HB

472

(File 1 of 7)

HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: February 16, 2004 **FURTHER REFERRALS:**

Date of Committee Action: March 22, 2004

The JUDICIARY Committee considered: **HB 472**

HOUSE BILL NO. 472 **CLAIMS AGAINST HEALTH CARE PROVIDERS**

"An Act relating to claims for personal injury or wrongful death against health care providers; and providing for an effective date."

Recommends it be replaced with [ ] HCS *or* [X] CS *for* HB 472 (JUD)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____ **[ ] Same Title [ ] New Title**

[ ] attach amendments
[ ] add new referral to _____Committee
[ ] Letter of Intent_____Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LEG
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

NEW **FISCAL NOTES** *Assigned by Chief Clerk's Office				
List by Dept(s):	*FN#	Fiscal	Indet.	Zero
LAW				✓
CED				✓

PREVIOUS **FISCAL NOTES**				
List by Dept(s):	FN#	Fiscal	Indet.	Zero

Signing with recommendations	**Printed Last Name**	**DP**	**DNP**	**NR**	**AM**
	SAMUELS			✓	
	Holm			✓	
	Coon		✓		
	Ogg			X	
Tom Anderson	ANDERSON	X			
Mark Gruenberg	Gruenberg		✓		
			✓		
Chair	McGuire	✓			
Chair:					

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 472
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: DCED
Title: Claims Against Health Care Providers
RDU: Insurance (116)
Component: Insurance Operations
Sponsor: Representative Anderson
Requester: House Judiciary
Component No.: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2005 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This legislation limits the damages for non-economic losses that may be awarded against health care providers for personal injury or wrongful death.

This legislation has no fiscal impact on the operations of the division.

Prepared by: Linda S. Hall, Director
Phone (907) 269-7900
Division: Insurance
Date/Time 2/19/04 4:54 PM
Approved by: Edgar Blatchford, Commissioner
Date 2/19/2004
Agency: Department of Community & Economic Development

(Revised 12/2003 OMB)

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number: HB472-LAW-T&WC-2-20
Bill Version: HB 472
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: LAW
Title "An Act relating to claims for personal injury or wrongful death against health care providers..."
RDU CIVIL
Component Torts & Workers' Compensation
Sponsor Representative Anderson
Requester House Judiciary Committee
Component No.

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2004) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2005 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill adds a new section to the Code of Civil Procedure in order to place limits on the amount of recoverable damages for personal injury or wrongful death based on the provision of services by a health care provider. The bill makes a minor change to the requirement that health care providers obtain the informed consent of a patient prior to embarking on a course of action involving the patient, and that informed consent include information regarding risk of death, serious bodily harm, and common serious complications that may occur. The bill also makes clear that a health care provider is not responsible for certain types of advice given to advice that the patient elects not to follow.

Passage of this legislation will have no foreseeable fiscal impact on the Department of Law.

Prepared by: Kathryn A. Daughhetee, Director
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Division Administrative Services
Date/Time 2/20/04 2:40 PM
Approved by: Kathryn Daughhetee for Gregg D. Renkes, Attorney General
Date 2/20/2004
Agency Department of Law

(Revised 12/2003 OMB)

1 of 1 DOCUMENT

VICKI MARSINGILL and PAUL MARSINGILL, wife and husband, Appellants, v. JAMES O'MALLEY, M.D., Appellee.

Supreme Court No. S-9859, No. 5643

SUPREME COURT OF ALASKA

58 P.3d 495; 2002 Alas. LEXIS 163

November 22, 2002, Decided

SUBSEQUENT HISTORY: Rehearing denied by, 12/11/2002

PRIOR HISTORY: **[**1]** Appeal from the Superior Court of the State of Alaska, Third Judicial District, Peter A. Michalski, Judge. Superior Court No. 3AN-95-9909 CI.

DISPOSITION: Vacated and remanded with directions.

CASE SUMMARY:

PROCEDURAL POSTURE: Several months after having stomach surgery, appellant patient called appellee surgeon complaining of abdominal pain and nausea. Several hours later, the patient lost consciousness from an intestinal blockage and suffered permanent injuries. The patient sued the surgeon for medical malpractice. A jury rejected the claims, and the Superior Court, Third Judicial District (Alaska), entered judgment for the surgeon. The patient appealed.

OVERVIEW: On appeal, the patient argued it was an error to exclude evidence of the surgeon's failure to pass tests for surgeon board certification and whether the jury instructions correctly described the standard for deciding whether the surgeon gave the patient adequate information. The appellate court found no abuse of discretion in the rulings excluding evidence. As licensed physicians could practice surgery in Alaska without board certification, the surgeon's inability to pass board certification tests did not necessarily tend to prove that the surgeon lacked minimally necessary surgical skills or knowledge. However, the appellate court held that the jury should have been instructed to use the reasonable patient standard to decide if the surgeon gave the patient sufficient information about treatment choices. In denying the request for the instruction, the trial court deprived the patient of her right to have the jury decide the issue directly from the standpoint of a reasonable patient. Because the given instructions hinged entirely on the testimony of competing experts rather than on the jury's common sense and experience, giving those instructions was reversible error.

OUTCOME: The judgment was vacated and remanded for a new trial.

LexisNexis (TM) HEADNOTES - Core Concepts:

Torts > Malpractice Liability > Healthcare Providers
[HN1] See *Alaska Stat. § 09.55.540(a).*

Civil Procedure > Appeals > Standards of Review > Abuse of DiscretionEvidence > Procedural Considerations > Rulings on Evidence

[HN2] Appellate courts review decisions excluding evidence for abuse of discretion. An abuse of discretion occurs only when the court is left with a definite and firm conviction, after reviewing the whole record, that the trial court erred in its ruling.

Evidence > Relevance > Character EvidenceEvidence > Relevance > Confusion, Prejudice & Waste of TimeEvidence > Relevance > Relevant Evidence
[HN3] Alaska R. Evid. 402 provides that, with certain exceptions, all relevant evidence is admissible. But among the recognized exceptions to this rule of general admissibility, the rules of evidence incorporate provisions allowing courts to exclude relevant evidence whose probative value is outweighed by its potential to prejudice or confuse the jury, Alaska R. Evid. 403, and evidence of character or conduct whose primary purpose is to show that a person acted in conformity therewith on a specific occasion. Alaska R. Evid. 404(b).

Torts > Malpractice Liability > Healthcare Providers
[HN4] Since licensed physicians are allowed to practice surgery in Alaska without board certification, a physician's inability to pass one or more board certification tests does not necessarily tend to prove that the physician lacks minimally necessary surgical skills or knowledge. By adopting as a matter of public policy a medical licensing standard that authorizes physicians to perform general surgery without obtaining board certification, Alaska law establishes a baseline standard that precludes expert witnesses from dictating a more rigorous certification requirement.

Evidence > Procedural Considerations > Rulings on EvidenceTorts > Malpractice Liability > Healthcare Providers
[HN5] Courts generally disfavor admission of evidence showing that a defendant failed board certification tests when that evidence is affirmatively offered to prove lack of professional knowledge or skill. But courts also recognize that considerably greater latitude exists to admit such evidence through cross-examination or in rebuttal when it counteracts affirmative defense evidence introduced to show a special degree of skill, knowledge or relevant expertise. Yet at the same time, appellate courts addressing issues of admissibility in this area have consistently emphasized the need for great deference to the trial court's superior ability to determine whether particular evidence would have been more probative than prejudicial in a given case.

Civil Procedure > Jury Trials > Jury InstructionsCivil Procedure > Appeals > Standards of Review > De Novo Review
[HN6] The sufficiency of proposed jury instructions is a legal question to which an appellate court applies its independent judgment. A legally erroneous instruction warrants reversal only when it prejudices a party, that is, when substantial rights of the parties were affected or the error had substantial influence.

Healthcare Law > Treatment > Failures to Warn & Disclose
[HN7] The physician-patient relationship is one of trust. Because the patient lacks the physician's expertise, the patient must rely on the physician for virtually all information about the patient's treatment and health. A physician therefore undertakes, not only to treat a patient physically, but also to respond fully to a patient's inquiry about his treatment, i.e., to tell the patient everything that a reasonable person would want to know about the treatment.

Healthcare Law > Treatment > Patient Consent
[HN8] Alaska's informed consent statute, *Alaska Stat. § 09.55.556(a)*, requires physicians to disclose the common risks and reasonable alternatives to a proposed treatment or procedure but fails to specify what standard governs the scope of the disclosure requirement.

Healthcare Law > Treatment > Patient Consent
[HN9] Expert testimony does not play a determinative role in the context of the reasonable patient rule. Under this modern view, expert testimony concerning the professional standard of disclosure is not a necessary element of the plaintiff's case because the scope of disclosure is measured from the standpoint of the patient. A physician must disclose those risks which are material to a reasonable patient's decision concerning treatment. Although expert testimony remains relevant in narrowing the field of risks that are potentially material, materiality itself must ultimately be judged by asking what a reasonable patient would want to know.

Healthcare Law > Treatment > Patient Consent

[HN10] The determination of materiality in disclosing risks to patients is a two-step process. The first step is to define the existence and nature of the risk and the likelihood of its occurrence. Some expert testimony is necessary to establish this aspect of materiality because only a physician or other qualified expert is capable of judging what risk exists and the likelihood of its occurrence. The second prong of the materiality test is for the trier of fact to decide whether the probability of that type of harm is a risk which a reasonable patient would consider in deciding on treatment. The focus is on whether a reasonable person in the patient's position would attach significance to the specific risk. This determination does not require expert testimony.

Healthcare Law > Treatment > Failures to Warn & Disclose
[HN11] In the context of a pre-existing patient/physician relationship involving post-operative care, a physician's recommendation to do nothing in the face of threatening symptoms is the equivalent of a treatment recommendation and should be accompanied by a duty of disclosure. A physician's acquiescence in a patient's decision not to seek treatment in the same circumstances should likewise be regarded as equivalent to a treatment recommendation subject to the same duty.

Evidence > Witnesses > Judges & Jurors
[HN12] Alaska R. Evid. 606(b) flatly prohibits parties from questioning jurors as to any matter influencing their deliberations except on the question whether extraneous prejudicial information was improperly brought to the jury's attention or whether any outside influence was improperly brought to bear upon any juror. The rule likewise categorically bars the receipt of evidence of any statement by the juror concerning a matter about which the juror would be precluded from testifying.

COUNSEL: Robert H. Wagstaff, Law Offices of Robert H. Wagstaff, Anchorage, for Appellant.

Donna M. Meyers and Howard A. Lazar, Delaney, Wiles, Hayes, Gerety, Ellis & Young, Inc., Anchorage, for Appellee.

JUDGES: Before: Fabe, Chief Justice, Matthews, Bryner, and Carpeneti, Justices. [Eastaugh, Justice, not participating.]

OPINIONBY: BRYNER

OPINION: [*497] BRYNER, Justice.

I. INTRODUCTION

One night several months after having stomach surgery, Vicki Marsingill called her surgeon, Dr. James O'Malley, complaining of abdominal pain and nausea. Dr. O'Malley advised Marsingill to go to the emergency room and offered to meet her there, but Marsingill said she felt better and declined to go. Several hours later, Marsingill lost consciousness from an intestinal blockage and suffered permanent injuries. Marsingill sued Dr. O'Malley, claiming that he lacked the skill and knowledge to advise [**2] her properly and that the information he gave her over the telephone did not allow her to make an intelligent treatment decision. A jury rejected these claims. The main issues on appeal are whether the trial court erred in excluding evidence of Dr. O'Malley's failure to pass tests for board certification as a surgeon and whether the jury instructions correctly described the standard for deciding whether Dr. O'Malley gave Marsingill adequate information. We find no abuse of discretion in the court's rulings excluding evidence but hold that the jury should have been instructed to use the reasonable patient standard to decide if Dr. O'Malley gave Marsingill sufficient information about her condition and treatment choices.

II. FACTS AND PROCEEDINGS

In October 1994 Dr. O'Malley performed surgery to remove staples that another surgeon had previously placed in Vicki Marsingill's stomach to facilitate weight loss. By January 1995 Marsingill had recovered from the surgery and was cleared to return to work.

While dining out with a friend on the evening of February 14, 1995, Marsingill "suffered a sudden onset of illness, was in pain, felt nauseous, and was unable to eat, so [went] [**3] home." Her pain worsened over the next few hours, and she eventually asked her daughter to call Dr. O'Malley. Her daughter told Dr. O'Malley that Marsingill looked bad, that she was nauseous and in pain, that she was unable to burp or have a bowel movement, and that her stomach was "as hard as a rock." Dr. O'Malley then spoke directly with Marsingill, who sounded anxious and upset. She informed him that she was having abdominal pain, felt bloated, and could not burp. Dr. O'Malley advisedMarsingill that he could not

evaluate her over the phone but that "if she felt bad enough to call him at night" she should go the emergency room. He repeated this advice several times but did not venture any opinion about the cause of Marsingill's symptoms or tell her that her condition was potentially life-threatening or serious. He left it up to her whether to seek emergency room treatment.

When Marsingill asked what would happen at the emergency room, Dr. O'Malley informed her that the doctors there would probably take x-rays and insert a nasogastric tube to relieve the pressure in her stomach. n1 Dr. O'Malley knew that Marsingill had previously had nasogastric tubes inserted and, like [*498] most patients, [**4] strongly disliked them. Soon after hearing that she would likely need to have a nasogastric tube inserted if she went to the emergency room, Marsingill ended the call, telling Dr. O'Malley that she thought that she could burp and was feeling better.

n1 Inserting a nasogastric tube involves placing a tube through the patient's nose, down the back of the throat into the esophagus, and into the stomach.

After hanging up, Marsingill told her daughter that she was feeling better and would try to "tough it out for awhile." But later that night Marsingill's husband found her unconscious on the bathroom floor. Paramedics rushed her to the hospital, where an emergency operation later revealed that she had experienced an intestinal blockage. But by then the obstruction had caused Marsingill to go into shock; as a result, she suffered brain damage and partial paralysis.

Marsingill eventually filed suit against Dr. O'Malley, asserting four claims, only two of which currently remain relevant: (1) that the doctor lacked skill [**5] and knowledge in general surgery and, as a result, committed malpractice by giving Marsingill incompetent advice when she called about her symptoms and (2) that the doctor had breached his duty to give Marsingill enough information to enable her to make an informed choice about going to the emergency room for treatment.

To meet her burden of proving that Dr. O'Malley lacked knowledge and skills as a surgeon, Marsingill planned to introduce evidence that he had repeatedly failed tests for AMA board certification in general surgery. Marsingill maintained that this evidence was relevant to prove that Dr. O'Malley lacked the requisite degree of skill and knowledge and that it also would be admissible to impeach defense testimony and to establish the basis for her own experts' opinions.

But in a pretrial motion, Dr. O'Malley asked the trial court to exclude all evidence regarding his medical education and training except evidence that he had "graduated from medical school, completed a medical degree, and was not Board Certified." In support of his pretrial motion, Dr. O'Malley argued that evidence of his failed attempts at board certification was inadmissible character evidence and could [**6] not be properly used to show either a general lack of skill or an act of negligence on any particular occasion.

The trial judge granted Dr. O'Malley's motion to exclude the evidence and instructed both parties not to introduce evidence of "the details pertaining to Dr. O'Malley's medical education background." On several occasions during trial Marsingill moved to introduce evidence regarding Dr. O'Malley's lack of board certification, arguing that the doctor or his expert witnesses had opened the door to a broader inquiry into his background. The court denied each of these motions.

The expert testimony at trial focused on the symptoms of post-surgical bowel obstructions and the appropriate course of action for a physician to take in response to a patient's call complaining of these symptoms. Six medical experts testified -- three for Marsingill and three for Dr. O'Malley -- about the appropriateness of Dr.O'Malley's advice during the February 14 telephone call from Marsingill. Their opinions were sharply divided.

Marsingill's experts -- Drs. Battle, Modlin, and Ravden -- uniformly agreed that Dr. O'Malley's actions fell below the accepted standard of care. They particularly criticized [**7] Dr. O'Malley's failure to communicate to Marsingill the true seriousness of her situation, the extent of the risk she faced, and the importance of getting immediate help. Additionally, they questioned Dr. O'Malley's professional judgment in needlessly telling Marsingill that she would likely be treated with a nasogastric tube if she decided to go to the emergency room. Because installing such tubes involves a painful procedure, they emphasized, a competent physician who wanted to encourage a patient to seek emergency room treatment would not have offered up the prospect of being treated with a nasogastric tube.

In contrast, however, Dr. O'Malley's experts -- Drs. Gardiner, Macho, and Moossa -- uniformly disagreed with this assessment, insisting that on the whole Dr. O'Malley had provided "very good care." Dr. Gardiner, for example, described a physician's duty during a phone call as being very limited, concluding that Dr. O'Malley had done everything necessary to fulfil that duty. Dr. O'Malley's experts also were adamant in expressing their view that the doctor had acted properly in simply advising [*499] Marsingill to go to the emergency room, without engaging her in a speculative discussion [**8] of the possible causes of her symptoms. While acknowledging that Marsingill's prior abdominal surgeries placed her at heightened risk for an intestinal obstruction and that the symptoms she described on the telephone were consistent with such an obstruction, they emphasized that a physician cannot accurately diagnose a patient over the telephone and concluded that the doctor therefore had no "obligation to speculate." Dr. O'Malley's experts also took exception to the claim that it was improper for him to mention thelikelihood of Marsingill's being treated with a nasogastric tube at the emergency room. To the contrary, they claimed, Dr. O'Malley acted appropriately by giving Marsingill an honest and accurate answer to her question about what she could expect if she went to the emergency room.

In the course of their testimony, the expert witnesses also gave divergent opinions about the scope of a physician's ethical duty to give patients sufficient information to make intelligent treatment decisions. Section 8.08 of the AMA Code of Medical Ethics addresses this duty of disclosure, providing: "The patient's right of selfdecision can be effectively exercised only if the patient possesses [**9] enough information to enable an intelligent choice." Marsingill's experts maintained that Dr. O'Malley had violated Section 8.08 by failing to give her enough information to make an intelligent choice about whether to seek emergency room treatment. As already mentioned, Dr. O'Malley's experts took the opposite view, maintaining that the doctor had satisfied his duty simply by advising Marsingill that she should go to the emergency room for an examination.

Dr. O'Malley himself shifted positions: when initially questioned about his obligations under Section 8.08, he testified that the provision "applies to Mrs. Marsingill. It doesn't really apply to me." But he later reconsidered, acknowledging that Section 8.08 applied to his conduct -- that he did "have [an] obligation to give [Marsingill] enough information so that she could make an intelligent choice as to whether she should go to the emergency room."

At the conclusion of trial, Marsingill proposed jury instructions covering her alternative theories of liability -- that Dr. O'Malley committed malpractice by lacking adequate skill and knowledge to enable him to respond appropriately to her telephone calland that he breached [**10] his duty to give her enough information to enable her to make an informed decision about going to the emergency room for examination and treatment.

With respect to the second of these theories -- Dr. O'Malley's alleged breach of Section 8.08's duty to inform -- Marsingill's proposed instruction would have required the jury to decide the sufficiency of Dr. O'Malley's communications from the standpoint of a reasonable patient in Marsingill's position. But the trial court rejected the proposed "reasonable patient" instruction, instead directing the jury to measure Dr. O'Malley's compliance by relying exclusively on the expert testimony addressing his compliance with a general surgeon's professional standard of care.

After the jury returned a verdict in favor of Dr. O'Malley, Marsingill filed this appeal.

III. DISCUSSION

A. Evidentiary Claims Marsingill based her malpractice claim partly on the theory that Dr. O'Malley lacked the requisite skills and ability to recognize the likely cause of her symptoms and extent of the risk that she consequently faced; he thus negligently failed to communicate the urgency of her receiving immediate medical attention. n2 On appeal, Marsingill [**11] asserts [*500] that the trial court prevented her from proving this theory when it excluded relevant evidence revealing that Dr. O'Malley had repeatedly failed examinations for board certification in surgery. n3

n2 *AS 09.55.540(a)* defines the elements of a medical malpractice claim in Alaska:

[HN1] (a) In a malpractice action based on the negligence or wilful misconduct of a health care provider, the plaintiff has the burden of proving by a preponderance of the evidence (1) the degree of knowledge or skill possessed or the degree of care ordinarily exercised under the circumstances, at the time of the act complained of, by health care providers in the field or specialty in which the defendant is practicing; (2) that the defendant either lacked this degree of knowledge or skill or failed to exercise this degree of care; and (3) that as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

n3 [HN2] We review decisions excluding evidence for abuse of discretion. *Anchorage Nissan, Inc. v. State, 941 P.2d 1229, 1238 n.17 (Alaska 1997); Agostinho v. Fairbanks Clinic P'ship, 821 P.2d 714, 716 n.2 (Alaska*

1991). An abuse of discretion occurs only "when we are left with a definite and firm conviction, after reviewing the whole record, that the trial court erred in its ruling." *Peter Pan Seafoods v. Stepanoff, 650 P.2d 375, 378-79 (Alaska 1982).*

[12]**

[HN3] Rule 402 of the Alaska Rules of Evidence provides that, "with certain exceptions, 'all relevant evidence is admissible.'" n4 But among the recognized exceptions to this rule of general admissibility, the rules of evidence incorporate provisions allowing courts to exclude relevant evidence whose probative value is outweighed by its potential to prejudice or confuse the jury n5 and evidence of character or conduct whose primary purpose is "to show that [a] person acted in conformity therewith" on a specific occasion. n6

n4 *Cummings v. Sea Lion Corp., 924 P.2d 1011, 1017 (Alaska 1996)* (quoting Alaska R. Evid. 402). Rule 401 defines relevant evidence as "evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence."

n5 Alaska R. Evid. 403.

n6 Alaska R. Evid. 404(b); *accord* Alaska R. Evid. 404(a). *Trombley v. Starr-Wood Cardiac Group PC, 3 P.3d 916, 918, 920 (Alaska 2000).*

n7

[13]** n7

Here, Marsingill correctly posits that Alaska's medical malpractice statute allows a finding of liability when a physician's lack of skill or knowledge proximately causes injury to a patient; n7 but she incorrectly reasons that Dr. O'Malley's failure to achieve board certification is relevant and admissible to prove that a specific defect in knowledge or skill caused him to injure Marsingill on the occasion at issue.

[HN4] Since licensed physicians are allowed to practice surgery in Alaska without board certification, a physician's inability to pass one or more board certification tests does not necessarily tend to prove that the physician lacks minimally necessary surgical skills or knowledge. Thus, even if Marsingill's expert witnesses might have been willing to testify as to their personal opinion that a competent general surgeon should possess knowledge and skill necessary to receive board certification, the trial court correctly recognized that this testimony would be irrelevant under Alaska law. For by adopting as a matter of public policy a medical licensing standard that authorizes physicians to perform general surgery without obtaining board certification, Alaska law establishes **[**14]** a baseline standard that precludes expert witnesses from dictating a more rigorous certification requirement. n8

n8 *See Jackson v. Buchman, 338 Ark. 467, 996 S.W.2d 30, 34 (Ark. 1999)* ("Board certification is not required by law to practice surgery in Arkansas. Accordingly, the legal standard of care set out in [the Arkansas malpractice statute] is in no way affected by board certification.").

To prevail on her malpractice claim, then, Marsingill needed to make a more particularized showing that Dr. O'Malley lacked specific knowledge or skills that a competent surgeon would need regardless of board certification. Notably, the trial court gave Marsingill broad latitude to ask questions and introduce evidence for the purpose of showing that Dr. O'Malley did not know the common signs and symptoms of a bowel obstruction and that this particular lack of knowledge fell below the accepted standard of professional competence. Her ability to introduce this evidence gave Marsingill ample opportunity **[**15]** to present her malpractice claim to the jury. Considering the totality of the circumstances, we hold that it was not an abuse of discretion to grant Dr. O'Malley's pretrial motion to exclude evidence of his failed attempts **[*501]** to pass the test for board certification in general surgery.

After the trial court granted Dr. O'Malley's pretrial motion to exclude this evidence, Marsingill repeatedly sought its admission during the course of trial, maintaining that Dr. O'Malley and his experts opened the door to its use to impeach

and contradict their testimony. The trial court consistently declined to admit the evidence. Marsingill now challenges the trial court's rulings, renewing the arguments she raised below.

We begin by acknowledging that Marsingill's arguments on these points present close issues. As already noted above, [HN5] courts generally disfavor admission of evidence showing that a defendant failed board certification tests when that evidence is affirmatively offered to prove lack of professional knowledge or skill. But courts also recognize that considerably greater latitude exists to admit such evidence through cross-examination or in rebuttal when it counteracts affirmative defense **[**16]** evidence introduced to show a special degree of skill, knowledge or relevant expertise. n9 Yet at the same time, appellate courts addressing issues of admissibility in this area have consistently emphasized the need for great deference to the trial court's superior ability to determine whether particular evidence would have been more probative than prejudicial in a given case. n10

n9 *See, e.g., Campbell v. Vinjamuri, 19 F.3d 1274, 1277 & n.2 (8th Cir. 1994); Gipson v. Younes, 724 So. 2d 530, 532 (Ala. Civ. App. 1998)* ("When a physician sued for malpractice testifies as an expert, the fact that he had failed a board certification examination is relevant to his credibility as an expert."); *McCray v. Shams, M.D., 224 Ill. App. 3d 999, 587 N.E.2d 66, 70, 167 Ill. Dec. 184 (Ill. App. 1992)* (stating that failure to pass boards was material issue in examination of expert witness "because it bore on whether she was qualified to meet the standards of the specialty").

n10 *See Gipson, 724 So. 2d at 533* ("We have reviewed a number of decisions from other jurisdictions in which the courts have been required to determine whether a physician who testifies as an expert witness may be cross-examined about his failure to pass a board certification exam. The decisions are virtually unanimous in upholding the trial court's determination -- regardless of whether the determination resulted in admission or in exclusion of the evidence.").

[17]**

Here, Marsingill first claimed that Dr. O'Malley opened the door during a portion of his own testimony that occurred shortly after one of Marsingill's expert witnesses who was from England -- Dr. Modlin -- had finished testifying. When asked if he was board certified by the American College of Surgeons, Dr. O'Malley answered: "No, I'm not." He then added, "Neither is Dr. Modlin." Marsingill argued that, in giving this unsolicited response, Dr. O'Malley unfairly attempted to portray himself as being equally qualified with Dr. Modlin, when in fact Dr. Modlin is board certified in the United Kingdom and thus is accepted by the American College of Surgeons as having the equivalent of board certification in the United States.

Although the trial court denied Marsingill's request to refute Dr. O'Malley's unsolicited response with examination concerning his failures to pass the board certification test, the court did expressly allow Marsingill to correct any misleading impression through further questioning about the nature of Dr. Modlin's United Kingdom board certification and by confirming that Dr. O'Malley had no comparable qualifications.

Marsingill argues that Dr. O'Malley's statement **[**18]** was a gratuitous and improper attempt to mislead the jury. Since this is one reasonably possible view of the statement, the trial court might have had discretion to allow inquiry into Dr. O'Malley's board failures. But the trial court's alternative approach to the issue effectively prevented Dr. O'Malley from creating any misleading impression; and at the same time it avoided taking recourse in a remedy that would have answered one impropriety with yet another. On balance, we cannot say that the trial court abused its discretion in finding that Dr. O'Malley did not open the door in this instance.

Marsingill also attempted to introduce the board certification evidence to impeach what she claimed were Dr. O'Malley's attempts to portray himself as extensively qualified. Specifically, Dr. O'Malley testified on direct examination that he had operating privileges at all area hospitals and covered **[*502]** for virtually every surgeon in Anchorage; that he directed both the trauma center at Alaska Regional Hospital and the burn unit at Providence Hospital; that he received out-of-state referrals based on his expertise with burn patients; and that he had been contacted by the television program NOVA **[**19]** about filming a segment on treating frostbite patients. Marsingill argued that this testimony went "far beyond [Dr. O'Malley's] basic licensure qualifications," that it affirmatively raised the issue of Dr. O'Malley's general expertise as a surgeon, and that it thereby entitled Marsingill to impeach these claims by questioning Dr. O'Malley about his repeated failures to become board certified.

Dr. O'Malley rejoined that his testimony simply gave "general background information" and would not be perceived as asserting any extraordinary level of skill; moreover, he emphasized, the special expertise that he described was in the area of treating frostbite, not in gastro-intestinal surgery. The trial court found this argument persuasive and declined to allow impeachment through evidence of Dr. O'Malley's board failures.

It is a close question whether Dr. O'Malley's testimony exceeded the scope of the superior court's pretrial order, which limited the scope of testimony that both parties could present covering Dr. O'Malley's education and training. Thus, while inquiring into Dr. O'Malley's board failures would have been permissible as impeachment, we again must conclude that the trial [**20] court did not abuse its broad discretion in excluding that evidence. Under Evidence Rule 403, the trial court bears primary responsibility for determining admissibility of evidence by balancing its probative value evidence against its potential to create undue prejudice and confusion. Since the areas of expertise that Dr. O'Malley mentioned on direct examination were not germane to the areas at issue in Marsingill's claim, we cannot say as a matter of law that the probative value of Marsingill's proposed impeaching evidence outweighed its potential for causing prejudice and confusion.

Finally, Marsingill sought to use the board certification evidence to impeach various statements by Dr. O'Malley's experts regarding Dr. O'Malley's general qualifications -- particularly an opinion expressed by Dr. Gardiner that Dr. O'Malley is not deficient in knowledge or skills and an opinion by Dr. Moossa that Dr. O'Malley has the requisite level of surgical skill, as well as the judgment and knowledge to handle difficult problems. But as with the previous evidentiary decisions, the trial court's broaddiscretion to assess the admissibility and likely prejudicial impact of evidence precludes us from [**21] saying that the court abused its discretion. n11

n11 *See, e.g., Campbell, 19 F.3d at 1277; Hinson v. Clairemont Cmty. Hosp., 218 Cal. App. 3d 1110, 267 Cal.Rptr. 503, 510-12 (Cal. App. 1990).*

B. Jury Instructions Concerning the Standard for Deciding Breach of Duty To Disclose Marsingill next claims that the trial court erred in rejecting her proposed jury instructions regarding Dr. O'Malley's duty to give her adequate information during the February 14 phone call. As previously mentioned, Marsingill pursued two alternative theories of liability at trial that remain relevant on appeal. Under the first theory, she claimed that Dr. O'Malley lacked sufficient knowledge and skill to advise her properly as to her treatment choices and that these deficiencies caused him to commit malpractice by giving her deficient advice. Under the second theory, Marsingill claimed that a physician owes a duty to give patients enough information to make intelligent treatment choices. Marsingill [**22] claimed that Dr. O'Malley breached this duty of disclosure by failing to adequately inform her about the potential seriousness of her symptoms and the risks of failing to seek immediate examination and emergency room treatment.

Marsingill proposed separate jury instructions covering these theories. Her proposed instruction on her claim for failure to inform would have directed the jury that the question whether Dr. O'Malley breached his duty to give her sufficient information [*503] must be measured from the standpoint of the "reasonable patient." The trial court rejected this instruction and instead used a single instruction for both the medical malpractice theory and duty-to-inform theory. Although this instruction advised the jury of the separate factual basis underlying each of Marsingill's theories, it effectively treated both as medical malpractice claims, requiring the jury to determine whether Dr. O'Malley had given Marsingill sufficient evidence to meet his duty to inform by relying exclusively on expert testimony concerning whether the doctor's advice breached the professional standard of care. Marsingill challenges the trial court's ruling, asserting that the "reasonable patient" [**23] standard should have governed the jury's determination of whether Dr. O'Malley breached his duty to give her enough information to make an intelligent treatment choice. n12 We agree.

n12 [HN6] The sufficiency of proposed jury instructions is a legal question to which we apply our independent judgment. *Fairbanks N. Star Borough v. Kandik Constr. Inc., 795 P.2d 793, 797 (Alaska 1990), vacated in part on other grounds, 823 P.2d 632 (Alaska 1991); Chenega Corp. v. Exxon Corp., 991 P.2d 769, 775 (Alaska 1999)* ("A legally erroneous instruction warrants reversal only when it prejudices a party -- that is, when 'substantial rights of the parties were affected or the error had substantial influence.' ") (internal citations omitted).

