with no indemnity payment being made.

Frequency

The measure of claim count per unit(s) of exposure over a given time period. For example, if 2,500 insureds had 150 claims in 1984,

**Glossary
of
Terms**

the frequency would be .06 or 6 claims per 100 insureds for that year.

Incurred But Not Reported Reserves (IBNR)

Additional reserves established by actuaries in anticipation of claims arising from occurrences not yet reported to the company. Not a significant factor in claims-made coverage.

Incurred Loss

The total of ~~paid~~ losses (indemnity plus expenses) plus the case estimates (reserves) on open claims.

Indemnity Payment

A payment to a third party by an insurance company and/or the insured in satisfaction of a claim made against the insured.

Loss Development Factor

Adjustments by the insurance company applied to the incurred loss in order to estimate the final amount that will be paid for a given year.

Occurrence Insurance

A type of insurance whereby coverage is provided for a claim stemming from an event when the insurance policy was in force even if the claim is made after the policy expires.

Paid Claim Count

The total number of claims for which indemnity payments have been made and the claims are closed.

Paid Expense

An amount paid for costs associated with a claim but not including insurance company claim handling expenses. It includes defense costs such as lawyers' fees, filing fees, and expert witness fees. Paid Expense is also referred to as "allocated expense."

Permissible Loss Ratio

The ratio (or percent) of premium available for incurred losses after deduction of commissions, company expense, taxes, profit and contingencies.

Policyholder Surplus

For a stock insurance company the sum of its surplus and capital. Also, the amount by which the assets of the insurance company exceed its liabilities.

Premium

The amount paid by an insured for the coverage to be provided by the insurance company.

Premium Available for Losses (Net Premium)

The portion of the premium which is allocated to fund expected incurred losses. Calculated by subtracting Underwriting Expenses plus expected Underwriting Profit from total Premium collected.

Program Year

The period of time subject to a set of underwriting or rate actions associated with a particular line of insurance business.

Punitive Damages

Damages which are awarded separately from compensatory damages. Punitive Damages are awarded based on a finding of malicious or wanton misconduct on the part of the defendant, and are intended to serve as a punishment and a deterrent to others.

Pure Premium

The cost of claims per unit of exposure. Pure Premium is the product of Frequency times Severity.

Rate

The premium charged per unit of exposure at the limit of the insurance coverage purchased by the insured.

Reinsurance

A transaction whereby one insurance company agrees to accept all or part of the risk originally assumed by another insurance company.

Reported Claims Count

The total of all claims reported to the insurance company.

Reserve Premium

An additional premium collected to offset unexpected claims. State tax is the only expense charged against Reserve Premium. To the extent Reserve Premium is not used to pay losses, it is returnable to the policy holder along with interest at a specified interest rate. Reserve Premium is usually part of a profit sharing agreement and is subject to its terms and conditions. The amount of Reserve Premium is calculated as a percent of the Earned Premium for a specified layer of coverage.

Retroactive Coverage

Provides coverage for claims made during the policy period arising from negligent acts, errors or omissions occurring before coverage commenced, if the insured had no prior knowledge of a claim or potential claim arising out of such negligent acts, errors or omissions.

Severity

The total incurred loss divided by the number of claims within a stated period of time.

Ultimate Loss

The sum of Incurred Loss and Actuarial Adjustments attributed to a Calendar/Accident Year. Ultimate Losses for open years are referred to as "Projected Ultimates."

Underwriting Expense

The costs incurred by the insurance company to write a particular line of business. Included are commissions to agents, company claim handling expenses, premium taxes and general overhead expenses.

Underwriting Profit (Loss)

"The bottom line" results for an individual year or period of years. Profit or loss is calculated by subtracting ultimate losses and underwriting expenses from earned premium.

Written Premium

The total premiums collected on an annual basis by an insurance company for policies issued.

RETURN TO: _____



A BLUEPRINT FOR RISK MANAGEMENT FOR PROJECTS INVOLVING POLLUTION OR ASBESTOS EXPOSURES

INSURANCE

Many A/E firms have incorporated some risk management techniques within their practices and procedures though very few have formal risk management programs. Thus, it is not surprising that few design professionals recognize that insurance is but one facet of a comprehensive risk management program. The basic role of insurance is the transfer of risks from insured to insurer in exchange for the payment of the premium. Traditionally, design professionals have used this mechanism to transfer all or a part of the risk associated with professional liability to a professional liability insurer. Today, and for the immediately foreseeable future, this risk transfer mechanism is no longer available for liabilities associated with harm caused by pollution and asbestos.

Since the risks associated with pollution and asbestos can no longer be transferred to an insurer, alternatives must be sought. Three immediately come to mind.

1. Avoid the risk by not performing services on projects involving pollution or asbestos.
2. Accept the risk as a personal exposure.
3. Manage the risk by a careful analysis of the probability of loss, accepting some, rejecting some, and transferring some by mechanisms other than insurance (e.g., indemnification; see discussion on page 4.)

The purpose of this paper is to discuss the third alternative, risk management. Clearly, alternatives one and two, while they are viable for some firms, are not desirable, adequate or acceptable for most. How, then, without insurance for these exposures, can the growing need for design professionals' services be satisfied without unreasonably exposing the individuals and their firms to financial ruin from claims arising out of the pollution and asbestos hazards?

The first step in this analysis is to understand what is no longer insurable. Professional liability insurance for engineers and architects insures their legal liability

arising out of professional services performed for others. Subject to various policy provisions and exclusions, this insurance provides financial protection for claims alleging negligent performance of services. This paper focuses on two specific exclusions from coverage—one dealing with pollution, the other with asbestos.

For convenience, these exclusions, as found in the AIA/NSPE commended program, the Continental Casualty Company (CNA) policy as underwritten and managed by Victor O. Schinnerer & Company, Inc., are attached for your reference. While the specific language of the exclusions in other insurance policies may differ, the basic intent will be fairly consistent. You should, of course, review your own policy for the exact wording.

POLLUTION

Dealing first with the pollution exclusion, it should be noted that while the exclusion is quite broad, there are project types which are exempted from the exclusion in the VOSCO/CNA Program. This simply means that if the project under contemplation is one of those exempted, the exclusion does not apply. Thus, traditional risk transfer to the insurer continues for pollution exposures arising out of storm water systems, potable water systems and domestic waste water systems. Note that the exception to the exclusion for domestic waste water systems includes those domestic systems which receive industrial waste provided the industrial waste has been pretreated in accordance with applicable regulations.

The second thing to note with respect to the pollution exclusion is that the policy will continue to respond to claims to remedy "faulty" design services. If, for example, you design a storage tank and, as a result of your negligence, the tank leaks, the policy will, subject to its

**Pollution/
Asbestos**

Published by the Office for Professional Liability Research of Victor O. Schinnerer & Company, Inc., in cooperation with the American Institute of Architects, the National Society of Professional Engineers/Professional Engineers in Private Practice, and Continental Casualty Company, one of the CNA insurance companies.

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terms and conditions, cover the costs associated with the tank repair.

While the general language of the pollution exclusion is quite broad, as evidenced by the definition of "pollution," many projects will fall within the noted exceptions. But what of those that do not?

Again, it is important to understand that the pollution exclusion does not preclude all claims arising out of a project which has a pollution hazard. In other words, the "project" is not excluded; only those claims arising out of or alleged to arise out of pollution are excluded. Thus, if you have an industrial client for whom you are performing services, even though those services include the identification, management, treatment or containment of pollutants, coverage under the CNA professional liability policy continues for claims other than those arising out of the discharge, escape, release, or dispersal of pollutants.

ASBESTOS

As can be seen rather readily, the asbestos exclusion is both broad in its scope and very explicit in its intent. This reflects the attitude of the worldwide insurance and reinsurance industry that it simply cannot, for reasons discussed in detail¹ elsewhere, cover any exposures associated in any way with asbestos.

As with the pollution exclusion, the underwriting intent is not to exclude coverage for all services on projects which contain asbestos. Nor is the "project" excluded. Only those claims involving or alleged to involve or relate to asbestos are excluded.

In regard to both the pollution and asbestos exclusions (and, indeed, in regard to all exclusions and other insurance policy terms and conditions) design professionals are strongly advised to read, understand, and discuss the wording with their attorneys.

LIABILITY

The next step in our analysis is to examine the term, "liability." For engineers and architects, liability is most commonly associated with a "negligence standard." While under certain conditions, other kinds of liability, e.g., liability for breach of contract, may be imposed, the concern here is with negligence.

Negligence is the breach of a duty and professional liability is predicated on a breach of duty causing harm. A professional duty is breached when the professional, in carrying out or failing to carry out a duty, fails to use that degree of skill and competence generally exercised by one's peers.

In contrast, your client's liability, as related to harm caused by pollution, will most likely be predicated on a theory of strict liability; that is, liability without regard to fault. This is certainly true for owners, operators, transporters and generators under the terms of "Superfund" and under many of the environmental laws of the various states. Note, however, that the doc-

trine of strict liability usually does not apply to the rendering of professional services.

The risks associated with the pollution and asbestos hazards have, therefore, two peculiar components. First, the standard of care for professionals, the degree of skill and competence required, is by no means easily identified. What is "safe" or what is "clean?" What are the standards by which the rendering of services will be judged? Hazardous and potentially hazardous substances are being identified almost daily. Definitions of "acceptable levels" have been slow to emerge and do not yet embrace most hazardous or potentially hazardous substances. Second, with the growing application of liability without fault, your clients are going to be more and more anxious to find some mechanism to shift some or all of their burden to others. The fear is that you, the design professional, will be a likely target.

RISK IDENTIFICATION

Given the above considerations, is there any way a design professional can become involved in projects with uninsurable risks without being subjected to personal financial ruin? The answer is "no" if you use *possibilities* as the basis of your deliberations. Almost anything is possible and it takes little or no imagination to construct a claim scenario growing out of pollution emanating from a project involving hazardous or toxic substances or asbestos abatement. On the other hand, if through objective risk identification and analysis your deliberations are focused on *probabilities*, then a program of pro-active risk evaluation can provide you with a tool whereby certain of the uninsurable risks can be managed. Once identified, risks can be managed. Risks that are not identified or are ignored are those which are least capable of being dealt with successfully should they later materialize.

Using probability of loss as a guide and defining loss as including claims for damages as well as costs of defending those claims, you can assign projects to any one of three categories: Category I projects would be those with a low probability of loss; Category II projects would be those with some (moderate) probability of loss; Category III projects would be those with a high probability of loss. Assignment to a particular category would depend to some extent on subjective evaluations. However, a measure of objectivity can be achieved by assigning a scale of relative values of "zero" to "ten" to various considerations, ten being the highest probability of loss and zero being the lowest. Use of a simple matrix or "scorecard" will facilitate the evaluation. Each firm will be able to determine for itself what considerations are most useful in assessing risk.

RISK ANALYSIS/ASSESSMENT

The following list may suggest some of the factors that would be included and a methodology.

1. **Capability and Capacity** — The best opportunity to manage risks occurs before a commission is accepted. The first task involves an examination of your firm's capabilities and capacity to perform the required services.

- a. Do you have appropriate experience with this type of project and with rendering the services that will be required?
- b. Will consultants be required? Are qualified consultants available to you?
- c. Do you have the capacity for this project? What is the workload forecast? If additional hiring will be required, will you be able to hire qualified employees in sufficient number? Will the firm be able to assimilate the required new hires without straining management controls?

2. **Client** — Given the very competitive nature of practice within the design professions, client evaluation has had little or, at best, a very low priority in determining whether or not to seek or accept a particular commission. Proper risk assessment must, however, include an evaluation of the client. Time and effort spent on client evaluation is an important element in risk management. Some things to look for and evaluate include:

- a. **Other projects** — Has your relationship with this client been good, bad or indifferent on other projects? Does the client have confidence in you and you in him? If a new client, what is his reputation in dealing with other design professionals?
- b. **Solvency** — Is the client financially strong? If you require indemnity from the client, will the client be in a position to honor the agreement when the time comes?
- c. **Site** — Have you visited the site? Does the client control the site?
- d. **Target** — Has the client already been identified as a polluter? Is governmental action against the client pending or imminent?
- e. **Public relations** — How is the client perceived by the community? Is there likelihood of adverse public reaction to the project?
- f. **Sincerity** — Is the client making a serious effort to abate, eliminate or avoid a problem? Is the client merely trying a "bandaid" approach?
- g. **Access** — Is the client providing you with free access? Is there full disclosure? Is the client responding to your inquiries with prompt and candid answers?
- h. **Attitude** — How much site monitoring will the client undertake? Will proper operation be maintained?
- i. **Technical expertise** — Does the client have in-house design and/or construction capabilities?

If so, how will this affect your independence in rendering your services?

j. **Future business potential** — Is there the potential for future commissions from this client? For a continuing professional relationship?

3. **Project** — Looking closely at the project itself can be revealing as to the probability of loss.

- a. **Degree of difficulty** — Are the project requirements unique, complex, or do they border on the "state of the art?"
- b. **Controlling regulations** — Will the operations be subject to governmental controls and reporting requirements? Are there any unusual codes, statutes or ordinances?
- c. **Budget** — Is the proposed budget realistic in terms of the project requirements? Are funds readily available or definitely committed?
- d. **Time** — Is the time schedule realistic?
- e. **Funding** — What is the source of the client's funding? Are necessary funds likely to be available when required to maintain the progress of the project? Are there any funding contingencies?

4. **Contract** — Since the starting point for determining the design professional's duty is the contract you sign with your client, great care should be taken in assessing the responsibilities enumerated therein.

- a. **Authority** — Does the proposed contract grant authority to carry out your responsibilities?
- b. **Scope of services** — Are they clearly defined? Be alert to nebulous requirements, such as "as necessary" or "as required."
- c. **Limitation** — Does the proposed contract include objectionable responsibilities such as direction, control or supervision of the *Work*?
- d. **Multi-phase** — Will you have responsibility for more than one phase, e.g., study, identify and design?
- e. **Indemnity** — Is the client attempting to shift its responsibility by requiring indemnity? Remember, the client "owns" the pollutant and should, therefore retain the liabilities associated with it.
- f. **Vicarious liability** — Must the firm hire others for whom it will be responsible? If so, who has the right of selection?

5. **Compensation** — Is the proposed fee appropriate to the scope of services to be provided and the probable liability risk? Just as insurance companies require the payment of a premium before accepting risk, so should the design professional require a fee commensurate with any risks.²

- a. **Profit** — What is the profit potential? *Losses are paid out of profit.*

- b. Cash flow — Is there any projected impact on cash flow?
- c. Severity — Will any probable loss be large, moderate or small?
- d. Class action — Is there a probability of large legal defense costs?
- e. Audits — Are there audit requirements? (i.e., is your fee subject to audit?)

Having evaluated these considerations, as well as all the others you deem appropriate, and assigned values to each, your matrix is complete and you can now place the proposed project in one of the three categories outlined above.

Category III projects, those with "scores" or ratings of 7.5 through 10 on your matrix, may be the easiest to deal with at this point. They probably are those that ought to be rejected. In a very real sense, the risk management technique to be employed for projects evaluated as falling into Category III is risk avoidance.

At the other end of the scale, Category I projects, those with "scores" of 0 to 4, have risks that are relatively the most manageable. These projects probably ought to be accepted.

The most difficult decisions (whether to accept or reject) will involve those projects which fall within Category II, those with "scores" of 4 to 7.5 on your risk assessment matrix. However, only the firm itself, through its management, can make the "go/no-go" decision, whether the project be rated as Category I, III or II.

Assuming the decision is made to proceed with the project, the wording of the contract, the agreement for professional services, becomes even more critical and should be re-evaluated at this point. In this re-evaluation, and during any ensuing negotiations with the client, remember who "owns" the pollutant or asbestos. It is the client who owns the pollutant or asbestos and who, therefore, is in the best and, incidentally, the most equitable position to fund any risks and liabilities associated with it.

INDEMNIFICATION

It has been suggested by many that providing services on a project which might involve pollution or asbestos exposures can only be done after another form of risk transfer has been accomplished: the inclusion of a hold harmless or indemnity agreement in the client—A/E contract. In its *White Paper—The Liability Crisis*, NSPE counsels: "Faced with a choice of taking on a project which may entail pollution or asbestos exposures, or declining the project because of the uninsurable risks, the engineer has little choice but to seek protection through an indemnification clause." Such clauses are not, of course, guarantees, but in many cases they do offer a significant degree of protection.⁴ As with all contract provisions, indemnity agreements can have important and serious legal consequences. They

should be discussed with your attorney, preferably before entering negotiations with your client but, certainly, before they are signed.

The NSPE/PEPP Professional Liability Committee has developed this indemnification clause for projects which may have a pollution exposure:

"In consideration of the unavailability of professional liability insurance, it is agreed that the OWNER shall indemnify and hold harmless, ENGINEER and their consultants, agents, directors, officers and employees from and against all claims, damages, losses and expenses, direct and indirect, and consequential damages, including but not limited to fees and charges of attorneys and court and arbitration costs, arising out of or resulting from the performance of services by ENGINEER, or claims against ENGINEER arising from the work of others, related to hazardous waste or pollution-related activities, to the fullest extent permissible by law, regardless of any action or omission (active, passive or comparative negligence included) on the part of ENGINEER.

The above indemnification provision extends to claims against ENGINEER which arise out of, or related to, or are based upon, the actual, alleged or threatened discharge, dispersal, release or escape of pollutants, and any directive to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize pollutants. "POLLUTANTS" means any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids or alkalis, chemicals and waste."

It has been suggested that in addition to an indemnity provision, you discuss with your attorney the advisability of including language by which the owner specifically agrees not to bring claim against you. In other words, not only would the owner agree to indemnify the A/E, he would agree not to bring claims as well.

In the first of three special issues of its newsletter, *MEMO*, (September 1985) the American Institute of Architects reprinted the following indemnification clause used by one of its members on projects that may contain asbestos:

"From Washington, D.C., Antonio C. Ramos, AIA, and his attorney, Arthur T. Kornblut, who is also chairman of the American Bar Association Forum Committee on the Construction Industry and an architect himself, comes the language for a hold-harmless clause involving asbestos abatement—the most-often-requested text:

The Architect hereby states, and the Owner acknowledges, that the Architect has no professional liability (errors and omissions) or other insurance, and is unable to reasonably obtain such insurance, for claims arising out of the performance of or failure to perform professional services, including but not limited to the preparation of reports, designs, drawings and specifications, related to the investigation, detection, abatement, replacement or removal of products, materials or processes containing asbestos. Accordingly, the Owner hereby agrees to bring no claim for negligence, breach of contract, indemnity or otherwise against the Architect, his principals, employees, agents and consultants if such claim in any

way would involve the Architect's services for the investigation of or remedial work related to asbestos in the Project.

The Owner further agrees to defend, indemnify and hold the Architect and his principals, employees, agents and consultants harmless from any such asbestos-related claims that may be brought by third parties as a result of the services provided by the Architect pursuant to this Agreement."

What about projects on which asbestos or pollution are not anticipated but are discovered after the project is under way? The NSPE *White Paper—The Liability Crisis* considers that possibility:

"Already the question has been raised as to what action the engineer (architect) should take if a particular project does not indicate the likelihood of either a pollution or asbestos concern, but during the course of the work such a potential problem develops. It would be impractical in such an instance for the engineer (architect) to unilaterally terminate services. To do so, in fact, might well generate a claim for breach of contract. One suggestion to deal with this kind of potential problem is to add a clause in the owner-engineer (owner-architect) agreement and in supplementary general conditions (emphasis added) to the effect that when and if such conditions are observed the engineer (architect) or contractor, as the case may be, shall cease all work related to the pollution or asbestos conditions and notify the owner of the circumstances. The owner will then be obligated to determine what course of action is to be taken, such as bringing in experts for advice on how to deal with the condition."

And, in the December 1985 issue of AIA's *MEMO*, a similar idea was presented:

"If you cannot or do not wish to negotiate a hold harmless clause with your client on asbestos-abatement, consider the following: Explicitly state in your contract that you are not an expert; that you have not been trained in the special requirements of asbestos-abatement (if you have not); that you cannot be expected to recognize the many forms of asbestos, and that if asbestos is found on the site and recognized as such, all work will cease without penalty to you so that the client can take the appropriate steps for its removal."

CONCLUSION

Though the withdrawal of insurance coverage for asbestos and pollution exposures has made apparent the need for A/E's to implement formal risk analysis procedures for projects with these exposures, this sort of exercise can be of decided value on all projects. Indeed, careful risk identification and analysis on all

projects before services are performed has long been advocated by the Office for Professional Liability Research and others. Without intending to diminish, at all, the importance of insurance as a risk transfer mechanism, the suggestion here is that risk management techniques are more important to the A/E firm in coping with risks it retains than they are to insurers.

Aside from the risks associated with asbestos and pollution exposures (which risks are retained not by choice), what are the risks which an A/E firm ordinarily retains? Deductible provisions of professional liability insurance policies most readily come to mind. In addition to the already high costs of professional liability insurance, design professionals are responsible for payments of losses and defense costs to the extent of the deductible obligation of the insurance policy. Note that these deductibles apply on per claim basis. As a device to control the cost of insurance, most A/E firms have been steadily increasing the levels of their deductibles. This means there is more of the A/E's funds exposed to loss on each and every claim, whether or not the insurer ultimately is called upon to make a payment. Stated in risk management terms, this is risk retention.

Another "risk" retained by A/E's though seldom recognized as such is one of the most expensive aspects of claims and one of the most difficult to measure—time. What is the value to be assigned to the cost of some firm member (or, in many cases, several members) who, when claim is made, sift through project files, reconstruct events, meet with insurance representatives and defense attorneys, go through protracted legal discovery proceedings and on and on, all at non-billable time.

Clearly, anything that can help to identify and analyze these and other risks—up front—will help to reduce the time spent on claims and the money spent within the deductible obligation, to the direct and immediate benefit of A/E firms.

¹ *Guidelines for Improving Practice*, Vol. XV, No. 1; Vol. XV, No. 6; Vol. XVI, No. 3; Vol. XVI, No. 5.

² For a more thorough discussion of this topic, see "Relating Risk to Compensation" by Joseph Dundin, *Architectural Technology*, May/June 1986.

³ For more information on indemnification, see *Guidelines for Improving Practice*, Vol. IV, No. 9; Vol. IV, No. 10; Vol. XIII, No. 8; and Vol. XV, No. 3.

Appendix A

Notice Sent to Firms Insured in VOSCO/CNA Program

Asbestos and pollution exclusions applying to claims arising out of past, present and future services will be endorsed to the policy, subject to approval of your State Insurance Department where appropriate.

POLLUTION

This exclusion does not void coverage for a project or for remedial (fix-it) costs associated with a claim also involving pollution. The exclusion does eliminate all coverage for claims due to alleged or actual damages caused by pollution. For example, a design or specification error could result in a hazardous/toxic substance escaping from a hospital and polluting a town's water supply. The policy will respond to the

costs associated with correcting the cause of the problem at the hospital but not to bodily injury to or property damage sustained by third parties as a result of the release of the hazardous/toxic substance.

ASBESTOS

This exclusion does not void coverage for a project. However, there will be no coverage for claims arising out of or in any way related to asbestos or asbestos products.