Marsingill's alternate theory of liability did not question the competency of any medical care or treatment administered by Dr. O'Malley and so did not depend on whether he breached the professional standard of care that governs a general surgeon; [**24] rather it questioned the adequacy of the information that he disclosed concerning Marsingill's treatment options, asserting that the doctor owed her a duty of disclosure and that he breached this duty. Our decisions have previously distinguished between the standard that governs a physician's duty to render adequate care and the standard that governs a physician's duty to disclose or inform. We first noted the distinction in *Pedersen v. Zielski*:

[HN7] The physician-patient relationship is one of trust. Because the patient lacks the physician's expertise, the patient must rely on the physician for virtually all information about the patient's treatment and health. A physician therefore undertakes, not only to treat a patient physically, but also to respond *fully* to a patient's inquiry about his treatment, i.e., to tell the patient everything that a reasonable person would want to know about the treatment. n13

n13 *822 P.2d 903, 909 (Alaska 1991).*

Elaborating further on this distinction in *Korman* [**25] *v. Mallin*,n14 we noted that [HN8] Alaska's informed consent statute n15 requires physicians to disclose the common risks and reasonable alternatives to a proposed treatment or procedure but fails to specify what standard governs the scope of the disclosure requirement. n16 After observing that the law traditionally measured a physician's duty to disclose "by the professional standard in the field," *Korman* rejected that approach in favor of "the modern trend" of case law, which "measures the physician's duty of disclosure by what a reasonable patient would need to know in order to make an informed and intelligent decision." n17

n14 *858 P.2d 1145 (Alaska 1993).*

n15 *See AS 09.55.556(a).*

n16 *Korman, 858 P.2d at 1148.*

n17 *Id. at 1148-49.*

Korman went on to hold that [HN9] expert testimony does not play a determinative role in the context of the reasonable patient rule: "Under this modern view, expert testimony concerning the [**26] professional standard of disclosure is not a necessary element of the plaintiff's case because the scope of disclosure is measured from the standpoint of the patient." n18 Emphasizing that "a physician must disclose those risks which are 'material' to a reasonable patient's decision concerning treatment," n19 *Korman* borrowed from the Louisiana Supreme Court's decision in *Hondroulis v. Schuhmacher* n20 to explain that, although expert testimony remains relevant [*504] in narrowing the field of risks that are potentially material, materiality itself must ultimately be judged by asking what a reasonable patient would want to know:

[HN10] The determination of materiality is a two-step process. The first step is to define the existence and nature of the risk and the likelihood of its occurrence. "Some" expert testimony is necessary to establish this aspect of materiality because only a physician or other qualified expert is capable of judging what risk exists and the likelihood of its occurrence. The second prong of the materiality test is for the trier of fact to decide whether the probability of that type of harm is a risk which a reasonable patient would consider in deciding on treatment. [**27] The focus is on whether a reasonable person in the patient's position would attach significance to the specific risk. This determination does not require expert testimony. n21

n18 *Id. at 1149.*

n19 *Id.*

n20 *553 So. 2d 398 (La. 1989).*

n21 *Korman, 858 P.2d at 1149* (quoting *Hondroulis, 553 So. 2d at 412).*

In the present case, Marsingill insists that *Korman*'s reasonable patient rule -- not the professional standard of care in the field -- governed the scope of Dr. O'Malley's duty to give her enough information to enable her to make an intelligent treatment decision. n22 Dr. O'Malley responds that neither *Korman* nor Alaska's informed consent law should extend to this case because the duty of disclosure they describe "simply does not apply unless the physician recommends or proposes a specific treatment or procedure." n23 According to Dr. O'Malley, in the present case, "the factual predicate for the . . . duty to disclose, i. **[**28]** e., a recommended treatment or procedure is totally absent." Hence, Dr. O'Malley contends, "Marsingill's theory that Dr. O'Malley failed to adequately appreciate and communicate the seriousness of her condition was properly included in the ordinary medical negligence instruction."

n22 Marsingill also cites California cases in support of her position, primarily *Truman v. Thomas, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (Cal. 1980),* and *Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (Cal. 1972).*

n23 Dr. O'Malley discusses cases from California and New Jersey in support of this proposition. *See, e.g., Arato v. Avedon, 5 Cal. 4th 1172. 858 P.2d 598, 605, 23 Cal. Rptr. 2d 131 (Cal. 1993); Scalere v. Stenson, 211 Cal. App. 3d 1446, 260 Cal.Rptr. 152 (Cal. App. 1989); Farina v. Kraus, 333 N.J. Super. 165, 754 A.2d 1215, 1223-24 (N.J. Super. 1999); Eagel v. Newman, 325 N.J. Super. 467, 739 A.2d 986, 989-90 (N.J. Super. 1999).*

[29]**

But on the particular facts of this case, Dr. O'Malley's position is unpersuasive. We assume for present purposes that Dr. O'Malley is correct in asserting that *Korman* and Alaska's implied consent statute both extend only to situations involving recommendations for specific medical procedures and treatment. Yet when Marsingill called Dr. O'Malley on the night of February 14, she was seeking a recommendation for treatment of her abdominal pain and distress. Uncontradicted evidence establishes that Dr. O'Malley advised her to go to the emergency room for treatment that would likely entail having a nasogastric tube inserted into her stomach. And despite Dr. O'Malley's argument to the contrary, the record supports the conclusion that this advice amounted to a recommendation for treatment. n24

n24 Dr. O'Malley asserts that one of Marsingill's experts, Dr. Ravden, "admitted" that "simply going to the hospital is neither a treatment or procedure." Yet this argument neglects to mention that Dr. Ravden expressly identified nasogastric intubation as a procedure "used in the treatment of a bowel obstruction."

[30]**

Furthermore, there was evidence that Dr. O'Malley acquiesced in Marsingill's decision not to go to the emergency room. [HN11] In the context of a pre-existing patient/physician relationship involving post-operative care, a physician's recommendation to do nothing in the face of threatening symptoms is the equivalent of a treatment recommendation and should be accompanied by a duty of disclosure. A physician's acquiescence in a patient's decision not to seek treatment in the same circumstances should likewise be regarded as equivalent to a treatment recommendation subject to the same duty.

As we have previously mentioned, Section 8.08 of the AMA Code of Medical Ethics gives rise to a duty of disclosure in such situations, requiring that patients be given "enough information to enable an intelligent **[*505]** choice." All six expert witnesses at trial agreed that this duty to inform applied in Marsingill's case. Indeed, even Dr. O'Malley conceded that the duty attached, expressly acknowledging that he had an "obligation to give [Marsingill] enough information so that she could make an intelligent choice as to whether she should go to the emergency room." Hence, no one disagreed that a duty of reasonable **[**31]** disclosure existed -- that Dr. O'Malley did in fact have a duty to give Marsingill enough information to make an intelligent choice about immediately going to the emergency room for treatment; the only significant disagreement centered on issues concerning the scope and breach of the duty to inform. n25

n25 The consensus of testimony agreeing that this duty of disclosure arose in the present setting makes it unnecessary for us to determine whether Alaska's informed consent statute would have independently encompassed the duty had Section 8.08 not applied.

Yet these are precisely the issues that *Korman* describes as lying outside the realm of professional expertise and as falling within the fact-finding powers that the reasonable patient rule assigns to lay jurors. In denying the request for an instruction on the reasonable patient standard, then, the superior court deprived Marsingill of her right to have the jury decide the issue directly, from the standpoint of a reasonable patient. The court instead required **[**32]** the jury to filter its decision through the experts' views of what patients should be told. Because the instructions hinged the determination of breach entirely on the testimony of competing experts rather than on the common sense and experience of the jury, we must conclude that giving those instructions amounted to reversible error. n26

n26 Dr. O'Malley cursorily argues that if any error occurred on this point it was harmless because the factual similarity between Marsingill's medical malpractice and failure-to-inform theories of liability rendered any difference between the two theories immaterial. But this argument is unpersuasive, for, as *Korman* expressly recognizes, the differences in the standards that govern the jury's determination of breach make these theories significantly different. Although Dr. O'Malley further contends that Marsingill "conceded that she could argue her theory within the confines of the general medical malpractice instruction," this argument misstates the concession: While acknowledging that the malpractice instruction actually given allowed her to argue her factual theory, Marsingill specifically objected that the instruction would deprive her of the right to have her theory decided under the correct legal standard.

[33]**

IV. CONCLUSION

The judgment is VACATED, and this case is REMANDED for a new trial on Marsingill's claim for breach of the duty to provide enough information to allow her to make an intelligent treatment choice. On remand, the jury must be instructed to decide the claim from the standpoint of a reasonable patient. n27

n27 Because our decision on the standard for determining a breach of the duty to disclose requires a remand for retrial, we need not resolve Marsingill's remaining claims of error. To provide appropriate guidance on remand, however, we think it necessary to comment on two aspects of the remaining claims.

First, Marsingill argues that reversible error occurred when Dr. O'Malley's trial counsel argued in his closing argument to the jury that "plaintiff is asking you to basically take everything he's worked for his whole life, to ruin his reputation as a physician. That's unbelievable." Although we need not decide if this comment amounted to reversible error, we believe that it could readily have been understood as an improper suggestion that a judgment awarding damages against Dr. O'Malley would not be covered by his insurance.

Second, Marsingill argues that the superior court erred in denying her motion for a new trial, which was based on the jury's alleged confusion regarding an aspect of the jury instructions. Because this issue emerged from a post-trial interview with jurors conducted by a paralegal who worked for Marsingill's trial counsel and was supported by the paralegal's affidavit, we take this opportunity to remind counsel that [HN12] Evidence Rule 606(b) flatly prohibits parties from questioning jurors as to any matter influencing their deliberations except "on the question whether *extraneous* prejudicial information was improperly brought to the jury's attention or whether any *outside* influence was improperly **[*506]** brought to bear upon any juror." Alaska R. Evid. 606(b) (emphasis added). The rule likewise categorically bars the receipt of "evidence of any statement by the juror concerning a matter about which the juror would be precluded from testifying."

[34]**

ALASKA STATE LEGISLATURE

Rep. Lesil McGuire, Chair
Rep. Tom Anderson, Vice-Chair
Rep. Jim Holm
Rep. Dan Ogg
Rep. Ralph Samuels
Rep. Les Gara
Rep. Max Gruenberg

State Capitol, Room 120
Juneau, AK 99801-1182
(907) 465-4990
Fax (907) 465-6592

House Judiciary Committee

Memorandum

To: Leg. Legal

From: Vanessa Tondini, Committee Aide
House Judiciary Committee

Date: March 22, 2004

Re: CS Request

Please create a final draft House Judiciary Committee Substitute for work order # 23-LS1743\D, HB 472, incorporating the attached amendment (Conceptual Amendment #1). The bill was passed out of committee today.

If you have any questions, please call me at 4990. Thank you!

conceptual
AMENDMENT #1 - PASSED

OFFERED IN THE HOUSE
BY REP. HOLM

TO: CSHB 472 (JUD)

Page 2, Line 22, following "death.":

Insert "The limits on damages in this subsection do not apply if it is shown by clear + convincing evid. that the personal injury or wrongful death was the result of reckless or intentional misconduct."

Page 2, Line 25, following "judgment":

Insert "unless it is shown by clear + convincing evidence that the personal injury or wrongful death was the result of reckless or intentional misconduct"

clear + convincing evidence

conceptual to conform to 9.17.020(b) (pun. dam.)

A. to A #1 to include gross negligence FAILED

* (incorporate) use the same exact language, criteria & standard of proof that is used for punitive damages in AS 9.17.020(b)
(create a separate subsection or incorporate into existing subsections ... however you feel is most appropriate.

23-LS1743\A.6
Bullock
3/22/04

AMENDMENT #2 - FAILED
by Rep. Gara

OFFERED IN THE HOUSE
TO: CS HB 472(JUD)

Page 2, line 19, following $250,000:

Insert ", except that the limit on damages is $1,000,000 if it is shown, by clear and convincing evidence, that the injury is a serious debilitating physical injury or disfigurement. Each limit applies"

(DELETED) RESCINDED

A. to A#2 - PASSED

Insert:
"or if the defendant acts with criminal negligence as defined in AS 04.21.080(1), except that the term "reasonable person" shall be/mean "reasonable medical practitioner in the field."

Page 2, line 25:

Delete "$250,000"

Insert "the limit in (d) of this section"

L

From Jerry Lockhart

Courts that have addressed this burden of proof issue under similar statutory provisions have required proof by "clear and convincing" evidence. *See, e.g., Castellano v. Bitkower,* 216 Neb. 806, 346 N.W.2d 249, 252 (Neb. 1984) (stating that the appropriate standard of evidence regarding lost notes is "clear and convincing" evidence); *Lutz v. Gatlin,* 22 Wash. App. 424, 590 P.2d 359, 361 (Wash. App. 1979) ("To establish a lost instrument, the evidence must be clear, cogent and convincing.")

Clear and convincing evidence has been characterized as evidence that is greater than a preponderance, but less than proof beyond a reasonable doubt. *Castellano* provides a useful statement of the standard, holding that "clear and convincing evidence means and is that amount of evidence which produces in the trier of fact a firm belief or conviction about the existence of a fact to be proved." 346 N.W.2d at 253; *see also Welton v. Gallagher,* 2 Haw. App. 242, 630 P.2d. 1[illegible]t of 81 (Haw. App. 1981), *aff'd,* 65 Haw. 528, 654 P.2d 1349 (Haw. 1982)

Rep Gara
Attn: Ryan

23-LS1743\A.5
Bullock
3/16/04

AMENDMENT #6 - FAILED
Reoffered by Rep. Gruenberg A#3 CSHB472(JUD) FAILED

OFFERED IN THE HOUSE BY REPRESENTATIVE GARA

TO: HB 472

Page 2, following line 27:

Insert a new subsection to read:

"(g) The limitation on damages under (d) of this section shall be adjusted by the administrative director of the Alaska Court System on October 1 of each year, calculated to the nearest whole percentage point between the index for January of that year and January of the prior year according to the Consumer Price Index for all urban consumers for the Anchorage metropolitan area compiled by the Bureau of Labor Statistics, United States Department of Labor. The administrative director of the Alaska Court System shall provide notification of a change in the limitation of damages to the clerks of court in each judicial district of the state. The court shall adjust the award for noneconomic damages under this subsection and (e) of this section, if necessary, before the entry of judgment."

23-LS1743\D
Bullock
3/22/04

CS FOR HOUSE BILL NO. 472(JUD)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-THIRD LEGISLATURE - SECOND SESSION

BY THE HOUSE JUDICIARY COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES ANDERSON, Fate

A BILL

FOR AN ACT ENTITLED

"An Act relating to claims for personal injury or wrongful death against health care providers; and providing for an effective date."

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

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE FINDINGS AND INTENT. (a) The legislature finds that the national medical malpractice crisis continues to affect the state, and patient access to physicians will be dramatically affected if physicians cannot afford, or obtain at any price, malpractice insurance.

(b) It is the intent of this Act to

(1) alleviate a medical malpractice insurance crisis that the legislature believes will, if not corrected, threaten the quality of the state's health care; the legislature believes that the continuing availability of adequate medical care depends directly on the availability of adequate insurance coverage, which in turn operates as a function of costs associated with

medical malpractice litigation; the legislature believes that decreasing the limits on noneconomic damages will help to contain the costs of malpractice insurance by controlling damages and will significantly help to provide for a stable malpractice insurance market for health care providers, thereby maximizing the availability of medical services to meet the state's health care needs;

(2) modify the decisions of the Alaska Supreme Court in Marsingill v. O'Malley, 58 P.3d 495 (Alaska 2002) and Korman v. Mallin, 858 P.2d 1145 (Alaska 1993); and

(3) clarify the law of informed consent in medical malpractice cases.

*** Sec. 2.** AS 09.55.548 is amended by adding new subsections to read:

(c) In an action to recover damages for personal injury or wrongful death based upon the provision of services by a health care provider, damage claims for noneconomic losses shall be limited to compensation for pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium, injury to reputation, and other nonpecuniary damage.

(d) Notwithstanding AS 09.17.010, the damages awarded by a court or a jury for claims allowed under (c) of this section, including a loss of consortium or other derivative claim, arising out of a single injury or death may not exceed $250,000 regardless of the number of health care providers against whom the claim is asserted or the number of separate claims or causes of action brought with respect to the injury or death.

(e) The jury may not be informed about the limitation on damage claims for noneconomic losses in (c) of this section, but an award for noneconomic losses in excess of $250,000 shall be reduced before the entry of judgment.

(f) Multiple injuries sustained by one person as a result of a single incident shall be treated as a single injury.

*** Sec. 3.** AS 09.55.556 is amended to read:

Sec. 09.55.556. Informed consent. (a) A health care provider is liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of the

common risks and reasonable alternatives to the proposed treatment, [OR] procedure, **or course of action,** and that, but for that failure, the claimant would not have consented to the proposed treatment, [OR] procedure, **or course of action**.

(b) It is a defense to any action for medical malpractice based upon an alleged failure to obtain informed consent that

(1) the risk not disclosed is too commonly known or is too remote to require disclosure;

(2) the patient stated to the health care provider that the patient would **or would not** undergo the treatment, [OR] procedure, **or course of action** regardless of the risk involved or that the patient did not want to be informed of the matters to which the patient would be entitled to be informed;

(3) under the circumstances, consent by or on behalf of the patient was not possible; or

(4) the health care provider, after considering all of the attendant facts and circumstances, used reasonable discretion as to the manner and extent that the alternatives or risks were disclosed to the patient because the health care provider reasonably believed that a full disclosure would have a substantially adverse effect on the patient's condition.

*** Sec. 4.** AS 09.55.556 is amended by adding new subsections to read:

(c) A health care provider, when informing a patient of the common risks and reasonable alternatives to a proposed treatment, procedure, or course of action, shall disclose a known risk of death or serious bodily harm and explain the common complications that may occur. A health care provider is required only to disclose that information that a skilled health care provider of the same or reasonably similar specialty would disclose under similar circumstances.

(d) A health care provider is not liable for advice given to a patient by telephone, radio, electronic mail, telemedicine, or other electronic communication if the advice is that the patient seek further care or evaluation at the health care provider's office, a clinic, an emergency room, or a hospital, and the patient elects not to follow that advice.

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to

read:

APPLICABILITY. This Act applies to suits against health care providers initially filed on or after the effective date of this Act.

* **Sec. 6.** This Act takes effect July 1, 2004.

23-LS1743\A.1
Bullock
3/10/04

AMENDMENT #1 - PASSED
by Rep. Gara

OFFERED IN THE HOUSE

TO: HB 472

Page 2, line 19, following "$250,000":

Insert ", except that, in the case of severe permanent physical impairment or severe disfigurement, the damages may not exceed $1,000,000. The limit on damages applies"

Page 2, line 25:

Delete "$250,000"

Insert "the maximum amount allowed under (d) of this section"

m/ rescind
action on adopting
A #1
~~MASS~~ PASSED

L

ALASKA STATE LEGISLATURE

Rep. Lesil McGuire, Chair
Rep. Tom Anderson, Vice-Chair
Rep. Jim Holm
Rep. Dan Ogg
Rep. Ralph Samuels
Rep. Les Gara
Rep. Max Gruenberg

State Capitol, Room 120
Juneau, AK 99801-1182
(907) 465-4990
Fax (907) 465-6592

House Judiciary Committee

Memorandum

To: Leg. Legal

From: Vanessa Tondini, Committee Aide
House Judiciary Committee

Date: March 20, 2004

Re: CS Request

Please create a work draft House Judiciary Committee Substitute for work order # 23-LS1743\A, HB 472, with the attached two amendments (4A and 4B). I have also written the changes into the text of the accompanying bill draft for clarification. The bill will be reheard on Monday, March 22 at 1:00p.m.

If you have any questions, please call me at 4990. Thank you!

Gara

Amendment 4A - PASSED

~~Default~~

Delete at p3 line 22

~~"serious bodily" and~~ ("most")

P. 3

A.4B Delete at line 23, "serious" - PASSED

~~and insert at line 22 the words~~

~~"risks" after "common"~~

and

HOUSE BILL NO. 472

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-THIRD LEGISLATURE - SECOND SESSION

BY REPRESENTATIVE ANDERSON

Introduced: 2/16/04
Referred: Judiciary

A BILL

FOR AN ACT ENTITLED

"An Act relating to claims for personal injury or wrongful death against health care providers; and providing for an effective date."

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

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(1) alleviate a medical malpractice insurance crisis that the legislature believes will, if not corrected, threaten the quality of the state's health care; the legislature believes that the continuing availability of adequate medical care depends directly on the availability of adequate insurance coverage, which in turn operates as a function of costs associated with

medical malpractice litigation; the legislature believes that decreasing the limits on noneconomic damages will help to contain the costs of malpractice insurance by controlling damages and will significantly help to provide for a stable malpractice insurance market for health care providers, thereby maximizing the availability of medical services to meet the state's health care needs;

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(d) Notwithstanding AS 09.17.010, the damages awarded by a court or a jury for claims allowed under (c) of this section, including a loss of consortium or other derivative claim, arising out of a single injury or death may not exceed $250,000 regardless of the number of health care providers against whom the claim is asserted or the number of separate claims or causes of action brought with respect to the injury or death.

(e) The jury may not be informed about the limitation on damage claims for noneconomic losses in (c) of this section, but an award for noneconomic losses in excess of $250,000 shall be reduced before the entry of judgment.

(f) Multiple injuries sustained by one person as a result of a single incident shall be treated as a single injury.

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common risks and reasonable alternatives to the proposed treatment, [OR] procedure, **or course of action,** and that, but for that failure, the claimant would not have consented to the proposed treatment, [OR] procedure**, or course of action**.

(b) It is a defense to any action for medical malpractice based upon an alleged failure to obtain informed consent that

(1) the risk not disclosed is too commonly known or is too remote to require disclosure;

(2) the patient stated to the health care provider that the patient would **or would not** undergo the treatment, [OR] procedure**, or course of action** regardless of the risk involved or that the patient did not want to be informed of the matters to which the patient would be entitled to be informed;

(3) under the circumstances, consent by or on behalf of the patient was not possible; or

(4) the health care provider, after considering all of the attendant facts and circumstances, used reasonable discretion as to the manner and extent that the alternatives or risks were disclosed to the patient because the health care provider reasonably believed that a full disclosure would have a substantially adverse effect on the patient's condition.

*** Sec. 4.** AS 09.55.556 is amended by adding new subsections to read:

(c) A health care provider, when informing a patient of the common risks and reasonable alternatives to a proposed treatment, procedure, or course of action, shall disclose a known risk of death or serious bodily harm and explain the ~~most~~ common ~~serious~~ complications that may occur. A health care provider is required only to disclose that information that a skilled health care provider of the same or reasonably similar specialty would disclose under similar circumstances.

(d) A health care provider is not liable for advice given to a patient by telephone, radio, electronic mail, telemedicine, or other electronic communication if the advice is that the patient seek further care or evaluation at the health care provider's office, a clinic, an emergency room, or a hospital, and the patient elects not to follow that advice.

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to

read:

APPLICABILITY. This Act applies to suits against health care providers initially filed on or after the effective date of this Act.

*** Sec. 6.** This Act takes effect July 1, 2004.

23-LS1743\A.3
Bullock
3/10/04

AMENDMENT #2 - FAILED
by Rep. Ogg

OFFERED IN THE HOUSE

TO: HB 472

Page 2, line 22, following "death.":

Insert "The limits on damages in this subsection do not apply if the personal injury or wrongful death was the result of gross negligence or reckless or intentional misconduct."

Page 2, line 25, following "judgment":

Insert "unless the personal injury or wrongful death was the result of gross negligence or reckless or intentional misconduct"

23-LS1743\A.4
Bullock
3/10/04

AMENDMENT #3 - FAILED
by Rep. Gruenberg

OFFERED IN THE HOUSE

TO: HB 472

Page 3, lines ~~19~~ 20 - ~~30~~ 25:

Delete all material.

Renumber the following bill sections accordingly.

2 Amdts to H0472 "A" Version

By: Gruenberg WITHDRAWN

A.5A.

(A) page 3 ~~between~~ line 22 after "and" insert "clearly"

(B) page 3 line 26 after "advice" insert "clearly"

AMENDMENT #1 - withdrawn (never offered)

To HB 472

IN THE HOUSE JUDICIARY COMMITTEE

March 3, 2004

Page 2, Line 11-16 Delete all language

Insert:

(c) In an action to recover damages for personal injury or wrongful death based upon the provision of services by a health care provider, damages shall include both economic and non economic damages. Damage claims for non economic losses shall be limited to compensation for pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium, injury to reputation, and other non pecuniary damage.

Page 4, Line 4, after "*Sec.6." insert:

AS 09.55.560 is amended by adding a new subsection to read:
(6) "Economic damages" means objectively verifiable monetary losses incurred as a result of the provision of, use of or payment for (or failure to provide, use or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities. All other damages are "non economic" damages.

Renumber language in old Section 6 accordingly.

AMENDMENT #2 - withdrawn (never offered)

To HB 472

IN THE HOUSE JUDICIARY COMMITTEE

March 3, 2004

Page 3, Line 20 -23, Delete all language through "...that may occur."

Medical Malpractice in Alaska

Amounts Paid Per Claim, by Year

Year	# of Claims Paid	Average Amount Paid per Claim (Total Damages)
1993	17	$278,785
1994	19	$212,577
1995	9	$108,917
1996	15	$58,081
1997	24*	$137,942
1998	13*	$198,315
1999	20	$380,102
2000	26*	$305,952
2001	26	$218,564
2002	22	$322,998
2003	18	$341,983

*one award amount is listed as "confidential" in this year

Information provided by the Alaska State Medical Board

ALASKA STATE MEDICAL BOARD

REVISED 03/05/2004

SORTED BY DATE PAID

Board	Practitioner Name	Occurred	Award	Case/Court #	Date Paid	Res	Brief Description of Claim
MED	Veuthey, Pierre	11/7/1983	$5,000		5/16/1990	SET	Willard case - no details available
MED	Kemp, Aaron	08/89	$22,000	3131	7/1/1990	SET-B	Alleged UGI bleed following anti-inflammatory med for hem disc
MED	Hoag, Robert	1983-87	$15,000	87-2-19441-8	8/3/1990	SET-A	Pap smear misdiagnosed
MED	Tangpricha, Vilhavas	5/18/1988	$45,000	88-18043	8/30/1990	SET-B	Alleged failure to dx & tx respiratory arrest; pt death
MED	Foote, James Timothy	7/6/1987	$75,600	4FA-88-908CIV	11/1/1990	SET-A	Delayed dx of appendicitis resulting in rupture
MED	Nathanson, Steven E.	11/3/1988	$7,500		11/8/1990	SET-B	After rhinoplasty pt complained of obstruction on nose
MED	Brown, Carolyn	9/12/1985	$20,000		12/3/1990	SET-B	Alleged negligent tx of ectopic pregnancy
MED	Kennedy, Ronald E.	12/2/1985	$269,112	3AN-87-377	3/17/1991	SET-A	Alleged negl vein/vein rather than vein/artery graft during bypass
MED	Manuel, Michael	12/13/1988	$10,750		5/7/1991	SET-B	Sponge left in breast during augmentation surg
MED	Halter, Loren	1/22/1987	$55,000	3KO-88-504	6/14/1991	SET-A	Alleged misdx & tx of burns resulting in additional wounds;tx
MED	Heilman, Doris	8/12/1987	$150,387	4FA-89-1375	6/17/1991	CA	Alleged unnec surg w/o full consent
MED	Brudenell, Ross	11/13/1987	$125,000	3AN-89-09303	6/18/1991	SET-A	Alleged negl bone graft to r wrist; wound infect & sepsis
MED	Ake, Burton Kenneth	7/28/1987	$71,500	3AN-91-1314	6/25/1991	SET-A	Alleged sexual misconduct during office pelvic exam
MED	Johnson, R. Holmes	8/12/1978	$200,000	3AN-91-2051	6/26/1991	SET-A	Alleged failure to dx & transfer for tx epidural hemorrhage
MED	Doramus, Alfred	3/14/1988	$28,000	4FA-90-350	8/26/1991	SET-A	Alleged failure to remove post introcular lens that dislocated
MED	Mays, Denton	3/1/1988	$140,000	3AN-88-11350	9/23/1991	SET-A	Alleged improp use of hypnosis for SLE & sex assault
MED	Deal, Clyde	7/28/1981	$15,000	3KO-87-72CI	10/8/1991	SET-A	Alleged negl hernia repair/surg resulting in rmvl of testicle
MED	Stewart, Mary Lu	11/1/1985	$500,000	57-254504 K3	10/30/1991	SET-B	Alleged that chemotherapy was factor in death
MED	O'Malley, James E.	1/9/1988	$30,000	3AN-90-5688	11/22/1991	SET-A	Alleged failure to remove sponge following appendectomy
MED	Nicholson, Thomas A.		$20,000		11/22/1991	CA	Pt alleged injured 2 fingers during barium enema
MED	Reinbold, William B	8/17/1983	$4,000	3AN-90-8759CIV	12/17/1991	OOC	Scalpel blade left in knee after surgery
MED	Belknap, Alan R.	1/14/1987	$10,000	90-C-321	12/18/1991	SET-A	Alleged failure to note breast masses in mammograms
MED	Beal, David	3/18/1987	$145,000	3AN-89-1690	12/27/1991	SET-A	CSF leak following sinus surgery
MED	Borgeson, Marvin E.	2/6/1987	$128,859	4FA-88-221CIV	1/16/1992	SET-A	Alleged delay in dx septic hip resulting in osteomyelitis
MED	Dingeman, Robert	2/6/1987	$128,859	4FA-88-221CIV	1/16/1992	SET-A	Alleged delay in dx septic hip resulting in osteomyelitis
MED	Kruger, Sandford M.	10/23/1989	$60,000		2/1/1992	SET-A	Pediatric death of 20-month old due to croup
MED	Johnson, Jay	8/3/1987	$325,000	23-349650	2/4/1992	SET-A	Failure to dx infection in hand of diabetic pt
MED	Boyeler, Natalie	4/11/1989	$225,000		2/14/1992	SET-B	Alleged failure to FU radiologist recomm re lung lesion; delay dx
MED	Rostykus, Paul S.	4/7/1989	$52,500	90CF0093	4/14/1992	SET-A	Alleged failure to dx & refer for tx; cardiac arrest, death
MED	Joosse, John W.	8/3/1989	$160,000	4FA-90-51CIV	4/17/1992	SET-A	Alleged negl fusion at L4-5 rather than L5-S1
MED	Heilman, Doris	5/16/1989	$50,000		4/20/1992	SET-B	Alleged tubal ligation while pg load to fetal death
MED	Barry, Peter A.	12/4/1989	$30,000	147341	4/27/1992	SET-A	Arthroscopy done on wrong knee
MED	Strohmeyer, Richard R.	3/22/1986	$60,000	3AN-88-3082	4/28/1992	SET-A	Alleged negl surg; casting of fx elbow; compt synd, fasciotomy
MED	Matrisciano, John D.	07/88	$29,950	NW CO49 980	6/1/1992	SET-B	Alleged pain during sex following inguinal hernia repair
MED	Borden, James B.	7/29/1991	$58,490		6/5/1992	SET-B	Alleged damage to bile duct during laporos cholecystectory
MED	Asher, Richard W.	6/18/1988	$90,000	A-90-381	6/10/1992	SET-A	Alleged failure to dx botulism & initiate tx
MED	Asher, Richard W.	6/18/1988	$17,500	A-90-381	6/10/1992	SET-A	Alleged failure to dx botulism & initiate tx
MED	Ellis, Richard	8/5/1986	$95,000	A275397	7/17/1992	SET-A	Alleged failure to dx & tx aseptic necrosis R femoral head
MED	Harrison, Harry	2/20/1987	$159,500	3AN-89-1262	7/21/1992	SET-A	Alleged delayed dx of necrotizing enterocolitis in newborn
MED	Jacob, Jack	2/20/1987	$53,000	3AN-89-1262	7/21/1992	SET-A	Alleged delayed dx of necrotizing enterocolitis in newborn
MED	Vasileff, Thomas	2/28/1989	$45,000	3AN-91-6689	8/3/1992	SET-A	Arthoscoped wrong knee
MED	Farleigh, Denise C.	2/20/1987	$148,750		8/5/1992	SET-B	Alleged delayed dx of necrotizing enterocolitis in newborn
MED	Moeller, Mark	11/11/1988	$150,000	3AN-90-8975	8/5/1992	SET-A	Alleged failure to dx abdominal aortic aneurysm rupture
MED	Johnstone, Bruce B.	1/72-7/74	$175,000		8/31/1992	SET-A	Alleged "physical contact" w/ pt result in emotional injury
MED	Emenhiser, Donald L.	5/1/1989	$17,500	L89-656	9/1/1992	SET-A	Failure to dx heart disease; failure to refer
MED	Alvarez, Rene	3/22/1988	$122,500	3KO-90-394	9/10/1992	SET-A	Alleged unnec TAB/BSO for tx of PID; alleged unnec surg
MED	Sangster, Joseph A.	10/6/1986	$300,000	3KN-88-825	9/22/1992	OOC	Alleged negligent performance in dx ureteral obstruction

ALASKA STATE MEDICAL BOARD

REVISED 03/05/2004

SORTED BY DATE PAID

Board	Practitioner Name	Occurred	Award	Case/Count #	Date Paid	Res	Brief Description of Claim
MED	Grimm, Arthur R.	1/12/1988	$200,000		11/3/1995	SET-B	Alleged failure to dx lung Ca resulting in death of pt
MED	Orlando, Michael R.	11/14/1991	$600,000	F300179/TM	12/19/1995	CA	During endoscopic sinus surg, optic nerve, rectu muscle cut
MED	Hoag, Robert (w/ Ritzen)	90-92	$150,000		1/1/1996	SET-B	Alleged negligence in interpret of pap smear
MED	Ritzen, Alex (w/ Hoag)	90-92	$150,000		1/1/1996	SET-B	Alleged negligence in interpret of pap smear
MED	Walker, Enlow R.	11/17/1994	$8,333	98-100062-SR	3/15/1996	SET-B	Alleged failure to notify pt of abnormal pap
MED	Dumas, Marc	2/16/1993	$70,000	4 FA 95 415	5/23/1996	SET-A	Failed to admit/observe inebriated pt; later dx cervical fx
MED	Tyler, Earl D.	2/17/1993	$70,000	4FA-95-415	5/28/1996	SET-A	Alleged negligent interpretation of MRI of spine
MED	Klepp, A. Leonard	4/15/1993	$5,040		7/19/1996	CA	Removal of lesion by laser & developed keloid.
MED	Liberatore, Marcia A.	9/23/1995	$2,245		7/26/1996	SET-B	Failure to Dx fractures/inadequate discharge instructions
MED	Davidhizar, Lavern R.	6/27/1994	$1,063	3KN-96-223	8/21/1996	SET-A	PA employee failed to advise pt of meds' side effects to sun
MED	Mackie, Scott P.	2/18/1989	$77,598	3AN-89-7746	8/29/1996	SET	HIV test w/o consent-results given to spouse before pt told
MED	Merchant, Clifford R.	5/20/1995	$23,500		9/11/1996	SET-B	Alleged failure to hosp w/ chest pain; pt had MI next day
MED	Palmer, William M.	5/5/1989	$150,000	1JU-96-1040	9/25/1996	SET-A	Alleged delay in Dx, treatment of breast cancer
MED	Williams, John D.	7/9/1992	$32,856	3AN-94-5234	9/30/1996	CA	Jury found insufficient data to support surgery repair to ear
MED	Roode, Peter G.	10/7/1994	$37,500		11/8/1996	SET-A	Alleged failure to diagnose heart attack
MED	Kim, Eui G.	10/19/1994	$35,000	3AN-96-6375	12/11/1996	SET-A	Urinary incontinence surgery complications
MED	Worley, Floyd	5/29/1995	$18,500		12/12/1996	SET-B	Alleged failure to dx ectopic prognancy w/ tubal rupture
PAD	Jones, Gary P.	9/14/1994	$25,000		2/25/1997	SET-B	Negligent care while responding to accident
MED	McConkey, Samuel A.	1/19/1991	$69,592	4FA-93-857	3/10/1997	CA	Following laser trtmt pt lost central vision in left eye
MED	Fortier, George M.A.	3/3/1982	$150,000	WRM129OUP0356	3/13/1997	CA	Alleged incompl vagotomy result in recurrent ulcer & 2nd surgery
MED	Fortson, Jayne S.	8/7/1996	$8,000		3/13/1997	SET-B	Pt received 1st degree burns during ultraviolet light therapy
MED	Crouch, Edward E.	2/2/1993	$70,000	7011398-M	4/10/1997	SET-B	Tunic of eye punctured due to negligent injection of Kenalog
MED	Tinsley, Ronald E.	4/8/1994	$54,000	1JU-95-747	4/10/1997	SET-A	Alleged failure to remove nasal packing resulted in reoperation
MED	Palmer, William M.	5/5/1994	$180,000	1JU-95-2173	4/14/1997	SET-A	Alleged unnec laporoscopic surg; negligent follow-up
MED	Murphy, Neil J.	10/4/1994	$750,000		5/6/1997	SET-B	Wrongful death, gas embolism of heart during routine hys/lap
MED	Lacort, Linda L.	12/14/1990	Confidential	93-1648 RI SupCt	5/12/1997	SET-A	Breach of care; labor & delivery management
MED	Jackson, M. Marcell	1/28/1993	$10,000	3AN-95-1961	5/13/1997	SET-A	Alleged overdose of drug --withdrawal symptoms; fail to refer
MED	Gower, Roland E.	9/23/1992	$15,000	3AN-93-7693CI	5/15/1997	SET-A	Alleged negligent laparoscopic cholecystectomy
MED	Palmer, William M.	4/16/1996	$65,000		5/20/1997	SET-B	Alleged negl performance abd laparoscopy w/ injuries
MED	Senta, Michael	12/5/1994	$65,000	3PA-96-971	7/1/1997	SET-A	Failure to dx /tx colonoscopy--death due to hemorrhage
MED	Beyeler, Natalie	12/6/1994	$65,000	3PA-96-971	7/1/1997	CA	Failure to dx/treat compl/colonscopy/death/2nd splenic hemor
MED	Klester, W. Scott	6/1/1992	$15,000	3AN-96-10106	7/11/1997	SET-A	Failure to dx/tx cholesteatoma
MED	Newton, Douglas E.	4/18/1995	$50,000		8/6/1997	SET-B	Pt dx w/ anxiety; presented next day w/ MI
MED	Hileman, Stephen L.	2/6/1992	$65,000	93-01-07969-CV	8/28/1997	SET-A	Pt w/pancreatitis died of alleged fluid overdose
MED	Hibeg, Alisa M. Little	10/31/1995	$12,500		8/28/1997	SET	Perineal laceration after infant's delivery
MED	Linehan, Charles K.	7/9/1993	$565,000	96-2090	10/3/1997	CA	Delay in dx of melanoma; pt died of metastic Ca
MED	Swayman, Kenneth C.	2/24/1993	$50,000	95-2-33462-2SEA	10/31/1997	SET-A	Alleged improper & unnecessary foot surgery
MED	Smith, John James	7/20/1992	$394,704	3AN-94-10736	11/5/1997	SET-A	Pt died from rare Ca not dx by Pap tests
MED	Johnson, R. Holmes	2/4/1994	$222,500	A96-030	11/14/1997	SET-A	Alleged delay dx/tx cervical spine inj resulting in C-5 quardp
MED	Nathanson, Steven E.	12/31/1996	$250,000	3AN-97-3209	12/3/1997	SET-A	Allegation of poor surgery outcome
MED	Fellman, Lawrence J.	8/27/1994	$21,373	4FA-96-1874	12/18/1997	SET-A	Alleged negligent eval of thumb laceration;tendon lac req surg
MED	Wood, Lawrence P.	09/94	$85,000	128815	1/29/1998	SET-B	Failure to dx subtle C-spine fx
MED	Hawkins, Ileana	1/31/1991	$75,000		4/10/1998	SET-B	Misdiagnosed malignant lymphoma, result was death
MED	Heraper, Peter David	11/14/1997	$11,672		4/10/1998	SET-B	Dura perfd during ethmoidectomy w/ corebrospinu fluid leak
MED	Stephens, Burl S.	1/22/1994	$750,000	A [illegible]-259	6/9/1998	SET-A	Alleged failure to dx mass effect /cerebellum on CT scan
MED	Anderson, Richard S.	5/12/1997	$40,000		7/16/1998	SET-B	Inadvertant fetal death following amniocentesis
MED	Andersen, Roger Carl	7/13/1995	$150,000	97-[illegible]-Civ-HRH	7/24/1998	SET-A	Following surg for incont; lost kidney due to obstruct of ureter
MED	Conley, Thomas L.	11/5/1993	$658,104	98-10115 [illegible]-SW	7/30/1998	SET-A	Renal failure necessitating kidney transplant from mother
MED	Shannon, Charles R.	10/30/1995	$40,000	3AN-96-[illegible]3439	9/11/1998	SET-A	Misdx colonscopy of suspect tumor; tumor not found in surg

ALASKA STATE MEDICAL BOARD

REVISED 03/05/2004

SORTED BY DATE PAID

Board	Practitioner Name	Occurred	Award	Case/Court #	Date Paid	Res	Brief Description of Claim
MED	Tieva, Martin H.	8/4/1997	$700,000	SA-99-CA-1390	12/12/2000	SET-A	Failure to dx/tx papillary craniopharyngioma
MED	Deramus, Alfred D.	4/2/1997	$195,000	4FA-99-781	12/19/2000	SET-A	Alleged negl cataract surg & suspension of med; PO pt death
MED	Khabir, Jeffrey A.	Unknown	$287,500	95-8389NH	01/01/01	SET-A	Wrongful death
MED	Walters, Laura Marie	7/15/1997	$325,000	PR-000812TK	1/4/2001	PC	Failure to dx & tx angina, pt death
MED	Unsicker, Carl	8/1/1998	$62,500	PR99-02-007	1/22/2001	SET-B	Alleged failure of dx of fx carpal navicular
MED	Van Houten, Jay	4/9/1996	$450,000	3AN-99-114	2/7/2001	SET-A	Alleged improper management of medication, pt death
MED	Marble, Stephen P.	9/1/1992	$64,780	95-0902248	4/1/2001	SET-A	Alleged failure to supervise treatment/procedure
MED	Faucett, Ellen D.	7/17/1997	$500,000	3PA99625C1	4/2/2001	SET-A	Alleged failure to dx & trt Strep B in mother; injuries to newborn
MED	Godersky, John C.	5/27/1998	$325,000	3AN006554	5/21/2001	SET	Did spinal fusion surg on wrong site
MED	Van Houten, Jay	2/25/2000	$550,000	3AN-00-6907	5/29/2001	SET-A	Alleged excessive presc of meds, result in addiction, death
MED	Gower, Roland E.	3/24/1999	$250,000	3AN 00-03943CI	6/5/2001	CA	Alleged negligent transection of common bile duct
MED	Szekely, Daniel R.	7/19/1999	7/18/2228	C00-5432	7/6/2001	SET-A	Pt alleged should have been hospitalized nite before induct/fetal dth
MED	Crouch, Edward E.	10/11/1995	$701,500	3AN-97-8539CI	7/11/2001	SET-A	Alleged failure inform pt risks due to hx ROP; vision loss Rt eye
MED	Dix, Richard Michael	9/3/1997	$150,000	DM0662869622M001	7/25/2001	SET-B	Failure to prov antibiotics; closed fx radius/ulna w/ wound infect
MED	Kelley, William J.	3/9/1999	$55,000	3KN-00-1056	8/15/2001	SET-A	Wrongful death; cardiac arrest following bowel obstru surg
MED	Ford, Robert O.	10/26/1998	$175,000	71871	9/7/2001	SET-A	Alleged injury w/ Lasik surg; shouldn't have surg due to abn corneas
MED	Burton, Mark N.	1/13/1997	$131,250	SC20010059	9/17/2001	SET-A	Xray failed to reveal pulm nodule, delay in dx of lung Ca
PAD	Siddall, James J.	10/13/1998	$275,000	4FA-01-690 CIV	9/19/2001	SET-A	Removal of stuck contact lens resulted in corneal damage; transplt
MED	Lynch, Michael J.	8/23/1994	$120,000	97000305MI	10/2/2001	SET-A	Improper mgmt of diabetes during chemo for Ca
MED	Nordlund, John R.	1/25/1996	$312,300	3AN-98-3345	10/3/2001	SET-A	Alleged failure to dx post comm artery aneurysm
MED	Carlson, R. Lynn	7/13/1999	$175,000	43331	10/15/2001	SET-B	Pt w/ resp distr, PA gave inj in wrong loc; damaged radial nerve
MED	R. Lynn Carlson	7/13/1999	$175,000	Norcal 43331	10/15/2001	SET-B	PA injected Benadryl distally damaging radial nerve
MED	Barton, Theodore D.	2/4/2000	$217,000	3AN-01-07752CI	10/15/2001	SET-A	Alleged lack of informed consent, negl performed br biopsies
MED	Boesch, David E.	10/12/1999	$32,500	CV2000-018264	10/25/01	SET-A	Failure to dx dislocation of R 4th finger
MED	Anderson, John Nels	1998	$15,000	3KN-99-707	11/16/01	SET-A	Failure to obtain consent to use eggs for other pt
MED	Beal, David D.	10/14/1997	$125,000	3AN-99-10484	12/4/2001	SET-A	Unnec tonsillectomy due to mitigating circumstances
MED	Sitter, Stephen C.	10/14/1997	$23,333	3AN-99-10484	12/4/2001	SET-A	Alleged failure to supv CRNA, premature dischrg of pt from recovry
MED	Matsutani, Osamu	8/4/1997	$65,000	3AN-99-8672CI	12/11/2001	SET-A	Alleged failed to prevent suicide
MED	Fortson, Jayne	9/8/1997	$10,000	3AN-99-09717	1/18/2002	SET-A	Alleged sunburn-like reaction to tx of PUVA lite therapy for psoriasis
MED	Krauss, Seth L.	5/31/1999	$300,000	3AN-00-11749CI	1/22/2002	SET-A	Alleged negligence in failure to dx MI
MED	Cable, Harold F.	June, 1997	$1,000,000	3AN-98-6532CI	2/5/2002	SET-A	Alleged back problem worsed following surgery
MED	Magen, Ned A.	2/11/1998	$275,000	3KN00-97CI	2/19/2002	SET-A	Alleged misdx of meningococcus-meningococcemia
MED	Hansen, Peter O.	3/1/2001	$572,798	48611	3/10/2002	SET-B	Alleged negl prescribing of atenolol
MED	Boling, M. Todd	4/14/2000	$590,000	M000057852	3/21/2002	SET-B	Complications fr laparoscopic exam & adheiolysis
MED	Paton, William A.	3/16/1999	$60,000	3AN-01-05517	3/22/2002	SET-A	Alleged negl severed right median nerve during carpal tun surg
MED	Adams, Peter B.	5/14/1999	$80,000	3AN-01-7212	3/26/2002	SET-A	
MED	Goldberg, Marshall	5/24/1999	$50,000	30/519-92-8525	3/27/2002	PC	Alleged misdx/mistx of severe pre-eclampsia; fetal death
MED	Lawrence, Jeffrey D.	5/2/2000	$250,000	none	4/23/2002	SET-B	Suture in bladder from bladder suspension surg
MED	Stewart, Glenn	6/8/2000	$1,603,362	3AN-00-08446	4/26/2002	SET-A	Alleged that use of radiation to trt plantar's warts below std of care
MED	Jacoby, Kamy	3/31/1997	$25,000	98-2140640	4/30/2002	SET-A	Alleged negligence in removing drain, part of drain left in wound
MED	Belcher, Mark D.	9/4/1997	$83,333	3AN-99-9629	5/8/2002	SET-A	surg for perf apndx; died; autopsy found blood in lung pleural space
MED	Wennen, William W.	7/22/1999	$65,000	4FA-01-1400	8/5/2002	SET-A	Pt unhappy with outcome of eyebrow tattooing - darker than desired
MED	Snyder, John M.	9/2/1998	$400,000	3AN 00 9698	8/23/2002	SET-A	Alleged lack of post-op monitoring caused brain infarction
MED	Nyboer, Jan H.	4/22/1999	$5	3AN-01-5736	9/8/2002	SET-A	Alleged neg of two employees supp causing a detached retina
MED	Fawley, Howard H.	8/3/2001	$17,500	DMO663321502A002	10/23/2002	SET	Alleged failure to dx finger fracture
MED	Fawley, Howard Huff	8/3/2001	$17,500	DM0663321502A002	10/23/02	SET-B	alleged failure to dx finger fx on xray
MED	Nolan, Declan R.	1/19/1999	$650,000	2ANO13883C	11/5/2002	SET-A	Alleged negligent surgy and post-op follow up (?)
MED	Whipple, Bruce	4/1/1998	$561,455	4FA-00877CI	11/06/02	SET-A	Alleged negl in failure/delay to dx cerfical osteomyelitis
MED	Fell, William Russell	10/30/1999	$45,000	3PA011169C	11/14/02	SET-A	Residual facial nerve weakness following surgery, known risk

LEGISLATIVE RESEARCH REPORT

APRIL 16, 2003 REPORT NUMBER 03.177

PHYSICIANS IN ALASKA

PREPARED BY KATHLEEN L. WAKEFIELD, LEGISLATIVE ANALYST,

NUMBER OF DOCTORS PER CAPITA 1

Table 1: Growth Rate for Physicians Compared to Alaska Population, 1985-2002 2

DOCTORS IN ALASKA 3

RETIRED DOCTORS 4

LIST OF ATTACHMENTS 6

You asked several questions about physicians in Alaska, including the number of doctors per capita, the rate of growth in the number of physicians, the average age of physicians in Alaska, and factors that affect the number of doctors in the state. You wished to know if Alaska has difficulty attracting physicians, and if certain areas of the state experience a lack of doctors, as well as the number of Alaska students attending medical school. Finally, you wished to know about retired doctors in Alaska, limited liability laws in other states for retired doctors wishing to volunteer their services, and any cost benefits for retaining retired physicians.

NUMBER OF DOCTORS PER CAPITA

According to *State Rankings 2002*, Alaska ranked 46th out of the fifty states in the number of physicians per capita in 2000.[1] This report showed 193 physicians per 100,000 residents for

[1] "Rate of Nonfederal Physicians in 2000," *State Rankings 2002: A Statistical View of the 50 States*, Kathleen O'Leary Morgan and Scott Morgan, editors, 2002, p. 351.

Alaska; the national rate was 277 physicians per 100,000 residents.[2] Table 1 shows the rate of growth of the number of physicians in Alaska compared to population growth. As you can see, there is no correlation between population growth and growth in the number of doctors.

Table 1: Growth Rate for Physicians Compared to Alaska Population, 1985-2002

Fiscal Year	Number of Active Doctors*	Rate of Growth (Percentage Change by Year)	Population	Rate of Growth (Percentage Change by Year)
1985	815		543,900	
1986	934	15%	550,700	1%
1987	1,027	10%	541,300	-2%
1988	1,089	6%	535,000	-1%
1989	925	-15%	538,900	1%
1990	1,038	12%	553,171	3%
1991	1,004	-3%	569,054	3%
1992	1,152	15%	586,722	3%
1993	1,183	3%	596,906	2%
1994	1,417	20%	600,622	1%
1995	1,419	0%	601,581	0%
1996	1,593	12%	605,212	1%
1997	1,603	1%	609,655	1%
1998	1,826	14%	617,082	1%
1999	1,810	-1%	622,000	1%
2000*	2,034	12%	629,831	1%
2001*	1,850	-9%	633,900	1%
2002*	2,080	12%	637,943	1%

Notes: * These figures include only active medical doctors and doctors of osteopathy (with the exception of podiatrists, because those numbers include both active and inactive practitioners.) * Population figures for FY00-02 are estimates.

Sources: Alaska State Medical Board, Department of Community and Economic Development; State Demographer, Department of Labor and Workforce Development.

According to the Alaska State Medical Board, as of August 2002, approximately 52 percent of physicians licensed to practice medicine in Alaska are under age 50.[3] Acccrding to the American Medical Association, in 2000, of the 813,770 physicians licensed to practice in the United States, 17 percent were under age 35, 65 percent were age 35-64, and 18 percent were age 65 and over.[4]

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[2] These numbers include only "nonfederal" physicians. Federal physicians are those working at federally funded public health clinics, such as Indian Health Services doctors.

[3] Personal communication from Leslie Gallant, Executive Administrator, Alaska State Medical Board, Department of Community and Economic Development. Ms. Gallant can be reached at 907-269-8163.

[4] "Physicians in the United States and Possessions by Selected Characteristics," *Physician Statistics Now*, American Medical Association, *http://www.ama-assn.org/ama/pub/category/2688.html*, accessed April 8, 2003.

HEALTHCARE

- Main Page
- Press Releases
- In the Media
- Factsheets
- Reports
- Medical Malpractice Stories
- HMO Arbitration Abuse Report
- Casualty of the Day

OTHER TOPICS

- Corporate Accountability
- Insurance
- Citizen Advocacy
- The Justice System
- Billing Errors
- Energy
- About FTCR

FACTSHEET

Five Dangerous Myths About California's Medical Malpractice Restrictions

Myth#1: Legal Restrictions on Victims Lowered California Doctors' Malpractice Premiums.

Facts: Californians enacted the strongest insurance rate regulation in the nation in 1998 through insurance reform Proposition 103 (Prop 103), a ballot initiative passed by the voters and authored by FTCR president Harvey Rosenfield. This law resulted in a rate freeze, a rate rollback, and stringent regulation that reduced premiums in all lines of insurance -- including medical malpractice.

In 1975, California enacted a series of legal restrictions on injured patients -- the Medical Injury Compensation Reform Act (MICRA). Data from the National Association of Insurance Commissioners, summarized in graphs linked to below show that:

- Overall, California medical malpractice premiums increased dramatically during the first thirteen years with MICRA and substantially decreased after voters' approved Proposition 103. (See graph)
- Medical malpractice premiums remained extremely volatile after MICRA and did not stabilize until Prop 103 imposed rate regulation in 1988.
- In 1986, after a decade of MICRA, California was once again mired in an insurance crisis, with medical malpractice premiums rising at a rate of 26% annually, faster than premiums rose nationally during the same period. In fact, the year MICRA's cap of damages was upheld in cour (1985), California malpractice premiums increased by 20% and the following year rates jumped an additional 40%.
- Conversely, after three years of insurance regulation under Prop 103, medical malpractice rates had fallen by more than 20%. During the first decade of regulation, premiums were down by 7% and, if we adjust for inflation, medical malpractice premiums are down by 35% since the enactment of regulation.

adn.com
Anchorage Daily News

Patient Power

National groups and Alaska watchdogs encourage consumers to question health care providers

By ANN POTEMPA
Anchorage Daily News

(Published: March 2, 2004)

NEXT TIME YOU PAY A VISIT TO YOUR DOCTOR, ask questions.

Here's one to start with: "Did you wash your hands?"

Patients may take it for granted that doctors and nurses head to the sink before each exam, but local hospitals admit some of their employees don't. At one, a study showed that about a third of the staff wasn't washing up.

This new approach is a healthy self-defense for patients. It's a shift away from automatically trusting that the folks in scrubs and stethoscopes always do the right thing. This year, a national hospital accreditation agency gave consumers some muscle by creating seven National Patient Safety Goals that hospitals must meet (see list at left).

Too often, patients think: "Gosh, they're a *hospital*. They know what they're doing," said Dr. Norman Wilder, one of the founding members of Alaska's Patient Safety Collaborative, a group of patient safety advocates from medical facilities around the state.

But medical professionals make mistakes. Intentional or not, they can be deadly. An Institute of Medicine report in 1999 concluded that mistakes made in hospitals cause more deaths nationwide than do car accidents, breast cancer or AIDS. The report, "To Err Is Human: Building a Safer Health System," drew from studies of Utah, Colorado and New York hospitals. Alaska was not a focus of the study, but the error rates from participating states were extrapolated over total U.S. hospital admissions in 1997. The institute estimated that errors killed 44,000 to 98,000 people every year.

National agencies and Alaska's own advocates are coming up with new ways to help lower those numbers. Alaska's group is giving patients stickers that tell them to question their doctors. They're asking doctors to wear stickers that say they welcome inquiries.

Members of the collaborative talked about a recent serious error on the East Coast. Last year, a teen girl died after a medical team at Duke University Hospital performed a heart-lung transplant on her using an organ donor with the wrong blood type.

Alaska's collaborative didn't just point fingers Outside. Medical staff here admitted to giving the wrong drugs to patients. From now on, staff have to find two ways to correctly identify each patient before giving medications or taking blood. It's no longer acceptable to allow patients to simply nod "yes" when a doctor asks if they go by a certain name; patients might be stressed or tired and nod

METHODS

Study Design

A team of researchers from the Harvard School of Public Health and the Kaiser Family Foundation designed and analyzed both surveys. They were conducted in the United States.

Physicians

The fieldwork for the survey of physicians was conducted by Harris Interactive. The sample was randomly selected from the national list of physicians provided by Medical Marketing Service. This list, which includes both physicians who are members of the American Medical Association and nonmembers, is updated weekly. A questionnaire was mailed to 1332 physicians along with a check for $100 as an incentive for completing it. The survey was conducted between April 24 and July 22, 2002. A total of 831 physicians either completed the questionnaire on paper and returned it by mail (777) or completed and submitted it online (54). The response rate was 62 percent.[19] The margin of error was ±3.5 percentage points.

The General Public

A total of 1803 members of the public were contacted and deemed eligible for the national telephone survey, performed with random-digit dialing; 1207 adults (18 years of age or older) completed the survey. It was conducted in Spanish and English by International Communications Research between April 11 and June 11, 2002. Respondents were not given a financial incentive to participate. The response rate was 67 percent.[19] The margin of error was ±2.6 percentage points.

The Survey Questionnaire

To conduct parallel surveys, a single questionnaire was developed and modified to be appropriate for each group of respondents. The questionnaire was reviewed by physicians and experts in medical errors and was then pretested for length and comprehensibility. Both surveys were revised on the basis of the results of these tests. Twenty-nine questions were included in the survey of physicians and 38 in the survey of the public; 8 questions in each instrument had multiple parts. The questions focused on inpatient errors, since the majority of proposals address such errors.

The questionnaire asked whether an error had ever been made in the respondent's own care or that of a family member and, if so, what the health consequences of that error had been. Respondents were asked to state in their own words what they considered to be the two most important problems with health care and medicine. The responses were grouped in categories, one of which was medical errors. No respondents in the survey of the public and few in the survey of physicians used the term "medical error" when answering the question. Most respondents used terms such as "incompetent doctors" and "mistakes."

After answering the open-ended question, respondents in both surveys were given the following statement defining "medical error" to ensure that they had a common understanding of the term: "Sometimes when people are ill and receive medical care, mistakes are made that result in serious harm, such as death, disability, or additional or prolonged treatment. These are called medical errors. Some of these errors are preventable, whereas others may not be."

Respondents were asked how many in-hospital deaths they thought resulted from preventable medical errors each year. They were given a choice of five numbers from 500 to 500,000 or more. Among the choices were the IOM's higher estimate of 98,000 (rounded to 100,000), the IOM's lower estimate of 44,000 (rounded to 50,000), and the estimate of 4500 (rounded to 5000) made by another team of researchers using a different set of assumptions.[12] We also asked respondents to rate the importance of 11 factors that might contribute to medical errors and the effectiveness of 16 possible solutions.

We asked the following question about high-volume centers: "Suppose a patient needs a specialized medical procedure. This person can choose either a hospital that does a large number of these procedures or a hospital that does not do as many. At which hospital do you think this patient would be more likely to have a preventable medical error made in his or her care, or wouldn't it make a difference?"

The questionnaires included the following vignette, developed by physicians[20]: "A 67-year-old man goes to the hospital for surgery. He has an allergy to antibiotic drugs, which is noted on his medical record. The surgeon does not notice the information about the allergy and orders an antibiotic to be given at the end of the surgery. A hospital nurse gives the patient the antibiotic." To examine the hypothesis that respondents' views on the appropriate consequences for the health professionals would vary according to the severity of the error's outcome, we randomly varied the health consequences for the patient. Half of each group of respondents were told that the patient was harmed: "The patient wakes up with a rash all over his body and is gasping for air. The mistake is noticed, and the antibiotic is stopped, but the patient stops breathing. Despite every effort, the patient dies." The other half were told that the patient was not harmed: "The patient wakes up with a rash all over his body. The mistake is noticed, the antibiotic is stopped, and the patient fully recovers." The physicians were told that the language of the vignette had been simplified so that laypeople would understand it.

Statistical Analysis

We compared responses by testing differences between proportions, using Fisher's exact test. The statistical program that we used took into account the design effects for each of the surveys by calculating the effective sample size. Because previous research has shown that the salience of an issue is an important factor in the level of support for change, we limited analyses of graded responses to the proportion of respondents who said that a cause of errors was "very important" or that a solution would be "very effective."[21] All reported P values are based on two-sided tests.

To adjust for sampling biases due to sociodemographic differences in nonresponse rates and to ensure that the sample was representative, survey responses were weighted by computer with the use of a predetermined weighting scheme. The data in the survey of the public were weighted on the basis of the latest U.S. Census numbers for sex, age, race or ethnic group, level of education, number of people in the household, and number of land telephone lines. The data in the survey of physicians were weighted for region, specialty, training (foreign vs. U.S.), and number of years since graduation from medical school. There were no qualitative differences between unweighted and weighted results.

RESULTS

Experiences with Medical Errors

Thirty-five percent of physicians and 42 percent of the public reported that they had experienced an error in their own care or that of a family member (Table 1). Eighteen percent of physicians and 24 percent of the public reported an error that had had serious health consequences, including death (reported by 7 percent of physicians and 10 percent of the public), long-term disability (6 percent and 11 percent, respectively), and severe pain (11 percent and 16 percent, respectively). About a third of the respondents in both groups who reported experience with an error said that the health professionals involved in the error had told them about it or apologized to them.

Seventy percent or more of both groups of re-

LEGISLATIVE RESEARCH REPORT

MARCH 3, 2004

REPORT NUMBER 04.184

PHYSICIANS PRACTICING IN ALASKA

PREPARED FOR REPRESENTATIVE LES GARA

BY PATRICIA YOUNG, MANAGER

You wished to know the number of physicians practicing in Alaska as compared to the population over the last several years. You particularly wished to know if the per capita number of physicians is in a declining trend.

The attached table shows the number of active, state-licensed physicians by year since 1985, as well as the population and the number of practicing physicians per 1,000 residents for each year since that time.[1] As you will see, by this measure, the number of physicians per 1,000 residents has, overall, increased steadily.

We also include a chart prepared by the State Medical Board showing the numbers of physicians as well as other primary health providers since 1985.

I hope you find this information to be useful. Please do not hesitate to contact us if you have questions or need additional information.

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[1] These numbers reflect active, state-licensed medical doctors and doctors of osteopathy only. Doctors of podiatric medicine are not included because the numbers of active and inactive practitioners are not separated. We do not include federal physicians; because they are not licensed by the State Medical Board, their annul numbers are far less readily available.

907-465-3991
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Alaska Legislature
Legislative Research Services
w3.legis.state.ak.us/Research/research_home.htm

State Capitol
Juneau, AK 99801

Fiscal Year	Population	State Licensed Physicians	State-Licensed Physicians per 1,000 Residents
1985	543,900	815	1.50
1986	550,700	934	1.70
1987	541,300	1,027	1.90
1988	535,000	1,089	2.04
1989	538,900	925	1.72
1990	553,171	1,038	1.88
1991	569,054	1,004	1.76
1992	586,722	1,152	1.96
1993	596,906	1,183	1.98
1994	600,622	1,417	2.36
1995	601,581	1,419	2.36
1996	605,212	1,593	2.63
1997	609,655	1,603	2.63
1998	617,082	1,826	2.96
1999	622,000	1,810	2.91
2000	627,576	2,034	3.24
2001	632,674	1,850	2.92
2002	641,482	2,080	3.24
2003	648,818	2,099	3.24

Notes: Numbers of physicians reflect active state-licensed medical doctors and doctors of osteopathy only; doctors of podiatric medicine are not included because their numbers include both active and inactive practitioners; federal physicians are not included because they are not licensed by the State Medical Board.

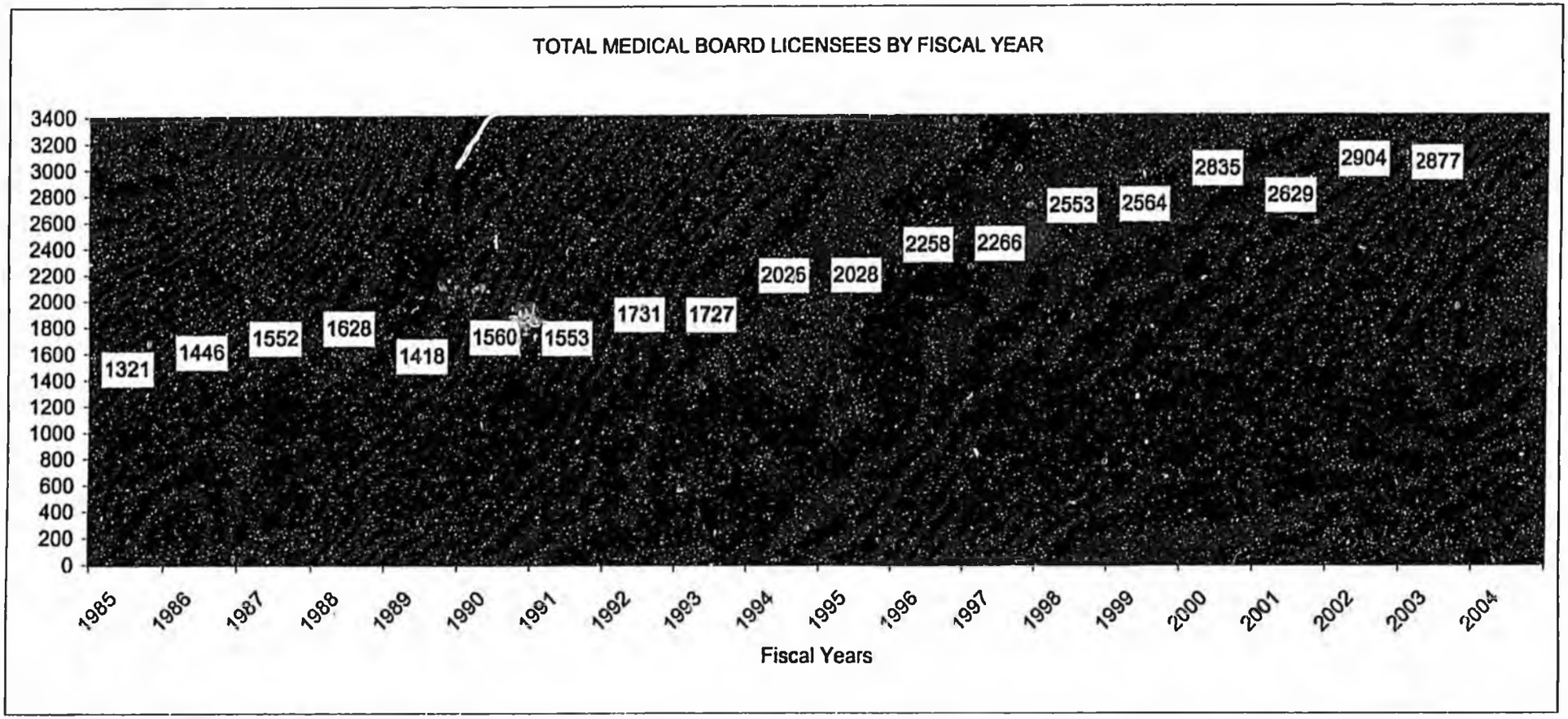
According to the American Medical Association, as reported in "Federal Physicians in 2001," Health Care State Rankings, 2003 (Morgan Quitno Press, 2003, p. 430), in 2001, Alaska had 147 federal physicians.