The language of the specific exclusions are enclosed. Please review this important information with your client.

Appendix B

ASBESTOS EXCLUSION

It is agreed that this policy does not apply to "claim" or "claim expense" alleged to or actually arising out of:

1. Specification of a product, material or process containing asbestos;
2. Failure to detect or advise of the existence or proportion of asbestos;
3. The performance or failure to perform "profes-

sional services" in the abatement, replacement or removal of a product, material or process containing asbestos;

4. Installation, modification, abatement, replacement or removal of a product, material or process containing asbestos;

whether by "you" or on "your" behalf.

All other provisions of this policy remain unchanged.

Appendix C

POLLUTION EXCLUSION

We will not defend or pay under this policy for "claim" and "claim expense" resulting from "professional services" performed by "you" and arising out of:

1. The actual, alleged or threatened discharge, dispersal, release or escape of "pollutants"; or
2. Any governmental or regulatory directive or request that "you" or anyone acting under "your" direction or control test for, monitor, clean up, remove, contain, treat, detoxify or neutralize "pollutants."

This exclusion does not apply to "claim" or "claim expense" resulting from "professional services" performed by "you" in the design and construction of treatment systems for:

1. Domestic sewage including those receiving industrial waste but only if such industrial waste is pretreated in accordance with applicable governmental or regulatory standards.
2. Potable water and;
3. "Storm water."

Additional Definitions

"Pollutants" means any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals, and waste. Waste includes materials to be recycled, reconditioned or reclaimed.

"Storm water" means water from rain, hail, snow or sleet.

All other provisions of this policy remain unchanged.

RETURN TO: _____



HOW YOUR PROFESSIONAL LIABILITY INSURANCE PREMIUM IS DETERMINED

By JAMES C. FARBER

The information in this article pertains to the rating methodology utilized in the premium computations for the smaller and medium sized architectural and engineering firms (\$0 to \$5 million in annual billings) insured in the CNA/Schinnerer Professional Liability Insurance Program. Because of their unique risk exposure and loss characteristics, somewhat different underwriting and rating methodology is used for larger firms (over \$5 million in annual billings) as it is for firms insured in one of the other CNA/Schinnerer programs — Land Surveyors, Landscape Architects, Design/Build, and Project Insurance.

INTRODUCTION:

In 1972, in response to the number of questions on the subject, we published Volume II, No. 10, of **GUIDELINES FOR IMPROVING PRACTICE**. That was the first article in the then brand new Insurance Section. The article was entitled, "Your Policy Premium—How it is Determined." In 1979, to reflect changes in the rating formula, a second article on the subject was published, "Determining Your Policy Premium—An Update," Volume VIII, No. 6.

Living to changes and refinements over the years in the rating structure, those articles no longer reflect current rating methodology. This is their replacement.

At Schinnerer & Co., we have always believed it is important for design professionals to have information on the factors which affect the cost of insurance. Thus informed, architects and engineers will be better able to comprehend liability risk exposures and their impact on professional liability insurance premiums.

The premium for an Architects' and Engineers' Professional Liability Insurance Policy is derived from the information provided in the application and supplemental material submitted by the design professional. The questions in that application are designed to accurately depict for the underwriters the exposures associated with a particular firm. From their understanding of the risks associated with a firm's practice, the underwriters can determine a premium which corresponds to those risks and is in accordance with rates

and underwriting rules on file with each state insurance department. Having chosen to operate as an "admitted carrier," Continental Casualty Company (one of the CNA companies) is subject to regulation by the insurance department of each state. Among other ramifications, this generally means that its rates, forms and underwriting rules must be approved by those state authorities.

Four main factors influence the premium of all firms: billings, location, type of services and claims experience.

BILLINGS:

A major factor used to determine policy premium is the firm's total annual billings for professional services. Total billings for professional services for the preceding twelve months are normally used as the basis for underwriting. The firm should use the twelve-month period that coincides with its accounting year (fiscal or calendar).

The CNA/Schinnerer application requires the design firm to report all billings for the past twelve months, including fees paid to consultants and billings from joint venture projects. Fees paid to consultants

**Your
Policy
Rating - III**

are not to be deducted because prime design professionals are vicariously liable for the acts of their consultants. Thus, there is an exposure which must be accounted in the premium computation process.

There are two categories of billings which most directly influence the premium calculation. One category includes fees received for design and construction-phase services (i.e., the traditional phases of a design professional's services), while the other category involves fees received for professional services related solely to feasibility studies, master-planning, reports or nonstructural interior design services.

Billings from normal design and construction-phase services create the full exposure anticipated by the established rates. Therefore, 100 percent of the fees received for services rendered in this category are utilized in the rating formula. The services included in the second category, however, create considerably less exposure to liability for the design professional. Therefore, billings for projects where a firm's only responsibility is to prepare a feasibility study or master plan or to provide nonstructural interior design services are adjusted to take into account the reduced exposure. This is accomplished by utilizing 25 percent of the fees reported in this category in the rating formula. In addition, revenues derived from landscape architecture and land surveying are also discounted.

LOCATION:

The state in which a firm's principal office is located is also a factor in the premium calculation. Based upon the loss experience within the CNA/Schinnerer program, state rates are established to reflect the claims exposure of firms located in each state. Thus, the rates for states in which firms have had fewer losses are lower than the rates for states with firms having less favorable loss experience.

TYPE OF SERVICES:

Classes of service which are used for rating purposes include architecture, electrical engineering, civil engineering, mechanical engineering, structural engineering and a combination of these. The rating factor for each discipline is determined by the actual experience of that discipline relative to the other disciplines. Historically, firms rendering primarily structural engineering services have had the most severe claims experience. Combined A/E firms or multidisciplined firms come next, followed by architectural firms, civil engineering firms and mechanical engineering firms. Electrical engineering firms have the most favorable claims experience.

CLAIMS EXPERIENCE:

Another important step in determining premium involves a careful review of the firm's claims experience,

including both paid and pending claims. Closed claims are reviewed on the basis of the amount of any settlement or judgment, plus the legal and other defense costs incurred. Pending claims are analyzed to determine what loss reserves have been established, the amounts paid to date and the design professional's potential liability as determined by CNA claims administrators and defense counsel. An experience modification representative of a firm's claims history, applied as a credit or debit adjustment in the rating process, is determined based upon the severity and frequency of the claims associated with that firm.

The severity of a firm's claims experience is determined by comparing the amount of money paid as a result of claims made against that firm, plus the total amount set aside as reserves for pending claims, to the total premiums paid by the firm over a period of time. The result is a percentage referred to as a firm's incurred loss ratio. Payments made by insureds within their deductibles are not included in the calculation.

While a firm's incurred loss ratio is the prime factor used to evaluate claim experience, consideration also is given to frequency of claims. Although simply reporting claims does not have an adverse effect on future premiums, an excessive number of reported claims may be indicative of potential loss-control problems.

Individual firm loss experience is a critical determinant of premium. Firms with adverse loss records may have a rate more than twice that of firms with favorable loss experience.

FACTORS YOU CAN CONTROL:

While the four factors discussed above are major influences on premium, there are other factors associated with a firm which can affect the premium charged. For example, certain types of projects lend themselves to greater exposures for the design professional. We view in-house quality control procedures and use of standard contract forms (those published by AIA and EJCDC) as positive indications of a firm's desire to prevent or minimize losses.

Not surprisingly, the premium charged will increase as the amount of coverage increases. Similarly, premium decreases as the deductible increases. Generally, we will offer quotations at several different options to give you flexibility in tailoring coverage to your particular needs and desires.

Questions frequently arise about the limit and deductible a firm "should" carry. The limit of liability really is a business decision to be made by the principals of a particular firm. It would be wise to remember though that the limit of liability on this type of policy is an aggregate limit of liability. This means that the limit of liability for the policy term is the total amount CNA will pay for all claims and claim

expenses during that policy term. In their decision, the principals must consider the exposures created by their firm, the possibility that more than one claim might be made during the policy period, the amount of protection desired and how much they feel they can afford to pay for that protection.

CONCLUSION:

A thoroughly completed application is required to determine an architects' and engineers' professional liability insurance premium. The complex nature of the rating process makes it inappropriate for our underwriters to provide "ballpark" quotations. Applications must be submitted early, well before existing

policies expire. This is a highly individualized process and underwriters need time to evaluate exposures and calculate appropriate premiums. A complete application not only allows the underwriters to tailor a proposal to fit your individual needs, but also allows the design firm the opportunity to present itself as it feels it should be viewed.

If in your opinion the application and your answers to the questions posed do not accurately portray your firm and the services you provide, a note should be attached to the application to expand upon answers. Please feel free to share with us any additional information that you believe will assist us in better understanding the nature of your practice, as that understanding ultimately determines your premium.



QUALITY ASSURANCE CHECKLIST

The following list of recommendations for avoiding professional liability losses has been developed from an examination of more than 30,000 claims filed against architects and engineers. It is hoped that design professionals will compare this checklist against current practices within their firms. We urge you to circulate this list in your firm. If you wish, you may make copies for distribution to each firm member.

I CLIENT SELECTION

- (a) Do assure yourself that your client has a financial capacity to undertake the proposed project.
- (b) Do avoid undertaking projects for clients whose past record indicates they are prone to litigation.
- (c) Do avoid undertaking projects of a purely speculative nature unless the client has a proven record of completing such projects.

II SELECTION OF CONSULTANTS

- (a) Do select your consulting professionals on the basis of their competence, and ability to perform the specific project at hand.
- (b) Do be certain that work performed by consultants is under written contract.
- (c) Do be certain that the contract with the consultant clearly outlines his scope of responsibility.
- (d) Do be sure that your consultants have an adequate number of staff personnel.
- (e) Do be sure that your consultants have evidence of sufficient financial responsibility, such as professional liability insurance, for the project.

III PERFORMANCE BY STAFF MEMBERS

- (a) Do appoint a qualified and experienced member of your firm to coordinate in-house quality control efforts.
- (b) Do establish checking procedures to detect simple errors and omissions in plans and specifications.
- (c) Do have the work of less experienced staff members carefully checked by a principal of the firm or by a responsible, experienced employee.
- (d) Do establish an office manual setting forth the duties and responsibilities of all positions in the firm.

IV CONTRACT DOCUMENTS

- (a) Do be thoroughly familiar with the terms of your agreement with your client.
- (b) Do be certain to have a written contract, preferably one of the NSPE or AIA standard forms, for every project, regardless of size.

- (c) Do be thoroughly familiar with the rights, duties and responsibilities assigned to you in the general conditions of the contract between the owner and the contractor.
- (d) Do use extreme care in modifying or supplementing standard forms of professional services contracts.
- (e) Do consult your lawyer concerning the effects of such modifications.
- (f) Do check with your insurance counsellor about the effect that contract changes may have on your insurance coverage.
- (g) Do be certain that any changes in services to be performed are reduced to writing and made on the basis of an amendment or supplement to the original agreement with the client.
- (h) Do not use non-standard contract forms without consulting your legal counsel to determine whether such non-standard contract forms impose responsibilities which you cannot or are not willing to assume.
- (i) Do be certain that the client understands that estimates of probable construction costs cannot be guaranteed.
- (j) Do be certain that the owner understands that an estimate of probable construction costs is not a promise to design the structure within a cost limitation.
- (k) Do make certain that all changes, directions or orders affecting fees, cost of the project or design or scope of the project are confirmed in writing.

V SPECIFICATIONS

- (a) Do inform all project personnel concerning the proposed content of the specifications while the drawings are being prepared.
- (b) Do coordinate the preparation of the drawings and specifications throughout the Con-

struction Documents Phase.

- (c) Do begin preparing the specifications when work on the drawings is begun; do not wait until the drawings are virtually complete.
- (d) Do not "over" specify or "under" specify—use just the right amount of text to communicate project requirements to the contractor.
- (e) Do use standard specification language so that all parties will be able to understand what is intended by the written word.
- (f) Do review the text of all specifications carefully to ascertain whether (1) it really reflects the intent of the design, and (2) the items specified can meet the performance requirements.
- (g) Do beware of typographic errors in the final version of the specifications.
- (h) Do consider subscribing to a master specification system such as MASTERSPEC.

VI USE OF MATERIALS AND EQUIPMENT

- (a) Do not use new materials or equipment without determining their suitability for the exact purpose for which you are specifying them.
- (b) Do not rely on producer's sales literature regarding the suitability of new material or equipment.
- (c) Do not rely on test reports furnished by the manufacturer unless the scope of the test and reputation of the tester are known.
- (d) Do make certain that the producer of new material or equipment knows how his product is to be used in your particular application.

VII CONSTRUCTION PHASE SERVICES

- (a) Do be certain that the owner understands that you are not and cannot be a guarantor of the contractor's performance.
- (b) Do be certain that the owner understands that his greatest protection against faulty workmanship lies in the competence and integrity of the contractor he selects.
- (c) Do avoid contractual language that might have the effect of making you responsible for the safety of personnel at the job site.
- (d) Do be careful that all of your dealings and those of your field representatives are through the general contractor and not directly with subcontractors.
- (e) Do not disapprove of subcontractors except in an objective and factual way, so as to avoid any possible claim for defaming a subcontractor.
- (f) Do be certain that the contractor and subcontractors fully understand the agreed on procedure for handling shop drawings.

- (g) Do not approve shop drawings in a manner that indicates approval for other than conformance to the design concept of the project and compliance with the specifications and drawings prepared by you.
- (h) Do make certain that all instructions to the contractor are confirmed in writing.

VIII BUILDING CODES AND ZONING RESTRICTIONS

- (a) Do be familiar with all zoning laws, building codes and restrictions applicable to the project.
- (b) Do be aware of the fact that in most cases building codes requirements are minimums.

IX OCCUPATIONAL SAFETY AND HEALTH ACT

(a) In the Office—Know Your Responsibilities as an Employer

1. Contact the Occupational Safety and Health Administration for copies of pertinent documents published in connection with the Act.
2. Examine safety and health facilities in your office for compliance with the Act.
3. Post required notices furnished by the OSHA Administration.
4. Hold periodic meetings with your office staff to review safety and health requirements.
5. If an inspector calls, be aware of the extent of his authority.
6. Keep records of "recordable" injuries.

(b) At the Construction Site—Know Your Responsibilities as an Architect or Engineer

1. Instruct your own employees to not intentionally expose themselves to hazardous conditions during periodic visits to the site.
2. Do not include a safety program in the Project Manual or the technical specifications.
3. Do not interfere with the contractors' responsibilities to provide a safe and healthful work environment for their employees.

(c) In the Design—Know Your Responsibilities as a Design Professional

1. Be aware of OSHA standards which affect design conditions.
2. Review applicable building codes in conjunction with a review of OSHA standards to determine when the Act takes precedence.
3. Advise the owner of budgetary adjustments necessitated by the Act's requirements.

**PRESENTATION GUIDE
FOR
“PROFESSIONAL LIABILITY”**

**A video produced by the
Professional Engineers in Private Practice
of the
National Society of Professional Engineers**

**This discussion guide was prepared courtesy of the
Sustaining University Program
Professional Engineers in Education**

A PRESENTATION KIT FOR "PROFESSIONAL LIABILITY"

A video produced by the Professional Engineers in Private Practice of the
National Society of Professional Engineers

The purpose of this video is to provide an historical perspective on professional liability claims made against consulting engineering firms, to review the severity of the issue, to offer advice on how to avoid claims, and in the event of a claim, on how to place the firm in a more defensible position.

CONTENTS

This presentation kit contains the following materials:

- A synopsis of the videotape dramatization
- Suggestions on how to organize the presentation
- Background on the issue of professional liability for the discussion moderator
- Discussion Questions (moderator's copy)
- Discussion Questions (students' copy—to photocopy for distribution)
- Selected Sections from "Guidelines for Improving Practice"
(Courtesy, Victor O. Schinnerer & Co., Inc.)
 - Glossary of Insurance Terms
 - A Blueprint for Risk Management for Projects Involving Pollution or Asbestos Exposures
 - How Your Professional Liability Insurance Premium is Determined
 - Quality Assurance Checklist

PROFESSIONAL LIABILITY is a dramatization of the history of a professional liability claim. It provides information on how a common liability exposure is created and attempts to educate its audience on how such exposure can be avoided. It is divided into three parts with a total running time of approximately one hour.

PART ONE: (22 minutes)

The firm of Apple & Bartlett is introduced and the basis for the case study of a client's claim against the firm documented. Expert commentary provides information on the history and severity of such claims and examines problems such as inconsistency in the assignment of responsibilities, difficulties in client selection, and constraints from underfunding the project. A discussion of the contract negotiation process, the risk and responsibility of the firm, and the creation of a design team utilizing the firm's capabilities is presented.

PART TWO: (18 minutes)

The development of the condition leading to the claim and the correct, and incorrect, actions the firm took in an effort to avoid a claim are detailed. Commentary examines the failure of firms to fully implement quality control procedures, the need to be realistic in the time and money needed for project completion, and the advantages of sound project management techniques. The importance of proper client selection procedures, recognition of the risks involved in a project, recordation of activities and communication, and a thorough understanding of the terms and conditions of the contract are discussed.

PART THREE: (16 minutes)

The aftermath of a claim against Apple & Bartlett is examined. Techniques for defending against such a demand for money or services are highlighted. The steps that a design professional must take to avoid assuming liability in a claim situation are enumerated. Comments on the methods of risk avoidance and claims management are included, as is summary information on the frequency and severity of claims against design professionals. The video seminar stresses that most claims arise from poor management, not poor engineering, and that management efforts such as using loss prevention tools and quality control procedures combined with a client screening process and the avoidance of unnecessary risk can be vital in preventing claims or, in the case of a claim, in defending against it.

SUGGESTIONS ON HOW TO PRESENT "PROFESSIONAL LIABILITY"

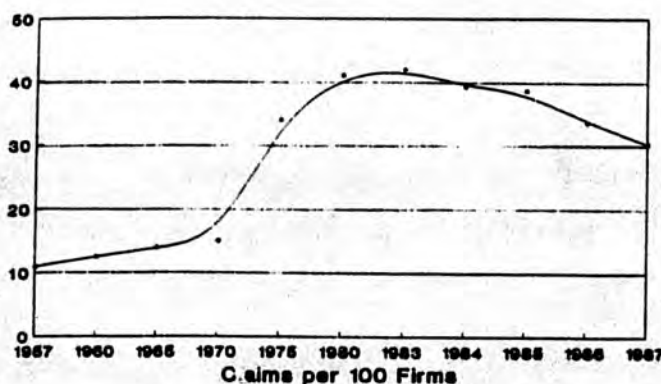
1. To be most effective, the video should be viewed in a group and discussed with the guidance of a moderator. However, if necessary, the tape is straightforward enough to be viewed and reviewed independently using an adaptation of this discussion guide.
2. Because the entire tape runs nearly an hour and is presented in three equal parts, you may wish to stop the tape for some discussion between each part.
3. Material in the video is appropriate for senior engineering seminars, engineering law or business courses.
4. The moderator/instructor may wish to have copies of this guide made to distribute to students at the end of the program.

BACKGROUND FOR DISCUSSION MODERATOR

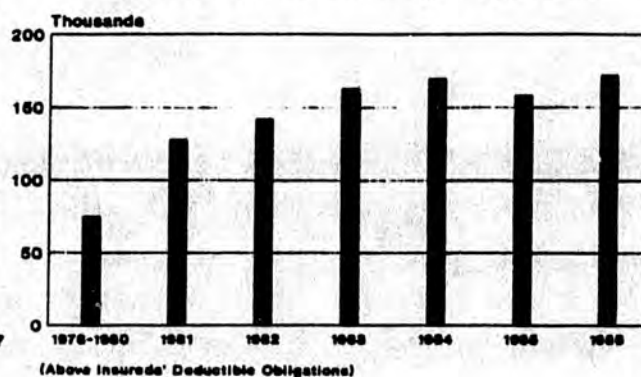
Update on Statistics

Since this tape was prepared, engineering firms appear to have made successful progress in avoiding and defending against claims. The frequency of claims has dropped significantly and the severity of claims appears to be stabilizing:

Frequency of Claims



Average Paid Claim Value
Claims with Indemnity Payments



Current data (5/11/89) indicate:

FREQUENCY OF CLAIMS* PER 100 FIRMS = 30.3%

NOTE: This doesn't mean that out of a random sample of 100 firms, an average of 30 firms will have claims brought against them; rather, it means that out of a random sample of 100 firms, those firms will collectively represent an average of 30 claims—e.g., one firm may have 6, another 2, etc.

SEVERITY OF CLAIMS MEASURED BY THE AVERAGE PAID CLAIM = \$ 171,763 in 1986

NOTE: This is the dollar amount associated with each claim where an indemnity payment to the claimant has been made by the insurance company. This is over and above the firm's deductibles and includes defense costs.

**DATA ON BODILY INJURY & DEATH CLAIMS (CURRENT TRENDS)
AS SHOWN IN % OF CLAIMS = 25%; % OF LOSSES = 15%**

NOTE: This means that only 25% of all claims are for bodily injury or death; 15% of the dollars paid on claims with an indemnity payment by the insurance company (indemnity and expense) go for bodily injury or death.

UPDATE ON CURRENT MAJOR SOURCES OF PROBLEMS

In addition to committee clients and sewage treatment plants, sewer pipelines and highways are projects that constitute a high percentage of claims. Problem areas within a project include walls and bearings, columns and beams, and roofs.

* Claim = demand for service or money alleging negligent performance.

DISCUSSION QUESTIONS FOR MODERATOR

1. According to the film, what makes a firm vulnerable to professional liability claims?

Vulnerability to claims usually starts with how the contract relationships are defined and the contract itself. It is important that a contract have clearly defined and delineated responsibilities of the engineer and the contractor, no co-responsibility between the engineer and the contractor, and that where there is a duty established for the engineer in its agreement there be the corresponding authority to carry out that duty in the General Conditions of the Contract for Construction.

Terms used to describe construction administration responsibilities of the engineer should be used carefully. "Supervision" during construction means to manage, direct, and control the contractor. Does the engineer do this? Is this within the engineer's control?

"Inspection" means to make a critical evaluation. How does this differ from the term "observation"? Inspection connotes a higher degree of care than does observation.

When in doubt, always look up the word in the dictionary and see what ordinary meaning is assigned to it. Then decide if this is what the engineer intends to do, and if it is within the engineer's control.

2. "Don't's" for Engineering Firms Considering a Contract:

Don't base your selection of a client on anything but quality. Don't take on a job before funding is assured. Why? If you sue to collect a fee the client withheld, counterclaims often result for breach of contract, negligence, etc.

3. And, before you accept a contract, remember:

- a) Select clients with care; check credentials and whether they have a history of bringing claims;
- b) Look at the project; can your firm handle it? Do you have the technical expertise? Do you have the time? What about your consultants?
- c) Understand the agreement . . . and the risk!; measure risks against responsibilities; if possible, use standard contract documents.
- d) Look at the fee—is it appropriate to the scope of services to be provided and the probable liability risk? Will any probable loss be large, moderate or small?

4. What were the management mistakes Apple & Bartlett made?

- a) Showed poor judgment in client selection;
- b) Signed bad contract, guaranteeing their work (this amounts to guaranteeing the work of all subcontractors as well and therefore is excluded from insurance coverage); the fee was too small and the completion date unrealistic;
- c) Discussed the contract with the insurance carrier's legal counsel only *after* signing it; (whether they'll be covered will depend on the kind of claim);

5. What did they do right ?

- a) Documented everything to a file (NOTE: do *not* include anything other than the facts—no opinions—they can be used against you in a court of law);
- b) Enforced strict quality control procedures;
- c) Had a good project team in place;
- d) Used the same team for Phase I & II of the project; took the entire team to the site;
- e) Established a single communications point with the client (their project manager) who served as the quality control "point-man";
- f) Knew the contract;
- g) Invoiced the client; refused to proceed unless paid for the work done.

6. What should you remember if threatened with legal action?

- a) Notify insurance carrier immediately of potential claim.
- b) Do not assume or admit liability; the problem is rarely the fault of any single party.

Do *not* rely on a "statute of limitations." Why? It is not a safe harbor; statistically, most claims are made during construction or within ten years after substantial completion.

SUMMARY

Are most claims the result of technical design error? No. What causes most claims is the engineer's assumption of responsibilities in execution of a project s/he never intended or realized s/he had assumed. claims can result from the signing of non-standard contract forms if these contracts call for unreasonable and unrealistic expectations of the design professional.

Successful claims avoidance and claims defense result from sound practice within the firm. The best investment an engineer can make is the investment of time spent in communicating with the client, educating the client on the design process and its limitations, and keeping the client informed. This helps avoid conflict—which costs everyone connected with the project time and money—up front.

REMEMBER: THE BEST DEFENSE IS GOOD PRACTICE.

Professional Liability was created and produced by the Professional Engineers in Private Practice, a division of the National Society of Professional Engineers. For more information about the activities of PEPP on behalf of consulting professional engineers, including other professional development programs, contact the PEPP staff director, NSPE, 1420 King Street, Alexandria, Virginia 22314.

The **Sustaining University Program** of NSPE's Professional Engineers in Education wish to thank Victor O. Schinnerer & Co., Inc., for their valuable help in developing this discussion guide.

"PROFESSIONAL LIABILITY"

Discussion Questions for Videotape

1. According to the video, what makes a firm vulnerable to professional liability claims?
2. What are the basic "don't's" a firm should remember before accepting a contract?
3. What steps should a firm follow before signing a contract?
4. What were the management mistakes Apple & Bartlett made?
5. What did their firm do right?
6. What should you remember if threatened with legal action?

D.6

DAVID E. ROGERS

LAWYER

P.O. Box 33932
JUNEAU, AK 99803

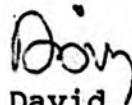
907-586-2366
FAX 907-586-6959

March 19, 1990

Hi.

Enclosed is my tentative summary of the claims experience information contained in one of the data volumes. I stress the word "tentative" because this stuff is a little complicated and I haven't had a chance to take a second look or seek verification from MICA or MIEC. Please use this information accordingly. In the next week or so, I also plan to send out revised versions of the data summary memo and highlight summary to reflect the information on peer review panel results provided orally to the Task Force by Janet Johnston which I just received in writing; and other minor changes.

Your friend,


David

A variety of solutions are under discussion including a plan proposed by Virginia Johnson, Dean of the School of Education at the University of Alaska Anchorage, called the Middle School Day Care Center, which would locate day care centers at the six middle schools in the Anchorage area with the curriculum being developed by the Director of the Day Care Centers.

It is difficult to determine if the cost of liability insurance contributes to the day care service gap. It is my understanding based on several informal conversations with people familiar with these issues that affordability and availability is less of an issue at the present time, even for new facilities. It is interesting to note that current policies exclude liability for molestation/abuse related circumstances and, in some cases, require adult/child ratios that exceed state standards.

5. CLAIMS EXPERIENCE - Preliminary Findings: *WJH*

a. Professionals: We requested claims experience data from all of the major admitted professional carriers. However, only information received from MICA and MIEC, the major medical liability carriers is useful. Generally, the information provided indicates that: 1) most medical malpractice claims/recoveries in Alaska fall within the 0-\$150,000 category (MICA tells us that the average claim is \$48,731; average claim where indemnity is paid is \$124,353; 2) there are few "jumbo" recoveries (over \$1 million), and none reported over \$3 million (through 1988), but payments on these claims typically represent a large percentage of total payouts for a given year (MIEC tells us that nationally about 3% of claims account for over 70% of loss costs; these numbers appear to be consistent with their Alaska experience); 3) Punitive damages are rarely, if ever, awarded; 4) most claims are settled prior to trial; many are settled without legal action; 5) for MICA at least, less than one-half of claims filed result in a payment to the claimant; 6) on the average, MICA defense costs are approximately 18 cents per dollar; this number varies depending whether the claim was settled without litigation whether there was a payment to the claimant and other factors; and 5) it is hard to predict which doctor will cause the big claims, although MIEC tells us that the highly, trained well regarded physicians often get the "jumbo" cases.

b. Self-insured/Uninsured entities: We have surveyed a wide variety of public and private "self-insured" entities. Results received from the State of Alaska, the University of Alaska, the Municipality of Anchorage, the Anchorage School District, the City of Fairbanks, the North Star Borough, the North Star Borough School District, the City and Borough of

Juneau, NANA Regional Corporation, Inc., Nabors Alaska Petroleum Services, Phillips Petroleum Company, the Carr-Gottsten Corporation, Petersburg General Hospital and Cordova Community Hospital indicates that: 1) the majority of claims are between 0 and \$50,000, public entities report more claim activity than private entities; 2) most are settled, often prior to formal legal action; 3) there are occasional large claim payouts (mostly the State of Alaska;) which typically represent a large percentage of total losses in a given year; 4) defense costs do not appear to be significant but this information requires further analysis. Please note that NANA has made two specific suggestions of issues that should be looked at by the Task Force which are contained in their letter to David Rogers dated January 31, 1990 attached.

6. ROLES AND MECHANISMS OF STATE AGENCIES: The information provided is self-explanatory. However, please note that the Division of Insurance has four primary functions: a) Market Conduct Surveillance (review and approve as appropriate all rate and form filings and perform market conduct examinations on insurance companies or producer licensees to ensure that the consumer is treated fairly in the marketplace); b) Licensing (to license qualified individuals and insurance companies to market insurance in Alaska); c) Financial Surveillance (primarily to ensure solvency - i.e. that the company has sufficient reserves to protect policy holders and pay their claims - and to determine if investments meet statutory requirements and if reinsurance agreements comply with Alaska law); and d) Consumer Complaint and Investigation (to investigate and resolve individual consumer complaints that are filed with the Division. Statistical data that is collected by this section is utilized by the market section as a means to identify licensees or trade practices that warrant further examination.

7. STATUS OF STATE SUIT AGAINST INSURANCE COMPANIES: This lawsuit was filed by 19 states against four major American primary insurance companies and a variety of reinsurance companies alleging anti-trust violations in the form of a pattern of collusion. According to the Attorney General's Office, the allegations are that leading primary insurance companies and reinsurers conspired to withdraw casualty and pollution coverage from the United States market; and that defendants coerced others to take actions which prevented other potential competitors from offering these types of coverage resulting in consumers paying more premium for less coverage than ever before. Tom Slagle of the American Insurance Organization adds that the primary thrust of the lawsuit was that various entities conspired to eliminate the occurrence policy for a claims made policy. In October of 1989, Federal District Court Judge Schwarzer granted defendants' motions to dismiss and entered final judgment

file D.7

Alaska State Legislature



Speaker of the House of Representatives

Pouch V
State Capitol
Juneau, Alaska 99811
(907) 465-3720

Official Business

Memorandum

TO: Liability Insurance Task Force Members

FROM: Representative Sam Cotten *SC*
Chairman

DATE: April 2, 1990

RE: Task Force

=====

Enclosed are the following:

1. Transcript from the "MacNeil/Lehrer Report". I have also ordered the video tape of this segment and expect it to arrive in Juneau shortly.
2. Preface, contents pages, and executive summary from the "Harvard Study." I have been given permission by Harvard's Copyright Office to photocopy and distribute these sections of the study. I have the full study in my office and if you desire to borrow this item, please contact me.

I would also request that each member of the Task Force submit his or her report (as discussed at the last meeting) to my office as soon as possible.

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

MAC NEIL/LEHRER NEWSHOUR

Wednesday, February 28, 1990

WNET, New York, New York

SHOW #3678

ANCHORS:

ROBERT MAC NEIL

JAMES LEHRER

NEWS MAKER:

DANIEL ORTEGA, President, Nicaragua

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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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 socio-economic background may not feel that he has the wherewithal or she has the wherewithal to pursue 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 health care 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, valiative procedures that are available to the valiative

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 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.

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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- 5D - Physician Record Review Manual

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- 8A - Patient Interview Survey Instrument
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- 9A - Physicians' Mailed Survey Instrument
- 9B - Letters, Charles Sherman, M.D. and Howard Hiatt, M.D. to New York State physicians regarding mailed survey
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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.

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

ACRONYMS

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DDA - Discharge Data Abstract
DOH - Department of Health
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MDC - Major Diagnostic Category
MLMIC - Medical Liability Mutual Insurance Company
MM - medical management
MMIA - Medical Malpractice Insurance Association
MSA - Metropolitan Statistical Area
NAIC - 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

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

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 Chauformier, 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

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.

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

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

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.

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

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

Alaska State Legislature

D.8



Speaker of the House of Representatives

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811
(907) 465-3720

Memorandum

TO: Liability Insurance Task Force

FROM: Rep. Sam Cotten
Chairman

DATE: April 12, 1990

RE: Harvard Study Materials

The Harvard Study materials sent to you were incomplete. Enclosed is a complete set of the information from that study.

**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**

Copyright 1990, President and Fellows of Harvard College

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GLOSSARY, continued

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 experts to examine it and to comment on its appropriateness.

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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 methodology. 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.

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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.

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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.

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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.

D.9

DAVID E. ROGERS
LAWYER

DRAFT

P.O. Box 33932
JUNEAU, AK 99803

907-586-2366
FAX 907-586-6959

June 17, 1990

Dear Task Force Member:

At long last, here is a draft final report for your review and comments. With the exception of the cover document ("Final Report of the House Liability Task Force") you've seen most of this before; although I have made several editorial and content changes to the primary memo and the "Highlight Summary" (see, for example, "Peer Review Panel Results" which incorporates additional information supplied by MICA).

Please look these materials over one more time and get back to me with your final comments and concerns. For example, I know at least one member is uncomfortable with the "Highlight Summary" in its present form. I will incorporate all reasonable suggestions.

On a related note, Dan Hensley has received information that approximately six new obstetricians have begun practicing in Anchorage in the last two or three years, and that two additional obstetricians will begin practicing there in the near future. In Dan's opinion, if "the information I was told is accurate, it seriously undermines the credibility of the representations made to the Task Force. It may be that increased competition, and not insurance rates, is causing the financial distress that we have been hearing about." I would appreciate comments on this situation from anybody out there who is in a position to respond.

Similarly, I would appreciate comments on the attached "Comparison of Results in the Justice case." This information purports to quantify the difference between judgements Alaska Style versus awards under the California rules. I think the issue deserves further analysis for the record.

That's about it. I'm sorry about the delay in getting this out to you but as some of you may know my stepson was in a serious automobile accident in April and his recovery was the only thing we could think about for awhile. The good news is that he is doing fine following excellent treatment at Bartlett Memorial Hospital.

I miss you guys.

Very Truly Yours,

A handwritten signature in dark ink, appearing to read "David". The signature is stylized with a large, looped "D" and a small dot above the "i".

David E. Rogers

In November of 1987, MICA went to trial on the Justice v. Humana Hospital case. MICA insured each of the three defendants including the hospital on a "tail" policy purchased when Humana bought Community Hospital. The two physician defendants were dropped the day before trial by the plaintiff's attorneys and the hospital became a single defendant.

CASE FACTS:

Justice was seen in the emergency room on two occasions in May of 1982, from a fall in an Anchorage bar. The visits were both in the middle of the night and 25 hours apart. 48 hours later the patient presented himself to Los Angeles County Hospital where he was admitted and discharged the next day. He was admitted yet again five days later, discharged, and finally readmitted twelve days later comatose with a right sided hemiplegia.

LEGAL ACTION:

Separate suits were filed in California and later in Alaska. L.A. County made a settlement with an agreement that if the plaintiff was successful in Alaska, L.A. County could recover 1/3 of the Alaska award to a maximum of \$300,000.

TRIAL RESULTS:

MICA tried to join L.A. County Hospital in a joint defense. Certainly they were responsible for the last and longest treatment. Our court would not allow this and further would not allow any negligence by L.A. County to be a defense. The outcome was a verdict with the plaintiff 10% negligent and Humana 90% negligent. The verdict was an award totaling 1.3 million with add-ons for prejudgment interest and Rule 82 increasing the award to in excess of 2 million dollars.

TORT REFORM EFFECTS:

The cost to Alaska to pay for the plaintiff who had already received retribution in California is substantial. Tort Reform legislation would have had an absolute impact on the results of this case. Under Tort Reform legislation the extent of L.A. County's negligence would have to be considered, the percentage of fault for Humana would be affected under joint and several liability, collateral source from the L.A. settlement would have to be offset and finally a cap on non-economic losses would have impacted the judgment.

MICA feels this is an excellent representation of the positive effects of California tort reform. Because of our own laws, Alaskans paid in the extreme for a plaintiff that had been compensated elsewhere. Our analysis of the Justice case leads us to the irrevocable conclusion that tort reform legislation will decrease costs to Alaska and its citizens.

COMPARISON OF RESULTS IN JUSTICE CASE

California

Alaska

(California WITH Tort Reform)

(Alaska WITHOUT Tort Reform)

\$32,000 per year for life expectancy of 42 years	\$305,618
$42 \times \$32,000 = \$1,344,000$	
\$75,000 payment on July 1, 1995 = 75,000	28,113
\$200,000 payment on July 1, 2005 = 200,000	28,101
\$400,000 payment on July 1, 2015 = 400,000	22,123
Present value of future payment as of July, 1985	\$383,958
Plus cash payment on July 1, 1985 = 50,000	50,000
Plus attorney fees present value as of July 1, 1985 = 130,000	130,000
Plus costs = 15,000	15,000
FUTURE VALUE = \$2,214,000	
TOTAL (TODAY'S COST)	\$578,958

Total Jury Verdict	\$1,449,160
Pts. 10% comparative neg.	-144,916
Subtotal	1,304,244
Present value of L.A. Hospital settlement as of July, 1985	-210,201
Subtotal	1,094,043
Collateral benefits pursuant to AS 09.55.548 (b)	- 89,378
Subtotal	1,004,665
Prejudgment Interest @ 10.5% per annum from May 30, 1982 (date of injury) through March 16, 1988	683,534
Subtotal	1,688,199
Rule 82 (a) attorney fees	171,319.90
JUDGMENT	1,859,518.90
Plus Costs (not yet known) (+)	

TORT REFORM WORKS!

In California, the plaintiff receives (\$2,214,000) from a structured settlement for a present cost of \$578,950.00.

In Alaska, the plaintiff receives \$1,859,518.90 (+) for a present cost of \$1,859,518.90 (+).

The cost to health care consumers in Alaska is three times the amount that it is in California.

Senate Bill 211 will enact reforms benefitting all Alaskan insurance consumers while protecting those the civil justice system serves.

DRAFT

FINAL REPORT OF THE HOUSE LIABILITY TASK FORCE

The Liability Insurance Task Force was established by the Alaska House of Representatives during the first session of the Sixteenth Alaska Legislature through House Resolution 10 (HR 10) in an effort to sort out the many controversies concerning "Tort Reform" and to "determine how the State may more effectively regulate insurance and provide civil justice"(see attached copy of HR 10). The task force consisted of the chairs of the House Judiciary, Labor and Commerce and Health, Education and Social Services Committees and other members appointed by the Speaker of the House including public members "who are involved in tort reform issues or who are involved in insurance or civil justice". A complete list of the Task Force membership is attached.

The resolution noted in particular the problems faced in the public and private sectors as a result of rising insurance costs. It concluded that a comprehensive review of "statutes, case law, practices of the insurance and legal fields and the relationship between insurance costs and civil justice" is warranted under the circumstances and instructed the task force to "recommend to the legislature any changes to the statutes appropriate and necessary for reducing insurance costs and improving civil justice".

PRIOR LEGISLATIVE EFFORTS

The issue of liability insurance availability first surfaced in Alaska in the early 1970's. By 1975, the medical community concluded that legislative relief was required. A bill creating a Joint Underwriting Association passed the legislature during the 1975 session, but was vetoed by Governor Hammond who instead created the Governor's Medical Malpractice Commission to study the problem and make recommendations to the Legislature. (See attached). On the basis of this report and following extensive hearings on the matter, the Legislature enacted a comprehensive program which set up the basic medical malpractice claims system in operation today and which created the Medical Indemnity Corporation of Alaska, a primary medical malpractice insurer and required all Alaska doctors to participate as a condition of licensure. This latter provision was repealed in 1978 where participation was made voluntary.

There were no significant additional developments until 1986 when the Legislature passed "Tort Reform" legislation largely in response to doctors and others who were concerned

about insurance availability and affordability (rates had climbed to record highs). Conference CS for Senate Bill 377 made a series of changes to our civil justice system including: Modified joint and several liability; Caps on non-economic damages (\$500,000 except damages relating to disfigurement or severe physical impairment); increased burden of proof for establishing punitive damages; limits on a person's ability to recover damages for personal injury incurred while that person was committing a felony; detailed provisions on requirements for damage awards; limited liability for certain directors and officers of non-profit corporations, non-profit hospitals (including hospital citizen advisory boards) and members of school boards and school districts and members of governing bodies, commissions and citizen's advisory committees of a municipality; and provisions on contributory fault, collateral benefits, apportionment of damages, offers of judgment, costs and attorney's fees, including pre-judgment interest, and the effects of a release. This legislation has been characterized as a "patch-work quilt" of necessary compromises, and, in the view of many tort reform advocates, did not go far enough toward making Alaska's civil justice system fair and predictable.

During the 1988 session, tort reform legislation intended to complete the 1986 effort was considered by the Legislature but significant differences between the House and Senate could not be resolved. However, the voters approved in November 1988 an initiative which eliminated joint liability for tort and other actions involving fault. A related provision limiting attorney contingency fees was disallowed by the Lieutenant Governor and is now the subject of litigation.

In 1989, there was another unsuccessful attempt to pass additional tort reform laws which led to HR 10 and this Task Force. Most of the controversial issues remain unresolved following the final session of the Sixteenth Alaska Legislature. However, please note that the Legislature did make several important changes to laws governing the regulation of professional conduct particularly the medical profession (See the final version of HB 146).

SUMMARY AND RESULTS OF TASK FORCE EFFORTS

At its first meeting Task Force members, tired of relying on "anecdotal evidence", concluded there was a need to establish a common factual basis for their consideration of the issues. Accordingly, a list of threshold factual questions was prepared collectively by the Task Force with instructions to Task Force Special Counsel, David Rogers, to develop the appropriate information in response to those questions and report back to the Task Force as soon as

possible for further discussion. The result of this fact gathering effort is contained in a seventeen volume submittal incorporated herein by reference. These attachments contain the best information available at the time primarily from "non-partisan" sources. For a detailed discussion of how the information was developed and what each packet contains see attachment # 1. A "Highlight Summary" is included as Attachment #2. A detailed summary of the information is contained in Attachment #3.

At its second meeting this information was summarized and presented to the Task Force by David Rogers with participation by representatives of state agencies and others and considerable discussion by Task Force members. At its final meeting a problem/solution format suggested by Rep. Fran Ulmer was reviewed but no final action was taken due to an inability to obtain consensus on most of the issues.

Nevertheless, at the request of Chairman Cotten, several Task Force members did offer their written conclusions and observations which are included as Attachment #4. While attitudes about what the problem is and what you can do about it are divergent, it is important to note that based on these written comments and comments made during Task Force deliberations, there appears to be agreement on two critical points:

- 1) THERE IS A NEED TO FURTHER CONSIDER ALTERNATIVE DISPUTE RESOLUTION MECHANISMS WHICH MAY REPRESENT AT LEAST A PARTIAL SOLUTION TO MANY OF THE PROBLEMS IDENTIFIED BY CRITICS OF THE PRESENT SYSTEM INCLUDING: UNREASONABLE DELAY, EXCESSIVE COSTS OF LITIGATION, UNPREDICTABILITY AND FAIRNESS OF COMPENSATION AND LACK OF ACCESS TO THE COURTS; and
- 2) THERE IS A NEED FOR FURTHER INFORMATION AND ANALYSIS OF ISSUES CONCERNING THE INSURANCE INDUSTRY AND REGULATION OF PROFESSIONAL CONDUCT.

CONCLUSION

Despite the frustration expressed by several members of the Task Force about our inability to draw final conclusions, there is general agreement that the materials gathered and reviewed over the past year have brought us one important step closer to a collective understanding of the problems and potential solutions faced by policymakers and the public in the civil justice arena. And by establishing a common factual basis that frees us from the never ending battle of anecdotal claims, the work of the Task Force should help decisionmakers narrow the focus of future discussions.

LIABILITY INSURANCE TASK FORCE MEMBERS

Legislative Members:

Representative Sam Cotten, Chair
Representative Red Boucher
Representative Virginia Collins
Representative Dave Donley
Representative Johnny Ellis
Representative Peter Goll
Representative Max Gruenberg
Representative Ron Larson
Representative Loren Leman
Representative Mike Navarre

Non-legislative Members:

Gary Fye, Gary Fye Company, PO Box 92971, Anchorage 99509, 272-1502
Insurance Investigator

Vince Haneman, University of Alaska, Dean of Engineer, 539 Duckering,
Fairbanks 99775, 474-7330, Educator/Engineer

Russ Huffman, M.D., Past President, Alaska State Medical Association,
701 Stearns Place, Paynesville, MN 56362, (612) 2443-3666,
Physician

Jeff Jefferson, Esq., 215 Fidalgo Street, Kenai 99611, 283-9187,
Attorney

Nancy Lord, PO Box 558, Homer 99603, 235-8252, Consumer

Ames Luce, Esq., Luce & Hensley, 1015 West Seventh Avenue, Anchorage 99501,
272-9403, Attorney

David McGuire, M.D., 4040 Laurel, Anchorage 99508, 562-4142, Physician

Al Parrish, Westmark Hotel, 880 H Street, Anchorage, AK 99501, 272-9403,
Businessman

Mary Pierce, MICA, Aleut Plaza, 4000 Old Seward #203, Anchorage 99503,
563-3414, MICA

Jim Witt, Teamsters, 4300 Boniface #449, Anchorage 99510, 269-4258,
Attorney

Alternates at March 2-3, 1990 Meeting

Bill Brock for Mary Pierce, PO Box 20709, Juneau 99802, 586-3656,
Financial Management Consultant and Chair of MICA

Dan Hensley for Ames Luce, Luce & Hensley, 1015 West Seventh Avenue,
Anchorage 99501, 272-9430, Attorney

Richard Ritter for Vince Haneman, Minch Ritter Voelckers Architects, 800
Glacier Avenue, Juneau 99801, 586-1371, architect

Special Counsel to Task Force

David Rogers, PO Box 33932, Juneau 99803, 586-2366, Lawyer

DAVID E. ROGERS

LAWYER

P.O. Box 33932
JUNEAU, AK 99803

907-586-2366
FAX 907-586-6959

ATTACHMENT #1

MEMORANDUM

TO: Liability Task Force

FROM: David Rogers *DR*

RE: Fact finding efforts

DATE: January 19, 1990

Our next meeting is set for March 2 (starting at 1:30 p.m.) and March 3 (if necessary; starting at 9:00 a.m.) in Juneau. Attached are materials compiled by my office to date which deal with the various factual matters identified by the Task Force at its first meeting in September. They provide a fairly comprehensive overview of the subjects under discussion although some materials may be dated and/or incomplete. I did not attempt to cover every conceivable angle given limits of time and space, although I did arbitrarily expand the scope of our inquiry into professional liability issues to include Nurses and Dentists.