Population figures for 2003 are provisional.

Sources: Alaska State Medical Board, and Alaska Department of Labor and Workforce Development.

TOTAL PHYSICIANS, PHYSICIAN ASSISTANTS, AND PARAMEDICS BY FISCAL YEAR

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03	FY04
MD/DO Active	815	934	1027	1089	925	1038	1004	1152	1183	1417	1419	1593	1603	1826	1810	2034	1850	2080	2099	
MD/DO Inactive	317	305	279	322	255	254	273	263	243	243	262	262	277	266	300	289	285	268	249	
DPM-Act/Inact	0	11	11	0	0	0	9	11	12	15	13	14	14	15	15	16	16	17	18	
PA-C-Act/Inact	111	111	134	126	138	157	159	186	177	216	200	231	221	255	244	266	245	284	266	
MICP-Active	78	85	101	91	100	111	108	119	112	135	134	158	151	191	195	230	233	255	245	
TOTAL	**1321**	**1446**	**1552**	**1628**	**1418**	**1560**	**1553**	**1731**	**1727**	**2026**	**2028**	**2258**	**2266**	**2553**	**2564**	**2835**	**2629**	**2904**	**2877**	
% Variance from Previous Year	–	+9.4	+7.3	+4.8	-12.9	+10	- .05	+11.4	- .02	+17.3	–	+11.3	.03	+12.6	+.04	+11	-7.8	+10.4	-.09	



MD - Medical Doctor (allopathic)

DO - Doctor of Osteopathy

DPM - Doctor of Podiatric Medicine

PA-C - Physician Assistant-Certified

MICP - Mobile Intensive Care Paramedic

Source: Leslie Gallant, Alaska State Medical Board

Part 1. The Real Relationship between Caps and Med Mal Premiums

On the surface, the theory behind caps on non-economic damage awards seems logical: caps would limit the payouts by insurers, and the lower payouts, in turn, would naturally enable the insurers to reduce med mal premiums. As we shall demonstrate below, however, in the real world of the med mal insurance business, only the first half of this theory is working.

Caps do reduce the burden on insurers...

Using data provided by the National Practitioner Data Bank, we compared the median payouts in the 19 states with caps to those in the 32 states without caps[4] for the period between 1991 and 2002, with the following results:

- **Payouts reduced.** In states without caps, the median payout for the entire 12-year period was $116,297, ranging from $75,000 on the low end to $220,000 on the high end. In states with caps, the median was 15.7% lower, or $98,079, ranging from $50,000 to $190,000.[5] Since caps in many states were not imposed until late in the 12-year period, this represents a significant reduction.

- **Growth in payouts slowed substantially.** The median payout in the 32 states without caps increased by 127.9%, from $65,831 in 1991 to $150,000 in 2002. In contrast, payouts in the 19 states with caps increased at a far slower pace—by 83.3%, from $60,000 in 1991 to $110,000 in 2002.

In short, it's clear that caps do accomplish their intended purpose of lowering the average amount insurance companies must pay out to satisfy med mal claims.

But insurers continue to increase premiums at a rapid pace, regardless of caps.

Using 1991 to 2002 data published by the Medical Liability Monitor, we examined the median med mal premiums paid by doctors in three high-risk specialties—internal medicine, general surgery, and obstetrics/gynecology. The results:

1. **States with caps had sharper increases in median annual premiums.** Since the insurers in the states with caps reaped the benefit of lower med mal payouts, one would expect that they'd reduce the premiums they charged doctors. At the very minimum, they should have been able to slow down the rate of premium increases. Surprisingly, the data show they did precisely the opposite:

    - In the 19 states with caps, the median annual premium increased by 48.2%, from $20,414 in 1991 to $30,246 in 2002.

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[4] For the purposes of this analysis, the District of Columbia is being referred to as a "state" since it effectively operates as such with regard to insurance regulation.

[5] Adjusted for inflation in order to evaluate figures spanning multiple years.

Americans for Insurance Reform - Fact Sheet

California Restrictions On Malpractice Victims Have Not Affected Malpractice Premiums

Premium Data Shows California Law Is No Model For The Nation

Data released today by two consumer groups show that California's 22-year experience with the nation's most draconian limits on the rights of medical malpractice victims has failed to slow premium increases for doctors and hospitals. In fact, over the last decade, the average malpractice premium in California has grown more quickly than it has in the nation overall.

The California-based Foundation for Taxpayer and Consumer Rights and New York-based Center for Justice & Democracy (CJ&D) hired nationally recognized actuary J. Robert Hunter, former Texas Insurance Commissioner and Federal Insurance Administrator under Ford and Carter, to compare national malpractice premium trends to those in California. Hunter found that from 1991 to 2000, malpractice premiums in California have stayed close to national premium trends. The 2000 average premium per doctor in California was only 8.2 percent below that of the nation ($7,200.61 vs. $7,843.75) while the average malpractice premium in California between 1991 and 2000 actually grew more quickly (3.5 percent), than it did in the nation overall (1.9 percent.) According to Hunter, "there is not much difference in the rates or the rate of change between California and the nation based on the latest decade of experience."

In the mid-1970s, California enacted severe laws restricting the rights of patients who have been injured by malpractice, allowing them to recover no more than $250,000 in noneconomic compensation no matter how egregious the malpractice or serious the injury. The medical establishment is campaigning to spread this severe cap on damages not only to other states, but to the entire nation in recently introduced federal legislation (H.R. 4600), arguing falsely that this cap has kept premiums dramatically downward.

"If there are savings to limiting the rights and recovery of innocent victims of dangerous and culpable doctors, then insurers have not passed them on to physicians," said Jamie Court, executive director of the Foundation for Taxpayer and Consumer Rights. "California is a failed model for the national restrictions being proposed on patients. California patients have been denied adequate compensation and representation for their injuries, and California doctors have seen almost no premium savings. Only the insurers have gotten rich in the good times."

"This study disputes one of the most sensationalized fictions driving the movement to limit lawsuits against malpracticing doctors and hospitals – the notion that California's brutal restrictions on patients' rights, enacted in the mid-1970s, have slowed the growth of malpractice premiums," said CJ&D Executive Director Joanne Doroshow. "In fact, the opposite has happened. Over the last 10 years, California's premiums have grown faster than the nation's.

"This analysis has, for the first time, exposed as an insidious public relations scam the notion that California's cruel law has controlled the growth of malpractice insurance premiums. This law has had terrible consequences for many innocent people, while doing nothing to improve the affordability of liability insurance for doctors."

in Ga. over malpractice; Sharply rising insurance expenses cause some doctors to drop services," *Macon Telegraph*, December 30, 2002.

Illinois

In Illinois, ***the number of malpractice claims stayed about even over the course of the 1990s.*** ... Payouts to people who sued both doctors and hospitals jumped sharply in the early 1990s, but they've held relatively even since then. ... ***76 percent of malpractice claims were dismissed without payment in 1999.***" (emphasis added). Editorial, "Ups And Downs," *St. Louis Post-Dispatch*, February 3, 2003, part 1 of a 2 part series entitled, "Malpractice Insurance: Q & A."

Kentucky

"[T]he number of ***doctors per person in Kentucky has increased faster than in the rest of the nation since the early 1980s.***" Gideon Gil, "2003 Kentucky General Assembly; Study: Jury award limits wouldn't cut doctors' premiums," *Courier-Journal* (Louisville, KY), February 25, 2003. "In 2001, 69 malpractice suits went to trial in Kentucky, according to the Kentucky Trial Court Review. Plaintiffs won only 19. And just six plaintiffs won $1 million or more." John Cheves and Karla Ward, "Ob/Gyn, Bye Patient Illustrate Problem," *Lexington Herald-Leader*, February 4, 2003.

Mississippi.

"Medical groups have claimed doctors are fleeing Mississippi, relocating to states with more stable legal climates. So far, the numbers don't bear that out. In fact, ***the state has gained 564 doctors over the past five years.*** The state Medical Association has said the growth in doctors lags behind the state's population growth. But while Mississippi still ranks last in the nation in the number of doctors per capita, it has made dramatic gains since 1995. ***Only four states have grown faster in physician population***: Alabama, Alaska, Arkansas and South Dakota. (emphasis added). Joey Bunch, "Crisis or PR campaign?; Pro and con forces seek to win hearts and minds of Mississippians," Biloxi Sun-Herald, August 11, 2002.

In October 2002, lawmakers limited jury awards for non-economic "pain and suffering" damages to $500,000. Despite enactment of the cap, premiums continued to skyrocket and, for some doctors, coverage is still unavailable at any price. See., e.g., Ben Bryant, "Tort reform has done little to ease malpractice crisis," *Biloxi Sun-Herald*, February 2, 2003.

Missouri

"[Gov. Bob] Holden's insurance report, a four-month study of the medical malpractice market, said ***that litigation that resulted in a cash payment had dropped 42 percent from 1988 to 2001,*** and that ***the number of claims overall had fallen from 2,244 to 1,599, or 29 percent, since 1987.*** (emphasis added). Deslane Aaron, "Malpractice rates gain Holden's attention," *Springfield News-Leader*, February 7, 2003. "In Missouri, the number of malpractice claims actually dropped over the course of the 1990s. ...In Missouri, average payments to patients who sued doctors rose 23 percent from 1992 to 2001. But that was less than the 26 percent rise in the consumer price

Legislative Research Services

Alaska State Legislature
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March 16, 2004

Memorandum

TO: Representative Les Gara

FROM: Cherie Nienhuis
Legislative Analyst

RE: Per Day Recovery for Noneconomic Losses Totaling $250,000

You requested information about the daily recovery for noneconomic losses over a period of 50 years. You specifically referenced House Bill 472, which provides a maximum of $250,000 for these types of losses.

As you requested, with no compounding, the per day recovery would simply be the amount of $250,000 divided by 18,262 (365.25 times 50 years).[1] Using this formula, we calculate a rate of $13.69 per day for the maximum noneconomic losses attainable under HB 472.

I hope you find this information to be useful. Please do not hesitate to contact us if you have questions or need additional information.

[1] There will be approximately 12 leap years over a 50-year time span, adding 12 days to the calculation.

AARP Alaska

March 11, 2004

The Honorable Lesil McGuire, Chair
House Judiciary Committee
Alaska State Capitol, Room 118
Juneau, Alaska 99801-1182

RE: HB 472 (Anderson)—Oppose Unless Amended

Dear Chair McGuire:

On behalf of the AARP members in Alaska, we ask that you and your colleagues on the House Judiciary Committee oppose HB 472, authored by your Committee Vice-Chair Representative Tom Anderson and co-sponsored by Representative Bud Fate, unless it is amended.

The issue of medical malpractice is often perceived as a battle between trial lawyers and insurance companies and physicians. We think it is also important to consider the victim of malpractice as well as **the ultimate goal of medical error reduction.**

AARP believes that state legislatures should not place limits on the amount of punitive damages or on joint and several liability, or unreasonable limits on damage awards for pain and suffering. We believe that a cap of $250,000 is, on its face, unreasonable.

For a cap to be reasonable, it would:

- Start at a level based on current conditions, not the arbitrary $250,000 figure chosen in California some 20 years ago,
- Provide flexibility for different types of cases,
- Include exceptions for egregious cases,
- Be indexed for inflation, and
- Be tied to other reforms, including mandatory error reporting and prompt payment requirements.

We oppose caps on punitive damages because these awards are relatively rare and generally imposed only in the most egregious cases, and thus are not a significant factor in malpractice premium problems

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James G. Parkel, President | William D. Novelli, Executive Director and CEO | www.aarp.org

Should you have any questions about our position, please feel free to contact Marie Darlin (907-586-3637), Coordinator of the AARP Capital City Task Force, Patrick Luby (907-762-3314), Legislative Representative, or me (907-245-5259.

Thank you for your consideration.

Sincerely,

Marguerite Stetson

Marguerite Stetson
AARP State Coordinator for Advocacy
3009 Northwood Street
Anchorage, AK 99517-1871
907-245-5259 (voice)
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CC: Vice-Chair Tom Anderson
Representative Jim Holm
Representative Dan Ogg
Representative Ralph Samuels
Representative Les Gara
Representative Max Gruenberg
Representative Bud Fate
Marie Darlin
Patrick Luby

Subject: Quotes from Insurance Company executives
Date: Mon, 1 Mar 2004 12:22:56 -0900
From: "Jeff Friedman" <jfriedman@frwusa.com>
To: <Representative_mike_hawker@legis.state.ak.us>
CC: <Representative_tom_Anderson@legis.state.ak.us>,
<Representative_les_gara@legis.state.ak.us>,
<Representative_lesil_mcguire@legis.state.ak.us>, <Senator_con_bunde@legis.state.ak.us>

Mike,

Regarding HB 472, there is little if any credible evidence to support the claims that malpractice litigation is a significant driver of health care costs. It is my understanding that when insurance industry executives were put under oath by the Florida legislature last year, they admitted that the rate increases they were passing on to doctors, were the result, by and large, not of judgments or settlements, but of their own investment failures. Other insurance executives and pushers of "tort reform" including caps on non-economic damages have repeatedly admitted that such caps will not result in lower insurance rates for doctors:

"I don't like to hear insurance-company executives say it's the tort system - it's self inflicted."

> ~Donald J. Zuk, chief executive of Scpie Holdings Inc., a leading malpractice insurer in California, Wall Street Journal, June 24, 2002.

"No responsible insurer can cut its rates after a [medical malpractice tort 'reform'] bill passes."

> ~Bob White, President of First Professional Insurance Company, the largest medical malpractice insurer in Florida, talking about a proposed $250,000 cap in the January 29, 2003 Palm Beach Post.

"I don't think we would argue that the premiums are likely to go down. We believe it will have the effect of reducing the increases in the future. And one of the reasons the premiums won't go down is that even if noneconomic damages are capped, the losses for economic loss, medical expenses, for example, are still in this current environment escalating at, medical inflation is running in the double digits. I forget exactly what it was last year. So even if you were to cap noneconomic damages, the economic damages will still cause acceleration in the premiums. So it would not go down, I want to clarify if I misspoke and said I thought the premiums would go down."

> ~Cliff Webster, representing the Washington State Medical Association & Chairman of the Washington Liability Reform Coalition, testifying before the Washington State Legislature, House Judiciary Committee, Feb. 21, 2003.

"Insurers never promised that tort reform would achieve specific premium savings..."

> ~From a press release published March 13, 2002, by the American Insurance Association (AIA).

"[M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and 'I've never said that in 30 years.'"

> ~Victor Schwartz, General Counsel of the American Tort Reform Association, as paraphrased and quoted in "Tort Reforms Don't Cut Liability Rates, Study Says," published in Business Insurance July 19, 1999.

"We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates."

> ~Sherman Joyce, President of the American Tort Reform Association, as quoted in "Study Finds No Link Between Tort Reforms and Insurance Rates," Liability Week, July 19, 1999.

"Insurance was cheaper in the 1990s because insurance companies knew that they could take a doctor's premium and invest it, and $50,000 would be worth $200,000 five years later when the claim came in. An insurance company today can't do that."

~Victor Schwartz, general counsel to the American Tort Reform Association, "Dose of Legality," Honolulu Star-Bulletin, April 20, 2003.

"While MICRA was the legislature's attempt at remedying the medical malpractice crisis in California in 1975, it did not substantially reduce the relative risk of medical malpractice insurance in California."

~James Robertson, Assistant Vice President and Associate Actuary, SCIPIE Indemnity Company (California's second largest medical malpractice insurer), in written testimony responding to a question from an administrative law jugdge who is overseeing a case in which SCIPIE has requested a 15.6 % rate hike. April 30, 2003

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

Testimony Provided by

Alex Malter, MD, MPH
President

Alaska State Medical Association

Before the State of Alaska
House of Representatives
Judiciary Committee

February 25, 2004

Testimony of the Alaska State Medical Association
Presented February 25, 2004

Madam Chair McGuire and House Judiciary Committee Members, my name is Alex Malter. I am an internist in private practice in Juneau, and also have the privilege of representing the Alaska State Medical Association (ASMA) as its current president. ASMA represents physicians statewide and is primarily interested in ensuring that Alaskans receive high quality health care

I am here today to express ASMA's support of HB 472, and to urge you to support the bill as well. The medical liability reforms it establishes are important to Alaskans for a variety of reasons. I expect others to testify, for example, how HB 472 will help stabilize the professional liability market, and, by so doing, effectively temper future increases in federal and state expenditures on health care. I would like to concentrate my remarks, however, on explaining how strong medical liability reforms will be critically helpful in recruiting and retaining enough well-trained physicians to provide for the future health care needs of Alaska's citizens.

Access to health care services is precariously limited in the state. Alaska has one of the smallest-- if not the smallest-- number of physicians per capita in the country. A January 19, 2004 American Medical News story pertaining to the special Medicare payment reforms for Alaska noted the crisis in work force: "Alaska has long ranked among the worst states in terms of physician supply. In 2002, the state had fewer than 1,350 doctors in private practice and another few hundred in the military or other government posts. The state has a population of 644,000 ... Only six states had a lower doctor to patient ratio".

The article went on to identify Idaho as the state with the worst physician shortage, estimating that state had one non-government physician for every 544 patients. However numbers from ASMA's own 2002 database-- which we believe to be more accurate than data used in the article-- showed only 1,115 physicians in active practice, or approximately one physician per 578 patients. Thus, it is quite probable that for 2002 Alaska actually had the lowest physician to patient ratio in country. Updated calculations based on our 2003 numbers indicate this is almost certainly still true, with one physician per 553 patients. By comparison, the state would need about 50% more actively practicing physicians to approach the national average of one doctor per 360 patients.

Further exacerbating the problem, Alaska's physician work force is relatively old compared to the rest of the country. The ASMA database shows that over half of the state's practicing physicians are older than 51, setting up a looming recruitment crisis. This scenario was was corroborated by the State Medical Board in a September 2002 Anchorage Daily News article titled "Shingle Shortage?" Finally, a 2002 local study of physicians by Providence Health System confirms the work force is aging, and highlights immediate shortages of certain specialists in Anchorage, including general internal medicine, psychiatry, and general surgery.

It is because of this imminent recruiting challenge that medical liability reform is so critically important in Alaska right now. This state does not have the capacity to "grow" physcians on its own. Alaska has no medical school, and of the small number of students who graduate annually from the WWAMI program, some do not return to practice here. Likewise, our lone family practice residency training program is relatively small. Alaska is-- and will continue to be-- a net importer of doctors. As such, we compete with other states that have physician shortages, a competition that is largely influenced by the state's medical practice environment.

A recent American Medical Association study of medical students found that the legal environment and the availability of affordable medical liability insurance plays a major part in a graduate's decision as to where to consider setting up practice. Alaska needs to optimize its medical-legal environment to help us recruit the doctors we need. That is why the Alaska State Medical Association supports HB 472. With its $250,000 cap on non-economic damages, the bill provides the "gold standard" liability reforms that will help create the healthy practice environment so important to physician recruitment.

ASMA understands that medical liability reform is only one element in developing this healthy environment. Still, because the State has already had the foresight to enact other important medical practice reforms, we believe liability reform is the most critical element remaining. Indeed, we are pleased to have been able to help state reach this point through our recent work on other important legislation, including the Alaska Patient Bill of Rights, Prompt Pay legislation, Physician Joint Negotiation legislation, and federal Medicare payment reforms targeted to Alaska. ASMA has even offered ideas to the current Administration regarding strategies by which the state could actively "market" Alaska to out-of-state physicians. As a result of these previous and ongoing efforts, ASMA believes that, except for strong medical liability reform, Alaska's practice environment is actually quite favorable.

Finally, I'd like to point out that in the gallery today are Dr. Jeanne Bonar, ASMA's immediate Past President, and Dr. Paul Worrell, the Association's President Elect. Their attendance today, along with mine, demonstrates that ASMA's past, present, and future are all committed to work to help attract the well-trained doctors the state needs. Thank you for your attention, and I again urge you to support HB 472.

I'd be happy to answer any questions that you may have at this time.

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EUGENE F. WILES
1922-1990

December 19, 2002

John Troxel, M.D.
Jeanne Bonar, M.D.
Peter Lawrason, M.D.
Alaska State Medical Association
4107 Laurel Street
Anchorage, Alaska 99508

RE: Marsingill v. O'Malley, M.D.

Dear Dr. Troxel, Dr. Bonar, and Dr. Lawrason:

I am writing this letter to you in your capacity as officers of the Alaska State Medical Association. The Supreme Court of the State of Alaska recently issued an opinion in Marsingill v. O'Malley, Supreme Court No. S-9859. The case arose out of post-surgical care provided by James O'Malley, M.D., to Vicky Marsingill in February, 1995. Plaintiff's allegations specifically arose out of a telephone conversation between Dr. O'Malley and Mrs. Marsingill late one evening, where Mrs. Marsingill made complaints that were of disputed significance. Dr. O'Malley advised her to go to the Emergency Department, but she elected not to follow that advice. A jury trial resulted in a verdict in favor of Dr. O'Malley, and plaintiff appealed. The Supreme Court, in overturning the verdict, ruled that the trial court should have given an instruction proferred by Marsingill indicating that the question of Dr. O'Malley's breach of his duty to "give sufficient information" must be measured "from the standpoint of the reasonable patient". For reasons explained below, I believe the decision may have significant impact on the potential liability of all health care providers in the state and should be addressed with the incoming State Legislature. I suggest you consult with your own counsel concerning my analysis and the potential impact the Marsingill decision may have on the delivery of health care in Alaska.

The first 13 pages of the court's opinion are more or less irrelevant insofar as the reversal is concerned. They are also irrelevant as far as your daily practice is concerned.

The court begins the critical aspect of its analysis on p. 14. It notes that Marsingill had two theories of liability, only the first of which it seems to have classified as a medical malpractice claim. The second theory is Marsingill's claim "that a physician owes a duty to give patients enough information to make intelligent treatment choices." They characterized Dr. O'Malley's breach of the duty of disclosure as a failure to "adequately inform Marsingill about the potential seriousness of her symptoms and the risk of failing to seek immediate examination and emergency room treatment." The supreme court noted that Judge Michalski, in instructing the jury, treated both claims as "medical malpractice claims", "requiring the jury to determine whether Dr. O'Malley had given Marsingill sufficient evidence to meet his duty to inform by relying exclusively on expert testimony concerning whether the doctor's advice breached the professional standard of care."

The court reasoned that the alternate theory of liability did not question Dr. O'Malley's competency or the medical care or treatment Dr. O'Malley actually provided. To that degree, once we get to the retrial of this matter we will argue that that issue had already been decided and need not be retried. We will also argue, based upon the court's statements, the decision has already been made that there was no breach of the professional standard of care that governs a general surgeon. Specifically, the court has stated that the second, or alternative theory "did not depend on whether he breached the professional standard of care that governs the general surgeon. It was based solely on the "adequacy of the information" disclosed about treatment options. What is extremely difficult to fathom about the decision is that all of the cases relied upon by the court as well as all of the language used comes from informed consent, which is governed by statute in Alaska, or so we thought.

The court distinguishes between the standard that governs the duty to render adequate care and the standard that governs a physician's duty to disclose information. It cited Pedersen v. Zielski and noted: "A physician therefore undertakes, not only to treat a patient physically, but also to respond *fully* to a patient's inquiry about his treatment, i.e., to tell the patient everything that a reasonable person would want to know about the treatment." Of course, as I am sure you note, that case refers specifically to "treatment". The Pedersen case, which I was involved with, concerned a transected aorta and allegations of actual fraud on the part of the physician. None of the allegations were upheld.

The court further goes on and notes that under the Korman v. Mallin decision it has adopted the so-called "modern trend" which "measure[s] the physician's duty of disclosure by what a reasonable patient would need to know in order to make an informed and intelligent decision." What is left out in that quotation is that Korman again specifically involved informed consent and specifically involved actual treatment of the patient.

The court discounts the need for expert testimony in establishing this scope of disclosure, but does not totally eliminate it. On p. 16 of the decision it indicates expert testimony is not a necessary element because the scope of disclosure is measured from the standpoint of the patient. However, it goes on to say on p. 17 that expert testimony remains relevant in narrowing the field of risks that are "potentially material". By that, I take it that expert testimony is appropriate in describing what the risks are. It indicates that "some" expert testimony is necessary to establish materiality because only a physician or other qualified expert is capable of judging risks and the likelihood of its occurrence. It defines the focus as "whether a reasonable person in the patient's position would attach significance to the specific risk" and further notes that this "determination does not require expert testimony".

The court internally recognizes that its prior decisions were all made in the context of what could only be characterized as informed consent allegations when it states: "We assume for present purposes that Dr. O'Malley is correct in asserting that Korman and Alaska's informed consent statute both extend only to situations involving recommendations for specific medical procedures and treatment". I believe they assume that because that's what the statute says. Recognizing what the statute says, the court then does what most of us are not allowed to do in real life, it takes the square peg and puts it in the round hole. It makes the jump of saying a recommendation to go to the emergency room "amounted to a recommendation for treatment". It glosses over the idea that none of our experts considered going to the hospital or the emergency department as "treatment" nor did Dr. Ravden, their expert, believe that "simply going to the hospital is a treatment or a procedure". The court then blindly and with apparent deafness, accepts Wagstaff's assertion that "nasogastric intubation is a procedure". If nasogastric intubation is their procedure or treatment, then it seems like the only thing O'Malley should have had to advise Marsingill on would have been the risk associated with nasogastric intubation and the alternative to nasogastric intubation.

The court really goes out on a limb with its assertions on pp. 18 and 19 where it suggests Dr. O'Malley "acquiesced" in Marsingill's decision not to go to the emergency room and then goes on to say "a physician's recommendation to do nothing in the face of threatening symptoms is the equivalent of a treatment recommendation and should be accompanied by a duty of disclosure." How any human being with an IQ that exceeded zero could have concluded from this record that Dr. O'Malley "recommended doing nothing" and that was somehow the equivalent of a treatment recommendation is beyond comprehension. Somehow Dr. O'Malley's telling Mrs. Marsingill to go to the emergency department several times, informing her O'Malley would meet her there, informing her that O'Malley would assure that she would not have to wait in the waiting area with other patients, and informing her of various steps that might be taken to diagnose

her complaints, metamorphed into a "recommendation to do nothing".

In that the "recommendation to do nothing" was "equivalent to a "treatment recommendation'", we now have informed consent kicking in. Once that leap has been made by the court it can then invoke Section 8.08 of the AMA Code of Medical Ethics, which specifically involves informed consent. Under Section 8.08 the duty of disclosure is to give "enough information to enable an intelligent choice." The dramatic weakness in the court's decision comes in Marsingill's own rejection of the idea that she had an informed consent claim. She repeatedly, through her attorney, maintained she did not have an informed consent claim. The court's ultimate decision was that failure to give the instruction "deprived Marsingill of her right to have a jury decide the issue directly, from the standpoint of a reasonable patient."

How does this affect physician's practice and what a physician needs to do from this point forward? First, we must start with the idea that the overwhelming support of your peers concerning the appropriateness of any advice you give to a patient will not be enough to prevent you from having to go through a trial concerning that advice. In every instance and for virtually everything you do, you must first look to what the mythical "reasonable patient" would want to know. That can apply to telephone conversations, conversations in the hospital, or conversations in your office with your patients. I believe the most immediate concern involves the same situation Dr. O'Malley was involved with here -- the telephone call in the middle of the night. Unfortunately, what is lost in all of this is that it doesn't really look to what a reasonable physician would say to a patient when confronted with a complaint over the telephone. Virtually anything you tell the patient can be misconstrued, and if the patient decides not to follow advice you provide, you can conceivably be held responsible for that patient's failure to follow that advice. Regardless of the nature of the complaint, if you decide to take a telephone call, I recommend a graduated approach with the ultimate goal being

for the patient to report to the emergency department virtually every time you receive such a call. I would provide the patient with all conceivable scenarios with the reported symptoms until the patient agreed to go to the emergency department. I would specifically include statements to the effect that there is a reasonable chance the patient could die or suffer serious bodily harm by failing to go to the emergency department. I would have a dictaphone available at all times to enable you to document for your records what actually transpired in any of those telephone conversations. The safest method might simply be to inform the patient at the commencement of the telephone conversation that you are recording the conversation for purposes of your records, and then simply placing the tape of that conversation in your medical record, with transcription only occurring in the event there was a dispute that developed over the contents of the conversation. This method would not work if you were away from home or office.

Alternatively, I would instruct answering services to simply play a pre-recorded message to all patients who call to the effect that any complaint they have may be serious, cannot be diagnosed on the telephone, and that they should proceed immediately to the emergency department for evaluation by an emergency physician. Using that approach, no questions can possibly exist concerning what transpired within the confines of the telephone conversation and there can be no "acquiescence".

Both approaches lessen a physician's ability to have a meaningful interaction with his patient in the context of reported complications or symptoms. Both approaches may dramatically affect patient census in the emergency department and will undoubtedly cause unnecessary visits to the emergency department by patients who truly do not need to go. Eventually, this approach may cause patients to cease calling physicians giving the limited meaningful information they can be provided. Unfortunately, I cannot see any alternative given the court's decision.

I hope this has been helpful. If you have any questions, please give me a call. Thank you for your attention to this matter.

Sincerely,

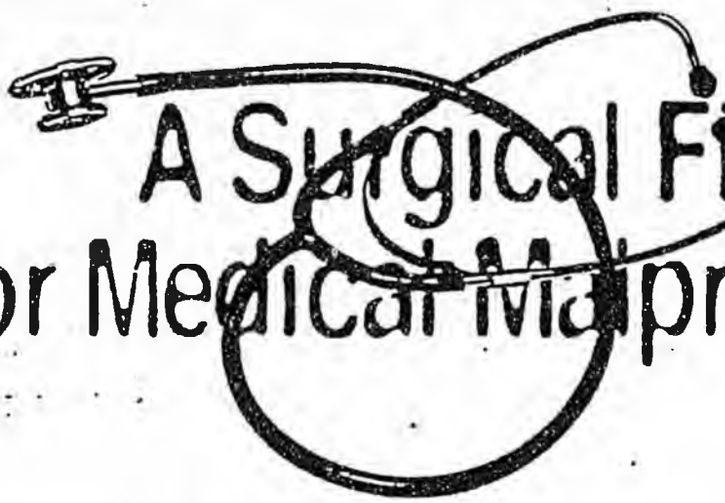
DELANEY, WILES, HAYES,
GERETY & ELLIS, INC.

Howard A. Lazar

HAL:msb

Enc.

65830w



A Surgical Fix for Medical Malpractice

Reforms Work Best as a Package, Study Shows

By Jeffrey Speicher

Almost everyone agrees: The medical malpractice system in the United States serves no one well. Although a few multimillion dollar settlements draw public attention, most individuals who suffer real injury at the hands of their physician or hospital accept less than the full value of their claim—and endure long delays before receiving compensation. Those most harmed—people left with lifelong medical needs or permanent loss of income—are most likely to be underpaid.

Physicians, who in the 1950s faced a 1-in-7 chance of being sued over the course of a career, now see the odds reduced to 1-in-7 *per year.* As a result malpractice insurance premiums have skyrocketed, causing many practitioners to abandon their specialties or adopt costly defensive-medicine procedures. Many insurers, buffeted since the early '70s by recurrent cycles of higher claims frequency and larger jury awards, have withdrawn from the market, which has reduced availability of coverage and further driven up costs. And as for attorneys . . . . well, even some thoughtful legal scholars believe the system is out of whack.

According to Randall Bovbjerg of Washington's Urban Institute, author of numerous studies on medical malpractice, many of the system's problems arise from a basic difference between doctors and lawyers: Physicians think about healing injuries, attorneys about resolving disputes. Says Bovbjerg, "Doctors see medical malpractice as a way to make injured patients whole—financially as well as physically. Lawyers come into the process after a conflict arises, and their focus is on justice for their client."

Jeffrey Speicher is manager of member communications for the Academy and an editor for Contingencies.

This difference in worldview intertwines medical malpractice with the legal system. Malpractice must balance the need to compensate deserving claimants, deter future violations by making doctors more careful, and obtain justice for both patients and medical providers. All this from what Bovbjerg defines as "mainly an insurance system run by experts."

A group of those insurance experts, members of the American Academy of Actuaries, recently suggested an approach to make the system less costly. According to the Academy report, "Medical Malpractice Tort Reform: Lessons from the States," the mixed results of reform attempts by the states point the way to effective federal action.

"Congress should adopt a comprehensive approach to tort reform by adopting a package of measures," says Jim Hurley, an actuary with Tillinghast/Towers Perrin and leader of the Academy group. "Our report provides a synthesis of measures that have been effective at the state level."

A Package Deal

The California Medical Injury Compensation Reform Act (MICRA) of 1975 shows the success of the package approach. Before MICRA's adoption, the state's percentage of total U.S. loss payments was significantly higher that its proportion of the nation's physicians. By 1981, California's loss payments had dropped and were about even with its percentage of physicians. Costs continue to fall, even as California's share of physicians remains stable. Writes the Academy group: "The relationship of decreased relative costs to the timing of reform provides strong evidence for the effectiveness of the MICRA package." [See Figure 1.]