Additional information will be forwarded upon receipt.

If I have missed an issue that you are concerned about or failed to address a question raised at the last meeting please let me know as soon as possible and I will try to respond before our next show. Please note there are some overlaps since several folks responded to my questions in one letter/submittal which cannot be easily divided (note, for example, information regarding dentists and nurses in "Availability/Affordability;Insured Percentage"); certain reports and studies fall into more than one category. There may also be missing or out of order pages etc. although I have gone through everything pretty carefully to avoid this problem. Each section was stapled if it could be stapled, bound if not, or "rubberbanded" if it couldn't be stapled or bound. All sections have holes for a three ring notebook if you prefer that method of keeping things organized.

I have not attempted to "stack the deck" one way or the other. Generally, I have tried to give you the best available information from "non-partisan" sources

(particularly those identified in the Group #1 and #2 game plans). However, I have also taken the liberty of including what some may consider "partisan" materials (from both sides of the fence) where I felt the information was relevant or helpful in defining a point of view on the many interrelated issues before us. I anticipate that some of the materials contained in this second packet will be rejected by the Task Force for one reason or another when it draws its final conclusions.

You may also want to take a second look at your first packet for other views on the issues.

Additional suggestions are encouraged. If I have left something out which has been recommended by one party or another I am happy to reconsider. It is also quite possible that constructive information in my possession has been lost in the shuffle.

This should not be considered a final product as there are gaps and other problems (some yet to be discovered) which will hopefully be resolved as the process continues. I apologize for the long delay between meetings, but I had to start from scratch and things have arrived in bits and pieces often requiring additional analysis and follow-up; further complicated by last minute realizations that I had missed a piece of the puzzle, endless problems with scheduling our second meeting (Christmas, Session, and busy Task Force members) and other logistical difficulties. After you (and I) have had a chance to start digesting all this and prior to our next meeting, I'll send out a memorandum with my thoughts and observations along with additional materials.

I know there is a lot to review in a fairly short period of time but the subjects addressed are complex and I thought it best to give you as much original data as possible for starters rather than to simply offer a summary of my impressions and conclusions. Fortunately, some of these materials can be skimmed easily.

Just pretend you are a student studying for a mid-term exam.

My thanks and compliments to the many people and organizations who bent over backwards to assist me in this effort without complaint; and a special thanks to Julie Kraft who was always there when I needed her advice and assistance.

Here is a brief discussion of major attachments by topic as set out in the Task Force Group 1 and Group 2 "to do" lists:

1. INSURANCE RATES: You will find attached rate information (current to this date), including "tail" coverage quotes,

received from the major admitted carriers who have responded to informational requests similar to that contained in the "Claims Survey" section. These surveys were sent to as many admitted carriers as we could identify at the time for each of the target professional groups (Lawyers, Physicians, Hospitals, Architects, Engineers and Land Surveyors). In an effort to broaden the scope of our inquiries, I am also including current rate filings provided by the Division of Insurance for Nurses, Nurse mid-wives, Dentists, and Accountants. No other rates have been included but I am told that the Division of Insurance is developing a comparative analysis of auto and home owner's rates which I will pass along.

Finally, I've attached the MIEC rate filing documents provided by the Division of Insurance for your information. Rates filings for other liability policies of admitted carriers (including MICA, which was too thick to include) are available in my office for anyone who is interested. Please let me know. I am also attempting to nail down rates for those non-professional categories listed as problem areas by the Division of Insurance and/or the Alaska Independent Insurance Agents and Brokers Association; and determine general rate trends for the major professional categories over the last several years. I have not focused on "surplus lines", "purchasing groups" and similar issues because you have to draw a line somewhere but we may want to take a closer look in the future. More on this topic in the analysis memorandum. Stay tuned.

2. AVAILABILITY OF INSURANCE: Information developed by the Division of Insurance, the Alaska Independent Insurance Agents and Brokers Association, various professional organizations and the Division of Occupational Licensing, along with responses from several of the major admitted carriers (included in the claims survey section) are attached. This is pretty good stuff. Please read these materials carefully. I am told that relevant additional data developed by the Division of Insurance in December concerning surplus lines (which apparently can only be used when there is an admitted carrier availability problem) will be provided in the near future. Information regarding CPA's (and hopefully Day Care facilities) will follow.

3. PERCENTAGE OF UNINSURED: All available information is included for Doctors, Lawyers, Engineers, Architects, Land Surveyors, Dentists and Nurses. Information regarding CPA's and Day Care Facilities will be forwarded as soon as possible. You will note that with the exception of Doctors, most of the data on this topic is dated, speculative or non-existent. A current survey would be necessary to adequately answer this inquiry. I suspect that most, if not all, of the professional organizations would be willing to conduct such a survey if necessary; but given the effort

required I have not asked them to pending Task Force discussion. However, I have prepared a draft questionnaire which I can share with you upon request. A survey conducted by the Alaska State Medical Association which apparently addresses this issue and perhaps related questions is currently underway with results available by mid-February if all goes according to plan.

4. AVAILABILITY OF SERVICES: This has been hard to pin down since the Task Force provided little guidance on the "other services" category. I have surveyed with a broad brush state and federal agencies, professional and other organizations and individuals who might have something to add to the discussion. All available information received to date is included for target professionals (expanded list). Additional information regarding CPA's is in progress. I'm still working on the "other services" category and waiting for a response from the Department of Health and Social Services; information compiled to date is attached. In addition, I just received word from the Alaska State Medical Association that there are doctor availability problems in the following communities: Haines, Tok, Ketchikan and Dillingham as well as a variety of specialized service gaps (eg. no Ob/Gyn) in other communities. I've also heard that Craig currently has no doctors but this hasn't been confirmed.

Finally and for your information, I am told that it is very difficult for people to find lawyers to represent them in Worker's compensation and certain medical malpractice cases.

5. WHO RECEIVES WHAT FROM SETTLEMENT: See attached "pie chart" from the Rand Corporation contained in the so-called "three-level" study discussed below. Similar information is contained in "Costs and Compensation Paid in Tort Litigation" by Kakalik and Pace also included in that section. Based on my discussions with various interested parties, it appears that no such breakdown has been developed for Alaska, but I suspect that the results would be comparable.

6. CLAIMS EXPERIENCE OF SELF-INSURED ENTITIES: I also sent a claims survey to target self-insurers in Alaska (all major public entities that we could identify at the time and a couple of private entities); results received to date are included (State of Alaska, Municipality of Anchorage, Anchorage School District and the University of Alaska) along with a couple of letters from hospitals in Cordova and Petersburg. A second, less complicated request went out recently to a wider cross section of self-insured's in an effort to pick up more information since several entities were either unable or unwilling to respond to my naively comprehensive original request. In addition, as I mentioned

above, most of the major players in the Alaska admitted professional liability market have responded as best they could with the exception of National Union (lawyers liability) which has apparently declined to respond.

Please note that this section begins with the heading "Claims Information-Professionals".

7. ROLES AND MECHANISMS OF STATE AGENCIES: The attached materials summarize the duties of three state agencies which have primary roles in this arena - The Division of Insurance in the Department of Commerce and Economic Development, which regulates insurance activities in the state; the Division of Risk Management in the Department of Administration which is responsible for handling claims against the State of Alaska, a "self-insured" public entity; and the Division of Occupational Licensing within the Department of Commerce and Economic Development which regulates several of the professional groups discussed in the attachments including Doctors, Dentists, Nurses, Architects, Engineers, Land Surveyors, and Certified Public Accountants. I am still waiting for information on State agencies involved in licensing/certification of hospitals, day care facilities, etc. but I should have more on this soon.

8. STATUS OF STATE SUIT AGAINST INSURANCE COMPANIES: See attached memo from Attorney General's office which tells us what has happened to date along with comments from industry representative Tom Slagle.

9. PEER REVIEW PANEL RESULTS; TOTAL NUMBER OF MEDICAL MALPRACTICE CASES: As you will see from reading the attached letter from the Alaska Court System much of this information is not readily available. The last document in this section does contain potentially useful information but, ironically, I've lost track of the source. Hopefully, someone out there can help me fill in the blanks. I'm also trying to determine annual costs to the State Court system relating to tort litigation and how long it takes to resolve a typical negligence case from the filing of a complaint to final disposition.

10. OTHER SOLUTIONS TRIED ELSEWHERE; MATRIX OF STATE SYSTEMS; FEDERAL ACTIONS: I have included information developed by the National Conference of State Legislatures, a New York law firm which tracks these issues and miscellaneous other sources including the Rand Corporation. There is also a separate attachment on "pre-judgement interest" in response to a specific Task Force inquiry. The James Ludlam article ("Battle for Medical Malpractice Reform") while partisan was included because it contains useful information on legislative strategy issues and "tort reform" pros and cons among other things. I've also attached

an NCSL summary of pending 1989 legislation around the country to give you a sense of current thinking on the subject and a copy of an Alaska Attorney General's opinion on the constitutionality of several proposals contained in HB 166; but please note my unsolicited opinion that the conclusions contained in this memorandum are speculative and debatable.

There is duplication in this section but I wanted to give you a choice of formats. Some information may be dated (e.g. Statute of Repose/Limitations) due primarily to the ever present possibility of judicial decisions overturning these laws on constitutional grounds.

At a minimum, I recommend that you read the NCSL narrative and the Wilson, Elser report and take a quick look at what was going on around the country in 1989. An interesting overall view of Federal and State activities is also contained in Chapter 8 of the Winston/Litan book discussed below.

11. ALTERNATIVE CLAIMS RESOLUTION MECHANISMS: I've included a sampling of information on this topic which should give you a pretty good sense of some of the more significant alternatives which are in operation or under consideration. This section includes a 1984 Rand study on state court arbitration, a comparison of three medical liability reform proposals, and discussions of the Hawaii arbitration system and the Virginia Birth Related Neurological Injury Compensation Act. I also direct your attention to Huber who argues direct "first party" insurance (apparently similar to the policies some people purchase before they get on airplanes) and comments contained in the Litan et. al. piece discussed below. Finally, you may want to refer to my original information package for a review of Governor Cowper's "No Fault" medical malpractice proposal.

12. IMPACTS OF U.S. TORT SYSTEM CHANGES: This information is hard to come by. I have tried to provide several reasonably credible perspectives on the question, although at first glance the evidence appears to be somewhat contradictory. This section includes information from Rand ("Assessing the Effects of Tort Reform"; "Frequency and Severity of Malpractice Claims"), and actuaries Milliman and Robertson along with several other articles on the subject. Please note that the Danzon report on Frequency and Severity of Claims is often referred to by other civil justice commentators. The Maine report discussed below also addresses these issues.

13. LEGISLATIVE RESEARCH REPORTS. All reports prepared to date on liability issues are attached.

14. RAND STUDY-THREE LEVELS: It took awhile to find this study but I am pleased to introduce "Trends in Tort Litigation, The Story Behind the Statistics" by Hensler et. al. I have also included a recent Maine medical malpractice study which you may find interesting along with several other reports (mostly from Rand) which address a number of questions raised by the Task Force; and will be happy to order additional materials in your discretion (see attached Rand Bibliography).

15. RESULTS AND AMOUNT OF SELF-REGULATION: Attached are applicable statutes, regulations, current annual reports, national standards, disciplinary statistics, state by state comparisons and observations supplied by various professional organizations and regulators, along with information regarding educational programs and requirements. More will follow as soon as it arrives in my office including the Alaska Bar Association's latest annual report and a general discussion of trends over the last few years.

16. CHANGES IN TIME IN LAW OF LIABILITY AND DAMAGES: The Huber and Brodeur books (five copies each) just arrived and are available upon request. Call if you want one. I have also included an excellent overall discussion of the issues (including a summary of the kinds of changes which have occurred over the last 30 years) edited by Stephan Litan and Clifford Winston of the Brookings Institution which I urge you to review, particularly the Forward and Chapters 1 and 8. I have talked to Mr. Litan and concluded that he does not appear to have any axes to grind.

17. CHANGES IN INSURANCE SERVICES; HOW THE PUBLIC IS TREATED: While it is not exactly responsive to this specific question, I have included a report prepared by well known consumer advocate Robert Hunter which hits on a number of topics before us. This also can be considered a partisan effort (which may require a rebuttal from the insurance industry and others), but I feel we have an obligation under the terms of our mandate to review Mr. Hunter's many findings and conclusions since he is considered by many to have a steady and enlightened handle on the issues before us. As I mentioned before, Gary Fye is also willing to discuss the service issue at our next meeting if there is no objection from the group. Otherwise, I am open to additional suggestions on how to further explore this topic and related questions.

18. INSURANCE DEPARTMENT REPORT: Jim Jordan, formerly of the Division of Insurance, says there is no such report.

19. MISCELLANEOUS: I have also included several additional attachments which may fall into the "bias" category but are still worth reviewing in my opinion. These include excerpts

from a Tillinghast study on U.S. and World trends, a claim data overview by ISO, Inc., information prepared by Al Tamagni, Senior regarding Alaska Court Rules and related matters, a 1986 report prepared by several state Attorney's General on the causes of the liability insurance situation, A Louis Harris study and others.

Have fun and feel free to call with questions, etc.

Remember, "no pain, no gain".

ATTACHMENT # 2

SUMMARY OF DATA HIGHLIGHTS

I. AVAILABILITY AND AFFORDABILITY OF INSURANCE.

A. Availability has improved. Based on information received by the Task Force to date from the Division of Insurance and various professional liability carriers, there appear to be no significant availability problems for most professionals with certain limited exceptions. According to the Alaska Independent Insurance Agents and Broker's Association, Inc. there are some availability problems for non-professional categories like day care centers, liquor liability, small specialty and general contractors, pollution and any small business that requires liability coverage only.

B. Generally, rates appear to have stabilized within the last year or so although costs are still perceived as prohibitive and/or unreasonable for some categories, most notably testing labs, structural engineers, attorneys doing SEC work, pollution and asbestos work, real estate developer combinations, computer programmers and certain physician categories including but not limited to OB/GYN. Many experts tell us that this is a cyclical business and anticipate another round of availability/affordability problems in the future.

C. Affordability is relative; the greater percentage of income represented by insurance premiums, the greater the concern. It is interesting to note that nationwide medical malpractice premiums were 6.2% of physician's gross income in 1986; the national average for Architects and Engineers is 4.2% - it is estimated that in Alaska the average is 7%. We have no comparable information for lawyers.

II. PERCENTAGE OF UNINSURED.

A. Based on information provided by the Alaska State Medical Association the total percentage of uninsured physicians in Alaska is 24% in cities, 12% in towns and 56% in the Bush. The study further indicates that OB/GYN (44.7%), Family Practice (34%) and Orthopedics (23%) have the largest block of uninsured. A more recent survey by the Medical Association of Family Practice and OB/GYN practitioners indicates that 15% are uninsured (based on a response rate of over 50%); a majority of these in urban areas. The differences between these numbers may be explained by the fact that the latter survey takes into account doctors who are insured by group programs although additional information and analysis is required.

B. Only four out of 23 hospitals surveyed by MICA are uninsured/self-insured.

C. Only 2% of Dentists are uninsured.

D. There are no current and reliable Alaska statistics for lawyers, nurses, architects and engineers; although nationally it is estimated that 49% of Architectural firms do not carry liability insurance; for engineers, 42% of 1-5 person firms, 17% of 6-10 person firms and 15% of 11-25 person firms are "bare".

E. We simply do not know enough to comfortably answer the question of how many professionals are uninsured (or limiting their practices, getting out of the business altogether or significantly limiting coverage) because of the cost of insurance; or for strategic and/or philosophical reasons which have nothing to do with premium expenses. A survey conducted by the various professional organizations is the best way to clarify this issue along with the related question of how many other professionals are uninsured.

III. AVAILABILITY OF SERVICES.

A. There are a variety of service gaps that we have been able to identify including: significant doctor availability problems in several communities particularly relating to obstetrical and pre-natal care, day care service needs, certain legal services gaps (worker's compensation cases, medical malpractice, low and middle income legal services), nursing shortages, and the need for travel funds to transport rural residents to urban areas for diagnosis and treatment. It is interesting to note that according to the most recent Alaska State Medical Association survey, 32% of doctors who used to practice obstetrics don't anymore, primarily due to the cost of insurance. Also note that many feel there is a crying need for a comprehensive medical insurance program which covers those many unfortunate folks who "slip through the cracks" for a variety of reasons including lack of health insurance and inability to obtain relief through the civil justice system.

B. With the exception of physicians (and possibly Day Care providers), the cost or availability of liability insurance does not appear to be a major contributing factor to these service gaps.

IV. PEER REVIEW PANEL RESULTS AND RELATED STATISTICS.

A. There is little useful information readily available from the Court System regarding peer review panel results, the frequency and severity of liability actions, the length of time it takes to process an average case and/or the costs of litigation to the court system or the parties. However, we

do know that between January 1, 1987 and July 1, 1989, 177 malpractice cases have been filed in Alaska State Courts: 90 Medical Mal.; 56 Legal Mal.; and 31 "Other". Information provided by the Alaska State Medical Association suggests that as of December 22, 1989 there have been 338 medical malpractice claims processed through the peer review panel program since the current system was established in the 1970's, an average of 26 claims per year with no particular upward trends indicated. Of approximately 178 claims reviewed, the expert advisory panel sided with the defendant 138 times and with the plaintiff 40 times. Finally, MICA has carefully reviewed 90 (out of a total of 244 cases since inception) which contain sufficient information for meaningful evaluation and has found that there were fifteen reports adverse to Health care providers, eleven reports that were mixed or equivocal as to the health care provided and Sixty Five reports that were favorable to the health care providers.

B. This information gap appears to be common throughout the United States and consistently has been identified as a problem in attempting to understand and resolve issues relating to reform of the civil justice system.

V. RESULTS AND AMOUNT OF SELF-REGULATION.

A. Based on information provided to date, it is difficult to tell if a relatively small number of professionals (repeat offenders) cause a relatively large percentage of complaints and/or disciplinary actions. Certainly, the number of disciplinary actions taken annually appear to represent a relatively small percentage of the total number of professionals. Please note that only Physicians, Nurses and Dentists have mandatory continuing education requirements. Lawyers have an extensive optional program.

B. Comprehensive risk management programs (including peer review, quality assurance and education) by regulators, professional associations and insurance carriers appear to be the modern trend.

C. In response to a specific Task Force question, Alaska was ranked #2 per capita in the nation in Doctor Discipline for 1987 by the Public Citizen Health Research Group (a Ralph Nader organization); up from 19 in 1986.

VI. STATE AND FEDERAL LEGISLATIVE ACTIVITY.

A. Most states have adopted "tort reform" legislation in one form or another over the years including, for example, measures relating to limits on recovery (e.g. caps), statutes of limitation and repose, modification of joint and several liability, periodic payments of awards, reduction of compensation by collateral sources and limits on attorney

contingency fees. The constitutionality of many of these measures has been challenged in state and federal courts; some upheld, some not for a variety of reasons. The most comprehensive reforms have been enacted in Alaska, Washington, Hawaii, Colorado, New Hampshire, New York, Florida, Illinois and California.

B. During the 1980's, legislative activity on these issues peaked in 1986 when 36 state legislatures passed tort reform laws. In 1989, only seven legislatures enacted such laws, although many measures were pending. The focus of state activity appears to have shifted to regulation of the insurance industry and auto insurance matters, including "Proposition 103" and "no fault" proposals.

C. At the Federal level, Congress is most concerned with products liability issues and changes to the McCarran-Ferguson Act which, among other things, provides limited anti-trust immunity to insurers.

VII. ALTERNATIVE PROPOSALS.

A. There are a variety of alternative systems in place or under consideration which may provide some relief; although most commentators agree that more analysis is required. These include: 1) court annexed mandatory arbitration programs (with "de novo" appeal rights) for cases which fall within certain limits and other administrative arbitration and/or adjudication proposals including pre-trial peer review screening panels and voluntary, binding arbitration mechanisms; 2) "No-fault" alternatives like the Virginia Birth-Related Neurological Injury Compensation Act which establishes a fund financed by voluntary payments from physicians and hospitals to cover actual and necessary medical and related expenses, loss of earnings from age 18-65 based on a discounted formula and reasonable expenses incurred in connection with filing the claim including attorney's fees. A similar program is operated in Florida which also allows recovery of up to \$100,000 in non-economic damages. Also note that Governor Cowper has proposed a general medical malpractice "no-fault" system and Alaska currently has arbitration and peer review systems applicable to medical malpractice, court ordered arbitration procedures for small claims (need more information on this) and recognizes certain contractual arbitration agreements; and 3) a variety of other proposals including use of direct "first party" insurance and state subsidization of certain insurance premiums for qualified applicants (see, for example, HB 449 and 450 by Donley and Gruenberg).

B. Reviewers of the Hawaii and other court annexed arbitration programs have found that they seem to achieve their goals of reducing litigation costs, increasing pace and maintaining the satisfaction of participants. A Rand

Study ("Reforming the Civil Justice System, How Court Arbitration May Help" by Deborah Hensler) indicates similar attitudes about the California and Pennsylvania programs.

VIII. THE RAND THREE-LEVEL STUDY.

A. This study, "Trends in Tort Litigation - The Story Behind the Statistics" by Deborah R. Hensler, Mary E. Viana, James Kakalik, and Mark A. Peterson, attempts to settle three highly controversial issues which dominate discussions about the need to reform our civil justice system: How much litigation is there? Are jury awards stable? How much does litigation cost and who gets the money?

B. The authors tell us that one of the reasons for confusion is that there is not a single tort system. Instead, there are at least three types of tort litigation, each with its own distinct class of litigants, attorneys and legal dynamics - 1) the world of routine personal injury torts, exemplified by auto suits. These occur frequently and usually involve modest injuries and relatively low financial stakes. Settled law and routine procedures lend an air of stability to this world; 2) the world of high stakes personal injury suits such as products liability, malpractice and business torts. Here the litigation is newer, the law increasingly uncertain; and 3) the world of mass latent injury cases, such as asbestos litigation, Dalkon Shield cases and other suits arising from mass exposure to drugs, chemicals or toxic substances. The lack of "fit" between traditional tort law and the facts of these cases lead many to view them as problematic.

C. What is the story behind the statistics? The author's found that: Routine personal injury torts such as auto cases are growing slowly in frequency and costs, and their outcomes -inflation adjusted - have not changed much over the last 25 years; Higher stakes torts such as malpractice and product liability are growing faster in frequency and costs, and their outcomes have increased dramatically over the past 25 years in the jurisdictions observed intensively, and substantially in the shorter five year period for which they had national data; Mass latent injury torts, once identified, tend to explode in number, carry high transaction costs and have highly uncertain outcomes.

Please note that an article in the New York Times just brought to my attention suggests that these trends may be altering based on a recent study by two Cornell Law School professors which concludes that published opinions since the mid-1980's "have moved toward benefiting defendants over plaintiffs".

D. In response to a specific Task Force question about "who gets what" the authors tell us that: for auto cases 19% of

total litigation dollars go to the defendant's lawyers for legal fees and expenses, 26% are for plaintiffs legal fees and expenses, with 52% left for the plaintiff; Non-Auto-30%, 24% and 43% respectively; Asbestos, etc.- 37%, 26% and 37%. We have a few Alaska specific numbers on this question. For example, MICA tells us that on the average they spend approximately 18 cents on the dollar in defending claims; although this number varies depending on whether there is formal legal action, whether there is a plaintiff recovery and other factors.

IX. IMPACTS OF U.S TORT SYSTEM CHANGES- FREQUENCY, SEVERITY AND RATES.

A. While malpractice claim severity has risen roughly twice as fast as the Consumer Price Index, Patricia Danzon in a study prepared for the Rand Corporation ("Frequency and Severity of Malpractice Claims-New Evidence") tells us that certain tort reforms - particularly caps on awards, periodic payment of future damage provisions and shorter statutes of limitation/repose - appear to reduce the frequency and severity of medical malpractice claims as compared to what would have happened if the law had not been enacted. This conclusion is more or less confirmed in other studies contained in our information packet including the recent National Academy of Sciences Study (which acknowledges a "modest" reduction in medical malpractice claim frequency and severity), the 1988 Winston/Litan anthology by the Brookings Institution and the 1989 study done for the Maine Legislature by the Public Health Resource Group, Inc. (but there is disagreement over the significance of this impact).

B. However, there appears to be no definitive evidence that any reduction in claim frequency and severity effects the cost or availability of insurance; although the experience in California suggests that certain tort reform measures may at least contribute to stability (in the context of doctor owned insurance companies at any rate); and Danzon argues that certain reforms that reduce the uncertainty in estimating malpractice claim costs "may be expected to reduce premiums by a modest amount over and above the reduction in mean expected losses" (although she also mentions other factors such as litigation expenses and "changes in the timing of disbursement of loss reserves, and hence investment income").

C. The jury is still out on this one. More time may tell.

X. ALASKA CLAIMS EXPERIENCE- PRELIMINARY FINDINGS.

A) Professionals: Based on information obtained to date it appears that: 1) most medical malpractice claims/recoveries are under \$150,000; 2) there are few "jumbo" recoveries (over \$1 million), and none reported over \$3 million

(through 1988) but payments on these claims typically represent a large percentage of total losses for a given year; 3) punitive damages are rarely, if ever, awarded; 4) most claims are settled before trial, many settled without formal legal action; 5) less than half of MICA claims resulted in a payment to the claimant; and 6) MICA's defense costs, on average, are about 18 cents for every dollar, but this number varies depending on a number of factors.

B) Self-Insured/Uninsured Entities: Based on the results of a survey of several major public and private entities obtained to date, it appears that: 1) the majority of claims/recoveries are between 0 and \$50,000, claims against public entities tend to be larger; 2) most are settled prior to formal legal action; 3) there are occasional large payouts (mostly State claims) which typically represent a large percentage of total losses for a given year; and 4) defense costs do not appear to be significant but this observation requires additional information and analysis.

XI. WHAT SHOULD THE LEGISLATURE DO?

A. The four primary commentators relied on (Rand, Brookings, National Academy of Sciences and the Maine Legislative Study by the Public Health Resource Group, Inc.) agree that sweeping alternatives to the existing system are intriguing but require more study. It is less clear how they feel about partial alternatives like the Hawaii arbitration program.

B. In the meantime, Winston/Litan et al. support "fault based" rules of liability and argue that in terms of reducing uncertainty and eliminating inappropriate levels of compensation under a "fault based" system there is a strong case for limiting non-economic damages in tort cases but only in a way that takes into account the age of the injured party and the severity of the injury. In the same report, Patricia Danzon also argues for more restrictive statutes of limitation, provisions requiring periodic payment of future damages and modification to collateral source rules which will give public and private insurers rights of subrogation against the tort reward. The authors oppose stiffer regulation of insurance rates and support greater solvency regulation by state regulators.

C. On the other hand, the Maine group concludes that new tort reforms at this time are questionable policy options to reduce insurance premiums and to insure medical care availability pending more information that should be available within the next two years. If reforms are pursued they further suggest they be designed to expire after a period of time if the price of insurance and availability of essential medical services do not improve by some measure satisfactory to the legislature. In any event, the report cautions that you cannot just target one set of issues.

Instead, Legislatures should develop a carefully balanced mix of changes to the tort, regulatory (for example, they suggest requiring rate changes to be spread over time and requiring insurer's to demonstrate effective cost control programs) and medical care delivery systems (they suggest investigations of multi-claim physicians, greater efforts to diffuse potential complaints, information collection requirements and, possibly, adoption of "care standards") based on a considered understanding of what will be gained and what will be lost.

D. The National Academy of Sciences, which focuses on the issue of medical liability and obstetrical care, takes a different tack. On the basis of its findings - that the costs of the current system in terms of impaired obstetrical care are great, that tort reforms are so far largely ineffective, and that data evaluating the merits of proposed alternatives to the tort system are lacking - the report concludes that state legislatures should not focus on further reform efforts within the existing tort system but should instead redirect their energies toward developing alternatives to the traditional tort system for resolving medical malpractice claims and towards implementing these alternatives in certain circumstances.

E. Other commentators on the issues before us, like Robert Hunter, advocate various forms of insurance regulatory reform; risk management and disclosure requirements; certain tort reforms like limiting attorney's fees for both sides (although he focuses on defense fees), penalties for frivolous actions and settlement incentives; and increased use of alternative systems except in defective products and similar cases which Hunter feels should be subject to common law principles without damage limits as a necessary deterrence measure.

F. A very recent study completed by Harvard University was available to late in the process to be included in this report but should be carefully reviewed before any final conclusions are drawn.

Finally, you may want to keep in mind the words of Gustave H. Shubert, Director of the Institute for Civil Justice of the Rand Corporation, who observed in 1986: "I think underlying all our problems with the civil justice system is the inability of this country to decide whether it wants to have a pure compensatory system or whether it wants to have a fault based liability system. We can't decide whether everybody should be compensated for every injury no matter what its cause, or whether we want compensation to be limited in a strict way, in a comparative way, or in a contributory way to those who have caused the injury. My personal assessment is that we are experiencing the disadvantages of trying to operate both systems in tandem,

the worst of both worlds. We are attempting to compensate everyone with a fault-based system and we are incurring huge social overhead costs by attempting to do so. I believe it is time to focus on that overall choice and to be rational in doing so".

ATTACHMENT #3

ALMOST EVERYTHING YOU EVER WANTED TO KNOW ABOUT LIABILITY
ISSUES (and were afraid to ask???)

Here is a general summary by category of the information contained in the multi-volume factual submittals along with occasional editorial commentary as appropriate:

1. RATES: See Attached rate information including rate filings for selected entities.

2. AVAILABILITY/AFFORDABILITY OF INSURANCE: According to the information compiled by the Division of Insurance the market for professional liability insurance is "soft". Their specific findings based on a survey of major brokers placing professional liability are:

- * The situation is improving which is to be expected in a soft market;

- * Prices are coming down;

- * Coverage is generally available but sometimes at high premium or with restrictive conditions. Non-availability appears to occur with home inspection services and any small unseasoned professional;

- * Some insurers are now writing as part of a package policy;

- * Policies are usually "claims made" with defense within limits and adjustment cost included in any applicable deductible;

- * Pollution usually has a \$25,000 deductible;

- * Costs are perceived to be prohibitive for testing labs, structural engineers, attorneys doing SEC work, pollution and asbestos work, real estate/developer combinations and computer programmers. They cited the following examples:

Lloyds- testing lab-\$1/2 million coverage
\$50,000 premium last year; \$1 million coverage
\$25,000 this year.

CNA- mechanical engineer doing some electrical
and survey-\$3 million in billings-\$1 million
coverage, \$25,000 deductible, \$129,000 premium.

- * Only Allstate was identified during their survey as providing unlimited Civil Rule 82 coverage on its personal

lines coverage. Demand is not there although markets could be found.

The Alaska Independent Insurance Agents and Brokers, Inc. also looked at availability/affordability of other lines of liability insurance based on a survey of members from all areas of the state. They concluded that only the following categories have both availability and affordability problems: Day Care Centers, Liquor Liability, Small Specialty and General Contractors, Pollution, and any small business that requires liability coverage only (no supporting property or auto).

These findings are more or less confirmed by responses to our professional liability claims survey discussed below, informal conversations with representatives of insurance companies and in letters contained in this section from representatives of various professional organizations and regulators. Generally, there does not appear to be an availability problem for most professionals at this time. Affordability, as Keith Brown points out, is relative. Note that Dan Rowley estimates that insurance premiums for Alaska Architectural and Engineering firms are approximately 7% of annual gross billings, as compared to the national average of 4.2%; according to the Medical Malpractice Liability Study prepared for the Maine Legislature (see discussion below) nationwide medical malpractice premiums were 6.2% of physicians gross practice income in 1986. I have no comparable statistics for Alaska. Also note that according to Mr. Rowley seven out of eleven carriers nationally have a maximum limit of \$1 million; six of those carriers don't do business in Alaska. Finally, note that in addition to the groups identified by the Division of Insurance rates for certain physicians are very high as we will see in more detail below.

3. PERCENTAGE OF UNINSURED: a) Physicians: Based on information provided by the Alaska State Medical Association the total percentage of uninsured is 24% in cities, 12% in towns and 56% in the bush. According to my notes, the study further indicates that OB (44.7%), Family Practice (34%) and Orthopedics (23%) have the largest block of uninsured. The results of a recent detailed questionnaire sent out to over 600 doctors gives us a different picture. Based on responses from over 50% of those surveyed, 15% of the Family Practice and OB/GYN physicians are uninsured in Alaska. Apparently, this figure takes into account a variety of group insurance programs not reflected in the other information provided by the State Medical Association. The results also suggest that a majority of uninsured Family Practice and OB/GYN's are located in Anchorage and other urban areas. Please note that MICA insures approximately 50% of Alaska insured physicians, MIEC approximately 30% and CNA approximately 10% through

group practices that meet CNA criteria; b) Hospitals: Based on a recent survey of 23 hospitals by MICA four (Kodiak Island, Central Peninsula Hospital, Cordova Community and Petersburg General) are uninsured/self-insured. The others are either insured through MICA (most), affiliations with a national chain or the Federal government. MICA also insures twelve health related health care facilities, many of which are "rural" including a skilled nursing facility, clinics, intermediate care facilities and home health services; c) Lawyers: Information on lawyers is based on a survey conducted several years ago when availability was limited and prices had skyrocketed; although market circumstances have changed for the better since then according to Keith Brown, former Chairman of the Alaska Bar Association's Professional Liability Insurance Committee. If I am reading the results correctly, at that time, 275 firms were covered by liability insurance, 120 were not; d) Architects, Engineers, Land Surveyors: There is no statistical information available for Alaska, although nationally 49% of architectural firms do not carry professional liability insurance - 42% of 1-5 person, 17% of 6-10 person and 15 percent of 11-25 person engineering firms are "bare". Rich Ritter of the Alaska Chapter of the American Institute of Architects estimates that 70% of the architect and engineering firms he does business with in Alaska carry professional liability insurance; although he is aware of one major Anchorage firm recently going bare apparently due to the high cost of insurance. Nurses: No numbers are available. Note that Gail McGuill of Occupational Licensing tells us that while nurses typically are covered by their employers' policy increasing numbers are purchasing their own policies to protect themselves further; Dentists: According to Frank Thomas-Mears, writing on behalf of the Alaska Dental Society, approximately 2% of Alaska dentists are uninsured. We have no information for CPA's or other professionals at this time.

We don't have a solid answer to the question of how many professionals are going bare (or limiting their practices, reducing coverage or getting out of the business altogether) because they can't afford the premiums; or who do not carry insurance for philosophical or logistical reasons. A survey conducted by each professional organization is the best way to clarify this issue along with the related question of how many professionals are in fact uninsured.

4. AVAILABILITY OF SERVICES: The information contained in this section is limited. What follows is a discussion of some of the service gaps in Alaska that I have been able to identify and comments on whether these gaps are attributable to the affordability or availability of liability insurance: a) Health Care: There are a number of communities in the state (mostly rural) that are having difficulties recruiting and retaining physicians. According to the Health

Association of Alaska and the Alaska State Medical Association Haines, Tok, Ketchikan, Dillingham, Wrangell and Petersburg (and possibly Craig) are having doctor availability problems along with other communities with specialized care gaps. In addition, according to a 1988 survey of availability of obstetric care for low income women, fewer than half of the physicians surveyed (93% of the 196 family practice and OB/GYN physicians surveyed responded) are now providing obstetric care; "within two years only slightly more than a third of the surveyed physicians may be offering obstetric services in Alaska." In the more recent survey of Family Practice and OB/GYN physicians discussed above 32% of doctors formerly providing obstetrical services have stopped performing this service primarily due to the cost of liability insurance.

Many others also attribute this situation to the cost of liability insurance and other health care cost factors. For example the Report of the Governor's Interim Commission on Health Care (September 1988) states that rural providers, especially those providing obstetrical care, have been particularly hard hit by the increase in medical liability insurance: "The cost of medical liability insurance has created a particularly severe problem for pregnant women in rural areas. Non-Native residents of Glenallen, Dillingham, Bethel, and some other communities have lost access to local obstetrical and prenatal care because local providers are either unable or unwilling to pay for the expensive premiums" (at page 57). The report contends that medical liability insurance premiums had more than doubled between 1985 and 1988. See also the comments of Harlan Knudson of the Health Association of Alaska.

For native rural residents the problem, according to Dr. Ward Hurlburt of the Public Health Service, is particularly one of finding money to fund travel costs for diagnostic and treatment services in the larger cities : "As we discussed, as health professionals, we could point to many places in our program where, with added funding, we could do a better job. If I were to select one area, however, to point to where I could see a need related to medical services for rural Alaskans, I would identify the lack of funding for travel...At this time...we are basically paying only for emergency travel. If the State were wanting to identify an area for potential positive impact on the provision of Native services for rural Alaskans, I would suggest consideration of the development of a mechanism for supporting travel costs." The Department of Community and Regional Affairs tells us that this position was echoed in a Resolution passed in November by the North and Northwest Alaska Mayors Conference which proposed an insurance program which will cover both transportation to Anchorage or Fairbanks and services provided by non-Indian Health service facilities in these towns.

There also appears to be a nursing shortage in Alaska. According to Gail McGuill of the state Division of Occupational Licensing : "It has recently been more severe than the cyclical shortage in rural communities and in certain specialty areas of practice. Almost all acute care and long term care facilities in the state have had to utilize "traveling nurses", nurses retained through agencies for short term periods of employment...Of the four main issues discussed in this letter, I view the nursing shortage and the problems it has caused for the health care industry in our state to be the most crucial one. Although, a concentrated effort of agencies in Alaska working together to remedy the shortage has not occurred, individual agencies and organizations have been attempting to alleviate the problem with the resources available to them." There are many cited reasons for this situation including poor pay and benefits, lack of hospital administration support, limited opportunities to further professional education, inadequate staffing, state laws that limit nursing practice, lack of access to child care facilities, insufficient in service education and lack of competent support personnel. The cost (or availability) of liability insurance does not appear to be a significant contributing factor.

b) Legal Services: We have no Alaska specific information. However, from my experience over the years and in talking to others in the profession I can identify several service gaps worth noting - representation of claimants in state and federal workmen's compensation matters; certain medical malpractice claims; low income legal services that cannot be provided by Alaska Legal Services and/or the Alaska Pro Bono program; and general legal services for middle income people who don't qualify for assistance but can't afford standard legal rates for a variety of basic legal services involving personal and family matters; a problem I've seen in my own practice many times which may be growing due to the increasing need for some legal services in our society. These gaps do not appear to be due to high liability insurance premiums.

c) Engineering/Architectural/etc Services: We have no Alaska specific information on this but according to Rich Ritter of the Alaska Chapter of the American Institute of Architects there is no apparent availability problem despite the fact that over 50% of Alaska Architects, Engineers and Land Surveyors have left the state in recent years. He feels that "there is still a core group of experienced professionals remaining in Alaska available to provide professional services". It is not clear how much of the attrition is due to the cost of liability insurance versus the dramatic recent economic slump.

d) Dentists: Frank Thomas-Mears tells us that Dental services in rural areas are not impacted by affordability and availability of insurance since a majority of dental practitioners are employed by the Public Health Service and protected under the Federal Tort Claims Act. Of those private practice dentists which either contract with the PHS or native corporations most are insured.

d) Day Care: The only other significant service gap that I have been able to identify to date (other than the need for a comprehensive health insurance program to take care of people who "slip through the cracks" under our current system, a subject which is being addressed elsewhere; and sewer and water system and similar service needs which are well beyond the scope of our duties) concerns Day Care Facilities. According to the report of the Governor's Interim Commission on Children and Youth parents "often have difficulty finding child care that meets their needs and matches their resources." This is particularly a problem for parents who work rotating shifts, nights or weekends, parents with infants and parents with school age kids who need before and after school supervision: "Too few programs offer flexible hours, overnight care and flexible staffing to ensure safe care for children. Not enough family child care homes exist to accommodate the needs of parents who work a non-traditional or normal schedule. The result is a near crisis in urban and rural Alaska." Recent changes to Federal welfare laws (the Federal Family Support Act of 1988) will exacerbate this problem. It is estimated that the welfare reform work and training requirements will result in the need for day care space for an additional 2400 children statewide.

And child care is expensive. According to the Governor's Interim Commission a recent survey of 600 American families indicates that 40% of their respondents felt they cannot afford their current child care arrangement or the arrangement they would prefer. They add that evidence indicates Alaskans would agree. In March 1987 infant care ranged from \$321 to \$521 per month, pre-school care from \$301 to \$450 per month, school age child care from \$132 to \$215 per month and care for children with special needs from \$600 to \$1,200 per month. The report adds that high quality care may be even more expensive.

A variety of solutions are under discussion including a plan proposed by Virginia Johnson, Dean of the School of Education at the University of Alaska Anchorage, called the Middle School Day Care Center, which would locate day care centers at the six middle schools in the Anchorage area with the curriculum being developed by the Director of the Day Care Centers.

It is difficult to determine if the cost of liability insurance contributes to the day care service gap. It is my understanding based on several informal conversations with people familiar with these issues that affordability and availability is less of an issue at the present time, even for new facilities. It is interesting to note that current policies exclude liability for molestation/abuse related circumstances and, in some cases, require adult/child ratios that exceed state standards.

5. CLAIMS EXPERIENCE - Preliminary Findings:

a. Professionals: We requested claims experience data from all of the major admitted professional carriers. However, only information received from MICA and MIEC, the major medical liability carriers is useful. Generally, the information provided indicates that: 1) most medical malpractice claims/recoveries in Alaska fall within the 0-\$150,000 category (MICA tells us that the average claim is \$48,731; average claim where indemnity is paid is \$124,353; 2) there are few "jumbo" recoveries (over \$1 million), and none reported over \$3 million (through 1988), but payments on these claims typically represent a large percentage of total payouts for a given year (MIEC tells us that nationally about 3% of claims account for over 70% of loss costs; these numbers appear to be consistent with their Alaska experience); 3) Punitive damages are rarely, if ever, awarded; 4) most claims are settled prior to trial; many are settled without legal action; 5) for MICA at least, less than one-half of claims filed result in a payment to the claimant; 6) on the average, MICA defense costs are approximately 18 cents per dollar; this number varies depending whether the claim was settled without litigation, whether there was a payment to the claimant and other factors; and 5) it is hard to predict which doctor will cause the big claims, although MIEC tells us that the highly, trained well regarded physicians often get the "jumbo" cases.

b. Self-insured/Uninsured entities: We have surveyed a wide variety of public and private "self-insured" entities. Results received from the State of Alaska, the University of Alaska, the Municipality of Anchorage, the Anchorage School District, the City of Fairbanks, the North Star Borough, the North Star Borough School District, the City and Borough of Juneau, NANA Regional Corporation, Inc., Nabors Alaska Petroleum Services, Phillips Petroleum Company, the Carr-Gottsten Corporation, Petersburg General Hospital and Cordova Community Hospital indicates that: 1) the majority of claims are between 0 and \$50,000, public entities report more claim activity than private entities; 2) most are settled, often prior to formal legal action; 3) there are occasional large claim payouts (mostly the State of Alaska;) which typically represent a large percentage of total losses

in a given year; 4) defense costs do not appear to be significant but this information requires further analysis. Please note that NANA has made two specific suggestions of issues that should be looked at by the Task Force which are contained in their letter to David Rogers dated January 31, 1990 attached.

6. ROLES AND MECHANISMS OF STATE AGENCIES: The information provided is self-explanatory. However, please note that the Division of Insurance has four primary functions: a) Market Conduct Surveillance (review and approve as appropriate all rate and form filings and perform market conduct examinations on insurance companies or producer licensees to ensure that the consumer is treated fairly in the marketplace); b) Licensing (to license qualified individuals and insurance companies to market insurance in Alaska); c) Financial Surveillance (primarily to ensure solvency - i.e. that the company has sufficient reserves to protect policy holders and pay their claims - and to determine if investments meet statutory requirements and if reinsurance agreements comply with Alaska law); and d) Consumer Complaint and Investigation (to investigate and resolve individual consumer complaints that are filed with the Division. Statistical data that is collected by this section is utilized by the market section as a means to identify licensees or trade practices that warrant further examination.

7. STATUS OF STATE SUIT AGAINST INSURANCE COMPANIES: This lawsuit was filed by 19 states against four major American primary insurance companies and a variety of reinsurance companies alleging anti-trust violations in the form of a pattern of collusion. According to the Attorney General's Office, the allegations are that leading primary insurance companies and reinsurers conspired to withdraw casualty and pollution coverage from the United States market; and that defendants coerced others to take actions which prevented other potential competitors from offering these types of coverage resulting in consumers paying more premium for less coverage than ever before. Tom Slagle of the American Insurance Organization adds that the primary thrust of the lawsuit was that various entities conspired to eliminate the occurrence policy for a claims made policy. In October of 1989, Federal District Court Judge Schwarzer granted defendants' motions to dismiss and entered final judgment against the states. The states have appealed this decision to the Ninth Circuit Court of Appeals; a decision is expected next fall. According to the Attorney General's Office, Alaska has actively participated in this case (against the advice of industry representatives according to Slagle) and intends to continue.