At the head of the Academy's list for lawmakers is a nationwide cap on jury awards for noneconomic damages such as pain and suffering. As evidence, Hurley points to Ohio where malpractice costs fell after a 1975 cap on damages, only to rise dramatically after court challenges led to a 1985

American Academy of Actuaries Bi-Monthly

FIGURE 1

Malpractice Loss Payments in California as a Percentage of the U.S. Total, 1975–94

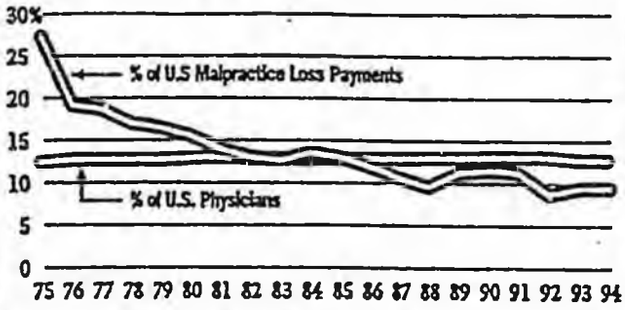
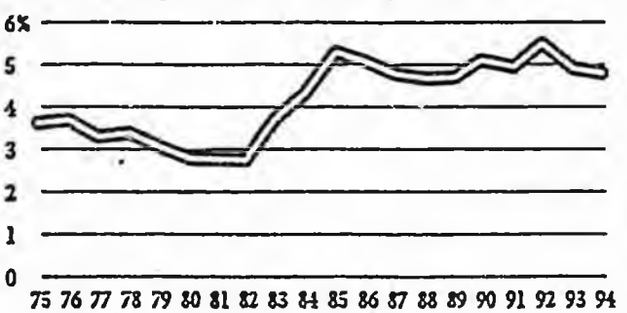


FIGURE 2

Malpractice Loss Payments in Ohio as a Percentage of the U.S. Total, 1975–94



ruling that overturned the cap. [See Figure 2.]

Such a cap should be established on a per-medical-injury basis at a level low enough to have an impact—at $250,000, for example. In addition, a mandatory collateral-source offset rule is needed to ensure that double and triple indemnification cannot be collected through multiple suits. Under this rule, a jury or judge would have to consider compensation paid from other sources.

Above all, the Academy report warns against piecemeal or faulty changes. Loss experience in New York shows that the individual tort reform measures adopted in that state over the past two decades did not improve costs relative to the U.S. total. "Poorly crafted malpractice reform—either individual measures that are too limited or broad transformations that are too far-reaching—can have unintended consequences that drive up costs," says Hurley.

Above all, the Academy report warns against piecemeal or faulty changes. "Poorly crafted malpractice reform—either individual measures that are too limited or broad transformations that are too far-reaching—can have unintended consequences that drive up costs."

The Academy's suggested approach involves what medical malpractice experts call "takeaway" reforms—preserving the current reliance on the tort system, but eliminating some of the costliest and most abused features.

Other voices in the debate, including representatives of the medical community, call for a back-to-the-drawing-board approach. Unfortunately, the design that comes back often relies on a no-fault model. While no-fault medical malpractice insurance would largely untangle the process from the legal system, no-fault often rewards individuals whose claims would otherwise be denied. Says Hurley, "No-fault would drive frequency of claims through the roof—some gue by a factor of at least two and perhaps by a factor of eight or more. It's scary how many things can be compensated under the typical no-fault system."

Frequency of claims, according to Hurley, is the key driver of costs. "Over the past two decades, the plateaus and surges of claims frequency have been difficult to anticipate and measure, but the long-term trend has been up," says Hurley. Size of claims also is an important cost factor, but dollar amounts in settlements have been increasing in a more predictable fashion over time.

No-fault also would take most cases out of court and make malpractice a transaction between insurer and claimant. Advocates claim that this would cut legal costs—which are enormous. For example, according to the Insurance Services Office, legal defense costs for insurers alone accounted for 14 percent of total tort costs in 1992.

However, experience in Florida and Virginia, where no-fault for obstetric cases is already in place, does not show substantially reduced costs or less need for legal counsel. Says Bovberg, "*Everyone* who uses the no-fault system in Florida and Virginia consults a lawyer."

Other options exist. A proposal by Jeffrey O'Connell, professor at the University of Virginia School of Law, seeks a middle way between no-fault and status quo. He would shorten the process and lower costs through an early offer of payment of noneconomic damages.

O'Connell is blunt about his disgust with the current state of affairs. "Medical malpractice is a nightmare of useless circularity," he says. However, according to O'Connell, the system is not co..sistently biased against defendants. Most proposed changes, on the other hand, invariably favor the defendant. Justice—as well as political reality—requires benefits for the plaintiff as well.

"Reform requires a quid pro quo," says O'Connell. "While the Academy has described quite lucidly the options for takeaway reform, such measures could not get through Congress without being so watered down as to be meaningless," says O'Connell. "True reform should involve a fair trade: making it easier for claimants to be paid, but paying them less, as under workers compensation laws."

An Offer You Can't Refuse

O'Connell's ideas have found sponsorship on Capitol Hill. A bill introduced in the 104th Congress by Sen. Mitch Mc-

Connell (R-Ky.) would create an early-offer plan for all tort claims, including medical malpractice. Under the proposal, a defendant in a personal injury claim is given the option of offering payment to the injured party within 180 days of the claim. The defendant purchases for the claimant a comprehensive major medical insurance policy that covers medical expenses, rehabilitation, and lost wages beyond monies received from collateral sources. In addition, reasonable hourly fees for the claimant's attorney would be paid.

Claimants who are offered such a settlement within 180 days of the claim would be obliged to accept. This won't get egregious medical offenders off the hook, however. A normal tort claim could be pursued for noneconomic damages, but with a higher-than-current standard of evidence.

> Medical malpractice is a nightmare of useless circularity.

The plaintiff must prove that the medical provider's misconduct was wanton or intentional.

Because the defendant would not be forced to offer a settlement, physicians and their insurers could take their chances in court in the case of bogus claims. However, the risk might be too great. O'Connell cites a prominent medical malpractice defense lawyer who estimates that he'd make an early offer in 200 of the his firm's 250 current cases. So the balance is tipped toward the defendant, but not without providing a substantial benefit to the plaintiff: Timely resolution and quick settlement.

The limit on legal fees would discourage what O'Connell calls "the unconscionable abuse of the system by some members of my profession." Among other criticisms, the Virginia professor points out that contingent fees are often not truly contingent on risk. Attorneys take the same settlement percentage from open-and-shut cases as from complex cases, a practice that subsidizes work on failed litigation and which O'Connell denounces as an illegal tax on deserving claimants.

Hurley gives O'Connell's proposal a mixed review. "To its credit, the early-offer plan is not mandatory for defendants, which leaves the tort system in place to challenge claims perceived as nonmeritorious," says Hurley. He also notes that periodic insurance payment to claimants allows compensation to be made as costs are incurred, eliminating the burden of large lump-sum payouts. Also, O'Connell's plan emphasizes two fundamentals that the Academy report identified: mandatory recognition of collateral benefits and controlling noneconomic damage costs. In fact, the O'Connell plan eliminates consideration of noneconomic damages altogether unless the case goes to court.

However, Hurley notes, the periodic payment plan theoretically would have to remain in force for decades. Will claimants be out in the cold after the disability policy limits are reached, or will the insurer face unlimited exposure? Another concern: Like no-fault, the early-offer plan could give incentives for unmerited claims. Insurers may pay a doubtful claim rather than incur expensive litigation costs and risk a large judgment award. In addition to increased costs, Hurley worries about a basic question: "Is it the right message to send to individuals who think doctors and insurers have deep pockets? The system may have practical advantages, but in terms of equity, it is hardly fair."

No matter which remedy is tried, no action will slash premium costs immediately, Hurley cautions. "Tying tort reform to premium reductions, as has been done in some states, is unrealistic," he says. "There is little evidence that the cost savings can be translated directly into lower costs for health care providers. More likely, reform will slow the rate of premium cost increases."

The course of reform will be determined by elected officials at the state and federal levels. The debate will be long, no matter which option—if any—is approved. In the meantime, the cost of inaction continues to be passed on to the public in the form of increased medical fees and reduced services.

By working together in recent years, insurers and healthcare providers have begun to bring medical spending under control. Effective medical malpractice reform is one way to keep the momentum going. □

Answer to Brain Drain, page 13: The house number is 76.

Fall
1996

ISSUE BRIEF
AMERICAN ACADEMY of ACTUARIES

Medical Malpractice Tort Reform: Lessons from the States

The cost of insuring physicians against medical malpractice claims has increased dramatically in recent years. Skyrocketing premium costs and a string of highly publicized lawsuits have led many physicians to curtail certain high-risk procedures. By reducing the availability of important medical services, this practice of defensive medicine could have serious public-health consequences. In addition, increased malpractice insurance expenses are passed on to patients and health plans, thus fueling medical inflation.

To combat these ill effects, several states have adopted reforms designed to reduce the cost of medical malpractice insurance. More recently, Congress has attempted to follow the initiative of the states but has been unable to enact comprehensive medical malpractice tort reforms into law.

To date, state efforts have enjoyed varying degrees of success in reducing medical malpractice insurance rates. What can be learned from the experience of the states? How can these conclusions be applied at the federal level? The American Academy of Actuaries Work Group on Medical Malpractice Reform has studied the impact of state reforms and offers its comments to state and federal officials who are considering national tort reform.

Findings

Any federal medical malpractice tort reform effort should be based on a *package* of measures that have exhibited some success in stabilizing medical malpractice costs. The most effective elements of such a package are a cap on noneconomic damages and an offset for collateral payments from other sources. These reforms would limit the financial exposure of health-care providers to lawsuits and would ensure that damages could not be collected through multiple suits. While there are significant limitations on data used to study specific tort reforms, persuasive results can be observed by looking at medical malpractice costs in certain states over time and relating that experience to the timing of particular tort reform measures.

In the following comparison of cost levels in three states that have enacted tort reform measures, paid losses of the individual states as a percentage of the U.S. total are used as the measure of costs. The percentage of physicians in each state as a total of U.S. physicians is used as a reasonable benchmark. The degree to which the percentage of paid losses differs from the percentage of physicians measures the effectiveness of the reforms. All else being equal, the relative cost percentages of paid medical malpractice claims should remain constant over time. Any observed changes in a state's relative cost levels provide an indication of the effectiveness of tort reform. The three states studied are California, New York, and Ohio.

The American Academy of Actuaries is the public policy organization for the actuarial profession, providing unbiased actuarial information to elected officials and regulators.

Members of the Work Group on Medical Malpractice Reform: James D. Hurley, ACAS, MAAA; William E. Burns, ACAS, MAAA; Linda A. Dembiec, FCAS, MAAA; Aileen C. Lyle, FCAS, MAAA; and Edward M. Wrobel Jr., FCAS, MAAA

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Reform Act (MICRA) package of reforms was enacted in 1975, medical malpractice costs have fallen substantially as a percentage of the U.S. total.

- New York. Individual reform measures were adopted in 1975, 1981, 1985, and 1986. No observable improvement in the state's relative costs has resulted. The New York reforms did not include a cap on damages.

Ohio. Reforms enacted in 1975 included a cap on damages. The cap was overturned in 1985, after which costs rose dramatically and have remained high.

California

The California loss data (Exhibit 1) illustrate that while the state's proportion of the U.S. physician population has remained relatively stable, its per-

Exhibit 1
Malpractice Loss Payments in California as a Percentage of the U.S. Total, 1975–94

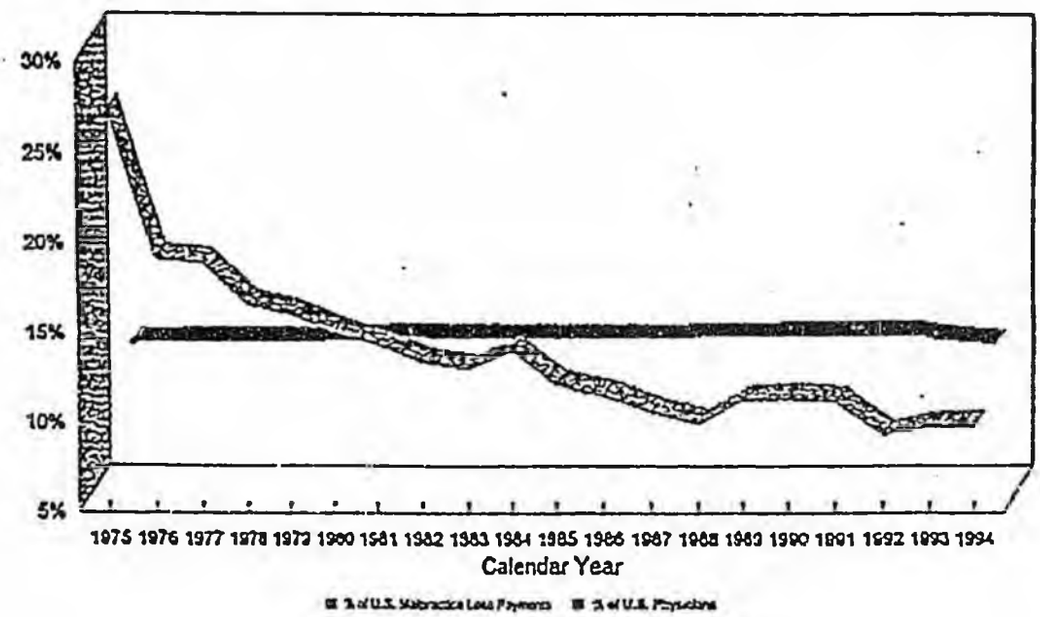
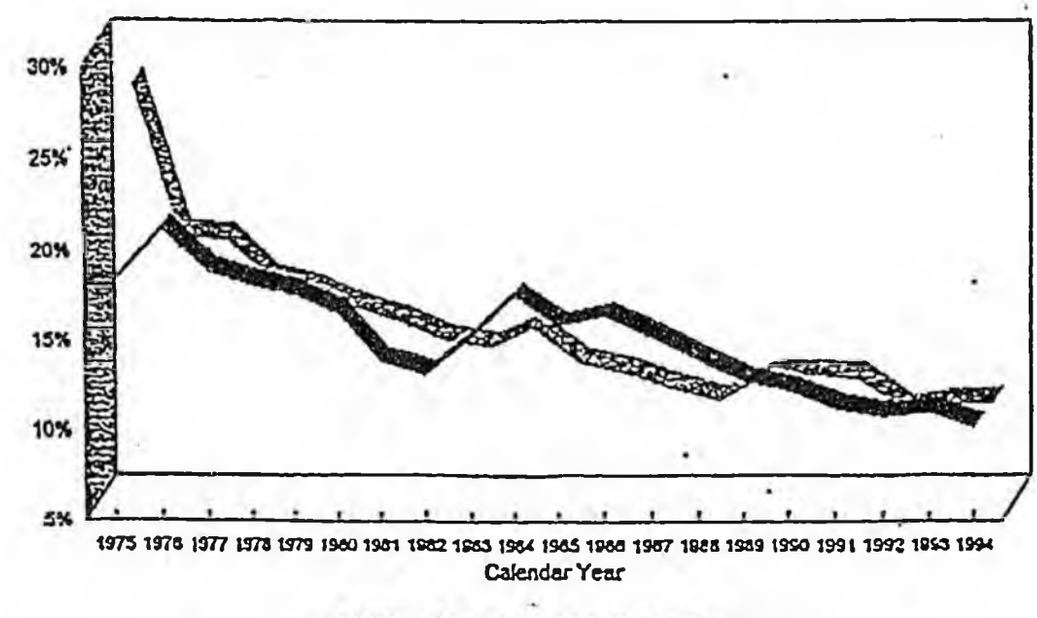


Exhibit 2
Malpractice Premiums and Malpractice Loss Payments in California as a Percentage of the U.S. Total,



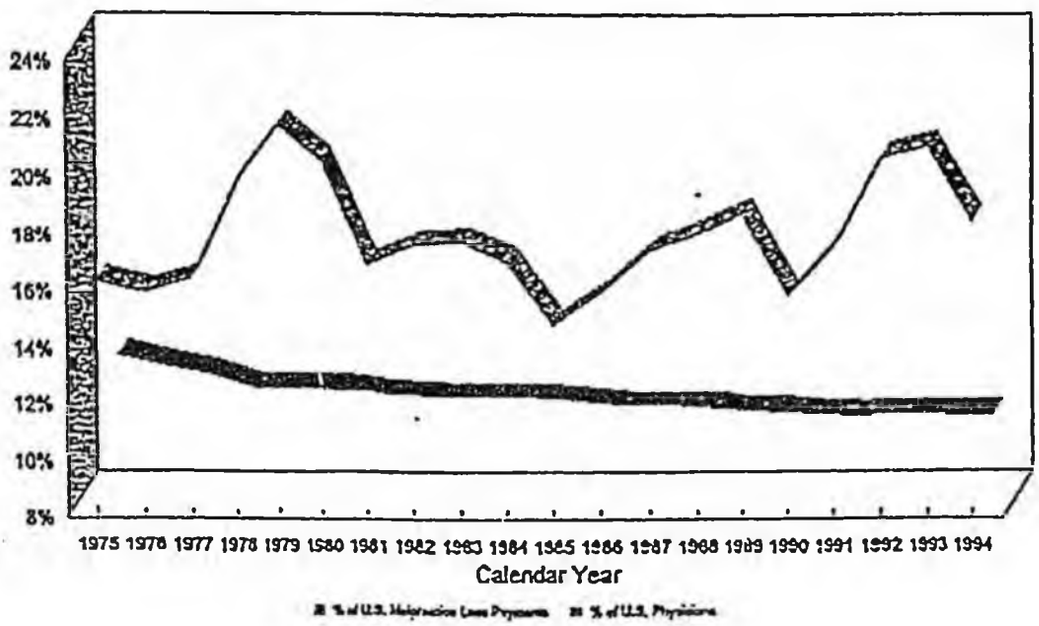
centage of loss payments has dropped dramatically since enactment of the MICRA package of tort reforms. Before MICRA's adoption in 1975, California's percentage of loss payments was significantly higher than its proportion of physicians. By 1981, California's loss payments had dropped and were about even with its percentage of physicians. Since that date, California has continued to benefit from MICRA: Costs continue to drop as a percentage of the U.S. total, even as the percentage of physicians remains stable. Although other factors affect these data, the relationship of decreased relative costs to the timing of reform provides strong evidence for the effectiveness of the MICRA package.

Many opponents of tort reform argue that insurance premiums do not drop after medical malpractice reform. Indeed, costs and premiums normally rise with inflation, and tort reform may only slow the increases. However, the California data show that premiums declined as losses declined. Exhibit 2 compares the paid loss data from Exhibit 1 with California premiums as a percentage of the total U.S. medical malpractice premiums. Although year-to-year fluctuations do occur, premiums have fallen in proportion to the decline in losses. Competition tends to keep companies at an appropriate profit margin, and any extra profits are normally short-lived.

New York

The New York loss experience is shown in Exhibit 3. It shows that the individual tort reform measures implemented in New York did not improve New York's experience relative to that of other states. New York's loss payment percentage does not show any observable pattern of decline or improvement over the 19-year period, despite the various tort reform measures adopted. The New York reforms did not include a cap on damages and were enacted in piecemeal fashion. Therefore, this result supports the merits of a cap on damages and the concept of a package of reforms.

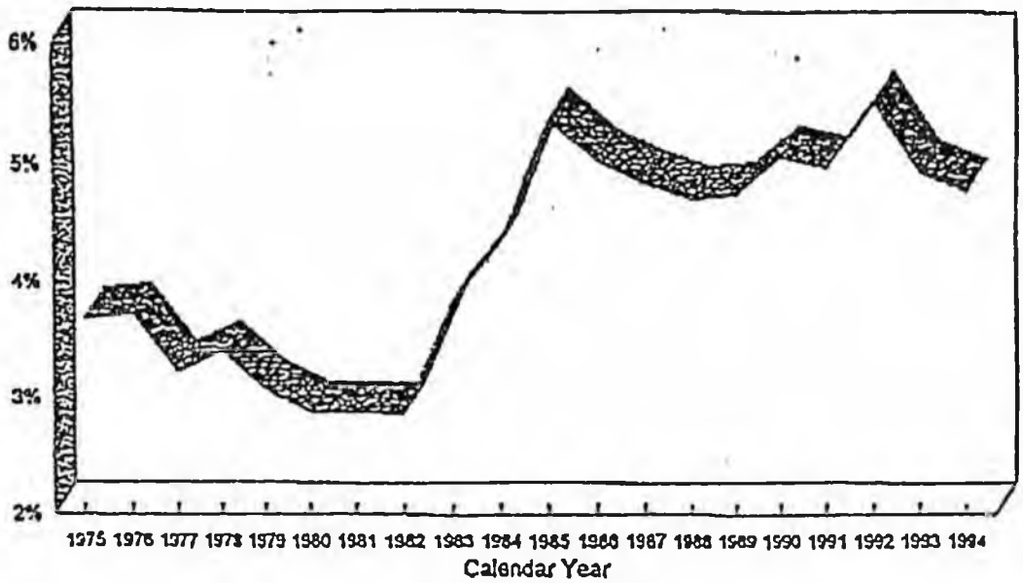
Exhibit 3
Malpractice Loss Payments in New York as a Percentage of the U.S. Total, 1975–94



Ohio

The final example is Ohio, with data presented in Exhibit 4. The data show a gradual decline in costs following tort reform in 1975. The Ohio cap on damages came under court challenge in 1982, resulting in sharp increases that reached a peak in 1985 when the cap was finally overturned. Since 1985, costs in Ohio have remained high, with no signs of decreasing. Again, the data appear to support a tort reform package and the specific benefit of a cap on noneconomic damages.

Exhibit 4
Malpractice Loss Payments in Ohio as a Percentage of the U.S. Total, 1975–94



Conclusions

California's experience indicates that properly implemented medical-malpractice tort reform can reduce the cost of medical malpractice insurance. After reviewing several states' experience with medical malpractice tort reform and examining studies on the issue, the Academy work group has concluded the following:

- a package of reforms is more likely than individual reforms to achieve savings in malpractice losses and insurance premiums, and
- key among the reforms in the package are a cap on noneconomic awards and a mandatory collateral-source offset rule.

For reform to be effective in reducing costs, the cap on noneconomic awards should be established on a per-medical-injury basis at a level low enough to have an impact (e.g., $250,000). In addition, a mandatory collateral-source offset rule is needed to ensure that double and triple damages cannot be collected through multiple suits. Under this rule, each suit would have to consider damages already paid from other sources.

Although these reforms have been successful in reducing the cost of medical malpractice insurance, elected officials and regulators must still consider the effects of medical malpractice reform on physicians, consumers, health plans, and other interested parties. When considering medical malpractice reform, state and federal officials should weigh the impact on society as a whole and strive for a balanced, comprehensive solution.

HEARTBEAT

The "Pulse" of ALASKA STATE MEDICAL ASSOCIATION MEMBERS Volume 105 Nov/Dec 2002

Informed Consent
Recent Supreme Court Decision

A recent Alaska Supreme Court decision may impact how you provide informed consent.

Marsingill v. O'Malley (Supreme Court No. 5-9859, Opinion No. 5643, dated 11/22/02), according to several Anchorage defense attorneys, may provide for new standards for providing informed consent with a potential impact on the delivery of care in Alaska.

Attorney Howard Lazar wrote a letter to ASMA physician officers that expressed his analysis of this case, advice he would provide to physicians, and a suggestion that the issues raised be addressed by the Legislature.

The case, which was the subject of the decision, involved a call at night to a physician. The physician recommended that the patient go to the ER, but the patient chose not to go and subsequently lost consciousness and suffered permanent injuries. The basic issue was that a recommendation to go to the emergency room constituted a "treatment" and therefore needed appropriate informed consent. The most far-reaching corollary is that the Supreme Court stated that the informed consent must be in terms of what a "reasonable patient" would want to know about the treatment.

Mr. Lazar states in part, in his letter of 12/19/02, to ASMA's officials:

"...How does this affect physician's practice and what a physician needs to do from this point forward? First, we must start with the idea that the overwhelming support of your peers concerning the appropriateness of any advice you give to a patient will not be enough to prevent you from having to go through a trial concerning that advice. In every instance and for virtually everything you do, you must first look to what the mythical "reasonable patient" would want to know. That can apply to telephone conversations, conversations in the hospital, or conversations in your office with your patients. I believe the most immediate concern involves the same situation Dr. O'Malley was involved with here – the telephone call in the middle of the night. Unfortunately, what is lost in all of this is that it doesn't really look to what a reasonable physician would say to a patient when confronted with a complaint over the telephone. Virtually anything you tell the patient can be misconstrued, and if the patient decides not to follow advice you provide, you can conceivably be held responsible for that patient's failure to follow that advice. Regardless of the nature of the complaint, if you decide to take a telephone call, I recommend a graduated approach with the ultimate goal being for the patient to report to the emergency department virtually every time you receive such a call. I would provide the patient with all conceivable scenarios with the reported symptoms until the patient agreed to go to the emergency department. I would specifically include statements to the effect that there is a reasonable chance the patient could die or suffer serious bodily harm by failing to go to the emergency department. I would have a dictaphone available at all times to enable you to document for your records what actually transpired in any of those telephone conversations. The safest method might simply be to inform the patient at the commencement of the telephone conversation that you are recording the conversation for purposes of your records, and then simply placing the tape of that conversation in your medical record, with transcription only occurring in the event there was a dispute that developed over the contents of the conversation. This method would not work if you were away from the home or office.

Alternatively, I would instruct answering services to simply play a pre-recorded message to all patients who call to the effect that any complaint they have may be serious, cannot be diagnosed on the telephone, and that they should proceed immediately to the emergency department for evaluation by an emergency physician. Using that approach, no questions can possibly exist concerning what transpired within the confines of the telephone conversation and there can be no "acquiescence".

Both approaches lessen a physician's ability to have a meaningful interaction with his patient in the context of reported complications or symptoms. Both approaches may dramatically affect patient census in the emergency department and will undoubtedly cause unnecessary visits to the emergency department by patients who truly do not need to go. Eventually, this approach may cause patients to cease calling physicians giving the limited meaningful information they can be provided. Unfortunately, I cannot see any alternative given the court's decision...."

ASMA recommends that you contact both your professional liability insurance company and your attorney to seek guidance regarding "informed consent" in your practice in light of this decision.

The issues involved are important and ASMA is exploring ways, including legislation, to resolve them.

* * *

American Medical Association

Physicians dedicated to the health of America

FOR IMMEDIATE RELEASE **December 8, 2003**

MEDICAL STUDENTS NOT IMMUNE TO NATION'S MEDICAL LIABILITY CRISIS

New AMA survey shows medical students reconsidering choice of specialty and state for residency

CHICAGO—America's medical liability crisis is causing the nation's medical students to seriously consider whether they want to practice a high-risk specialty or apply for a residency in one of the 19 states currently in crisis, according to a new American Medical Association survey (highlights available online at http://www.ama-assn.org/ama1/pub/upload/mm/31/ms-mlrhighlights.pdf). This is the first survey conducted of medical students to determine what impact the nation's medical liability environment is having on medical students' decision-making. Nearly 4,000 surveys were completed from 45 states and the District of Columbia. The survey was conducted by the AMA Division for Market Research and Analysis.

"It's very sad that our nation's medical students are being forced to make career decisions based on factors other than their passion for medicine and where they would receive the best training," said AMA Medical Student Trustee David A. Rosman. "We watched, horrified, as the crisis was forcing our most experienced mentors to stop performing high-risk procedures or providing care in crisis states. It is frightening to realize that because this crisis is affecting specialty choice, there may not be anyone to take their place."

The survey found that 96 percent of students indicated the issue of medical liability is a crisis or a major problem. Half of the respondents indicated the current medical liability environment was a factor in their specialty choice, and 39 percent said the medical liability environment was a factor in their decision about a state in which they would like to complete residency training.

Additional top-line survey findings include:

- 69 percent of students whose professors discussed the liability situation said the professors also discussed defensive medicine, including increasing unnecessary or excessive care.
- 61 percent of students are extremely concerned the current medical liability environment is decreasing physicians' ability to provide quality medical care.
- 48 percent of students in their third or fourth year of medical school indicated the liability situation was a factor in their specialty choice.

"These survey results will be an important benchmark to gauge how the crisis continues to affect patients' access to medical care," said AMA President Donald J. Palmisano, MD, JD. "The students' responses underscore the need for America's lawmakers to listen. Fix the crisis now. Enact meaningful medical liability reform legislation."

The AMA strongly urges the U.S. Senate to support a vote on legislation—The Patients First Act of 2003 (S. 11)—which was introduced earlier this year. Similar legislation (HR 5) already has passed the U.S. House of Representatives.

Visit http://www.ama-assn.org/ama/pub/article/3216-8223.html to read more, including comments from medical students on how they have been personally affected by the crisis.

For more information, please contact:

Daniel Blaney-Koen
Field Communications Manager
(312) 464-4415

AMA survey: Medical students' opinions of the current medical liability environment

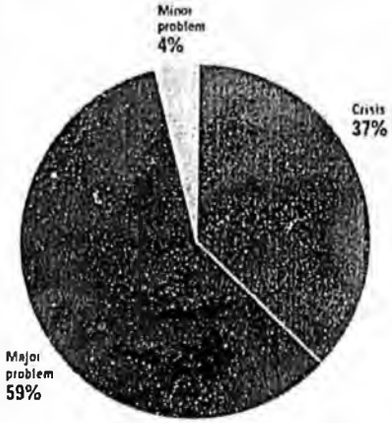
Highlights

Background

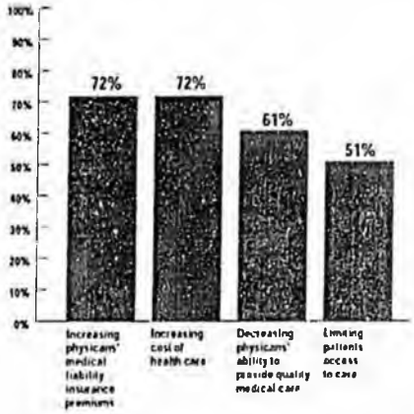
There have been numerous surveys of physicians on the current medical liability environment, including AMA's recent National Professional Liability Survey. However, this is the first major survey of medical students on the subject. This survey examined medical students' awareness of the medical liability situation, concerns related to the current medical liability environment, and the impact of the current medical liability environment on medical students' specialty decision and their choice of state in which they would like to complete their residency training.

Students are concerned

Nearly all respondents indicated that the issue of medical liability is a crisis or a major problem; 37 percent indicated that it is a crisis, and 59 percent indicated that it is a major problem.



Of the seven possible effects on the practice of medicine asked about in the survey, the majority of students are extremely concerned that the current medical liability environment is increasing physicians' medical liability insurance premiums, increasing the cost of health care, decreasing physicians' ability to provide quality medical care, and limiting patients' access to care.



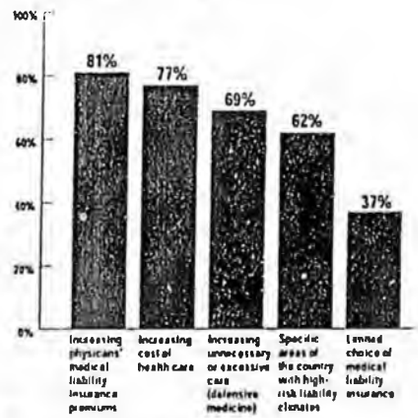
Crisis affects future physicians

Thirty-nine percent of the respondents indicated that the medical liability situation was a factor in their decision about the state in which they would like to complete residency training. Fifty percent of the respondents indicated that the medical liability situation was a factor in their specialty choice. Forty-eight percent of students in their third or fourth year of medical school indicated the liability situation was a factor in their specialty choice.

Professors talking with students

Thirty-eight percent of the respondents indicated that their professors discussed the current medical liability situation with them. Those whose professors had discussed the situation were asked to indicate from a list of topics what had been discussed. The table below shows what proportion of students whose professors discussed the issue covered certain topics.

Did your professor discuss...*



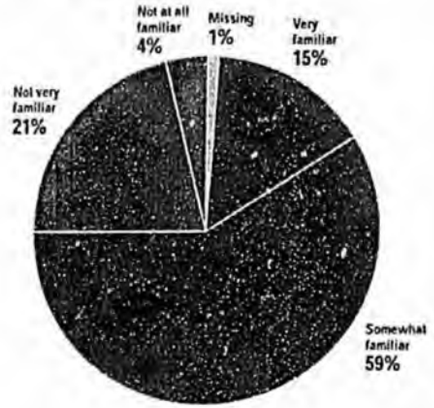
*Of those respondents whose professors discussed the current medical liability situation

American Medical Association Division of Market Research and Analysis. November 2003

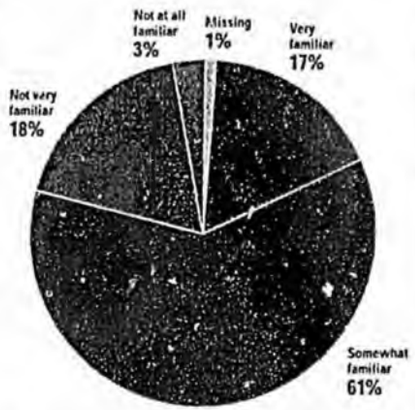
Awareness of the situation

To assess awareness of the medical liability situation, respondents were asked how familiar they are with the current medical liability, or medical malpractice, situation.