8. PEER REVIEW PANEL RESULTS: With the exception of information concerning the number of professional

malpractice cases filed in Alaska state courts between January 1, 1987 and July 1, 1989 (177: 90 medical mal.; 56 legal mal.; 31 other), there is no official information available from the court system on peer review panel matters or other issues relating to frequency and severity of claims/judgments; although within the last year or so the court system has started to keep track of how long a case takes from start to finish. The data contained on the last page of this section regarding peer review panel results since 1977 was developed by the Alaska State Medical Association. While incomplete, it suggests that there is no apparent upward trend in cases processed through expert advisory panels (an average of 26 per year; although this does not appear to be consistent with the Court System statistics discussed above) and defendants are not always vindicated. Of 178 cases evaluated, the panels sided with the defendant 138 times and with the plaintiff 40 times. You may also want to refer to information prepared by Al Tamagni Sr. of Pension Services Ltd. regarding pending civil cases in Anchorage Superior Court.

Information provided by MICA during Task Force deliberations involving 90 cases where panels had been appointed (only definitive information available; MICA has dealt with a total of 244 lawsuits from its inception to March 1990) tells us that: 1) There were 15 reports adverse to health care providers with payment resulting in all instances by MICA and/or co-defendants; 2) Eleven reports were either mixed or equivocal as to the health care provided. In one instance, that case is still pending (as of March 5, 1990) with no resolution. Five cases resulted in settlement by MICA. Two cases were dismissed by the plaintiff. Another case was dismissed by the plaintiff but it was unclear what the basis for the dismissal was- voluntary or successful defense motion for summary judgement. Two of the cases resulted in payment by other co-defendants but no contribution from MICA; 3) Sixty-five reports were favorable to the health care providers. Five are still pending without resolution. One was tried to a plaintiff verdict with a substantial recovery. Three were tried to a defense verdict with no recovery of costs and fees by MICA. Twenty-eight cases were dismissed by one mechanism or another. Twelve were dismissed by plaintiff in return for a waiver of costs and fees. Seven were dismissed on successful motions for summary judgement with virtually no recovery of costs and fees by defense. Nine were dismissed but the basis for dismissal was unclear. Finally, in one case, the MICA defendant was dismissed by the plaintiff who proceeded to try the case against a co-defendant and recover a substantial sum through a plaintiff verdict and large judgement.

9. RESULTS AND AMOUNT OF SELF-REGULATION: Given the large amount of information contained in this section, I will only

attempt to set out several general observations about the subject:

a) With the exception of lawyers, all target professionals (doctors, architects, engineers, land surveyors, dentists and nurses) are regulated by the Division of Occupational Licensing within the Department of Commerce and Economic Development through various regulatory Boards. Lawyers are governed by the Alaska Bar Association (and its Board of Governors) created by statute as an "instrumentality of the State". All groups also have independent professional organizations (e.g. The Alaska Dental Society, the Alaska State Medical Association, The Alaska State Nurses Association, The Alaska Chapter of the American Institute of Architects, the Juneau Bar Association, etc.)

b) All target groups are subject to a variety of admission and licensing requirements, grievance procedures, and disciplinary sanctions for improper conduct; along with certain peer review procedures, sometimes required as a condition of membership in their respective professional associations. Note that lawyers are subject to rules promulgated by the Alaska Supreme Court.

c) Only Physicians, Nurses and Dentists have mandatory continuing education requirements. For example, physicians are required to complete at least 17 continuing medical education hours per year to retain a medical license provided through hospitals, the Alaska State Medical Association, local medical societies and physician specialty associations. Lawyers have an extensive optional continuing legal education program. Architects, Engineers and Land Surveyors apparently have no continuing legal education requirements or voluntary programs.

d) Based on information gathered to date, it is difficult to determine if, in fact, a relatively small number of professionals cause a relatively large percentage of complaints/disciplinary actions but some statistics included in this section suggest that is the case. The Alaska Bar Association tells us that since 1982 there were 1505 complaints against 710 attorneys. 57% of the attorneys had only one complaint against them which accounted for 27% of the complaint volume. 18% of the attorneys had two complaints against them which accounted for 17% of the complaint volume. The remaining 25% of the attorneys had three or more complaints against them and were responsible for 56% of the complaint volume. However, additional information provided on disciplinary actions taken against lawyers suggests that there are repeat offenders but they do not dominate the statistics except in the disbarment and probation categories.

Certainly, the number of disciplinary actions taken annually appear to represent a relatively small percentage of total professionals in several of the target groups. Please note that according to the Alaska Bar Association, there has been a marked increase in informal requests for ethics opinions from Bar Counsel which suggests that lawyers are attempting to practice preventative medicine, so to speak.

e) All target groups are subject to specific statutory or regulatory provisions regarding unprofessional conduct. In addition, Physicians apparently follow the American Medical Association "Principles of Medical Ethics", as a condition of membership in the Alaska State Medical Association; Nurses apparently follow the Code of Ethics of the American Nurses Association; Lawyers are subject to a Code of Professional Responsibility promulgated by the Alaska Supreme Court; Dentists who belong to the Alaska Dental Society (2/3 of all Alaska dentists) agree to adhere to a Dental Code of Ethics (along with agreeing to be subject to peer review and mediation procedures); same with Architects, Engineers and Land Surveyors who each have separate codes adherence to which is a condition of membership to their respective professional organizations.

f) As to a specific task force question concerning Alaska physician disciplinary actions compared to other states, the information provided by the Public Citizen Health Research Group ranks Alaska #2 (per capita) in Doctor discipline for 1987; up from 19 in 1986 (Pam Ventgen tells us that in 1981 there was 1 disciplinary action; 0 in 1982; 4 in 1983; 2 in 1984; 1 in 1985; 2 in 1986; 5 in 1987; 5 in 1988 and 7 in 1989. She also points out that HB 70, passed in 1987 provided for a full time investigator and an executive secretary for the medical board which may help explain these numbers) The recommendations contained in this report are also worth noting: Increase license fees to \$500 per year and use all money to finance doctor disciplinary actions; Require periodic re-certification of doctors based on written exams and audits of doctor performance such as medical record review; Grant subpoena power to state licensing boards to go after evidence necessary to evaluate doctors; Grant state boards emergency powers to suspend a doctor's license to practice, pending investigation, when continued practice is considered to constitute a hazard to public safety; Require all hospitals to have a risk management program designed to prevent injury to patients (according to the American Hospital Association only 60 percent of hospitals have such programs and only half of these are excellent programs); Require all insurance companies to experience-rate doctors with sub-specialties, whereby doctors with the best records pay the lowest premiums, and multiple malpractice "loser" doctors pay the most; Require insurance companies to immediately disclose and forward to the state licensing board the filing of

malpractice claims, as well as the results of all malpractice settlements and adjudications (see HB 146 now in House HESS); Require hospitals or other institutions taking disciplinary actions against doctors to publicly disclose and forward to the state licensing board the details of such actions; Provide immunity and confidentiality to all those reporting doctor malpractice, incompetence, substance abuse or fraud to state medical boards (see HB 146); Provide strong consumer representation on state medical boards; Do not allow the state medical society to control membership on the boards; Officials should make strong, public statements indicating a commitment to strong doctor discipline and protection of patient's safety. It is my understanding that several of these suggestions have already been adopted in Alaska.

10. MATRIX OF STATE SYSTEMS; FEDERAL ACTIVITY: It is difficult to briefly summarize this material but several general observations can be made:

a) Legislative responses to the increasing cost and availability of insurance and apparent claim trends can be broadly categorized into civil justice- or tort reform - measures, insurance regulatory reform measures and risk management measures. According to Patricia Young formerly of the Legislative Research Agency from information provided by the National Conference of State Legislatures (NCSL), in 1986 the emphasis was on civil justice reform. The legislative focus in 1987 turned to immunities- from sovereign immunity extended to counties, cities and towns, to immunity from personal liability extended to groups of public employees and volunteers. More recently however legislative activity in civil justice reform has declined and the focus has shifted to regulation of the insurance industry, including the anti-trust suit discussed above. In 1989, the majority of legislative activity regarding liability dealt with regulation of the automobile insurance industry, including California's proposition 103 and similar measures introduced in other states.

b) The significant "tort reform" measures enacted over the years include laws relating to limits on recovery (caps) of damages; abolition or modification of Joint and Several Liability; reduction of compensatory awards by collateral sources, or at least notification to the jury of such sources; limits on attorney's contingency fees; limits on punitive damages; periodic payment of awards; penalties for frivolous suits; settlement incentives; limits on prejudgment interest; and establishment of statutes of limitation and repose. Proposals concerning alternative systems and similar issues will be discussed below. I have little "easy to read" summary information on the status of proposals regarding regulation of the insurance industry,

professional competency laws and similar approaches to the problem.

c) According to the recent report by the New York law firm of Wilson, Elser, Moskowitz, Edelman and Dicker (Wilson) contained in this section, a majority of the states have considered or enacted "tort reform" laws as described above in various forms. The constitutionality of many of these measures has been challenged in state and federal courts with mixed results; some upheld, some not for a variety of reasons. See also the Alaska Attorney General's opinion for a discussion of some of these cases including the recent decision by the Washington Supreme Court on their cap mentioned below.

d) According to the Wilson Report, in 1989, the most significant activity concerning Civil Justice reform occurred in the courts rather than the Legislatures. In 1986 thirty-six state (36) legislatures passed tort reform laws (varying in degree and significance). In 1989 only seven (7) states enacted reforms; although many measures were pending (see NCSL 1989 pending legislation summary). NCSL tells us that four state courts rendered decisions in litigation questioning the constitutionality of damages caps. In Maryland, the cap on non-economic damages in all civil suits was upheld; in Kansas, a \$100,000 cap on such damages in wrongful death actions was upheld; the Virginia Court upheld a cap on total damages in medical malpractice cases; but in Washington, the cap on all non-economic damages was ruled unconstitutional (letter from Brenda Trolin dated December 23, 1989).

e) According to the Wilson Report, states which enacted the most extensive reforms in 1986 include Alaska, Washington, Hawaii, Colorado, New Hampshire, New York, California, Florida and Illinois (See Wilson starting on page 1 of the Introduction for a detailed breakdown of how many states enacted various reform measures in 1986 and 1987; and for a discussion of 1989 tort reform enactments).

f) Alaska, in 1986, enacted a series of civil justice changes including: Modified joint and several liability; caps on non-economic damages (\$500,000 except damages relating to disfigurement or severe physical impairment); increased burden of proof for establishing punitive damages; limits on a person's ability to recover damages sustained while that person was committing a felony; detailed provisions on damage award requirements; limited liability for certain directors and officers of non-profit corporations, non-profit hospitals (including hospital citizen advisory boards) and members of school boards and school districts and members of governing bodies, commissions and citizen's advisory committees of a municipality; and provisions on contributory fault,

collateral benefits, apportionment of damages, offers of judgement, costs and attorneys, including pre-judgment interest, and the effects of a release. This legislation has been characterized by tort reform advocates as a "patch work quilt" of necessary compromises, and, in their view, did not go far enough toward making Alaska's civil justice system fair and predictable. As you know, Alaska also has a medical malpractice claims system created during the 1970's.

g) On the automobile insurance front, California's Proposition 103 is the biggest news. This reform measure narrowly adopted by California voters in November 1988 included a one year 20% roll back in most property/casualty "insurance charges" from November 1987 levels; a 20% automobile insurance discount for "good drivers", as defined as those with no more than one moving violation in three years; a requirement of advance state approval for insurance rate increases after November 1989; and election, instead of appointment, of the State Insurance Commissioner starting in 1990. Prop 103 also requires the Insurance Commissioner publish for consumers a list of rate comparisons, and compels insurance companies to notify their customers of the right to join an "independent, non-profit corporation which shall advocate the interests of insurance consumers in any forum." The California Supreme Court upheld all of 103's long term restrictions on insurance rates and practices, but struck down the provision that would require insurers to be "substantially threatened with insolvency" before they could receive relief from rollback. The Court held that insurers may charge rates above the rollback level whenever insurers can justify them as not being excessive.

Many states are also considering "No-fault" automobile insurance proposals in response to escalating auto insurance costs. Note that according to NCSL at least 20 states already have no-fault legislation in many different forms particularly on issues relating to restrictions on the right to sue, conditions necessary to sue for pain and suffering and first party coverage.

h) The Wilson Report concludes as to state activity: "In general, although state legislatures have reviewed thousands of bills addressing the Civil Justice System and insurance regulation, disputes persist as to what precisely are the problem areas, and solutions to the perceived problem areas remain elusive. It is likely that state legislative activity will continue in the area of civil justice reform and the courts will be entertaining arguments relative to the interpretation and validity of these reforms for some time." See Wilson at page 7.

i) Federal activity in this area has confined itself primarily to products liability. For the past several years Congress has seriously considered proposals to federalize

products liability law. Detailed discussions of current proposals are contained in the Wilson materials at pps. 77 and 93. In addition, Congress is considering a variety of proposals to modify the McCarren-Ferguson Act, a 1945 law that provides limited anti-trust immunity to insurers and continues the authority of the state to serve as the primary regulators of the insurance industry. A proposal to modify the doctrine of Joint and Several liability also is pending in the Senate according to my sources.

j) Two final notes. On the question of "pre-judgement interest", according to a 1983 Rand Note prepared by Stephan Carrol (which hasn't been updated according to Carrol) at least 26 states had pre-judgement interest laws on the books. The Note also suggests that juries implicitly provide pre-judgement interest at a rate equal to the underlying inflation rate plus 3.7 per cent per year in addition to any applicable statutory pre-judgement interest rate.

As to contingency fees, commentators argue that limiting those fees will potentially increase the amount of compensation paid to claimants, increase the likelihood that a case is dropped, decrease the likelihood of litigation to verdict and deter frivolous suits by placing the plaintiff's lawyer at financial risk; but will also preclude some victims with legitimate claims from obtaining representation. It is not clear whether the presence of contingency fee arrangements increases the total number of claims (See Frank Sloan "State Responses to the Malpractice Insurance "Crisis" of the 1970's: An Empirical Assessment"-Vanderbilt University, 1985). One study also concludes that in modest cases contingent fee lawyers spend less time on a case than hourly fee lawyers; but there is no statistically significant evidence of a differential in effort for larger cases, although there is an indication that if there is an effect is in the opposite direction (see Rand, "The Impact of Fee Arrangement on Lawyer Effort" by Kritzner et. al.) For detailed discussions of these issues see "Rand Three Level Study and Other Reports" and various references to the subject contained in "Impact of U.S. Tort System Changes". Note that Danzon suggests that contingency fee limits reduced the amount of settlements by 9%, reduced the number of cases litigated to verdict by 1.5%, and the number of cases dropped by 5% (See Maine Malpractice Study at page 36).

11. ALTERNATIVE PROPOSALS: Here is a summary of some of the more significant alternatives I have been able to identify that are either in effect or under consideration today:

a) Arbitration and Screening Panels: According to the Rand article by Deborah Hensler entitled "Reforming the Civil Justice Process, How Court Arbitration May Help" arbitration programs may be established by state statute or by rule of a

state supreme court or a local court. Typically, under these programs the Court is authorized to compel arbitration for cases that fall within certain limits (Rand says \$25,000 is the typical cutoff); with certain exceptions. However, any of the parties to a suit may reject an arbitration award and request that the case be calendered "de novo" (without regard to the arbitration verdict). This appeal option is generally considered necessary to ensure that the litigants right to a trial is not abrogated. In 1984, Rand's Institute for Civil Justice estimated that arbitration programs are operating in more than 100 trial courts around the country and estimated that over 100,000 cases are arbitrated annually through this process. Apparently, there also are voluntary, binding program options.

Typically in court annexed arbitration programs cases are heard by private attorneys or retired judges who volunteer to serve as arbitrators and, according to Rand, receive only a small honorarium for their efforts. Arbitration hearings usually are private, informal and often brief. After giving the parties an opportunity to settle, the facts of the case are heard with the litigants often appearing as witnesses. If accepted, an arbitrator's award is entered as a judgement and is enforceable. As a disincentive for frivolous appeals, some programs require applicants who request a trial de novo to reimburse the court for arbitrator's fees; in some programs court costs and attorneys fees may be levied on unsuccessful appellants, or applicants who do not improve their position (e.g. Hawaii-if the court does not alter the award by at least 15% in favor of the appealing party; see Patricia Young memo in this section). Note that such programs also are required by some carriers

Does it work? The reason for these programs is to reduce congestion, costs and delay. According to Rand preliminary information derived from two studies of a new program in California and an older program in Pennsylvania arbitration can and does contribute significantly to reducing congestion, costs and delay. These findings are confirmed by the Hawaii and North Carolina experiences discussed in this attachment. For example, reviewers from the University of Hawaii of the Hawaii program which covers all tort cases with a probable jury award of \$150,000 or less concluded in January of 1989 that: "Hawaii's Court Annexed Arbitration Program appears to be meeting its goals of reducing litigant costs, increasing pace, and maintaining the satisfaction of participants..." "To our knowledge no other arbitration program in the country claims to be reducing litigation costs; Hawaii leads the nation in this area." Similarly, a 1989 evaluation of the North Carolina program by the University of North Carolina concludes that the program: disposed of cases faster than standard procedures; reduced trials and out of court settlements replacing them with "promptly scheduled adversarial hearings in a courtroom

before specially trained arbitrators"; and improved litigants satisfaction with the outcome and procedure used in their cases. The study also notes that attorneys were satisfied with the program and, in a survey, voted strongly in favor of continuing it.

However, the Rand study cautions that program design and implementation are critical factors in determining success. Some of the design issues that must be considered include: setting jurisdictional limits of the program, establishing procedures for determining case eligibility, adopting guidelines and procedures for selecting arbitrators and deciding how many arbitrators will hear each case, where the hearings will take place and whether there will be financial disincentives for appealing.

Please be advised that the American Medical Association, The American Hospital Association and the Physician Insurers Association of America each have proposed versions of alternative systems apparently involving arbitration or a form of administrative adjudication with various limitations on recovery. I do not have sufficient first hand information on these proposals at this time to go into specific differences but you may want to refer to the analysis prepared for MICA by Jerry Cogan. The State Alternative version of the PIAA proposal is also included for your information. Also note that the AHA calls for a study of a Medical Indemnity Fund as a supplemental method for compensating medical malpractice victims financed by assessments or surcharges levied on medical malpractice insurers and the self-insured.

In Alaska, arbitration and peer review systems applicable to medical malpractice (AS 9.55.535 and 536) and court ordered small claims arbitration procedures (AS 9.43.190-220) are available. In addition, state law recognizes certain contractual arbitration agreements (AS 43.010-180; Uniform Arbitration Act). I have no other information on the latter two options.

b) The No-Fault Alternative to Tort Recovery: James Ludlam ("The Battle for Medical Malpractice Tort Reform: A Report From the Front Lines" prepared for the Annual Meeting of the American Academy of Hospital Attorney's, June 1989) tells us that in the 1970's and 1980's there was much discussion of possible no-fault alternatives to compensating plaintiffs for catastrophic injuries including "trip insurance" under which a patient bought his own coverage, or a system for which there would be payment without fault on the basis of a worker's compensation type schedule (similar to that proposed by Governor discussed in my introductory memo to the Task Force dated September 15, 1989). There was little or no action on these proposals. In fact, the California Medical Association and the California Hospital Association

concluded that these systems would be more expensive than the existing tort system based on a study of over 25,000 charts and dropped the whole idea.

Then, in 1987 North Carolina and Virginia adopted no fault programs followed by Florida in 1988. The North Carolina program was restricted to vaccine related injuries which were compensated for out of a fund consisting of state appropriations with a limit of \$300,000. Damages only can be awarded under this system to the person receiving the vaccine.

The Virginia Birth-Related Neurological Injury Compensation Act, mentioned at our first Task Force meeting, apparently was adopted to meet a crisis in the availability of insurance for physicians practicing obstetrics (according to Ludlam, it was expected that 25% of the OB/GYN's were going to lose coverage by the end of 1987). The Act applies only to patients of physicians and hospitals that have voluntarily participated in the program by payment of \$50 per delivery with a \$150,000 maximum by a hospital and a \$5,000 fee for a physician doing obstetrics. These payments are voluntary. In addition, all other physicians are assessed a fee of \$250 as a condition of licensing. If the fund falls short there is an annual premium tax on all liability carriers in the state. The purpose of the fund is to assure lifetime care of infants with severe neurological injuries sustained during labor, delivery and resuscitation, and to be the sole and exclusive remedy for those who participate. The fund is administered by the Industrial Commission of Virginia with the assistance of an expert panel of three physicians. Compensation is limited to actual and necessary medical and related expenses, loss of earnings from age 18-65 based on a discounted formula and reasonable expenses incurred in connection with filing the claim including attorney's fees.

Following in the footsteps of Virginia, the Florida legislature passed a comprehensive malpractice reform package in 1988. Part of the package was a no-fault state run fund to provide for the care and treatment of babies born with permanent, severe disabilities due to mechanical failure or malpractice. The Fund, administered by the State Worker's Compensation Division, is to be financed by an annual payment of \$5,000 per year by each participating physician. The parents may recover the cost of care and rehabilitation and up to \$100,000 for non-economic damages. As an aside, the total Florida legislation (114 pages) also included caps for other cases, arbitration options, a new watchdog unit called the Medical Quality Assurance Division, hospital reporting requirements of malpractice cases involving doctors and other provisions designed to provide notice of certain events. It is interesting to note that there are no caps if both parties refuse arbitration.

One final note on alternative systems. Peter Huber ("Liability-The Legal Revolution and its Consequences") calls for a return to contract principles in the form of direct first party insurance.

Other miscellaneous procedures to provide faster and less expensive ways to resolve disputes include: "fast tracks" for certain types of cases; dismissal of inactive cases; penalties for last minute settlements made after the trial is underway; procedures designed to limit filing of motions and pleadings; procedures limiting discovery; and procedures which set firm trial dates.

12. THE RAND THREE LEVEL STUDY AND OTHER REPORTS: "Trends in Tort Litigation- The Story behind the Statistics" by Deborah R. Hensler, Mary E. Vaiana, James S. Kakalik, and Mark A. Peterson attempts to set the record straight on many of the underlying issues that we too are attempting to sort out. They start by reminding of us of how all this began:

"Over the past two years, manufacturers, physicians, consumer advocates and trial attorneys have vigorously debated the costs and benefits of the tort system as a mechanism for compensating and deterring injuries. The debate began with a perceived "insurance crisis". Liability insurance premiums, particularly for medical malpractice and commercial lines, increased sharply and insurance for some kinds of activities became unavailable at any price. While there is broad consensus that obtaining and paying for insurance was a pressing problem, there was little agreement about the cause or its solution. On the one hand, insurers linked rising rates and unavailability to trends in tort litigation, thus focusing attention on the legal system. In many states and at the federal level, insurers, manufacturers, health care professionals and local government officials formed coalitions to support substantive changes in tort law. On the other hand, trial attorneys and consumer groups generally opposed these changes arguing that what needed reform was not the tort law but poor management practices in the insurance industry."

The authors go on to say that not only did these groups hold different positions on these issues they also held sharply different views of reality (and presented contradictory statistical data to support their claims):

"Proponents of change argued that there has been an explosion of liability lawsuits in the past five years, that recent verdicts demonstrate that civil juries are "out of control" and that the monetary benefits delivered by the tort system to injured parties are overshadowed by the enormous costs of administering the system. Tort reform was needed to counteract these trends. Opponents of tort reform

argued that the litigation explosion is a myth, that jury awards have been basically stable for 25 years, and that the transactions costs of the system are acceptable, given the systems twin objectives of compensation and deterrence. Tort reform was not only unnecessary - it might be harmful to those whom the system is intended to serve."

In the author's words, "Where does the truth lie?" In an effort to resolve these apparent contradictions and put the issues in perspective for policy makers this report attempts to answer three questions - How much litigation is there? Are jury awards stable? How much does litigation cost, and who gets the money? A summary of their basic conclusions follows:

a) One of the reasons for confusion is that there is not a single tort system. Instead, there are at least three types of tort litigation, each with its own distinct class of litigants, attorneys and legal dynamics. The FIRST is the world of routine personal injury torts, exemplified by auto suits. They occur frequently and usually involve modest injuries and relatively low financial stakes. Settled law and routine procedures lend an air of stability to this world. The SECOND is the world of high-stakes personal injury suits such as product liability, malpractice and business torts. Here the litigation itself is newer, the law is still evolving, and the stakes per case are larger and increasingly uncertain. The THIRD is the world of mass latent injury cases, such as asbestos litigation, Dalkon Shield cases and other suits arising from mass exposure to drugs, chemicals or toxic substances. The lack of "fit" between traditional tort law and the facts of these cases leads many to view them as problematic.

b) How much tort litigation is there? Based on data compiled from the Administrative Office of the U.S. Courts, the National Center for State Courts and the Rand Institute for Civil Justice they have concluded that: accident cases are a steady or declining percentage of court action; non-auto personal injury cases such as malpractice and product liability are growing moderately in state courts and more dramatically in federal courts; and mass latent injury cases have the potential for explosive growth as new evidence of harms is developed.

c) Are jury awards stable or out of control? Based primarily on data compiled by Rand from Cook County, Illinois and San Francisco, California between 1960 and 1984 (only data available in the U.S. that can be used to discuss long term trends) they have concluded that: Plaintiffs in auto cases involving modest injuries and expense continue to obtain modest awards and, at least in recent years, these awards generally hold after trial; Plaintiffs in product liability and malpractice cases are winning more frequently and

obtaining higher awards; Deep pocket defendants in product liability cases ultimately pay much, if not all the awards against them, even after post-trial adjustments; Jury behavior seems more unpredictable, but this may simply be because we do not have a very good sense of why juries make the decisions they do. The authors suggest that these trends may hold nationwide because of the similarities between the jurisdictions studied.

d) Litigation costs - How much, to whom? Based on Rand studies of litigation costs the authors state: "Our snapshot of litigation shows that the costs of litigation consumed about half of the \$29 to \$36 billion dollars that were spent on litigation. When we disaggregate these costs, we see that in more complex cases (non-auto torts) the costs of litigation were higher. In the case of asbestos claims, the only mass latent injury cases for which these data have been assembled, litigation costs constituted almost two-thirds of the total per-claim expenditure." Their specific breakdown in percentage of totals: Auto - 19% in Defendant legal fees and expenses, 26% in Plaintiff legal fees and expenses and 52% to Plaintiff; Non-auto- 30%, 24% and 43% respectively; Asbestos- 37%, 26% and 37%. See also pie charts contained on pages 27 and 28 of the report and the Tillinghast cost breakdown contained in Miscellaneous on page 15.

e) What is the story behind the statistics? Here is the authors' summary of their findings: Routine personal injury torts such as auto cases are growing slowly in frequency and costs, and their outcomes-inflation adjusted- have not changed much over the last 25 years; Higher stakes torts such as malpractice and product liability are growing faster in frequency and costs, and their outcomes have increased dramatically over the past 25 years in the jurisdictions observed intensively, and substantially in the shorter five year period for which they had national data; Mass latent injury torts, once identified, tend to explode in number, carry high transaction costs and have highly uncertain outcomes.

Unfortunately, this report does not resolve the nagging underlying question of why have we had significant affordability and availability problems that have lead to considerable debate of these issues. Is it industry practice, increased claims loss experiences, or both? I have found no study or analysis which settles this question in my mind.

Please note that a recent study by two Cornell Law School professors recently reported in the New York Times indicates that since the mid-1980's published opinions have moved toward benefitting defendants over plaintiffs suggesting a possible shift in overall trends.

The Medical Malpractice Liability Study by the Public Health Resource Group, Inc. for the Maine Legislature submitted in June 1989 is also worth noting in some detail. Here are their general findings:

a) Premium rates for Maine Physicians have been rising to "record proportions" over the last ten years.

b) Frequency, severity and losses as a percentage of income do not indicate that the liability insurance problem in Maine is out of control. It does suggest that more efficient methods of estimating reserves, reinsuring and obtaining legal services could reduce the price of premiums for policy holders while continuing to provide high quality coverage. These are areas where policy changes could achieve savings to the insurance industry and ultimately the rate payers.

c) Maine is experiencing a steady decline in physicians who provide obstetrical services; although the decline appears limited primarily to urban areas. The principal reasons reported by physicians for this decline are the price of medical malpractice insurance and fear of a malpractice suit.

d) It is not clear whether tort reforms actually have succeeded in reducing the price of insurance or the frequency or severity of claims, or whether they will succeed in reducing or stabilizing premiums or claims in the future; although it is far easier to estimate the effect of certain reforms on the frequency and severity of claims than on the price of insurance or the willingness of physicians to practice high risk specialties. For example, caps on awards have potential to reduce the dollar amount of high stakes claims and limits on attorneys fees may increase compensation to plaintiffs (while also leaving some victims with smaller claims without representation, they add). Nor is it known if these parameters would have increased more than they have in the absence of reforms. Moreover, many state reform statutes have not been in operation long enough to have a clearly measurable effect. For these and other reasons, new tort reforms at this time are questionable policy options to reduce insurance premiums and to insure medical care availability. Ongoing studies to be completed within the next two years may provide a clearer picture. If reforms are contemplated, the legislature might consider designing them to expire after a certain period of time if availability and affordability of insurance and medical services does not improve by some measure acceptable to policymakers.

e) Alternative systems are appealing because they may help reduce inefficiencies and costs of the current tort system. Unfortunately, no state has implemented an exclusive alternative and it will be years before any evidence is

available on the impact of such approaches. Please note the report indicates that the Vermont Legislature is considering the AMA fault based administrative system discussed briefly above.

f) A principal goal of the government in a regulated industry like insurance is to get insurers to manage their business as efficiently as possible and provide a quality product to consumers at a reasonable price and at a fair return on investment. Accordingly, the Insurance Regulator should be directed to promulgate an investment income model and require insurers to demonstrate an effective cost control program. The report also suggests that the State could authorize insurance regulators to spread rate changes over three years and implement a merit rate system and/or system of deductibles which would have the effect of spreading the risk of claims payments and resulting rate increases to those policy holders responsible.

g) To keep professionals on their toes, the state could require investigations by the medical board of physicians who have three or more claims over a ten-year period which resulted in a payment; create an ombudsman within the board to defuse potential complaints before they are elevated to a claim; and require the board to collect additional information on the voluntary or involuntary loss of hospital privileges in or outside the state. They also suggest that the Legislature take a look at "care standards" that have been proposed by a variety of entities.

h) They conclude: "There are many approaches to controlling the rising and unstable malpractice liability premiums in Maine and their effect on access to care. These include changes in the tort system, the insurance regulatory system and the medical care delivery system. To target one while ignoring the other will create disequilibrium and lead to policies likely to fall far short of the mark. Each has some merit and some drawbacks. Each needs to be addressed with a realistic understanding of what will be gained and what will be lost. It was no surprise to many experts that the St. Paul Companies decided to lower their premiums due in part to a reduction in expected reserve demand for outstanding claims. Considering past history, however, the medical malpractice issue is likely to revisit Maine in a very few years. The severity of the problem will depend on how comprehensive an approach the Legislature takes now."

13. IMPACTS OF U.S TORT SYSTEM CHANGES: (Frequency, Severity and Rates - this section does not attempt to discuss impacts of tort reform on victim rights and related issues, but see pros and cons discussions contained in your first information packet along with the James Ludlam article discussed above): While tort reform measures do appear to affect the frequency and severity of claims there is no

solid proof to date that they also have a direct effect on the cost or availability of insurance.

Patricia Danzon of the University of Pennsylvania in a series of Rand articles (including in particular "Frequency and Severity of Malpractice Claims-New Evidence"- 1986) appears to have produced the most credible contemporary analysis of the relationship between certain tort reform provisions and the frequency and severity of medical malpractice claims. Although her study is restricted to medical malpractice claims her conclusions are worth examining in some detail:

a) Malpractice claim severity has risen roughly twice as fast as the Consumer Price Index. Nevertheless, the tort reforms enacted since the mid-1970's malpractice "crisis" affected the frequency and severity of malpractice claims over the decade from 1975-1984 in a manner broadly consistent with economic theory and previous evidence. Although claim frequency and severity have continued to rise despite reforms this trend does not indicate that the tort changes have had no effect.

b) For example, states that enacted shorter statutes of limitations and set outer limits on discovery rules have had less growth in claim frequency than states with statutes more lenient to plaintiffs. On the average, cutting one year off the statute of limitations for adults reduces claim frequency by eight percent. The effect would presumably be greater for a reduction from, say, four to three years than from ten to nine years.

c) Statutes permitting or mandating the offset of collateral benefits have apparently reduced malpractice claim severity by eleven to eighteen percent and claim frequency by fourteen percent relative to comparable states without collateral source offset. One of the reasons for this is that collateral source offsets often reduce the potential for recovery for a large number of claims, thereby reducing incentives to file.

d) Caps on awards have reduced severity by twenty-three percent. This percentage represents the average impact of the various forms of cap, over the period of 1975 and 1984, during which time some statutes were still under challenge. If the dollar thresholds are not revised periodically to keep pace with inflation, the future effect will presumably be greater, unless juries find ways of implicitly circumventing the limits by increasing allowances for uncapped components of the award.

e) Arbitration statutes apparently increased claim frequency, but reduced overall average severity. Disaggregated data would be necessary to determine whether

the reduction in observed average severity results from a reduction in awards per case or simply reflects the filing of more small claims. The net effect appears to be an increase in total claim costs, but compensation of more claimants.

f) None of the other reforms analyzed, including screening panels and limits on contingency fees, appears to have had any systematic impact on claim frequency or severity.

g) Urban areas have a particularly high frequency of non-meritorious claims (those closed without payment) and claims filed more than two years after the alleged injury. Per capita income, the unemployment rate, and the number of attorneys per capita have no statistically significant effects. The surgery rate in a state increases claim frequency, and the ratio of surgeons to medical specialists increases claims severity.

h) On average, severity of malpractice claims has increased at almost twice the rate of inflation of consumer prices over the last decade.

i) The above analysis on claim frequency and severity should not automatically be translated into an effect on premiums (a subject beyond the scope of this paper) for several reasons: First, the net potential impact on premiums also depends on litigation expenses and changes in the timing of disbursement of loss reserves, and hence investment income. Second, reforms that reduce the uncertainty in estimating malpractice claims costs- namely caps on awards, periodic payment of amounts for future damages and shorter statutes of limitation/repose- may be expected to reduce premiums by a modest amount over and above the reduction in mean expected losses. This result can be expected because of the reduction in the insurer's risk. Perhaps more importantly, she adds, by reducing uncertainty, such reforms should reduce the volatility in price and availability of malpractice insurance, which is a major inefficiency of the present malpractice system.

Please note that Danzon's claim severity conclusions are more or less confirmed by actuaries Milliman and Roberston, Inc. in their August 5, 1988 letter to MICA.

While this potential positive impact on insurance costs is theoretically possible and there is evidence that the experience in California (which has had time to test the theory) and perhaps other states bears this out (the informal opinion of Ray Bacon of the California Department of Insurance and Ron Neupauer of MIEC who feels strongly that California tort reform measures have had a significant impact on rates which currently are increasing less than inflation; although he agrees that other factors also come

into play), as well as evidence to the contrary, I have found no study that definitively concludes this has been the case. And I suspect no such study exists. See "Insuring Our Future: Report of the Governor's Advisory Commission on Liability Insurance," New York, 1986- "no research currently available quantifies the linkage or even irrefutably establishes that such a linkage exists." In fact, according to Franklin Nutter, president of the Alliance of American Insurers (quoted in the attached article from Public Citizen, "The Impact of Tort Changes on Insurance Rates"), "It is clearly impossible to say that if you adopt a certain tort reform, you will get 'X' reductions in premiums." Similarly, the Frank Sloan article entitled "State Responses to the Malpractice Insurance 'Crisis' of the 1970's: an Empirical Assessment" states: "The empirical results of the study presented here give no indication that individual state legislative actions, or actions taken collectively, had their intended effects on premiums." One last comment. When evaluating the significance of the California experience, it is useful to keep in mind that 90% of the insurance is provided by doctor owned companies which have a significant incentive to keep rates down.

Perhaps the most recent and detailed analysis of this issue in the context of medical liability and obstetrical care is contained in the 1989 report of the National Academy of Science Institute of Medicine's Committee to Study Medical Professional Liability and the Delivery of Obstetrical Care which has just been brought to my attention by a Task Force Member. While I have not had time to review this report in any detail, I have summarized their conclusions on the question of "tort reform". According to the study's Preface, the Institute of Medicine appointed a "distinguished interdisciplinary committee" (see attached list of participants) to evaluate the data relating to the effects of medical professional liability issues on access and delivery of obstetrical care. The preface continues that this study was a response to an inquiry of the American Academy of Pediatrics along with several other groups who believed that more attention to professional liability issues was "urgently" required. Here are there general findings on the basic question of legislative solutions to the problem:

a) Every state but West Virginia has enacted legislation modifying common-law tort doctrine that is intended to relieve the medical liability crisis; many are discussing additional reforms.

b) After evaluating these reforms (and reviewing the Danzon analyses, a 1987 Report of the General Accounting Office and others) the committee concluded that only a modest reduction in medical malpractice claim frequency and size of awards has been achieved. The committee also concluded that "the

many deleterious side effects of the tort system for resolving obstetrical claims - resulting in distortions of health care delivery patterns - have not been reduced by those tort reforms." (See Attachment to follow, Volume I page 127).

c) The committee believes that the problems created by the medical professional liability issues in obstetrics represent a serious threat to the delivery of obstetrical care in this nation. However, although some of the tort reforms already in place have merit, they do not appear sufficient to stem the exodus of obstetrical providers from the profession or to solve the attendant problems caused by the current professional liability climate in obstetrics.

d) On the basis of its findings - that the costs of the current system in terms of impaired obstetrical care are great, that tort reforms are so far largely ineffective, and that data evaluating the merits of proposed alternatives to the tort system are lacking- the committee concludes that state legislatures should not focus on further reform efforts within the existing tort system but should instead redirect their energies toward developing alternatives to the traditional tort system for resolving medical malpractice claims and toward implementing these alternatives in certain circumstances.

e) The committee recommends that states consider three proposals for additional research and implementation on a limited basis: the no-fault designated compensable events scheme (including those variants enacted in Virginia and Florida discussed above), the AMA-Specialty Society's fault based administrative system, and legislation authorizing the use of contractually determined legal relationships governing medical professional liability between providers and patients. The committee also recommends that the Federal Government provide grant funds to finance studies of proposed legislation and to begin pilot projects for limited implementation of various solutions.

Despite these findings, keep in mind that some commentators still feel that it may be too soon to draw any definite conclusions about the impacts of tort reform measures. According to Brenda Trolin of the NCSL a minimum of five years is needed before cases processed under previous systems clear the courts. Several additional years must pass before a sufficient number of cases have been processed through systems to determine whether changes have had the desired consequences.

And Patricia Young formerly of the Legislative Research Agency reminds us : "Because of the variations in state constitutions and laws regarding tort reform, identical reform measures may have dissimilar impacts in each state.

Thus, even those reform measures which appear promising require careful consideration in the context of an individual states circumstances to determine potential ramifications. Opponents frequently argue that constitutional rights-including equal protection, access to courts, and trial by jury- are violated by certain reform measures. Also, reform measures can encourage or discourage lawsuits. Although some measures may facilitate and expedite resolution, they may also encourage claims which would not otherwise be made."

One of the keys to better understanding of this issue is more and better information. Most agree that this general lack of statistical data is a problem. According to Stephan Carroll ("Assessing the Effects of Tort Reforms, 1987 at viii): "The kinds of data needed to assess the effects of reform are generally not now available... Three types of new data collection systems need to be considered: 1) systematic efforts to obtain data from insurers and self-insured defendants on the aggregate outcomes of liability claims; 2) special surveys of claimants, the bar, and insurers to obtain the detailed individual claim information needed to identify reform's winners and losers; and 3) systems for collecting information both on the other factors that impinge on the behavior of participants in the tort system, and therefore have to be controlled for, and on economic outcomes and injuries".

14. ROBERT HUNTER ("CHANGES IN INSURANCE SERVICES; HOW THE PUBLIC IS TREATED"): Given limits of time and space I will only summarize in "bullet" form Hunter's many recommendations contained in the publication called "How to Tame the Insurance Industry Cycle and Make the Legal System More Efficient- A Suggested Legislative Agenda for 1987" by Robert Hunter and Jay Angoff. Hunter's central premise is that limiting the ability of severely injured people to sue and be compensated for their injuries does not bring down insurance rates (see above for additional discussion of this issue). He proposes many reforms including: Requiring disclosure by insurance companies of data on actual income and payouts on different types of insurance; permit group insurance/risk-retention group programs; allow banks to write liability insurance; establish joint underwriting associations which provide insurance to those who can't get insurance in the voluntary market; establish state reinsurance programs which would authorize self-insureds to pay the state a premium in return for which the state would agree to pay all claims above a certain specified amount; establish state run insurance companies; establish interstate compacts for interstate reinsurance programs; prohibit arbitrary cancellations of policies; require experience rating where good risks pay less than those who are bad risks; to allow the market to work competitively despite the McCarran-Ferguson Act, establish flex-rating

which would allow insurance companies to raise or reduce rates without insurance commissioner approval within a "zone of reasonableness"; beef up enforcement by properly funding and staffing state insurance agencies; close the "revolving door" by discouraging or limiting the practice of hiring industry people to regulate the industry; establish an office of Insurance Consumer Advocate which would represent the consumer point of view at rate hearings and ensure that the insurance regulators do not rubber stamp insurance company rate requests; prohibit the pass through of lobbying expenses; require risk management by insurance purchasers and self-insureds which should reduce the frequency and severity of claims; allocate medical malpractice insurance costs more equitably. For example, doctors in high risk specialties pay for the risks that should be shared by others, doctors are broken down by insurance companies into too many categories with too few doctors in some categories, doctors pay for malpractice that could be more easily borne by hospitals, and doctors are not experienced rated; insurance companies should disclose names of doctors involved in claims and the amount of those claims. This information should be made available to various organizations and the public in general; limit lawyers fees on both sides. Hunter focuses on defense costs and contends that defense legal fees have doubled in ten years. States could limit defense fees by disapproving any rate that included within it more than a certain percentage (he suggests 25%) for defense costs which would force the insurer to keep an eye on fees insuring that a greater percentage of the money flowing through the system would end up in the hands of the injured person; penalize frivolous actions on both sides including frivolous motions and objections by defendants lawyers who charge by the hour; to encourage accountability to the public, prohibit secrecy agreements which prevent disclosure of the details of a settlement and other information about the case; encourage offensive collateral estoppel which prevents re-litigation of certain facts (i.e. once a fact is established it can be used in future cases); pass back collateral source benefits by requiring the defendant to pay the full amount of a verdict but excuse the source of collateral benefits from paying such benefits to the extent they are already included in the jury verdict and then require the source of the collateral benefits to reduce the cost of those benefits across the board based on these savings; create incentives to settle including penalizing defendants for refusing to make reasonable offers to settle, and penalizing plaintiffs for making unreasonable demands; and last but not least, establish alternatives to the tort system including no-fault systems (particularly for relatively minor injuries), arbitration, mediation, mini-trials, and other dispute resolutions systems. However, Hunter is careful to point out that cases involving defective products should be subject to common law principles without any limits on either

compensatory or punitive damages: "The stories of A.H Robins and the Dalkon Shield, Ford and the Pinto gas tank, Richardson-Merrell and MER-29, and Johns-Manville and asbestos are just a few of the scandals unearthed as a result of tort litigation. And it was only the fear of more litigation, and of large awards for both compensatory and punitive damages, which finally forces these and other dangerous products off the market and encourages the development of less dangerous substitutes."

15. CHANGES IN TIME IN THE LAW OF LIABILITY AND DAMAGES: "Liability, Perspectives and Policy" edited by Robert E. Litan and Clifford Winston of the Brookings Institution in Washington, D.C. (1988) provides insight not only into the question of how tort law has evolved over the last thirty years but also presents an excellent overview and summary of the many issues we have attempted to review in this memorandum and related attachments. Here are the key findings:

a) Tort law is largely based not on statutes but on common law, a body of legal principles developed case by case by judges, primarily those in state courts. It is difficult to generalize about the status of tort law in all jurisdictions but certain important changes in doctrines have occurred in the past several decades, all of which have expanded the system's function in spreading losses:

- * Whether by applying the negligence test in a flexible fashion or by imposing liability on parties whose behavior is causally related to accidents but who are not necessarily negligent (so-called strict liability) the courts have increased manufacturer's liability for defective products. Certain courts have held that a product can be defective even if it conforms to prevailing regulatory standards and if the manufacturer had no knowledge at the time of design or production that it would entail the risks later attributed to it in litigation.

- * The negligence standard itself has been extended through litigation to impose liability on a wide class of service providers not previously accustomed to being sued. Day care centers, ski lift, ice rink, and amusement park operators, tavern and restaurants, and not-for-profit organizations have all been taken to court for failures to warn of certain dangers and for the careless conduct of their employees. The exposure of these defendants to liability claims has been widened by the doctrine of joint and several liability, which allows prevailing plaintiffs to recover up to the full amount of a total damage award from any single defendant if the other defendants are unable to pay, and by the collateral source rule, which prohibited juries from reducing damages by subtracting insurance monies or other compensation plaintiffs receive from other sources.

* The concept of contributory negligence has been relaxed in many states so that negligent plaintiffs are no longer totally barred from recovery. Instead, they find their damages reduced by the proportion by which their negligence contributed to their injury. In addition, beginning with the Federal Tort Claims Act of 1946, which waived the federal government's sovereign immunity, courts have made state and local governments liable for tort suits.

* Courts have relaxed the standards the plaintiffs must satisfy in proving, under either the negligence or strict liability doctrine, that defendants have caused their injuries. This trend has been manifested primarily in product liability and so-called toxic tort cases, which have frequently required courts to decide whether plaintiffs' injuries have been caused by their exposure, often over long periods of their lives, to substances recently discovered to be associated with the development of cancer or other serious diseases. Courts have adopted a long range of rules to determine causation in such cases. Some have placed liability on the first or last source to which plaintiffs can establish they were exposed; others have made all manufacturers of the substance jointly and severally liable. In one noted case involving the exposure of Vietnam veterans to the chemical Agent Orange, a federal court actively encouraged a \$180 million settlement even though no hard scientific evidence had been uncovered that linked the chemical to the medical infirmities claimed by the plaintiffs.