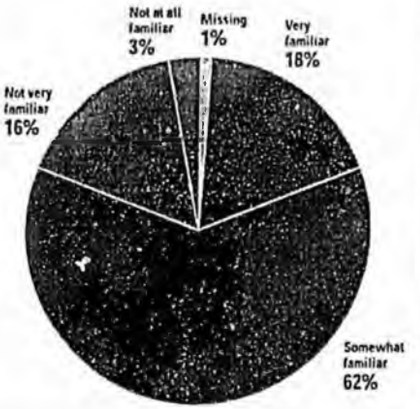
Their responses were:



Those medical students attending school in crisis states were more familiar with the liability situation. Those students who plan to practice in high risk specialties also were more familiar with the issue.



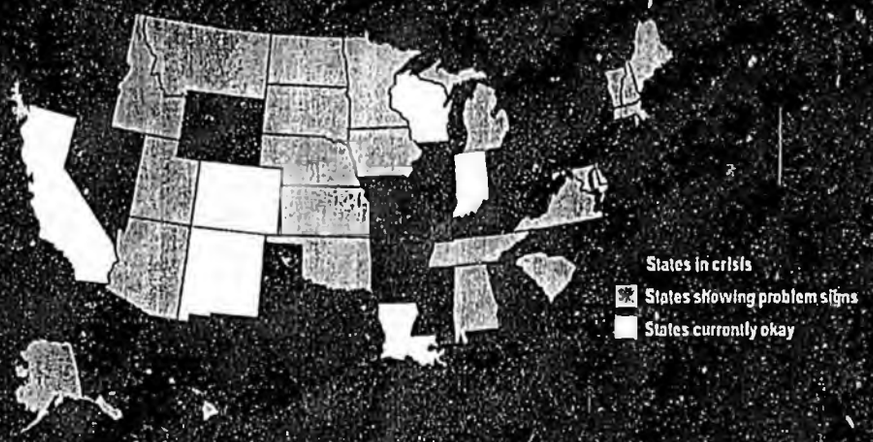
Students attending medical school in crisis state



Students who plan to practice in high risk specialty

American Medical Association Division of Market Research and Analysis. November 2003

A state of crisis



In August 2003 an e-mail with a hyperlink to the online survey was sent to 20,976 medical students for whom the AMA has e-mail addresses. A total of 3,952 surveys were completed and returned, for a response rate of 19 percent.

Analysis of the data was conducted to examine differences in results by year in medical school, specialty in which student plans to practice, (high risk specialty versus non-high risk specialty), and state of medical school (crisis state versus non-crisis state).

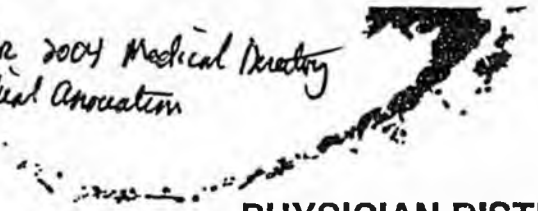
The specialties identified as high risk were: emergency medicine, general surgery, neurosurgery, obstetrics/gynecology, orthopedic surgery, and thoracic surgery.

The 19 crisis states that have been identified by the AMA are: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, West Virginia and Wyoming.

American Medical Association
Physicians dedicated to the health of America

515 North State Street,
Chicago, Illinois 60610

Source: Mock-up For 2004 Medical Directory
Alaska State Medical Association



Dorl

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 4, ~~2002~~ 2003

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Anchorage/Girdwood	~~630~~ 675	~~36~~ 37	~~68~~ 61	~~27~~ 24	~~761~~ 797
Barrow	35				35
Bethel	~~19~~ 18	2			~~21~~ 20
Cordova	2				2
Delta Junction	1				1
Dillingham	89				89
Eagle River	~~11~~ 12				~~11~~ 12
Fairbanks/North Pole	~~130~~ 131		36 34	1	166 -
Fort Yukon	1				1
Glennallen	23				23
Golovin	1				1
Haines	82				82
Homer	~~15~~ 18				~~15~~ 18
Juneau/Auke Bay	~~69~~ 68	2			~~71~~ 70
Kenai	76			1	87
Ketchikan/Klawock	30	3			33
Kodiak	~~20~~ 15	4			~~24~~ 19
Kotzebue	8 10				10
~~Metlaktla~~	~~1~~				~~1~~
Naknek	1				1
Nome	~~11~~ 10				~~11~~ 10
Palmer	~~26~~ 25				~~8~~ 25
Petersburg	56				56
Seldovia	1				1
Seward	56				56
Sitka	19	11			30
Soldotna	~~38~~ 39				~~38~~ 39
Talkeetna	1				1
Tok	1				1
Valdez	43				43
Wasilla	~~38~~ 41				~~38~~ 41
Wrangell	84				84
TOTAL	~~1115~~ 1164	59 ✓	~~104~~ 95	~~28~~ 26	~~1306~~ 1344

Source : 2003 Medical Directory
Alaska State Medical Association

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 4, 2002

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Anchorage/Girdwood	630	36	68	27	761
Barrow	3				3
Bethel	19	2			21
Cordova	2				2
Delta Junction	1				1
Dillingham	8				8
Eagle River	11				11
Fairbanks/North Pole	130		36		166
Fort Yukon	1				1
Glennallen	2				2
Golovin	1				1
Haines	3				3
Homer	15				15
Juneau/Auke Bay	69	2			71
Kenai	7			1	8
Ketchikan/Klawock	30	3			33
Kodiak	20	4			24
Kotzebue	9				10
Metlaktla	1				1
Naknek	1				1
Nome	11				11
Palmer	26				6
Petersburg	5				5
Seldovia	1				1
Seward	5				5
Sitka	19	11			30
Soldotna	38				38
Talkeetna	1				1
Tok	1				1
Valdez	4				4
Wasilla	38				38
Wrangell	3				3
TOTAL	**1115**	**59**	**104**	**28**	**1306**

Jim Jordan

From: "Gavitt, Brian (Murkowski)" <Brian_Gavitt@murkowski.senate.gov>
To: "Jim Jordan" <asma@alaska.net>
Sent: Tuesday, January 20, 2004 11:57 AM
Attach: ATT23321.gif
Subject: FW: fyi - - great story on AK victory

Did you see this article? Also, what are you hearing from the physician community? CMS just sent their press release highlighting the adjustment for Alaska. Let me know what you're hearing...thanks! Brian

-----Original Message-----
From: Maggie Elehwany [mailto:Maggie.Elehwany@ama-assn.org]
Sent: Tuesday, January 20, 2004 3:47 PM
To: Gavitt, Brian (Murkowski)
Subject: fyi - - great story on AK victory

GOVERNMENT & MEDICINE

Medicare law aims to bring Alaska physicians in from the cold

The reform package adds millions of dollars to help stabilize Medicare access for seniors in the state.

By Markian Hawryluk, *AMNews staff.* Jan. 19, 2004.

Washington -- Dwight Smith, MD, a family physician in Anchorage, Alaska, has a patient who can come to see him only in the winter. That's when the rivers are frozen over.

The elderly patient spends a full day traveling by snowmobile to get to his car, then drives four hours to see Dr. Smith. Other doctors are closer, but they don't take Medicare.

With this article
- Heavy patient load
- See related content
- Topic: Medicare

"We're in a health care crisis," Dr. Smith said. "And Alaska is the canary in the coal mine."

Now help for Alaska's physicians and their patients is on the way. The Medicare reform bill signed into law last month includes a payment

payment
▫ Regional news: West

boost for Alaska doctors and reforms to help rural physicians nationwide. But Dr. Smith and other Alaska physicians wonder if it's too little, too late.

Like everything in Alaska, the state's Medicare access woes are a lot bigger. Only two facilities still take new Medicare patients in Anchorage, which is home to about half of the state's population. One is the community health center, and the other is the state's only family practice residency program.

"All the other providers either left town because they went bankrupt or couldn't make it financially with Medicare, or they got out of Medicare and take only private insurance and private-pay patients," Dr. Smith said.

2003 Medicare payments in Alaska covered 37% of physicians' costs.

Even the residency program limits the number of new Medicare patients it takes every month. "We're still booked into December [2004]," Dr. Smith said.

Outside of Anchorage, the situation is even worse.

"If you're in a small town such as Toke or Glenallen where you've only got one doc, they've got nobody else to go to, so you cannot turn anybody away whether they have Medicare, Medicaid or no insurance," he said. "Docs are struggling to survive because they cannot make it with their patient care mix."

Alaska has long ranked among the worst states in terms of physician supply. In 2002, the state had fewer than 1,350 doctors in private practice and another few hundred in the military or other government posts. The state has a population of 644,000, including 47,000 Medicare beneficiaries. Only six states had a lower doctor-to-patient ratio.

"We start from a situation where we have one of the lowest numbers of physicians per capita, and that has caused some pretty extensive and severe access problems for Medicare beneficiaries," said Jim Jordan, executive director of the Alaska State Medical Assn. "And there are specific shortages in some of the specialty areas that would tend to be types of docs seeing Medicare patients."

General internists are particularly in short supply. Part of the problem, Jordan said, is that Alaska has few options for training new doctors. The state has no medical school and only one residency program. Alaska sends 10 students a year to the University of Washington School of Medicine under a loan program and graduates another eight from the residency program.

In 2002,

"That's nowhere near dealing with the work-force situation," Jordan said. Because more

Medicare beneficiaries out of a population of 644,000.

rates up to at least the national average for all physicians. But Alaska's doctors were already paid above the average and would not benefit from that provision.

At the Alaska congressional delegation's insistence, the Medicare reform bill included $53 million for Alaskan physicians over the next two years. on top of $8 million in additional spending resulting from the elimination of a nationwide 4.5% cut scheduled for 2004. And Alaska's physicians will be able to make use of a 5% bonus payment available to areas in the bottom 20% in terms of physician supply.

Dr. Smith said the payments would help offset some of the added costs doctors incur by practicing in Alaska. But he doesn't think it's enough.

"All increasing the reimbursement for Alaska is going to do is slow the diuresis of physicians opting out of Medicare," he said. "All we're trying to do is put a plug in the dike, and it's not going to last very long."

Back to top.

ADDITIONAL INFORMATION:

Heavy patient load

Alaska's Medicare access problems are caused partly by a general physician shortage. Only six states had more people per non-federally employed physician than Alaska in 2002.

	Population per physician
Idaho	544
Oklahoma	540
Mississippi	529
Nevada	507
Wyoming	495
Iowa	490
Alaska	478

Source: American Medical Association

Back to top.

RELATED CONTENT *You may also be interested in reading:*

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1 of 1 DOCUMENT

JULIE KORMAN, Appellant, v. ROBERT E. MALLIN, Appellee.

No. 4002, Supreme Court File No. S-4976

SUPREME COURT OF ALASKA

858 P.2d 1145; 1993 Alas. LEXIS 90; 28 A.L.R.5th 845

September 3, 1993, Decided

PRIOR HISTORY: [**1]

Superior Court File No. 3AN-90-3486 Civil. Appeal from the Superior Court of the State of Alaska, Third Judicial District, Anchorage, Karen L. Hunt, Judge.

DISPOSITION:

REVERSED and REMANDED.

CASE SUMMARY:

PROCEDURAL POSTURE: Appellant patient challenged the grant of summary judgment by the Superior Court of the State of Alaska, Third Judicial District, in favor of appellee doctor in a medical malpractice action. The patient alleged that the doctor failed to establish, as a matter of law, that he adequately disclosed the risk of painful and unsightly scarring before the patient consented to elective breast reduction surgery.

OVERVIEW: When the patient consulted the doctor about a breast reduction operation, she was shown two videotapes that discussed the scarring that might be expected to occur, and the doctor informed her about some of the risks of the procedure and gave her pamphlets to read. The patient brought this action alleging medical negligence and lack of informed consent after her surgery resulted in broad, wide, and painful scars. The court reversed the grant of summary judgment by the superior court, holding that the scope of disclosure required under *Alaska Stat. § 09.55.556(a)* had to be measured by what a reasonable patient would need to know in order to make an informed and intelligent decision about the proposed treatment. The record did not show that the doctor explained to the patient in lay terms the nature and severity of the risk and the likelihood of its occurrence. Because the patient requested further information about scarring at the second consultation and the doctor did not explain the increased risk of such scarring attributable to the patient's smoking, the court was unable to conclude that the doctor's explanation of the risks satisfied his duty of disclosure as a matter of law.

OUTCOME: The court reversed, concluding that the superior court erred in granting summary judgment for the doctor on the record presented in this medical malpractice action, and remanded for further proceedings.

LexisNexis (TM) HEADNOTES - Core Concepts:

Civil Procedure > Summary Judgment > Summary Judgment Standard

[HN1] In reviewing a grant of summary judgment, the court will independently determine whether there were any genuine issues of material fact and whether the moving party is entitled to judgment as a matter of law. The court must draw all reasonable inferences in favor of the nonmoving party and against the movant.

Torts > Malpractice Liability > Healthcare Providers
[HN2] *Alaska Stat. § 09.55.556(a)* provides that a physician is liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of the common risks and reasonable alternatives to the proposed treatment or procedure, and that but for that failure the claimant would not have consented to the proposed treatment or procedure.

Torts > Malpractice Liability > Healthcare Providers
[HN3] The scope of disclosure required under *Alaska Stat. § 09.55.556(a)* must be measured by what a reasonable patient would need to know in order to make an informed and intelligent decision about the proposed treatment. Under the reasonable patient rule, a physician must disclose those risks which are "material" to a reasonable patient's decision concerning treatment. The determination of materiality is a two-step process. The first step is to define the existence and nature of the risk and the likelihood of its occurrence. "Some" expert testimony is necessary to establish this aspect of materiality because only a physician or other qualified expert is capable of judging what risk exists and the likelihood of its occurrence. The second prong of the materiality test is for the trier of fact to decide whether the probability of that type of harm is a risk which a reasonable patient would consider in deciding on treatment. The focus is on whether a reasonable person in the patient's position would attach significance to the specific risk. This determination does not require expert testimony.

Torts > Malpractice Liability > Healthcare Providers
[HN4] Merely identifying a risk does not necessarily provide a patient with the information necessary for an informed decision. A physician must not only disclose the identity of all known material risks, but also the likelihood of their occurrence in meaningful terms.

Civil Procedure > Summary Judgment > Summary Judgment StandardTorts > Malpractice Liability > Healthcare Providers
[HN5] For a trial court to decide on summary judgment that a doctor has disclosed sufficient information to allow a reasonable patient to make an informed decision about treatment, the record must establish that the physician explained to the patient in lay terms the nature and severity of the risk and the likelihood of its occurrence.

Civil Procedure > Jury Trials > Province of Court & Jury
[HN6] Whenever nondisclosure of particular risk information is open to debate by reasonable-minded men, the issue is for the finder of facts.

COUNSEL:

Charles W. Ray, Jr., Anchorage, for Appellant.

Sanford M. Gibbs, Hagans, Brown, Gibbs & Moran, Anchorage, for Appellee.

JUDGES: Before: Moore, Chief Justice, Rabinowitz, Matthews, and Compton, Justices. [Burke, Justice, not participating].

OPINIONBY: MOORE, Chief Justice.

OPINION:

[*1146] I. Introduction

In this "informed consent" case, Julie Korman appeals the trial court's grant of summary judgment in favor of Dr. Mallin. Korman maintains that Dr. Mallin failed to establish, as a matter of law, that he adequately disclosed the risk of painful and unsightly scarring before Korman consented to elective breast reduction surgery.

In deciding this case, we address for the first time the scope of disclosure required by the "informed consent" doctrine [**2] under Alaska law. We conclude that a physician must disclose those risks and benefits of a proposed procedure which a reasonable patient would need to know in order to make an informed and intelligent decision. Applying this reasonable patient standard to the case at bar, we conclude that the trial court erred in granting summary judgment [*1147] on the record presented and remand this case for further proceedings.

II. Facts and Proceedings

In April 1988 Julie Korman consulted Dr. Mallin, an Anchorage plastic surgeon, to inquire about a possible breast reduction operation. At this initial visit, Korman viewed two videotapes concerning breast reduction surgery. n1 Dr. Mallin then talked alone with Korman for approximately ten minutes about her needs and conducted a brief physical examination. After the examination, Dr. Mallin discussed the specific procedures with Korman in the presence of his medical assistant, Bari Lasky.

n1 The first videotape, entitled "Realistic Expectations," provides a general overview of the risks and benefits of plastic surgery. The second videotape, entitled "Reduction Mammaplasty," focuses on the breast reduction procedure itself. Both videotapes emphasize that plastic surgery results in permanent scars and that the degree of scarring is unique to each patient.

[**3]

Dr. Mallin's office notes indicate that he told Korman about some of the risks of the procedure at this time.

> Talked about infection, hemorrhage, nipple numbness, scars, possible need for implant to give upper fullness as well as nipple turning black and falling off. . . . Talked about how they heal in a different way, there can be allergies, infections, hemorrhage, numbness, scar capsules they would feel hard but get softer.

Lasky confirms that Dr. Mallin informed Korman of the risks of the procedure, including the risk of permanent scarring. In her deposition, Korman stated that in this discussion Dr. Mallin told her

> about the scarring, about what I could expect; the results . . . and . . . a little bit about insurance.

Dr. Mallin then gave Korman pamphlets on reduction mammaplasty and breast implants to read at home. n2

n2 The pamphlet on breast reduction provides the following information on scarring.

> Although the surgeon makes every effort to keep scars as inconspicuous as possible, reduction mammaplasty scars are extensive and permanent. The patient must be willing to accept the change from large uncomfortable breasts without scars to small comfortable breasts with scars. Scars remain highly visible for a year following surgery, then fade to some degree.

Line drawings indicate the location of the incisions and resulting scars.

[**4]

Korman visited Dr. Mallin's office on May 4 to complete the necessary consent forms. At this time, Dr. Mallin described the proposed surgery and drew a diagram of the operative procedure. While she was reading through the consent form, Korman states that she expressed concern over the risk of scarring and asked Dr. Mallin what she could expect. According to Korman, Dr. Mallin told her that there was no cause for concern.

> His exact words to me were I've done--don't worry about it, I've done hundreds of these. The worst that has ever happened is I had a lady lose one of her nipples; but her breasts were very large. I think that you'll be happy with the results.

In her affidavit, Korman states that Dr. Mallin did not explain to her "that thickened or widened scars[] and extremely painful scars" could occur. She also states that he did not explain to her in this context that her risk of scarring was 50% greater because she was a smoker. However, Korman admits to reading the following paragraph in "Dr. Mallin's Surgery and Procedure Consent Form."

> I am aware that all complications that have been told to me either verbal or written are increased by 50% because I smoke.

Lasky [**5] was also present during this discussion and stated in her affidavit that Dr. Mallin answered Korman's questions regarding her concerns of the risk of surgery and that Korman indicated that she understood the risks and that all of her questions were answered before she consented to the surgery. Wendy Brown, one of Dr. Mallin's office employees, witnessed Korman's execution of the consent forms and stated in her affidavit that Korman indicated that all of her questions regarding surgery were answered to her satisfaction and that [*1148] she understood that no guarantees were given to her concerning the outcome of the surgery.

Korman underwent surgery a few days later. She was very unhappy with the results -- particularly the broad, wide and painful scars.

In April 1990 Korman filed this malpractice action against Dr. Mallin, alleging both medical negligence and lack of informed consent. Pursuant to *AS 09.55.536*, an Expert Advisory Board was appointed to review Korman's medical malpractice claim. In January 1991 the Board rendered its decision, finding that Korman had not been injured by Dr. Mallin's care. The Board did not address Korman's informed consent claim.

Following the Board's decision, [**6] Dr. Mallin moved for summary judgment in May 1991. Korman opposed this motion. After oral argument, Judge Hunt granted Dr. Mallin's motion, commenting that reasonable minds "could not differ [in concluding] . . . that under the facts of this case [Korman] did give an informed consent, because she was advised of the scarring risk." This appeal followed.

III. Discussion

A. Standard of Review

[HN1] In reviewing a grant of summary judgment, we will independently determine whether there were any genuine issues of material fact and whether the moving party is entitled to judgment as a matter of law. *Drake v. Hosley, 713 P.2d 1203, 1205 (Alaska 1986).* We must draw all reasonable inferences in favor of the nonmoving party and against the movant. *Swenson Trucking & Excavating, Inc. v. Truckweld Equip. Co., 604 P.2d 1113, 1116 (Alaska 1980).*

B. The Doctrine of Informed Consent

[HN2] *Alaska Statute 09.55.556(a)* provides that a physician is liable for failure to obtain the informed consent of a patient if

> the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of the common [**7] risks and reasonable alternatives to the proposed treatment or procedure, and that but for that failure the claimant would not have consented to the proposed treatment or procedure.

AS 09.55.556(a).

Although *AS 09.55.556(a)* states that a physician must disclose the common risks and reasonable alternatives to a proposed procedure, it does not set forth the standard by which this disclosure should be measured. n3 The legislative history is similarly silent on this issue. This is a question of first impression in Alaska. n4

> n3 Compare *AS 09.55.540(a)(1)* which requires a patient to establish the professional standard of care in the field or speciality as one element of a medical negligence claim.
>
> n4 Prior to the enactment of *AS 09.55.556*, this court specifically declined to reach "the difficult and complex questions . . . regarding the duty and scope of disclosure required by the informed consent doctrine."

> *Poulin v. Zartman, 542 P.2d 251, 275 (Alaska 1975)* (holding that father of infant blinded after oxygen treatment failed to make out a prima facie informed consent claim because he failed to show that he would have declined the procedure if he had known of alternative treatment).

[8]**

Traditionally, a physician's duty to disclose information concerning treatment has been measured by the professional standard in the field. See, e.g., *Potter v. Wisner, 170 Ariz. 331, 823 P.2d 1339, 1341 (Ariz. App. 1991); Jacobs v. Painter, 530 A.2d 231 (Me. 1987).* See generally Laurent B. Fantz, Annotation, Modern Status of Views as to General Measure of Physician's Duty to Inform Patient of Risks of Proposed Treatment, *88 A.L.R.3d 1008, 1020-27 (1978).* This rule reflects the belief that holding a physician to a lay standard of disclosure would interfere with the flexibility a physician must have in determining what therapy would best suit the patient's needs. See *Ross v. Hodges, 234 So. 2d 905, 908-09 (Miss. 1970).* In order to establish a prima facie case, a plaintiff must usually present expert testimony of the professional standard of disclosure in the community and of the physician's failure to meet that standard. See *Culbertson* **[*1149]** *v. Mernitz, 602 N.E.2d 98, 102-04 (Ind. 1992)* (expert testimony of professional standard of disclosure **[**9]** required except where deviation from the standard of care is a matter commonly known to lay persons); see also Daniel E. Feld, Annotation, Necessity and Sufficiency of Expert Evidence to Establish Existence and Extent of Physician's Duty to Inform Patient of Risks of Proposed Treatment, *52 A.L.R.3d 1084, 1091-92 (1973).*

However, the modern trend is to measure the physician's duty of disclosure by what a reasonable patient would need to know in order to make an informed and intelligent decision. The Louisiana Supreme Court has articulated this standard as follows:

> The informed consent doctrine is based on the principle that every human being of adult years and sound mind has a right to determine what shall be done to his or her own body. Surgeons and other doctors are thus required to provide their patients with sufficient information to permit the patient to make an informed and intelligent decision on whether to submit to a proposed course of treatment. Where circumstances permit, the patient should be told the nature of the pertinent ailment or condition, the general nature of the proposed treatment or procedure, the risks involved in the proposed **[**10]** treatment or procedure, the prospects of success, the risks of failing to undergo any treatment or procedure at all, and the risks of any alternate methods of treatment.

Hondroulis v. Schuhmacher, 553 So. 2d 398, 411 (La. 1989) (citations omitted). See generally Fantz, supra, at 1034-43. Under this modern view, expert testimony concerning the professional standard of disclosure is not a necessary element of the plaintiff's case because the scope of disclosure is measured from the standpoint of the patient.

Our recent comments on the nature of the physician-patient relationship echo the concerns outlined by the Hondroulis court.

> The physician-patient relationship is one of trust. Because the patient lacks the physician's expertise, the patient must rely on the physician for virtually all information about the patient's treatment and health. A physician therefore undertakes, not only to treat a patient physically, but also to respond fully to a patient's inquiry about his treatment, i.e., to tell the patient everything that a reasonable person would want to know about the treatment.

Pedersen v. Zielski, 822 P.2d 903, 909 (Alaska 1991) **[**11]** (citations omitted). We are persuaded that the modern view is the better rule and hold that [HN3] the scope of disclosure required under *AS 09.55.556(a)* must be measured by what a reasonable patient would need to know in order to make an informed and intelligent decision about the proposed treatment.

Under the reasonable patient rule, a physician must disclose those risks which are "material" to a reasonable patient's decision concerning treatment. See *Hondroulis, 553 So. 2d at 411; Canterbury v. Spence, 150 U.S. App. D.C. 263, 464 F.2d 772 (D.C. Cir. 1972),* cert. denied, *409 U.S. 1064, 34 L. Ed. 2d 518, 93 S. Ct. 560 (1972).*

> The determination of materiality is a two-step process. The first step is to define the existence and nature of the risk and the likelihood of its occurrence. "Some" expert testimony is necessary to establish this aspect of materiality because only a physician or other qualified expert is capable of judging what risk

> exists and the likelihood of its occurrence. The second prong of the materiality test is for the trier of fact to decide whether the probability of that type of harm is a risk which a reasonable patient would consider **[**12]** in deciding on treatment. The focus is on whether a reasonable person in the patient's position would attach significance to the specific risk. This determination does not require expert testimony.

Hondroulis, 553 So. 2d at 412.

We also note that, in certain circumstances, a physician's failure to disclose a risk may be privileged.

> **[*1150]** The physician retains a qualified privilege to withhold information on therapeutic grounds, as in those cases where a complete and candid disclosure of possible alternatives and consequences might have a detrimental effect on the physical or psychological well-being of the patient, or where the patient is incapable of giving his consent by reason of mental disability or infancy, or has specifically requested that he not be told. Likewise the physician's duty to disclose is suspended where an emergency of such gravity and urgency exists that it is impractical to obtain the patient's consent. Finally disclosure is not required where the risk is either known to the patient or is so obvious as to justify presumption of such knowledge, nor is the physician under a duty to discuss the relatively remote risks inherent in **[**13]** common procedures, when it is common knowledge that such risks inherent in the procedure are of very low incidence. Conversely, where the physician does not know of a risk and should not have been aware of it in the exercise of ordinary care, he is under no obligation to make disclosure.

Sard v. Hardy, 281 Md. 432, 379 A.2d 1014, 1022-23 (Md. 1977); Canterbury, 464 F.2d at 788-79; see generally Alan Meisel, The "Exceptions" to the Informed Consent Doctrine: Striking a Balance between Competing Values in Medical Decisionmaking, *1979 Wis. L. Rev. 413.* As noted by the courts which have examined this issue, the burden of going forward with evidence pertaining to a privilege rests on the physician in whose hands the necessary evidence ordinarily rests. See *Hondroulis, 553 So. 2d at 413; Canterbury, 464 F.2d at 791.*

C. The Adequacy of Dr. Mallin's Disclosure

After deciding which legal standard to apply, the issue becomes whether the information Dr. Mallin provid[illegible] Korman satisfies this standard as a matter of law. Although Korman maintains **[**14]** that a patient would have "no inkling" that painful and unsightly scarring is a normal consequence of uncomplicated breast reduction surgery after reviewing the pamphlets, videos and consent forms provided by Dr. Mallin, we cannot agree. Dr. Mallin's office notes indicate he discussed scarring at both visits. Both the videos and pamphlets provided by Dr. Mallin emphasize that breast reduction surgery resulted in permanent scars. Finally the consent forms signed by Korman specifically refer to the risk of "unsightly and painful scarring." The trial court concluded that the information Dr. Mallin provided Korman clearly advised her of the scarring risk and therefore granted Dr. Mallin's motion for summary judgment.

Nonetheless, [HN4] merely identifying a risk does not necessarily provide a patient with the information necessary for an informed decision. n5 [HN5] For a trial court to decide on summary judgment that a doctor has disclosed sufficent information to allow a reasonable patient to make an informed decision about treatment, the record must establish that the physician explained to the patient in lay terms the nature and severity of the risk and the likelihood of its occurrence. See *Hondroulis, 553 So. 2d at 420.* **[**15]**

> n5 It is meaningless to tell a patient that a given risk is increased by 50% unless the patient is also told the original or baseline risk factor. For example, assuming the risk of unsightly scarring for nonsmokers is 2%, the risk for a smo[illegible]r rises to 3%. However, if the risk factor for nonsmokers is 20%, the risk for a smoker rises to 30%, a very significant increase. A physician must not only disclose the identity of all known material risks, but also the likelihood of their occurrence in meaningful terms. See *Hondroulis, 553 So. 2d at 420.*

After reviewing the record on appeal, we are unable to conclude that Dr. Mallin's explanation of the risks inherent in this procedure satisfied his duty of disclosure as a matter of law. In her affidavit, Korman states that she requested additional information about the scarring at the second consultation and that, in response, Dr. Mallin told her "not to worry" and that she would be happy with the results. A number of courts have held that a **[**16]** patient's request for more detailed information regarding a risk is a factor in determining whether there has been adequate disclosure. **[*1151]** See *Distefano v. Bell, 544 So. 2d 567, 571 (La. App. 1989)* (holding that physician's duty of disclosure was

"expanded" when patient requested physician to explain the "least likely" complications of proposed surgery), writ denied, *550 So. 2d 650 (La. 1989);* see also *Kinikin v. Heupel, 305 N.W.2d 589, 595 (Minn. 1981)* (holding that where a doctor is aware or should be aware that a patient attaches particular significance to a risk, further disclosure may be required even under the professional community standard). Our own comments in Pedersen emphasize a physician's duty to respond fully to a patient's questions concerning treatment. *822 P.2d at 909.*

Furthermore, although it is undisputed that Korman read that portion of the consent form which states that all risks of the procedure were increased by 50% because she smoked, this information has little meaning in the absence of a base probability figure establishing the average **[**17]** risk to an average patient. The record does not indicate that Dr. Mallin disclosed to Korman the probability that painful and unsightly scarring would occur in her case or explained the increased risk of such scarring attributable to smoking. Cf. *Barner v. Gorman, 605 So. 2d 805, 806 (Miss. 1992)* (where plaintiff, who underwent plastic surgery to minimize prominent neck scar, alleged that the surgeon had failed to disclose to her the risk of more severe scarring inherent in that procedure despite the fact that the risk of such recurrence was greater in a patient with her skin coloring); see also *Nisenholtz v. Mount Sinai Hosp., 126 Misc. 2d 658, 483 N.Y.S.2d 568, 570 (N.Y. Sup. 1984)* (holding that physician has a duty to provide a "reasonable explanation" of potential risks and available alternatives under New York informed consent statute).

There is no question that an individual contemplating elective cosmetic surgery will attach particular significance to the risk of "unsightly and painful" scarring. Although Dr. Mallin certainly provided Korman with a significant amount of information concerning the proposed procedure and its attendant **[**18]** risks, we cannot say that he satisfied his duty of disclosure as a matter of law in light of the above circumstances. [HN6] "Whenever nondisclosure of particular risk information is open to debate by reasonable-minded men, the issue is for the finder of facts." *Canterbury, 464 F.2d at 788* (footnote omitted). We conclude that it is a factual question whether Dr. Mallin's explanation of the scarring risk was adequate to allow a reasonable patient to make an informed and intelligent decision whether to undergo the procedure.

IV. Conclusion

We conclude that a physician must provide a patient with a reasonable explanation of the material risks of a proposed procedure so that the patient can make an informed decision concerning treatment. Taking the record in the light most favorable to Korman, we cannot conclude that Dr. Mallin discharged this duty as a matter of law. We therefore reverse the trial court's entry of summary judgment in favor of Dr. Mallin and remand for jury consideration of this issue.

REVERSED and REMANDED.

Alaska State Medical Association

Statement
to the

State of Alaska
House of Representatives
Judiciary Committee

By:

James Jordan, Executive Director
Alaska State Medical Association

February 25, 2004

Madam Chair McGuire, House Judiciary Committee Members, I am Jim Jordan, Executive Director for the Alaska State Medical Association, and will be testifying in that capacity today.

However, by way of disclosure, I also serve on the Board of Directors for the Medical Underwriters of California, which is the "attorney in fact", which is the operating company for the Medical Insurance Exchange of California (MIEC), one of the two remaining providers of medical liability insurance coverage for physicians in Alaska. You will receive testimony from an executive representing MIEC.

With the Chair's indulgence, I would like to tell you a short story about medical care in Alaska. This story is about a patient who had a routine physical last summer done by a general internist in Anchorage. That doctor, during the course of the examination discovered a suspicious tumor in the patient's lower GI tract. A hastily arranged colonoscopy, along with a biopsy, confirmed a very rare cancerous tumor – and one that is normally without symptoms. As a matter of fact, this type of cancer is typically not discovered until it has spread to the brain, heart and/or lungs. The good news is that it was caught at a very early stage by a skilled doctor and was successfully treated by surgical removal. So, you may wonder why I am relating this story to you that has a happy ending.

For one reason, this story is very personal. The patient referred to is my wife. For another, it highlights the need in Alaska for well trained physicians in sufficient numbers to provide the care that our citizens need and deserve.

The general internist who saw my wife is Dr. Richard Neubauer, who happens to be about my age as well as my own personal physician. Dr. Neubauer graduated from Yale Medical School and did graduate medical education at the University of Michigan. As I previously mentioned, he is a general internist. General internists are in very short supply in Alaska. A Fall 2002 Providence study shows a shortage of 43.25 full time experienced general internists in Anchorage alone. I believe you will hear testimony that the number of general internists continues to drop. Those remaining are overtaxed in their practices, in their emergency room call and coverage schedules, and, in some cases, have simply left the state to pursue a practice that allows them to have a family life.