* Finally, courts in certain jurisdictions have liberally interpreted statutes of limitation, which bar plaintiffs from recovering if they wait too long after suffering injury to file suit. In many toxic tort, product liability and medical malpractice cases it is difficult to determine when injury actually occurs. It could develop decades later when the symptoms of disease become observable. Although jurisdictions differ widely on this issue, the trend has been for courts not to invoke the statute of limitations to bar suits involving long-latent injuries.

These observations appear to be more or less consistent with the more detailed and critical analysis of these trends contained in Peter Huber's book "Liability, the Legal Revolution and Its Consequences" (1988).

b) The calls for reforming the civil justice system are less urgent now (1988) than they were in "recent months". As in previous insurance cycles, increases in premiums have moderated. In some instances, coverage that was withdrawn has reappeared. In 1986 the property and casualty industry earned 11.6 percent on its equity, a return lower than the manufacturing sector average of 13 percent during the past

decade but still considerably better than the disappointing performance of the previous two years.

c) The issues raised by the most recent crisis will not disappear. If nothing else, the dramatic increases in premiums and curtailments of coverage have called greater attention to the nation's civil justice system - whether it is working satisfactorily, and if not why - then at any point in recent memory. Moreover, interest in these issues will intensify if and when the underwriting cycle reverses course and turns against the industry once again. Chances are that it will in five to ten years.

d) Injuries pose three different and potentially conflicting challenges for all societies. One is to efficiently deter behavior that cause injuries. A second and related objective is to exact retribution against those responsible (the criminal law is a key component of this function). The third challenge is to compensate victims for their injuries. Compensation may be supplied by the government or the private sector (through insurance), and may or may not be linked to specific injuries or types of accidents. Tort law-rules allowing accident victims to seek compensation through the judicial system from the parties responsible - can be considered a mechanism for meeting all three of these challenges.

e) Of the millions of insurance claims filed each year, typically only 2% are resolved through litigation. Of cases brought to court, less than 5% are tried to verdict; the rest are settled.

f) The amounts actually received by successful plaintiffs are often much smaller than those originally awarded by juries due to trial judge and appellate overrides and/or the inability of some defendants to satisfy the judgement. In one study of 198 tort verdicts between 1984 and 1985 that resulted in awards of 1 million or more the final distributions to plaintiffs were on average 30% less than the original award. Successful plaintiffs received the jury award in only 51 cases.

g) As Rand noted average awards in tort cases in San Francisco and Cook County increased sharply, considerably faster than growth in real GNP and real prices of medical services.

h) Awards in medical malpractice cases and products liability cases were significantly higher and increased at a faster pace than those for personal injury cases generally.

i) Much of the Cook County and San Francisco increases are due to "explosive growth" in jury awards of \$1 million or more (Cook County-Two verdicts between 1960 to 1964

accounting for 4% of all personal injury awards; 67 verdicts between 1980 to 1984 accounting for 85% of awards; San Francisco- only 3.8 % of all personal injury case produced \$1 million plus awards which accounted for half of the total amounts awarded).

j) From the liability insurers point of view these statistics cause problems - Insurers can only remain profitable if they set their premiums to cover total expected claim costs, and large dollar claims increase uncertainty about the range of possible losses.

k) The greater frequency of large dollar awards can be partly explained by increases in non-economic damages - pain and suffering - as well as increases in punitive awards in certain cases. One commentator (George Priest, see page 10) finds that non-economic damages generally account for 30% to 40% of all tort damage awards and for even higher proportions of very large awards. Patricia Danzon draws similar conclusions according to Litan/Winston.

l) There are gaps in existing compensation programs and devices. For example, more than 30 million people in this country remain uninsured for medical purposes at any given time, and perhaps more than 20 million are uninsured throughout a given calendar year. In addition, many of those with insurance have limited coverage, especially for the catastrophic medical expenses often associated with major tort litigation. Gaps also exist in programs designed to compensate for income losses, although such coverage (provided through public and private disability programs) probably has increased over time. There is little evidence that expanded tort liability has efficiently filled in the gaps left by public and private the network of compensation plans. In fact, it may be undermining the compensation objective by inducing private insurers to withdraw coverage and raise premiums at the expense of low income consumers.

m) While they have broadened the availability of compensation, more liberal liability doctrines and larger damage awards and settlement may have overdeterred, forcing socially worthwhile products, services and activities to be curtailed, withdrawn from the market or eliminated. (A classic example of this phenomenon is the loss of physicians willing to perform obstetrics, as discussed in this memorandum under "Availability of Services" above and in the Danzon article contained in chapter 4 of this book. Similar effects are observed by Peter Huber in chapter 5 regarding hazardous waste facilities.)

n) Delivering compensation through the tort system is very expensive. According to Rand the United States spent between \$29 billion and \$36 billion in 1985. Of that amount less than half the total (\$14 billion to \$16 billion) was paid to

plaintiffs as damage awards; the rest went to lawyers and court administrators. Researchers at New York University, using a variety of methodologies, have arrived at similar estimates for administrative costs.

o) Because these costs are so high, interest has grown in supplementing or replacing the tort system with alternative means of compensation similar to the worker's compensation system. Most suggestions would place some sort of cap on total compensation - especially for pain and suffering - in return for automatic eligibility. More ambitious proposals envision separate funds, financed by taxes on employees or employers or both, to pay compensation awarded to victims of medical malpractice or exposure to toxic substances. But the limited experience with alternative compensation programs in the United States has not been encouraging. The federal black lung program, was established in 1969 to provide temporary compensation for an estimated 100,000 miners with pneumoconiosis. But due to broadened eligibility provisions by Congress, 542,000 miners, spouses and dependents have received benefits under the program by the end of 1981. Because of this experience, future proposals to establish compensation programs are unlikely to be given serious consideration by Congress or state legislatures unless they are accompanied by convincing demonstrations that their costs can be contained. The New Zealand experience, which does not cover disease or sickness, has not been evaluated comprehensively; and is of probable limited value in the United States which is larger and has a more heterogeneous population. In short, we simply do not know whether society would be better off if the process of identifying risks and hazards were further centralized by replacing the tort system with more intensive regulation.

p) Nevertheless, the most effective way of avoiding much of the transaction cost would be to provide ways of compensating injured parties that do not require the high fact-finding expenses characteristic of tort litigation. This suggests a tradeoff: relaxed standards for eligibility but limits on compensation, especially for non-economic damages. The Product Liability Reform Act of 1986 (S. 2760) offers the tradeoff within the tort system itself by giving plaintiffs incentives to accept manufacturers settlement offers that limited non-economic damages components. This approach could be generalized to all types of tort cases; although it is not clear whether an expedited settlement process would result in net savings.

q) Stiffer regulation of liability insurance rates or policies will not solve the liability crisis and conceivably could be counterproductive. Tighter regulations by some states will only induce some carriers in those states to reduce coverage they offer or even withdraw entirely. The only way in which regulation of the property-casualty

industry might be significantly improved is to strengthen solvency regulation by state insurance agencies. At the Federal level, it is unclear whether repeal of the McCarran-Ferguson Act would have a significant impact on insurers.

r) Virtually all tort reform measures would reduce compensation available through the system. In fact, there is evidence, at least for medical malpractice cases, that tort reforms have already reduced the frequency of claims and the growth rate of insurance premiums (he cites the 1987 update of the Tort Policy Working Group under the Reagan Administration contained in your first packet). But deterring injury is also an objective of tort law, and reducing compensation could weaken deterrence. The problem facing policymakers is that relatively little empirical information is available to indicate how tort compensation could be modified without compromising deterrence.

s) Judges should encourage juries to evaluate the costs and benefits of the behavior of both plaintiffs and defendants in tort cases in deciding which parties should bear the loss from the accident at issue.

t) The search for cost effective reforms should focus on modifications of the tort system to reduce uncertainty and eliminate inappropriate levels of compensation while retaining a fault-based rule of liability (which while costly and inefficient is probably less expensive than no-fault systems). Accordingly, there is a strong case for limiting non-economic damages in tort cases (as well as for more restrictive statutes of limitation, periodic payment of future damages and revised collateral source mechanisms that give private and public insurers rights of subrogation against the tort award, according to Danzon) but only in a way that takes into account the age of the injured party and the severity of the injury. By reducing non-diversifiable risk, such changes would also reduce the volatility of insurance premiums.

u) Finally, while some may be disappointed by the failure of Congress to enact comprehensive tort reform legislation, the experiments now being conducted by the states may prove more useful in the long run. Given the uncertainties about economic effects of different legal rules, we may one day be grateful that reform proceeded in the relatively uncoordinated fashion that it has in recent years. Today we simply know too little to be confident that any major overhaul of the U.S. tort system would produce more benefit than harm.

ATTACHMENT #4

Alaska State Legislature

P.O. Box V
Juneau, Alaska 99811
(907) 465-2828

Anchorage • District 10



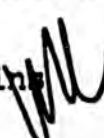
3111 C Street, Suite 412
Anchorage, Alaska 99503
(907) 561-2040

Member
Alaska Legislative
Council
Labor & Commerce
Committee
Special Committee
on Foreign Trade
Finance Sub-Committee
for Labor

Representative Virginia Collins

MEMORANDUM

To: Representative Sam Cotten, Chairman
Liability Task Force

From: Representative Virginia Collins 

Date: March 23, 1990

Subject: Statement-Liability Task Force

Several members of the task force expressed their concerns that the task force had been a failure. Given the time frames and the climate, I think that the task force really did the best it could.

The real failure, as I see it, is everybody's inability or refusal to address the real problem and that, I believe, is that the original purpose of the civil justice system, i.e., compensating innocent victims who have been injured or suffered a loss by another through no fault of their own, has been lost.

It seems that the civil justice system has become a means to redistribute the wealth. The only people who have to worry about being sued are those who have assets. The only victims who are compensated are those whose injury occurred at the hands of a wealthy individual or entity. This leaves us with an expensive, unworkable and unbalanced system, that in the end hurts us all.

Until we focus our efforts on returning the civil justice system to the purpose for which it was originally intended, we will continue to fail in our efforts to appropriately address these issues.

LAW OFFICES

Luce & Hensley

A PROFESSIONAL CORPORATION

1015 WEST SEVENTH AVENUE

ANCHORAGE, ALASKA 99501

L. AMES LUCE
DAN A. HENSLEYTELEPHONE (907) 876-1191
FAX: (907) 277-4864

March 27, 1989

Via FaxDavid E. Rogers, Esq.
Box 33932
Juneau, Alaska 99803Re: Liability Task Force Report

Dear David:

I have very serious objections to the Task Force issuing a report in the problem/solution form you have suggested. The reasons for my objections are:

- (1) The "problem" portion of the report suggests a widespread insurance problem when, in fact, the data gathered by the Task Force indicates that insurance problems only affect a limited segment of Alaska's businesses;
- (2) The "solution" portion of the report suggests that there are a number of viable solutions to insurance problems when, in fact, the data gathered by the Task Force indicates just the opposite; and
- (3) The report fails to mention that the Task Force has investigated only the tip of the iceberg of the insurance issue and that a substantial number of the Task Force members recommended that the investigation continue before the Task Force issues any reports or makes any recommendations.

Now let me move to the most important issue. The issue isn't what kind of report we do, but what kind of accountability we have to the legislature and to the public.

We were charged with investigating issues relating to insurance problems. We looked at issues of interest to some members of the committee -- legislative restrictions on victims' rights. We completely failed to consider issues such as insurance regulation, reinsurance, and similar questions. We haven't completed our job but we have been disbanded.

David E. Rogers, Esq.
March 27, 1990
Page TWO

Some persons, more cynical than I, might suggest that the reason we were disbanded is that the information we gathered concerning the impact of restrictions of victims' rights on insurance rates did not support further legislative activity in that area. Regardless of the reason for discontinuation of the Task Force, the fact remains that there is much work to be done before we can even begin to understand how best to reduce insurance rates (assuming reduction of rates is necessary). We will have wasted the public's money if we don't complete that work.

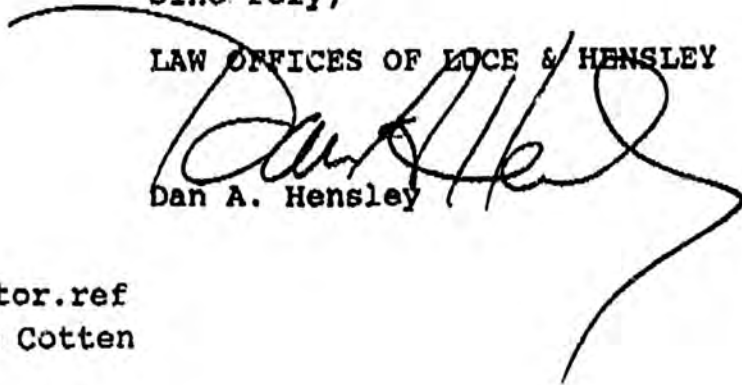
I realize that issuing any report from the Task Force may be problematic because there exist disagreements among the members as to the impact of the data gathered. As you know, I believe that the data gathered by the Task Force strongly supports the view that further legislative restrictions on victims' rights won't have any appreciable impact on insurance rates and certainly won't solve those insurance problems that presently exist in this state. However, I am sure that there will be no Task Force consensus on that view. Therefore, I don't expect you to issue a report taking that position.

I don't have any objection to a report which attempts to summarize the data gathered by the Task Force in an objective manner. You did just that in your February 22, 1990, draft. I would have no objection to the Task Force issuing a report in this form (as opposed to the March 2 edited form) if the report is prefaced with appropriate disclaimers, and if the report makes clear that there still is much work to be done to understand how insurance rates are made and how those rates can be impacted by legislation.

Thanks for the opportunity to participate and make these comments.

Sincerely,

LAW OFFICES OF LUCE & HENSLEY



Dan A. Hensley

DAH:fs
:udd:case:off.let.rog.tor.ref
cc: Representative Sam Cotten

March 21, 1990

TO: Speaker Sam Cotten
Chair, Liability Insurance Task Force

FROM: Nancy Lord *NK*

RE: Liability Insurance -- Conclusions and Recommendations

At the end of the task force's final, teleconferenced meeting last week, task force members agreed to submit their thoughts on the subject, to be compiled into a report. It is understood that the task force did not fulfill its charge to complete a comprehensive review of the issue and make recommendations to the legislature. The primary reason for this, in my opinion, was that the task force did not meet enough times to reach a common basis of fact and consider with any seriousness any of the options identified.

CONCLUSIONS

After participating in the two task force meetings and reading the enormous amount of material that was gathered, my personal conclusions are these:

The problem in Alaska concerning the availability and affordability of professional liability insurance is a complex one with no easy solutions. Following national trends, Alaska addressed the problem in 1986 by passing a "tort reform" package that was, among the states, one of the most substantial; this was followed in 1988 by passage of a ballot measure that eliminated joint liability for tort actions involving fault. There is no data suggesting that these changes in tort law, which restricted the rights of victims, have had any effect on making liability insurance more available or less costly. Nationally, the focus has now moved on to court challenges of "tort reform" and to efforts to reform the insurance industry, ensure better self-regulation by the professions, and provide alternative dispute resolution mechanisms.

In my opinion, the liability insurance problem in Alaska needs to be

Liability Insurance Task Force**N. Lord****Page 2**

further defined and addressed, not through more changes to our civil justice system but through Alaska-specific investigations into the insurance industry, the regulation of professionals, and alternative dispute resolution systems. An understanding of each of these subjects--how they operate and what possibilities they offer for reducing insurance costs while maintaining services--may provide the basis for recommending statutory changes.

RECOMMENDATIONS

1. If the legislature is interested in continuing a fact-finding effort, establish a continuing or new task force. To be more workable, such a task force might be either smaller or divided into committees; it might also be given a more narrow focus, such as to address specifically the medical malpractice issue. It might also be given the resources to contract for specific research. (Of all the reports we reviewed, the one I believe serves as the best model for an Alaskan effort is Maine's 1989 "Medical Malpractice Liability Study," which was prepared by a study team of public health experts, under the oversight of a special legislative committee.)
2. Review "tort reform" changes of 1986 and 1988 and determine what impact they have had on the rights of victims, insurance rates, insurance availability, etc.
3. Provide the Division of Insurance with a budget adequate to regulate the insurance industry, including having on-staff actuaries. Request or require (with sufficient funds) the division to do its own review of insurance regulation and identify areas it believes need attention or hold promise for meaningful reform.
4. A data-base is absolutely necessary to understand what is happening with insurance claims and profits. Require all insurance companies doing business in Alaska to report to the Division of Insurance such information as claims, settlements, premiums, investment income, reserves, and estimates of incurred claims. (Washington law may provide a good example.) Once this data is available, it should be possible to see if, among other things, the insurance companies are operating efficiently. (Generally, they do not, since they can pass along expenses to policy holders). Alaska could mandate that all insurers that do business in the state demonstrate

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Liability Insurance Task Force**N. Lord****Page 3**

an effective cost control program.

5. Investigate further the issue of reinsurance. From what I know about this, there's a definite potential of holding down premiums by having the State of Alaska, by itself or in a compact with other states, offer reinsurance as an alternative to the main reinsurers, particularly Lloyd's of London. Reinsurers are currently beyond the regulatory control of states, yet a large portion of premium costs (40% of medical malpractice premiums in Maine) go to cover reinsurance costs. Reinsurers hold major economic power over primary insurers, including in many cases dictating their terms and coverages. Alaska as reinsurer could assert its own influence on rates and coverage and, importantly, the efficiencies of primary insurers; it could also offer reinsurance to groups that self-insure; properly run, it could expect to make a profit.

6. Continue to investigate alternative dispute resolution mechanisms. While none of the systems we looked at were clearly working so well that we would want to adopt them, the general concept certainly holds much promise for providing more complete and timely compensation to victims while keeping costs down.

7. Encourage the adoption of risk management programs. Consider mandating that health care facilities develop and implement risk management programs.

8. Review the panel system currently used for peer review in the medical profession. There seemed to be consensus that this was not working well and could be improved. (HB 336, which changes the panel system, does not seem to be responsive to the problems we heard about.)

I appreciated being able to serve on the task force and hope that our efforts have helped advance the legislative discussion. Thank you for the opportunity to participate.

MICA Medical Indemnity
Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99508
(907)568-3414

March 29, 1990

Representative Sam Cotten, Speaker
House of Representatives
Alaska State Legislature
P.O. Box V
Juneau, AK 99811

Dear Speaker Cotten:

You offered members of the Legislative Liability Task Force the opportunity to review and draw some individual conclusions. This was an opportunity I did not want to miss. Although the Legislative Liability Task Force only had the opportunity to meet twice, I was impressed by the membership's ability to communicate and forward their own thoughts on some very complicated issues. At the final meeting on Friday, March 16, 1990, we still had not been able to reach conclusions as a group. I, however, would like to draw my own and am forwarding those to you in this letter.

Let me start by saying that the time spent, both interfacing with other members, and reading the data gathered by David Rogers from various sources, convinced me that this task was extremely complex. Experience has taught me that nothing this complex has a single, simple, easy solution. Although I do admit to that fact that the group didn't seem to agree upon exactly what the problems were, the fact that there were problems didn't allude anyone. In other words, I believe that everyone was convinced that the system was "broken". To what extent there was damage to the system, and what kinds of repairs needed to be made, seemed to be the questions that the group needed to tackle.

It seems to me that a three-pronged approach is necessary in solving the complex liability issue placed before us. These three remedies are as interwoven and complex as the problems they are attempting to solve. I have come to believe that, singly, they will not fix any of the problems but, taken in concert, will work towards attacking the issue from several fronts. I believe that these three remedies are: a thoughtful reform to the tort system, an organized approach to civil justice reform and, finally, increased regulation both of the insurance industry and of professional organizations.

Investigation of our own claims experience and discussions with our actuary have led us to conclude that there are some specific changes to the tort system which would, in the long run, reduce premiums. Certainly, limiting prejudgement interest, establishing a statute of repose, clarifying the statute of limitations, reducing contingencies fees to present value, and reducing the prejudgement interest rate are known changes that would reduce the cost to

Medical Indemnity Corporation of Alaska

the system. Information and testimony given to the Legislative Liability Task Force seems to point to the fact that no one can exactly quantify what the reduction would be. However, the fact that there would be a reduction seems to be, in my mind, a meaningful reason to make these changes.

I'm a firm believer and supporter of our current civil justice system. My question about the current system revolves around the word "justice". Is, in fact, justice being done under the current system? I feel that the task force was presented with evidence to the contrary. First of all, plaintiff attorney members of the task force testified that they would not pursue medical malpractice cases against a health care provider who was uninsured. They also said that they turned away all but the most compelling cases. This leads me to believe that there are citizens of the state of Alaska who have been legitimately injured and who have no recourse for recovery under the current system. We also had information presented to us that clearly proved the opposite exists: some victims are overcompensated. My feeling is that this is not the American concept of true justice. We were also presented with evidence that the court system is overburdened. Court cases are calendared by judges without any internal control over deadlines. Also, the judge is in charge of giving the jury instructions regarding what they can consider in a court case. The jury does not seem to be allowed the privilege of hearing all information and making their own decisions. That leads me to conclude that the current civil justice system has a variety of flaws. We, at MICA, at least, are interested in looking at an alternative to the current adjudication system.

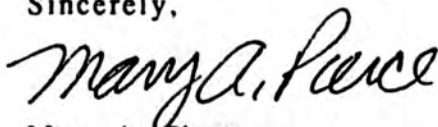
Gathering information for the task force proved difficult in some respects. Insufficient information regarding data from insurance companies on claims losses and risk management was certainly a problem. We also had difficulty in gathering data about the current court system. It is certainly difficult to draw conclusions when you have insufficient information. I believe that we need to take a good look at the requirements for both the insurance industry and the court system, then allow funding to give state government the mechanisms through the Division of Insurance, etc., to do their regulatory job. There also seems to be a variety of certification, licensing, and sanctions on the various professions. My feeling is that there should be some uniformity among the various professions as to sanctions for misconduct, disclosure requirements, education, recertification requirements, peer review and immunity for those peer reviewers.

These three approaches that I have presented here may, on review, seem complicated and overwhelming, but the problem is complicated and overwhelming. It seems when we were discussing these issues, I was reminded of a push button radio in a car where, when you push the button in to fix one problem, the remaining buttons all pop out. I'm afraid that if we don't look at all the issues, much like the buttons on the radio, and attempt to attack them comprehensively, we will end up with a partial fix that soon topples over without the support of other important component parts.

Medical Indemnity Corporation of Alaska

Let me conclude with saying that I do believe the task force performed a great service in providing a common data bank of information that the legislature can use in making further decisions about the problems. I would like to again thank the other members for the time that I know they committed to this effort. I'd also like to thank David Rogers for the wonderful job that he did, and you, Representative Cotten, for putting such a well balanced group together and allowing us the opportunity to share information and experiences.

Sincerely,

A handwritten signature in cursive script that reads "Mary A. Pierce". The signature is written in dark ink and is positioned above the typed name and title.

Mary A. Pierce
Executive Director

MAP/blb

cc William Brock
David Rogers