What would have happened had Dr. Neubauer not been around for my wife? Or for that fact, the surgeon, Dr. June George, who is one of only two board certified colo/rectal surgeons in the entire state? Perhaps a general surgeon could have treated her, but that same Providence study also shows a deficiency in Anchorage alone of 19.8 full time equivalent general surgeons. The shortages are real. Dr. Neubauer and I, being contemporaries, often muse, "Who will be around to care for us?"

HB 472 is an important element necessary to create the practice environment that will help us recruit the doctors we need in Alaska.

Now I will turn the testimony over to Dr. Alex Malter, and I will be happy to respond to any questions that you might have.

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

TO: Honorable Lesil McGuire # Pages 11

FROM: James Jordan, Executive Director

DATE: 2/27/04 To Fax # 907-465-6592

SUBJECT: Information Requested at HB 472 Hearing

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

February 27, 2004

Honorable Lesil McGuire
State Capitol, Room 118
Chair, House Judiciary Committee
Juneau, AK 99801-1182

Transmitted by Fax:
907-465-6592

Re: Information Requested at the 2/25/04 Hearing - HB 472

Dear Representative McGuire:

There were several requests for more information by two House Judiciary Committee members – Representative Ogg and Representative Gruenberg.

Representative Ogg requested that the number of physicians in Alaska from 1995 to the present be provided. Attached is that data, which came from ASMA's database, and is published in its Medical Directory. This data shows the number by location and by type of practice as well.

Representative Gruenberg asked ASMA to share with the Committee what ASMA had suggested to the Administration regarding an idea to help in recruiting new doctors to Alaska. This idea was presented to Joel Gilbertson, Commissioner of the Department of Health and Social Services. The suggestion was to have multi-departmental involvement – DHSS from the public health interest and Department of Community and Economic Development. The concept would be to use the already developed tourism promotional programs to highlight Alaska and what it has to offer. The connection is the "lifestyle" recruitment. Those of us living in Alaska also are tourists. The concept is to have a booth at select specialty societys' annual, national meetings. The national specialties targeted would obviously be ones that represent specialists in critical, short supply in Alaska. The physician community would partner by having a practicing, Alaska doctor at the booth to answer practice environment questions. (The critical shortage specialties could be identified by a joint effort of ASMA, the State Medical Board, DHSS, and perhaps also the Alaska State Hospital and Nursing Home Association).

I have spoken with the executive director of one of the national specialty societies (neurology) about such an effort at one of its national meetings. The concept met with a favorable response.

Please let me know if I may be of further assistance.

Sincerely,

James J. Jordan
Executive Director

PHYSICIAN DISTRIBUTION IN ALASKA

As of January 31, 1996

Town	Private Practice	Public Health	Military	Municipal State & Fed.	TOTAL
Adak			2		2
Anchor Point	1				1
Anchorage	446	56	59	29	590
Barrow		6			6
Bethel	17	2			19
Chugiak	1				1
Cordova	2				2
Delta Junction	2				2
Dillingham	10				10
Eagle River	9				9
Fairbanks/North Pole	125		40	1	166
Girdwood	2				2
Glennallen	2				2
Golovin	1				1
Haines	2				2
Homer	7				7
Juneau/Auke Bay	44	3		1	48
Kenai	4				4
Ketchikan	20	4			24
Kodiak	13	3			16
Kotzebue	5				5
Mellaktla	2				2
Naknek	1				1
Nome	8	1			9
Palmer	24				24
Petersburg	3				3
Seldovia	1				1
Seward	3				3
Sitka	11	14	1		26
Soldotna	28				28
Talkeetna	2				2
Valdez	4				4
Wasilla	25				25
Wrangell	1				1
TOTAL	826	89	102	31	1048

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 31, 1996

Town	Private Practice	Public Health	Military	Municipal State & Fed.	TOTAL
Adak			2		2
Anchor Point	1				1
Anchorage	493	52	68	33	646
Barrow	4	5			9
Bethel	22	2			24
Chugiak	1				1
Cordova	3				3
Delta Junction	2				2
Dillingham	9				9
Eagle River	10				10
Fairbanks/North Pole	122	2	38	1	163
Girdwood	2				2
Glennallen	2				2
Golovin	1				1
Haines	2				2
Homer	9				9
Juneau/Auke Bay	46	2		1	49
Kenai	4				4
Ketchikan	29	8			37
Kodiak	17	2			19
Kotzebue	9				9
Metlaktla	2				2
Naknek	1				1
Nome	8				8
Palmer	21				21
Petersburg	3				3
Seldovia	1				1
Seward	2				2
Sitka	18	12			30
Soldotna	32				32
Talkeetna	1				1
Valdez	4				4
Wasilla	24				24
Wrangell	3				3
TOTAL	908	85	108	35	1136

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 31, 1997

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Adak			1		1
Anchorage	520	43	62	32	657
Barrow	2	1			3
Bethel	21	2			23
Chugiak	1				1
Craig	1				1
Cordova	2				2
Delta Junction	2				2
Dillingham	10				10
Eagle River	10				10
Fairbanks/North Pole	129		31	1	161
Girdwood	1				1
Glennallen	2				2
Golovin	1				1
Haines	2				2
Homer	10				10
Juneau/Auke Bay	50	3		1	54
Kenai	4				4
Ketchikan	25	5			30
Kodiak	17	1		1	19
Kotzebue	8				8
Metlaktla	1				1
Naknek	1				1
Nome	9				9
Palmer	26				26
Petersburg	3				3
Seldovia	1				1
Seward	1				1
Sitka	17	12			29
Soldotna	33				33
Talkeetna	1				1
Valdez	4				4
Wasilla	26				26
Wrangell	4				4
TOTAL	**945**	**67**	**94**	**35**	**1141**

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 31, 1998

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Anchorage	531	36	54	34	655
Barrow	4	1			5
Bethel	25	3			28
Chugiak	1				1
Cordova	3				3
Delta Junction	2				2
Dillingham	11				11
Eagle River	10				10
Fairbanks/North Pole	133		40	1	174
Girdwood	1				1
Glennallen	1				1
Golovin	1				1
Haines	2				2
Homer	10				10
Juneau/Auke Bay	56	3		1	60
Kenai	4				4
Ketchikan	25	3			28
Kodiak	17	1			18
Kotzebue	7				7
Metlaktla	1				1
Naknek	1				1
Nome	9				9
Palmer	29				29
Petersburg	4				4
Seldovia	1				1
Seward	4				4
Sitka	19	10			29
Soldotna	33				33
Talkeetna	1				1
Valdez	4				4
Wasilla	23				23
Wrangell	4				4
TOTAL	977	57	94	36	1164

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 31, 1999

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Anchorage	564	38	78	38	718
Barrow	5				5
Bethel	19	2			21
Cordova	2				2
Delta Jct/Dot Lake	2				2
Dillingham	11				11
Eagle River	9				9
Fairbanks/North Pole	132		41	1	174
Fort Yukon	1				1
Glennallen	1				1
Golovin	1				1
Haines	3				3
Homer	12				12
Juneau/Douglas	56	2		1	59
Kenai	5				5
Ketchikan	27	5			32
Kodiak	17	4			21
Kotzebue	7				7
Metlaktla	2				2
Naknek	1				1
Nome	13				13
Palmer	28				28
Petersburg	5				5
Seldovia	1				1
Seward	4				4
Sitka	19	11			30
Soldotna	38				38
Talkeetna	1				1
Tok	1				1
Valdez	4				4
Wasilla	30				30
Wrangell	3				3
TOTAL	**1024**	**62**	**119**	**40**	**1245**

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 20, 2000

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Anchorage/Chuglak	566	38	73	38	715
Barrow	6				6
Bethel	20	3			23
Cordova	2				2
Delta Jct/Dot Lake	2				2
Dillingham	9				9
Eagle River	12				12
Fairbanks/North Pole	131		37		168
Fort Yukon	1				1
Glennallen	2				2
Golovin	1				1
Haines	3				3
Homer	14				14
Juneau/Douglas	59	2			61
Kenai	4				4
Ketchikan/Klawock	28	3			31
Kodiak	19	4			23
Kotzebue	5				5
Metlaktla	2				2
Naknek	1				1
Nome	13				13
Palmer	31				31
Petersburg	5				5
Saldovia	1				1
Seward	4				4
Sitka	18	11			29
Soldotna	38				38
Talkeetna	1				1
Tok	1				1
Valdez	4				4
Wasilla	30				30
Wrangell	3				3
TOTAL	1036	61	110	38	1246

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 20, 2001

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Anchorage/Chugiak	595	34	70	35	734
Barrow	5				5
Bethel	21	3			24
Cordova	3				3
Delta Junction	1				1
Dillingham	9				9
Eagle River	12				12
Fairbanks/North Pole	134		37		171
Fort Yukon	1				1
Glennallen	2				2
Golovin	1				1
Haines	3				3
Homer	14				14
Juneau/Auke Bay	66	2			68
Kenai	7				7
Ketchikan/Klawock	33	3			36
Kodiak	19	4			23
Kotzebue	10				10
Metlaktla	1				1
Naknek	1				1
Nome	11				11
Palmer	28				28
Petersburg	5				5
Seldovia	1				1
Seward	3				3
Sitka	17	11			28
Soldotna	36				36
Talkeetna	1				1
Tok	1				1
Valdez	3				3
Wasilla	34				34
Wrangell	2				2
TOTAL	**1080**	**57**	**107**	**35**	**1279**

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 4, 2002

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Anchorage/Girdwood	630	36	68	27	761
Barrow	3				3
Bethel	19	2			21
Cordova	2				2
Delta Junction	1				1
Dillingham	8				8
Eagle River	11				11
Fairbanks/North Pole	130		36		166
Fort Yukon	1				1
Glennallen	2				2
Golovin	1				1
Haines	3				3
Homer	15				15
Juneau/Auke Bay	69	2			71
Kenai	7			1	8
Ketchikan/Klawock	30	3			33
Kodiak	20	4			24
Kotzebue	9				10
Metlaktla	1				1
Naknek	1				1
Nome	11				11
Palmor	26				6
Petersburg	5				5
Seldovia	1				1
Seward	5				5
Sitka	19	11			30
Soldotna	38				38
Talkeetna	1				1
Tok	1				1
Valdez	4				4
Wasilla	38				38
Wrangell	3				3
TOTAL	**1115**	**59**	**104**	**28**	**1306**

Source: Mock-up For 2004 Medical Directory
Alaska State Medical Association

Done

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 4, ~~2002~~ 2003

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Anchorage/Girdwood	~~630~~ 675	~~36~~ 37	~~68~~ 61	~~27~~ 24	~~761~~ 797
Barrow	~~8~~ 5				~~8~~ 5
Bethel	~~19~~ 18	2			~~21~~ 20
Cordova	2				2
Delta Junction	1				1
Dillingham	~~8~~ 9				~~8~~ 9
Eagle River	~~11~~ 12				~~11~~ 12
Fairbanks/North Pole	~~130~~ 131		38 34	1	166
Fort Yukon	1				1
Glennallen	~~2~~ 3				~~2~~ 3
Golovin	1				1
Haines	~~3~~ 2				~~3~~ 2
Homer	~~15~~ 18				~~15~~ 18
Juneau/Auke Bay	~~69~~ 63	2			~~71~~ 70
Kenai	~~7~~ 6			1	~~8~~ 7
Ketchikan/Klawock	30	3			33
Kodiak	~~20~~ 15	4			~~24~~ 19
Kotzebue	~~8~~ 10				10
~~Metlaktla~~	~~1~~				~~1~~
Naknek	1				1
Nome	~~11~~ 10				~~11~~ 10
Palmer	~~26~~ 25				~~28~~ 25
Petersburg	~~5~~ 6				~~5~~ 6
Seldovia	1				1
Seward	~~5~~ 6				~~5~~ 6
Sitka	19	11			30
Soldotna	~~38~~ 39				~~38~~ 39
Talkeetna	1				1
Tok	1				1
Valdez	~~4~~ 3				~~4~~ 3
Wasilla	~~38~~ 41				~~38~~ 41
Wrangell	~~3~~ 4				~~3~~ 4
TOTAL	~~1115~~ 1164	59 ✓	~~104~~ 95 254	~~28~~ 26	~~1306~~ 1344

NORCAL Mutual Insurance Company

Legal Department

560 Davis Street, 2nd Floor • San Francisco, California 94111
(415) 397-9700 • (800) 652-1051 • Facsimile (415) 835-9819 • www.norcalmutual.com

February 20, 2004

Representative Tom Anderson
Alaska State House of Representatives
Alaska State Capitol, Room 432
Juneau, AK 99801

Re: AB472 Letter of Support

Dear Representative Anderson:

NORCAL Mutual Insurance Company, a physician owned and managed insurer providing medical liability insurance to approximately one-half of the practicing physicians in Alaska, supports AB472 because this legislation will make health care more readily available to the citizens of Alaska.

NORCAL, as the successor to MICA, has provided medical liability insurance to hundreds of Alaska physicians since 1991. During that time, there have been several efforts to reform the tort law in Alaska to bring Alaska law into parity with other states. Unfortunately, these efforts have not had the desired effect. HB472 is necessary to accomplish where other efforts have failed.

Today, Alaska finds itself as one of the costliest states for physicians. A major cost for Alaska physicians is medical liability insurance. Alaska physicians pay on average $30,627 per year, which is the eighth highest average cost in the county. By comparison, California physicians pay $14,564 per year on average. This means Alaska physicians pay 110% more on average each year than California physicians.

Alaska's expensive medical liability premiums are the result of high jury awards and settlements. The average medical liability payment in Alaska during 2001 was $308,476. This means Alaska payments are the fourteenth highest in the country. California payments by comparison averaged $178,499. This means Alaska payments were 72% higher than California.

Over the years, Alaska has experienced some of the most dramatic increases in the cost of medical liability in the country. According to the National Association of Insurance Commissioners (NAIC), Alaska premiums have increased by 1593.47% between 1976 and 2001.

Only seven states have seen a higher rate of increase. By comparison, California medical liability premiums have only increased by 182.16% during the comparable period.

Numerous studies have been done to determine why some states have experienced higher premiums, larger awards, and more dramatic year-to-year increases in cost than other states. These studies have uniformly found that medical liability reform is the single most important factor controlling medical liability premiums and losses. California's Medical Injury Compensation Reform Act (MICRA) has been identified as the most successful effort to control medical liability costs. MICRA's $250,000 cap on non-economic damages is the keystone of this legislation. We believe the $250,000 cap on non-economic damages contained in HR472 will go a long way toward bringing the cost of Alaska's medical liability insurance into line with national averages.

For these reasons, Alaska physicians and their patients will benefit through enactment of this legislation.

Very truly yours,

Philip R. Hinderberger
Senior Vice President and General Counsel
NORCAL Mutual Insurance Company

PRH/cm

cc: Steven S. Fountain, M.D.
Ronald Keller, M.D.
Jim Jordan, ASMA
Mike Hogan, APNS

February 23, 2004

Representative Lesil McGuire
Chair, House Judiciary

Re: **Support for HB 472**

Dear Representative McGuire,

I am writing as a healthcare provider in **support of HB 472**, relating to medical malpractice claims for personal injury and wrongful death.

While the focus of Section 1(a) is physicians, Advanced Nurse Practitioners in Alaska are experiencing skyrocketing liability insurance rates as well. Advanced Nurse Practitioners have been advised by our underwriters to expect a 75% increase in our rates this year alone. Certified Nurse Midwives now typically pay about $20,000 per year for malpractice insurance. These increased costs are ultimately passed on to patients, which decrease access to care for those with limited resources.

HB 472, which will limit non-economic damages in malpractice lawsuits to $250.000, will be very helpful in curbing the escalating cost of healthcare.

Respectfully,

Cathy Giessel

Cathy Giessel, MS, FNP-CS
12701 Ridgewood Rd
Anchorage, AK 99516
907 345 5470
cgiessel@mac.com

Alaska Board of Nursing
Alaska Nurse Practitioner Association Legislative Affairs Representative
American Academy of Nurse Practitioners, State Representative
Anchorage Health and Human Services Commission

Providence | Health System

3200 Providence Drive
P.O. Box 196604
Anchorage, Alaska
99519-6604

Tel 907.562.2211

February 20, 2004

The Honorable Lesil McGuire
Chair, House Judiciary Committee
Alaska State House of Representatives
State Capitol, Room 118
Juneau, AK 99801-1182

Dear Representative McGuire:

I understand that the House Judiciary Committee is holding a hearing on House Bill No. 472, relating to claims for personal injury or wrongful death against health care providers. Unfortunately, I will be traveling out of state on the day of the hearing, but I wish to add my voice in support of this important piece of legislation.

Providence Health System is in a unique position to experience first-hand the affects of the many critical issues facing Alaska's health care delivery system. Dramatic increases in awards for pain and suffering and other non-economic damages have led to significant increases in physicians' medical malpractice insurance rates and the loss of carriers willing to write medical malpractice insurance in Alaska. As I'm sure you are hearing from physicians and patients alike, some physicians are curtailing the kinds of care they provide and some are getting out of the business entirely as a result.

A physician needs assessment for the Anchorage community conducted by Providence Health System in the fall of 2002, revealed that based upon national physician benchmarks, Anchorage had 153 physicians less than the national average. This same assessment showed that by 2008, Anchorage falls close to 180 physicians below the national average. Providence has employed an aggressive physician recruitment strategy in an effort to bring Anchorage in line with the national physician benchmarks. One of the things we've learned in our recruitment efforts is that a reasonable limit on non-economic damages in medical malpractice cases, such as is called for in HB 472, is a key element in achieving positive results in recruitment efforts.

The passage of this legislation will go a long way toward helping create a better economic environment for physician practices, thus decreasing the physician shortage. I encourage members of the Alaska Legislature to vote for this bill's passage.

Sincerely,

E. Al Parrish
CE/VP, Alaska Region
Providence Health System

Gary L. Livengood
PO Box 10377
Fairbanks, Alaska 99710

March 1, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill number 472- Medical TORT Bill

Dear Representative Anderson:

I am writing to encourage your support of House Bill 472. I feel it is important to put a cap on awards issued in frivolous lawsuits. The costs for physicians and health care facilities keep going up. This increases the cost of health care. Also, Physicians have limited, or quit, their practices because of insurance costs.

Thank you for your time.

Sincerely,

Gary L Livengood

Gary L. Livengood

cc: Interior Delegation
House HESS Committee

Jane Walsh
1097 Vicki Lane
North Pole, AK 99705

March 1, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

Dear Representative Anderson:

Healthcare costs are at an all-time high. Alaska must join the other 25 states in passing this type of non-economic liability reform. Failure to act on this bill will threaten the quality of healthcare in every community in Alaska.

I urge you to vote in favor of the TORT Bill and enact legislation that will limit non-economic damages.

Thank you for your time and consideration,

Jane Walsh

Cc: Interior Delegation
House Judiciary

Shelby Nelson
340 Snowy Owl Lane
Fairbanks, AK 99701

Phone: 907-455-7112
Email: sdnelson@acsalaska.net

March 1, 2004

Representative Tom Anderson
Room 432
State Capital
Juneau, AK 99801-1182

RE: House Bill No. 472—Medical TORT Bill

Dear Representative Anderson:

Alaska must pass effective liability reform. Patient access to care is suffering and will worsen if the State fails to act. Physicians are being forced to limit services, retire early, or move to other states where liability premiums are more stable—all of which seriously threaten access to quality health care services.

This is a statewide problem that deserves and Alaskan solution. Currently, 25 states have enforceable damage caps. Damage caps are and effective way of stabilizing the liability insurance market by prohibiting excessive damage awards. Excessive awards can result in increased liability insurance premiums for all physicians. A full 72% of Americans favor capping non economic damages in medical liability cases, according t a 2003 Gallup poll.

I urge the senate to pass SB319 and the House to pass HB 472. Your actions now will save a potential crisis in the future.

Sincerely,

Shelby Nelson

Cc: Interior Delegation
House Judiciary

Jon Lundquist
752 Donohue Drive
Fairbanks, AK 99712
March 1, 2003

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT

Dear Representative Anderson:

I support the medical Tort Bill (H.B. No. 472). Due to the escalating costs and exorbitant jury awards, the costs of being a physician are increasing to the point where people are no longer willing to take the risk of becoming a doctor. In order to control these costs and avoid shortages, especially in rural areas, I urge you and your fellow Representatives to pass House Bill No. 472.

Sincerely,

Jon Lundquist

cc: Interior Delegation
House HESS Committee

Charles E. Holyfield
P. O. Box 10789
Fairbanks, Alaska 99710

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

Dear Representative Anderson:

I would like to voice support of HB-472, Medical TORT Reform as a way to continue premium healthcare in Alaska. By capping the potentially huge judgments in professional liability cases, the cost of healthcare can be maintained at a less expensive level for the public, physicians would be more readily available, and more high-risk procedures could be available to those requiring them.

HB 472 does not limit any economic damages, such as, past and future medical expenses. loss of earnings, or cost of domestic services, but rather, limits the non-economic damages to one quarter of a million dollars.

Please support this bill and help Alaska's healthcare future.

Sincerely,

Charles E. Holyfield

Cc: Interior Delegation
House Judiciary

Sheryl Barnett
1027 Noel Drive
Fairbanks, AK 99712

March 1, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

Dear Representative Anderson,

I am writing you in support of House Bill 472. I have lived in Interior Alaska for 25 years and have always appreciated having access to skilled health care in my "home town." But recently; I, like others in this community have become aware of physicians being forced to limit their practice or retire early or even worse move to other states where their liability premiums are more affordable and stable. I recognize this as a serious threat to my access to healthcare. Because of this threat I am writing in support of your introduction of House Bill 472 and I urge the House and Senate to support the Medical Tort Bill.

Sincerely,

Sheryl Barnett

Cc: Interior Delegation, House HESS Committee

Rodney Perdue
1422 Kent Court
Fairbanks, Alaska

February 27, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

Dear Representative And rson:

I am writing in response to the current situation with healthcare in Alaska, specifically with respect to Alaska's medical liability system.

I think that this situation is approaching the state of being a crisis because if left as is, it will cause a shortage of quality healthcare providers. This is a statewide problem and needs to have a statewide solution. He rising costs of medical insurance will make it unfeasible for many to continue in the field of practice that they are currently in.

I urge the Senate to pass SB319 and I also urge the House to enact similar legislation.

Sincerely,

Rodney Perdue

cc: Interior Delegation
House Judiciary

Sandra Larson
2537 Talkeetna
Fairbanks, Alaska 99709

February 27, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 - Medical TORT Bill

Dear Representative Anderson:

I am writing to you about the current situation with healthcare in Alaska, and Alaska's medical liability system.

The frivolous lawsuits that are commonplace today are endangering the availability of healthcare in the future. Liability insurers are leaving the market or raising the rates to astronomical levels.

Patients are paying escalating costs that are generated by our nation's dysfunctional medical liability system. The cost of liability insurance for physicians continues to escalate which causes physicians to limit services, retire early or move to other states where liability premiums are more stable. The continued availability of adequate medical care depends directly on the availability of adequate insurance coverage.

I urge the Senate to pass SB319 and I also urge the House to enact similar legislation.

Sincerely,

Sandy Larson

Sandy Larson

cc: Interior Delegation
House Judiciary

Elizabeth Woodyard
1070 Ellesmere
Fairbanks, Alaska 99709

February 27, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

Dear Representative Anderson:

I am writing in order to voice my opinion about the current situation with healthcare in Alaska, specifically with respect to Alaska's medical liability system.

Patients are paying escalating costs that are generated by our nation's dysfunctional medical liability system. The cost of liability insurance for physicians continues to escalate which causes physicians to limit services, retire early or move to other states where liability premiums are more stable.

The frivolous lawsuits that are commonplace today are endangering the availability of healthcare in the future.

I urge the Senate to pass SB319 and I also urge the House to enact similar legislation.

Sincerely,

Liz Woodyard

cc: Interior Delegation
House Judiciary

Debra Hall
959 Windflower Lane
Fairbanks, AK 99712

March 1, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

Dear Representative Anderson,

I am writing you in support of House Bill 472. I have lived in Interior Alaska for 25 years and have always appreciated having access to skilled health care in my "home town." But recently; I, like others in this community have become aware of physicians being forced to limit their practice or retire early or even worse move to other states where their liability premiums are more affordable and stable. I recognize this as a serious threat to my access to healthcare. Because of this threat I am writing in support of your introduction of House Bill 472 and I urge the House and Senate to support the Medical Tort Bill.

Sincerely,

Debra Hall

Cc: Interior Delegation, House HESS Committee

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
Administrative Offices 4141 Ambassador Drive
Anchorage, Alaska 99508
Telephone: 907-729-1900
Facsimile: 907-729-1901

Sent via facsimile: (907) 465-6592

March 2, 2004

The Honorable Lesil McGuire
Alaska House of Representatives
State Capitol, Room 118
Juneau, AK 99801-1182

Dear Representative McGuire:

Re: Opposing the $100 million "Plan B" Medicaid Program Reductions Proposed by the House Finance Committee's Health and Social Services Subcommittee

I write to urge you to oppose the "Plan B" reductions to the Alaska Medicaid Program recently proposed by the Health and Social Services Subcommittee of the House Finance Committee.

These proposed reductions would significantly impact Alaskans most in need—seniors, those with mental illness, developmental disabilities, and low-income adults. The reductions would:

- Eliminate dental services for 5,400 people;
- Eliminate speech and hearing therapy for 1,200 individuals;
- Eliminate eye glasses and other vision services for 12,000 people;
- Reduce access for 31,000 Medicaid patients by cutting rates to physicians by 10%;
- Reduce rates to hospitals by 10%, significantly hurting the sustainability of all of Alaska's hospitals, particularly the small rural hospitals; and
- Reduce pharmacy rates to 85% of the Average Wholesale Price, down from the current 95% level, hurting the ability of Alaska health providers to provide reasonably-priced pharmaceutical drugs to those Alaskans with the greatest need and least ability to pay.

Moreover, because the federal government in all cases pays at least a 50% match for State Medicaid expenditures, and pays up to 100% of Medicaid expenditures in many cases, **the overall economic impact to the State can reasonably be calculated to be in excess of $250 million, including a loss of at least $150 million in federal funds coming into Alaska.**

In conclusion, the proposed $100 million "Plan B" Medicaid cut will hurt not only those Alaskans who are most in need, it will also have a potentially disastrous effect on Alaska's economy.

Sincerely,

Don Kashevaroff
Chairman/President

March 2, 2004

To: Members of the House Judiciary Committee

Certain members of the legislature seemed poised to give the insurance industry, and our high and mighty brothers and sisters in the medical profession, yet another huge gift at the expense of ordinary Alaskans. Why? Ninety-eight thousand Americans die every year from medical errors in hospitals.[1]

If this was the aviation industry, killing what amounts to a couple of jumbo jets full of people a week, America would do something about it. Those planes would be grounded, investigations would be launched, ingenuity would be brought to bear and the problem would be solved or mitigated. Instead, the answer of some in the legislature, as reflected in SB 319 and HB 472, is to further immunize those at the helm of this unmitigated disaster and to further ensure that the few checks and balances that now exist will be further weakened and displaced.

Accurate records are not kept on these matters, but I pay pretty close attention. By my count, in the history of the state and territory of Alaska, there have been something on the order of fifteen jury verdicts in favor of plaintiffs in medical negligence cases.[2] That's all. Many of these verdicts, like one I acquired a few years ago, were Pyrrhic victories. The recoveries were relatively insignificant. This is apparently the "crisis" that motivates certain members of the legislature to strip Alaskans of their right to place their claims before a jury for its evaluation of their damages.

This legislation is not just bad public policy, in light of existing medical and legal reality, it is an embarrassment.

Very truly yours,

LAW OFFICES OF
MICHAEL J. SCHNEIDER, P.C.

Michael J. Schneider

---

[1]40% of Americans, in general, and a third of doctors say that they or their family members have been the victims of a preventable medical error. 10% of doctors say that a family member has died as a consequence of medical negligence. *New England Journal of Medicine,* December 12, 2002.

[2]Medical negligence cases broadly defined, e.g. nursing malpractice, dental malpractice, etc.

AARP Alaska

March 11, 2004

Vanessa OK

The Honorable Lesil McGuire, Chair
House Judiciary Committee
Alaska State Capitol, Room 118
Juneau, Alaska 99801-1182

RE: HB 472 (Anderson)—Oppose Unless Amended

Dear Chair McGuire:

On behalf of the AARP members in Alaska, we ask that you and your colleagues on the House Judiciary Committee oppose HB 472, authored by your Committee Vice-Chair Representative Tom Anderson and co-sponsored by Representative Bud Fate, unless it is amended.

The issue of medical malpractice is often perceived as a battle between trial lawyers and insurance companies and physicians. We think it is also important to consider the victim of malpractice as well as **the ultimate goal of medical error reduction.**

AARP believes that state legislatures should not place limits on the amount of punitive damages or on joint and several liability, or unreasonable limits on damage awards for pain and suffering. We believe that a cap of $250,000 is, on its face, unreasonable.

For a cap to be reasonable, it would:

- Start at a level based on current conditions, not the arbitrary $250,000 figure chosen in California some 20 years ago,
- Provide flexibility for different types of cases,
- Include exceptions for egregious cases,
- Be indexed for inflation, and
- Be tied to other reforms, including mandatory error reporting and prompt payment requirements.

We oppose caps on punitive damages because these awards are relatively rare and generally imposed only in the most egregious cases, and thus are not a significant factor in malpractice premium problems.

3601 C Street, Suite 1420 | Anchorage, AK 99503 | 907-341-2277 | 907-341-2270 fax | 1-877-434-7598 TTY
James G. Parkel, President | William D. Novelli, Executive Director and CEO | www.aarp.org

It's not just physicians who need malpractice reform. Consumers injured by medical errors are also served badly by the tort system, and real reform requires going beyond the doctor vs. lawyer debate.

The tort system does a poor job of compensating people injured by medical errors. It is slow, expensive, and most injured people get nothing at all. The tort system also encourages providers to cover up mistakes in order to avoid lawsuits, rather than report errors in order to learn how to prevent them in the future.

We need to move beyond the debate over caps. Proposals to set unreasonable limits on pain and suffering awards do not help injured people get compensation or reduce errors. In fact, such caps can make it even harder for people who are injured to get fair compensation. AARP believes they are also unfair to older people with limited income potential who thus get little in economic damages.

Real reform should lead to fair compensation and error reduction. The Institute of Medicine (IOM) has proposed demonstration projects to test reform designed to fix what is broken for consumers. IOM has proposed testing non-judicial, no-fault alternatives to the tort system for medical errors (but not for other types of harm to patients, such as nursing home negligence). These alternatives could foster fair compensation and error reduction—what we believe should be the goals of consumer-oriented reform.

Under the IOM proposal, people with legitimate cases of medical injury could be identified and compensated appropriately. Payments would be based on "avoidability" of errors rather than "negligence." Amounts would be preset in schedules for specific categories of errors, which would provide reasonable limits that may help stabilize malpractice premiums. Health providers would have to report errors and make payments promptly, which would help injured people get fair compensation.

Errors could be reduced so fewer people would be injured. By requiring providers to report errors, the IOM claims that experts would be able to analyze system-wide errors and find ways to prevent them. The result would be a system in which patient safety is continually improved. With fewer errors, the cost of compensating injured people could decline.

We assume that reducing medical errors is in the best interest of all Alaskans and is the real intent of Representative Anderson and HB 472. We encourage you and your colleagues on the House Judiciary Committee to amend HB 472 to reflect the recommendations of the Institute of Medicine. Fair compensation and error reduction—AARP thinks we can all live with that.

Should you have any questions about our position, please feel free to contact Marie Darlin (907-586-3637), Coordinator of the AARP Capital City Task Force, Patrick Luby (907-762-3314), Legislative Representative, or me (907-245-5259.

Thank you for your consideration.

Sincerely,

Marguerite Stetson

Marguerite Stetson
AARP State Coordinator for Advocacy
3009 Northwood Street
Anchorage, AK 99517-1871
907-245-5259 (voice)
907-245-5279 (fax)
ffmas@aurora.uaf.edu

CC: Vice-Chair Tom Anderson
Representative Jim Holm
Representative Dan Ogg
Representative Ralph Samuels
Representative Les Gara
Representative Max Gruenberg
Representative Bud Fate
Marie Darlin
Patrick Luby

Subject: [Fwd: House Bill 472]
Date: Mon, 01 Mar 2004 17:40:35 -0900
From: Mike Hawker <Representative_Mike_Hawker@Legis.state.ak.us>
Organization: Alaska State Legislature
To: Representative Lesil McGuire <Representative_Lesil_McGuire@legis.state.ak.us>, Representative Tom Anderson <Representative_Tom_Anderson@legis.state.ak.us>, Representative Dan Ogg <Representative_Dan_Ogg@legis.state.ak.us>, Representative Jim Holm <Representative_Jim_Holm@legis.state.ak.us>, Representative Ralph Samuels <Representative_Ralph_Samuels@legis.state.ak.us>, Representative Les Gara <Representative_Les_Gara@legis.state.ak.us>, Representative Max Gruenberg <Representative_Max_Gruenberg@legis.state.ak.us>

Vanessa-
P3 part in
my HB 472
packet so Q
can reference
THX
J

-------- Original Message --------
Subject: House Bill 472
Date: Sun, 29 Feb 2004 19:53:49 EST
From: Junelawyer@cs.com
To: Representative_Mike_Hawker@legis.state.ak.us

Representative Hawker:

As a resident of your district, I am writing you today about House Bill 472 and its corresponding Senate Legislation seeking to limit non-economic loss compensation to victims of medical malpractice to $250,000. The supposed justification is excessive verdicts/settlements causing insurers to cease doing business in Alaska and indirectly making it harder to attract good physicians to our State. While I am unable to comment on what facts of a specific case that would persuade a jury to award more than $250,000 and do not even practice in the area of medical malpractice, I can say that the purported justification does not make sense. There is nothing to indicate that the current recovery limits are inadequate or abused.

Awards of non-economic loss of greater than $250,000 are newsworthy events. Both defense and plaintiff lawyers are anxious to learn of these trials for purposes of evaluating cases. Similarly, so is the media. The same principles hold true for settlements without trial. I have not heard and question that there are examples of "runaway juries" in Alaska. With only a handful of insurers, the Legislature should be provided with verifiable facts. The truth of the matter is that lawyers for accident victims are constantly reminded that Alaska juries have become "conservative" in their damage awards. At the same time, insurer income has been more adversely impacted by the depressed state of investment markets than by jury verdicts.

In 1997, the Legislature promulgated comprehensive Tort Reform legislation. If there is truth to the conservative nature of Alaska juries, then it appears that the Tort Reform effort is working and there is no showing to further limit the rights of malpractice victims. On a Federal level, Congress has considered and rejected a similar cap. Again, the insurers were unable to demonstrate an income crisis related to jury verdicts.

If there is no crisis, what is prompting the push for legislation. I suspect the insurance and medical professions are like any business seeking to reduce costs in order to maximize profits. With policies having already been sold, reducing the risk potentially reduces costs and increases profits and nothing to increase the availability of coverage or to prevent medical malpractice.
While there is nothing wrong with a business being a profit maximizer, it is wrong for a highly paid profession to proclaim a crisis when one does not exist. Doing so is simply an exercise in fearmongering.

From a public policy standpoint the proposed legislation serves only to limit the recovery of the most egregious of accident victims and undermine the jury system. I would encourage you to do all you can to prevent passage of this legislation.

Marc W. June.
Law Office of Marc June
807 G. St., Suite 150
Anchorage, Ak. 99501

PS. Good luck on the Fiscal Crisis. I appreciate that is where you are spending the bulk of your time this session but know that this legislation will not pass if you do not support it.

Subject: [Fwd: HB 472]
Date: Mon, 01 Mar 2004 17:41:55 -0900
From: Mike Hawker <Representative_Mike_Hawker@Legis.state.ak.us>
Organization: Alaska State Legislature
To: Representative Lesil McGuire <Representative_Lesil_McGuire@legis.state.ak.us>, Representative Tom Anderson <Representative_Tom_Anderson@legis.state.ak.us>, Representative Dan Ogg <Representative_Dan_Ogg@legis.state.ak.us>, Representative Jim Holm <Representative_Jim_Holm@legis.state.ak.us>, Representative Ralph Samuels <Representative_Ralph_Samuels@legis.state.ak.us>, Representative Les Gara <Representative_Les_Gara@legis.state.ak.us>, Representative Max Gruenberg <Representative_Max_Gruenberg@legis.state.ak.us>

For my HB 472 file

-------- Original Message --------
Subject: HB 472
Date: Mon, 1 Mar 2004 11:30:30 -0900
From: "Jeff Friedman" <jfriedman@frwusa.com>
To: <Representative_mike_hawker@legis.state.ak.us>

1) Before reversing the Marsingill and Korman cases, I think you should read them. (disclosure: Our office is involved in the Marsingill retrial coming up this year) These cases take a common sense approach and allow the jury to use a reasonable person standard. The question is not what battling experts say should have happened, but what a reasonable person would have understood and done in those circumstances. 2) why are health care professionals given a break that other defendants don't have? Subsection d says they only have to pay a maximum of $250,000 in non-economic damages. Other defendants may be required to pay more than that amount in non-economic damages. 3) AS 09.55.556 (d) is a new section that is troubling. In Marsingill, the patient called the doctor on the phone. The doctor recomended going to the ER, but then told her things that would reasonably lead her to believe that going to the ER was not necessary. This mixed message is the basis for her claim. A physician should not be able to avoid liability by starting all phone conversations with "you should come to my office" and then proceding to give additional advice that undercuts the first statement. I think a jury should be trusted to decide whether the doctor's advice was negligent. 4) Then there is the final question as to whether there is even a malpractice crisis that needs to be addressed. In states where the legislature has put people under oath, no one has been willing to testify that there is a shortage of doctors or that high premiums are forcing doctors out of the state or the practice of medicine. In addition, insurance executives have testified under oath that capping damages does not have an effect on premiums. I'm working on getting you a copy of that testimony, but Sen. French should have it already from my partner, Jeff Rubin. Thanks for listening. Jeff

Subject: [Fwd: Quotes from Insurance Company executives]
Date: Mon, 01 Mar 2004 17:43:05 -0900
From: Mike Hawker <Representative_Mike_Hawker@Legis.state.ak.us>
Organization: Alaska State Legislature
To: Representative Lesil McGuire <Representative_Lesil_McGuire@legis.state.ak.us>,
Representative Tom Anderson <Representative_Tom_Anderson@legis.state.ak.us>,
Representative Dan Ogg <Representative_Dan_Ogg@legis.state.ak.us>,
Representative Jim Holm <Representative_Jim_Holm@legis.state.ak.us>,
Representative Ralph Samuels <Representative_Ralph_Samuels@legis.state.ak.us>,
Representative Les Gara <Representative_Les_Gara@legis.state.ak.us>,
Representative Max Gruenberg <Representative_Max_Gruenberg@legis.state.ak.us>

V Same 472 file

-------- Original Message --------
Subject: Quotes from Insurance Company executives
Date: Mon, 1 Mar 2004 12:22:56 -0900
From: "Jeff Friedman" <jfriedman@frwusa.com>
To: <Representative_mike_hawker@legis.state.ak.us>
CC: <Representative_tom_Anderson@legis.state.ak.us>,<Representative_les_gara@legis.state.ak.us>

Mike, Regarding HB 472, there is little if any credible evidence to support the claims that malpractice litigation is a significant driver of health care costs. It is my understanding that when insurance industry executives were put under oath by the Florida legislature last year, they admitted that the rate increases they were passing on to doctors, were the result, by and large, not of judgments or settlements, but of their own investment failures. Other insurance executives and pushers of "tort reform" including caps on non-economic damages have repeatedly admitted that such caps will not result in lower insurance rates for doctors: **I don't like to hear insurance-company executives say it's the tort system - it's self inflicted."**

~Donald J. Zuk, chief executive of Scpie Holdings Inc., a leading malpractice insurer in California, Wall Street Journal, June 24, 2002.

"No responsible insurer can cut its rates after a [medical malpractice tort 'reform'] bill passes."

~Bob White, President of First Professional Insurance Company, the largest medical malpractice insurer in Florida, talking about a proposed $250,000 cap in the January 29, 2003 Palm Beach Post.

"I don't think we would argue that the premiums are likely to go down. We believe it will have the effect of reducing the increases in the future. And one of the reasons the premiums won't go down is that even if noneconomic damages are capped, the losses for economic loss, medical expenses, for example, are still in this current environment escalating at, medical inflation is running in the double digits. I forget exactly what it was last year. So even if you were to cap noneconomic damages, the economic damages will still cause acceleration in the premiums. So it would not go down, I want to clarify if I misspoke and said I thought the premiums would go down."

~Cliff Webster, representing the Washington State Medical Association & Chairman of the Washington Liability Reform Coalition, testifying before the Washington State Legislature, House Judiciary Committee, Feb. 21, 2003.

"Insurers never promised that tort reform would achieve specific premium savings..."

~From a press release published March 13, 2002, by the American Insurance Association (AIA).

"[M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and 'I've

never said that in 30 years.'"

~Victor Schwartz, General Counsel of the American Tort Reform Association, as paraphrased and quoted in "Tort Reforms Don't Cut Liability Rates, Study Says," published in Business Insurance July 19, 1999.

"We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates."

~Sherman Joyce, President of the American Tort Reform Association, as quoted in "Study Finds No Link Between Tort Reforms and Insurance Rates," Liability Week, July 19, 1999.

"Insurance was cheaper in the 1990s because insurance companies knew that they could take a doctor's premium and invest it, and $50,000 would be worth $200,000 five years later when the claim came in. An insurance company today can't do that."

~Victor Schwartz, general counsel to the American Tort Reform Association, "Dose of Legality," Honolulu Star-Bulletin, April 20, 2003.

"While MICRA was the legislature's attempt at remedying the medical malpractice crisis in California in 1975, it did not substantially reduce the relative risk of medical malpractice insurance in California."

~James Robertson, Assistant Vice President and Associate Actuary, SCIPIE Indemnity Company (California's second largest medical malpractice insurer), in written testimony responding to a question from an administrative law jugdge who is overseeing a case in which SCIPIE has requested a 15.6 % rate hike. April 30, 2003

Subject: Quotes from Insurance Company executives
Date: Mon, 1 Mar 2004 12:22:56 -0900
From: "Jeff Friedman" <jfriedman@frwusa.com>
To: <Representative_mike_hawker@legis.state.ak.us>
CC: <Representative_tom_Anderson@legis.state.ak.us>, <Representative_les_gara@legis.state.ak.us>, <Representative_lesil_mcguire@legis.state.ak.us>, <Senator_con_bunde@legis.state.ak.us>

V. 472 file PB JHS

Mike,

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adn.com
Anchorage Daily News

Patient Power

National groups and Alaska watchdogs encourage consumers to question health care providers

By ANN POTEMPA
Anchorage Daily News

(Published: March 2, 2004)

NEXT TIME YOU PAY A VISIT TO YOUR DOCTOR, ask questions.

Here's one to start with: "Did you wash your hands?"

Patients may take it for granted that doctors and nurses head to the sink before each exam, but local hospitals admit some of their employees don't. At one, a study showed that about a third of the staff wasn't washing up.

This new approach is a healthy self-defense for patients. It's a shift away from automatically trusting that the folks in scrubs and stethoscopes always do the right thing. This year, a national hospital accreditation agency gave consumers some muscle by creating seven National Patient Safety Goals that hospitals must meet (see list at left).

Too often, patients think: "Gosh, they're a *hospital*. They know what they're doing," said Dr. Norman Wilder, one of the founding members of Alaska's Patient Safety Collaborative, a group of patient safety advocates from medical facilities around the state.

But medical professionals make mistakes. Intentional or not, they can be deadly. An Institute of Medicine report in 1999 concluded that mistakes made in hospitals cause more deaths nationwide than do car accidents, breast cancer or AIDS. The report, "To Err Is Human: Building a Safer Health System," drew from studies of Utah, Colorado and New York hospitals. Alaska was not a focus of the study, but the error rates from participating states were extrapolated over total U.S. hospital admissions in 1997. The institute estimated that errors killed 44,000 to 98,000 people every year.

National agencies and Alaska's own advocates are coming up with new ways to help lower those numbers. Alaska's group is giving patients stickers that tell them to question their doctors. They're asking doctors to wear stickers that say they welcome inquiries.

Members of the collaborative talked about a recent serious error on the East Coast. Last year, a teen girl died after a medical team at Duke University Hospital performed a heart-lung transplant on her using an organ donor with the wrong blood type.

Alaska's collaborative didn't just point fingers Outside. Medical staff here admitted to giving the wrong drugs to patients. From now on, staff have to find two ways to correctly identify each patient before giving medications or taking blood. It's no longer acceptable to allow patients to simply nod "yes" when a doctor asks if they go by a certain name; patients might be stressed or tired and nod

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE
PATIENT SAFETY
◂ Previous Volume 347:1933-1940 December 12, 2002 Number 24 Next ▸

Views of Practicing Physicians and the Public on Medical Errors

Robert J. Blendon, Sc.D., Catherine M. DesRoches, Dr.P.H., Mollyann Brodie, Ph.D., John M. Benson, M.A., Allison B. Rosen, M.D., M.P.H., Eric Schneider, M.D., M.Sc., Drew E. Altman, Ph.D., Kinga Zapert, Ph.D., Melissa J. Herrmann, M.A., and Annie E. Steffenson, M.P.H.

ABSTRACT

Background In response to the report by the Institute of Medicine on medical errors, national groups have recommended actions to reduce the occurrence of preventable medical errors. What is not known is the level of support for these proposed changes among practicing physicians and the public.

Methods We conducted parallel national surveys of 831 practicing physicians, who responded to mailed questionnaires, and 1207 members of the public, who were interviewed by telephone after selection with the use of random-digit dialing. Respondents were asked about the causes of and solutions to the problem of preventable medical errors and, on the basis of a clinical vignette, were asked what the consequences of an error should be.

Results Many physicians (35 percent) and members of the public

ARTICLE
- Table of Contents
- Abstract of this article
- PDF of this article
- PDA version of this article
- Editor's Summary
- Related Letters to the Editor

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- Citing Articles (33)

Special Article

PATIENT SAFETY

VIEWS OF PRACTICING PHYSICIANS AND THE PUBLIC ON MEDICAL ERRORS

ROBERT J. BLENDON, SC.D., CATHERINE M. DESROCHES, DR.P.H., MOLLYANN BRODIE, PH.D., JOHN M. BENSON, M.A., ALLISON B. ROSEN, M.D., M.P.H., ERIC SCHNEIDER, M.D., M.SC., DREW E. ALTMAN, PH.D., KINGA ZAPERT, PH.D., MELISSA J. HERRMANN, M.A., AND ANNIE E. STEFFENSON, M.P.H.

ABSTRACT

Background In response to the report by the Institute of Medicine on medical errors, national groups have recommended actions to reduce the occurrence of preventable medical errors. What is not known is the level of support for these proposed changes among practicing physicians and the public.

Methods We conducted parallel national surveys of 831 practicing physicians, who responded to mailed questionnaires, and 1207 members of the public, who were interviewed by telephone after selection with the use of random-digit dialing. Respondents were asked about the causes of and solutions to the problem of preventable medical errors and, on the basis of a clinical vignette, were asked what the consequences of an error should be.

Results Many physicians (35 percent) and members of the public (42 percent) reported errors in their own or a family member's care, but neither group viewed medical errors as one of the most important problems in health care today. A majority of both groups believed that the number of in-hospital deaths due to preventable errors is lower than that reported by the Institute of Medicine. Physicians and the public disagreed on many of the underlying causes of errors and on effective strategies for reducing errors. Neither group believed that moving patients to high-volume centers would be a very effective strategy. The public and many physicians supported the use of sanctions against individual health professionals perceived as responsible for serious errors.

Conclusions Though substantial proportions of the public and practicing physicians report that they have had personal experience with medical errors, neither group has the sense of urgency expressed by many national organizations. To advance their agenda, national groups need to convince physicians, in particular, that the current proposals for reducing errors will be very effective. (N Engl J Med 2002;347:1933-40.)

THE prevention of serious errors in medical care has long been of concern to health professionals, as well as courts and legislatures.[1] However, the recent report by the Institute of Medicine (IOM), *To Err Is Human*, focused attention on the problem, particularly its conclusion that, each year, more Americans die as a result of medical errors made in hospitals than as a result of injuries from automobile accidents.[2,3] At the time the report was released, a survey showed that half the American public followed the media coverage of it.[4] Since then, there have been many new efforts to reduce the incidence of medical errors.[5-10] However, there are those who disagree with the report's conclusions, arguing that the report overstated the magnitude of the problem.[11-14]

Still not known are the views of practicing physicians and the public with regard to both the number of deaths due to errors and the recommendations of national groups for reducing these errors. Many of the recommendations would change the daily practice of individual physicians and hospitals, so the support of practicing physicians may be crucial. New legislation and changes in public policy may require the backing of both physicians and the public.[15-18]

We conducted parallel surveys of physicians and the public to learn their views on medical errors. We posed the following questions: Have you had a personal experience with medical errors made in your care or that of a family member? How frequent and how serious is the problem of medical errors as compared with other problems in health care? What are the most important causes of medical errors? What actions should be taken to prevent medical errors? What should be the consequences for a health professional or institution involved in a medical error?

From the Department of Health Policy and Management, Harvard School of Public Health, Boston (R.J.B., C.M.D., J.M.B., A.B.R., E.S.); the Kaiser Family Foundation, Menlo Park, Calif. (M.B., D.E.A., A.E.S.); Harris Interactive, Rochester, N.Y. (K.Z.); and ICR/International Communications Research, Media, Pa. (M.J.H.). Address reprint requests to Dr. Blendon at the Harvard School of Public Health, Health Policy and Management, 677 Huntington Ave., Boston, MA 02115.

METHODS

Study Design

A team of researchers from the Harvard School of Public Health and the Kaiser Family Foundation designed and analyzed both surveys. They were conducted in the United States.

Physicians

The fieldwork for the survey of physicians was conducted by Harris Interactive. The sample was randomly selected from the national list of physicians provided by Medical Marketing Service. This list, which includes both physicians who are members of the American Medical Association and nonmembers, is updated weekly. A questionnaire was mailed to 1332 physicians along with a check for $100 as an incentive for completing it. The survey was conducted between April 24 and July 22, 2002. A total of 831 physicians either completed the questionnaire on paper and returned it by mail (777) or completed and submitted it online (54). The response rate was 62 percent.[19] The margin of error was ±3.5 percentage points.

The General Public

A total of 1603 members of the public were contacted and deemed eligible for the national telephone survey, performed with random-digit dialing; 1207 adults (18 years of age or older) completed the survey. It was conducted in Spanish and English by International Communications Research between April 11 and June 11, 2002. Respondents were not given a financial incentive to participate. The response rate was 67 percent.[19] The margin of error was ±2.6 percentage points.

The Survey Questionnaire

To conduct parallel surveys, a single questionnaire was developed and modified to be appropriate for each group of respondents. The questionnaire was reviewed by physicians and experts in medical errors and was then pretested for length and comprehensibility. Both surveys were revised on the basis of the results of these tests. Twenty-nine questions were included in the survey of physicians and 38 in the survey of the public; 8 questions in each instrument had multiple parts. The questions focused on inpatient errors, since the majority of proposals address such errors.

The questionnaire asked whether an error had ever been made in the respondent's own care or that of a family member and, if so, what the health consequences of that error had been. Respondents were asked to state in their own words what they considered to be the two most important problems with health care and medicine. The responses were grouped in categories, one of which was medical errors. No respondents in the survey of the public and few in the survey of physicians used the term "medical error" when answering the question. Most respondents used terms such as "incompetent doctors" and "mistakes."

After answering the open-ended question, respondents in both surveys were given the following statement defining "medical error" to ensure that they had a common understanding of the term: "Sometimes when people are ill and receive medical care, mistakes are made that result in serious harm, such as death, disability, or additional or prolonged treatment. These are called medical errors. Some of these errors are preventable, whereas others may not be."

Respondents were asked how many in-hospital deaths they thought resulted from preventable medical errors each year. They were given a choice of five numbers from 500 to 500,000 or more. Among the choices were the IOM's higher estimate of 98,000 (rounded to 100,000), the IOM's lower estimate of 44,000 (rounded to 50,000), and the estimate of 4500 (rounded to 5000) made by another team of researchers using a different set of assumptions.[12] We also asked respondents to rate the importance of 11 factors that might contribute to medical errors and the effectiveness of 16 possible solutions.

We asked the following question about high-volume centers: "Suppose a patient needs a specialized medical procedure. This person can choose either a hospital that does a large number of these procedures or a hospital that does not do as many. At which hospital do you think this patient would be more likely to have a preventable medical error made in his or her care, or wouldn't it make a difference?"

The questionnaires included the following vignette, developed by physicians[20]: "A 67-year-old man goes to the hospital for surgery. He has an allergy to antibiotic drugs, which is noted on his medical record. The surgeon does not notice the information about the allergy and orders an antibiotic to be given at the end of the surgery. A hospital nurse gives the patient the antibiotic." To examine the hypothesis that respondents' views on the appropriate consequences for the health professionals would vary according to the severity of the error's outcome, we randomly varied the health consequences for the patient. Half of each group of respondents were told that the patient was harmed: "The patient wakes up with a rash all over his body and is gasping for air. The mistake is noticed, and the antibiotic is stopped, but the patient stops breathing. Despite every effort, the patient dies." The other half were told that the patient was not harmed: "The patient wakes up with a rash all over his body. The mistake is noticed, the antibiotic is stopped, and the patient fully recovers." The physicians were told that the language of the vignette had been simplified so that laypeople would understand it.

Statistical Analysis

We compared responses by testing differences between proportions, using Fisher's exact test. The statistical program that we used took into account the design effects for each of the surveys by calculating the effective sample size. Because previous research has shown that the salience of an issue is an important factor in the level of support for change, we limited analyses of graded responses to the proportion of respondents who said that a cause of errors was "very important" or that a solution would be "very effective."[21] All reported P values are based on two-sided tests.

To adjust for sampling biases due to sociodemographic differences in nonresponse rates and to ensure that the sample was representative, survey responses were weighted by computer with the use of a predetermined weighting scheme. The data in the survey of the public were weighted on the basis of the latest U.S. Census numbers for sex, age, race or ethnic group, level of education, number of people in the household, and number of land telephone lines. The data in the survey of physicians were weighted for region, specialty, training (foreign vs. U.S.), and number of years since graduation from medical school. There were no qualitative differences between unweighted and weighted results.

RESULTS

Experiences with Medical Errors

Thirty-five percent of physicians and 42 percent of the public reported that they had experienced an error in their own care or that of a family member (Table 1). Eighteen percent of physicians and 24 percent of the public reported an error that had had serious health consequences, including death (reported by 7 percent of physicians and 10 percent of the public), long-term disability (6 percent and 11 percent, respectively), and severe pain (11 percent and 16 percent, respectively). About a third of the respondents in both groups who reported experience with an error said that the health professionals involved in the error had told them about it or apologized to them.

Seventy percent or more of both groups of re-

TABLE 1. RESPONDENTS' PERSONAL EXPERIENCE WITH PREVENTABLE MEDICAL ERRORS.

RESPONSE	PHYSICIANS (N=831)	PUBLIC (N=1207)	P VALUE
	percent		
All respondents			
Error made in own or family member's care	35	42	<0.001
Health consequences			
Serious	18	24	<0.001
Minor	10	13	0.03
None	7	5	0.06
Serious consequences			
Severe pain	11	16	<0.001
Substantial loss of time at work or school, or in other important activities	12	17	<0.001
Temporary disability	8	12	0.009
Long-term disability	6	11	0.003
Death	7	10	0.01
Respondents reporting an error*			
Parties who had "a lot" of responsibility for the error			
Doctors	70	81	<0.001
Nurses	25	25	0.15
Other health professionals	15	26	<0.001
The institution (e.g., a hospital, clinic, or nursing home facility)	22	43	<0.001
Health professional involved			
Told respondent that an error had been made	31	30	0.19
Apologized to respondent or family member	34	33	0.14
Respondent or family member sued health professional	2	6	<0.001

*A total of 290 physicians and 507 members of the public reported an error in their own care or that of a family member.

spondents who reported experience with an error assigned "a lot" of responsibility to the physicians involved (Table 1). The public was significantly more likely than physicians to attribute the error to the institution involved. Malpractice lawsuits after an error were reported infrequently (by 2 percent of physicians and 6 percent of the public). However, 48 percent of physicians reported that they had been named in a malpractice lawsuit at some time in their career.

Twenty-nine percent of physicians reported having seen an error in the previous year in their capacity as physicians. Among these physicians, 60 percent believed that a similar error was very or somewhat likely to occur at the same institution during the next year.

Views of Medical Errors

Neither physicians nor the public named medical errors as one of the largest problems in health care today. The problems cited most frequently by physicians were the costs of malpractice insurance and lawsuits (cited by 29 percent of the respondents), the cost of health care (27 percent), and problems with insurance companies and health plans (22 percent). In the survey of the public, the issues cited most frequently were the cost of health care (cited by 38 percent of the respondents) and the cost of prescription drugs (31 percent). Only 5 percent of physicians and 6 percent of the public identified medical errors as one of the most serious problems.

Before being given the definition of the term "medical error," 68 percent of the respondents in the survey of the public reported that they did not know what the term meant. After being given the definition, approximately half the respondents thought these errors are made very often or somewhat often when people seek help from health professionals, as compared with only one fifth of physicians (Table 2).

The majority of both physicians and the public believed that 5000 or fewer deaths in hospitals each year are due to preventable medical errors — a much lower number than either the high or low IOM estimate. A majority of respondents in both surveys thought that one half or fewer of these deaths could have been prevented.

Causes of Medical Errors

Of the 11 items listed as possible causes of medical errors, only 2 were thought by at least half the physicians to be very important causes: understaffing of nurses in hospitals (53 percent) and overwork, stress, or fatigue on the part of health professionals (50 percent) (Table 3). In the survey of the public, at least half

TABLE 2. BELIEFS ABOUT THE FREQUENCY OF MEDICAL ERRORS AND PREVENTABLE DEATHS.*

QUESTION AND RESPONSE	PHYSICIANS (N=837)	PUBLIC (N=1207)	P VALUE
	percent		
How often are preventable medical errors made?			
Very often	1	10	<0.001
Somewhat often	19	39	<0.001
Not very often	59	37	<0.001
Not often at all	21	8	<0.001
No response	0	6	
How many Americans die in hospitals each year because of preventable medical errors?			
500	17	24	<0.001
5000	46	36	<0.001
50,000	25	20	0.002
100,000	9	7	0.12
≥500,000	1	4	<0.001
No response	1	9	
What proportion of these deaths could realistically have been prevented?			
All of them	8	11	0.04
Three quarters of them	27	29	0.48
Half of them	41	42	0.71
One quarter of them	21	13	<0.001
None of them	2	1	0.05
No response	1	3	

*Percentages may not always sum to 100 because of rounding.

the respondents considered seven of the causes very important. The top four causes considered to be very important were physicians' not having enough time with patients (72 percent); overwork, stress, or fatigue on the part of health professionals (70 percent); failure of health professionals to work together or communicate as a team (67 percent); and understaffing of nurses in hospitals (65 percent).

When asked whether mistakes made by health professionals or those made by health care institutions were a more important cause of medical errors, a majority of respondents in both groups chose mistakes made by health professionals as the more important cause (55 percent of physicians and 55 percent of the public). In addition, a majority of both groups thought that patients were very often or somewhat often at least partially responsible for errors made in their care.

Proposed Solutions

Of the 16 proposed solutions, a majority of physicians thought that 2 would be very effective at reducing the number of medical errors: requiring hospitals to develop systems for preventing medical errors (55 percent) and increasing the number of nurses in hospitals (51 percent) (Table 4). A majority of the respondents in the survey of the public rated eight items as very effective. The top four items were giving physicians more time to spend with their patients (78 percent), requiring hospitals to develop systems for preventing errors (74 percent), providing better training of health professionals (73 percent), and using only physicians trained in intensive care medicine on intensive care units (73 percent).

There were important areas of divergence in the views of the two groups. For instance, only 3 percent of physicians but 50 percent of the public viewed suspension of the licenses of health professionals as a very effective way to reduce medical errors ($P<0.001$) — a difference of 47 percentage points — and only 23 percent of physicians but 71 percent of the public viewed a requirement that hospitals report errors to a state agency as very effective ($P<0.001$) — a difference of 48 percentage points. Only 21 percent of physicians, but 62 percent of the public, thought that encouraging voluntary reporting of serious medical errors to a state agency would be very effective. Eighty-six percent of physicians believed that hospital reports of errors should be kept confidential, whereas 62 percent of the public believed that reports should be made public ($P<0.001$).

High-Volume Centers

Seventy-one percent of physicians thought that an error would be more likely at a hospital that performs a low volume of procedures than at a high-volume center. The public was divided on this issue; about half the respondents thought that an error would be more likely at a low-volume center (49 percent), and the other half thought either that an error would be more likely at a high-volume center (23 percent) or that volume would make no difference (26 percent) (Table 4). In neither group did a majority of respondents think that limiting certain high-risk procedures to high-volume centers would be a very effective way to reduce medical errors (Table 3).

Consequences for Health Professionals Who Make Errors

The attribution of responsibility for an error in the vignette did not appear to be influenced by whether or not the error was associated with harm to the patient. Most respondents in both groups said that the surgeon had "a lot" of responsibility; a smaller proportion held the hospital responsible (Table 5). Physicians were more likely than the public to hold the nurse responsible for the error, regardless of the outcome.

In general, the public was more likely than physicians to believe that the surgeon should be sued for malpractice and fined and that the surgeon's license should be suspended, as well as to support sanctions against the hospital. Support for various consequences for those involved in the medical error differed sub-

TABLE 3. CAUSES OF PREVENTABLE MEDICAL ERRORS.

RESPONSE	PHYSICIANS (N=831)	PUBLIC (N=1207)	P VALUE
	percent		
Very important causes			
Understaffing of nurses in hospitals	53	65	<0.001
Overwork, stress, or fatigue on the part of health professionals	50	70	<0.001
Failure of health professionals to work together or communicate as a team	39	67	<0.001
Influence of HMOs and other managed-care plans on treatment decisions*	39	48	<0.001
Complexity of medical care	38	62	<0.001
Insufficient time spent by doctors with patients	37	72	<0.001
Poor training of health professionals	28	54	<0.001
Poor handwriting by health professionals	21	48	<0.001
Poor supervision of health professionals	16	50	<0.001
Uncaring health professionals	15	47	<0.001
Lack of computerized medical records	13	35	<0.001
The more important reason for errors			
Mistakes made by individual health professionals	55	55	0.72
Mistakes made by institutions	43	38	0.009
No response	2	7	
Volume of procedures†			
An error is more likely at a high-volume hospital	4	23	<0.001
An error is more likely at a low-volume hospital	71	49	<0.001
Volume does not make a difference	24	26	0.23
No response	1	3	
Patients are at least partially responsible for errors made in their own care			
Very often	10	11	0.51
Somewhat often	48	48	0.89
Not very often	41	35	0.002
Never	1	5	<0.001
No response	0	1	

*HMOs denotes health maintenance organizations.

†Percentages for the public do not always sum to 100 because of rounding.

stantially according to the outcome of the vignette. If the patient was harmed, physicians were significantly more likely to support malpractice lawsuits against the surgeon, the nurse, and the hospital, and the public was substantially more likely to support lawsuits and suspension of the surgeon's license.

DISCUSSION

Our results have a number of implications for national efforts to reduce medical errors. First, major efforts to change hospital and medical practice are likely to face some important challenges. Even though significant percentages of practicing physicians and the public reported personal experience with medical errors that had serious consequences and despite the media's interest in the problem, medical errors are not viewed by either group as one of the most important problems in health care. The costs of malpractice insurance, lawsuits, and health care costs were considered more important. The public and physicians are concerned about individual cases of medical errors, and when the patient is seriously harmed, both groups want some action to be taken. However, both groups believe that the number of in-hospital deaths resulting from errors is much lower than that suggested by the IOM and also believe that a substantial proportion of these deaths are not preventable.

Second, physicians and the public differ in their beliefs about measures that would be very effective in reducing the incidence of errors. The public appears to believe that a range of proposals aimed at reducing medical errors would be very effective. However, the majority of practicing physicians view only two proposals as very effective: requiring hospitals to develop systems for preventing medical errors and increasing the number of nurses in hospitals.

In particular, although the physicians surveyed believe that high-volume medical centers have fewer medical errors — a view espoused by several authors[22-25] — only a minority believed that moving patients to high-volume centers would be a very effective way to reduce medical errors. This may be due to the belief that errors occur infrequently and that changing medical practice would therefore have a limited effect. Half

TABLE 4. POSSIBLE SOLUTIONS TO THE PROBLEM OF MEDICAL ERRORS.*

SOLUTION	PHYSICIANS (N=931)	PUBLIC (N=1207)	P VALUE
	percent		
Very effective			
Requiring hospitals to develop systems for preventing medical errors	55	74	<0.001
Increasing the number of nurses in hospitals	51	69	<0.001
Giving physicians more time to spend with patients	46	78	<0.001
Limiting certain high-risk procedures to hospitals that perform many of these procedures	40	45	0.03
Improving the training of health professionals	36	73	<0.001
Using only physicians trained in intensive care medicine on intensive care units	34	73	<0.001
Reducing the work hours of physicians in training to prevent fatigue	33	66	<0.001
Increasing the use of computers to order drugs and medical tests	23	45	<0.001
Requiring hospitals to report all serious medical errors to a state agency	23	71	<0.001
Encouraging hospitals to report serious medical errors voluntarily to a state agency	21	62	<0.001
Including a pharmacist on hospital rounds when physicians review the care of patients	20	40	<0.001
Increasing the use of computerized medical records	19	46	<0.001
Having hospitalized patients taken care of by hospital physicians rather than by their regular physicians	6	16	<0.001
Suspending the licenses of health professionals who make medical errors	3	50	<0.001
Increasing lawsuits for malpractice	1	23	<0.001
Having a government agency fine health professionals who make medical errors	2	40	<0.001
Physicians should be required to tell patients when errors are made in their care			
Yes	77	89	<0.001
No	22	9	
No response	1	3	
Hospital reports of serious medical errors			
Should be confidential (used only to learn how to prevent future mistakes)	86	34	<0.001
Should be released to the public	14	62	<0.001
No response	0	4	

*Percentages for the public do not always sum to 100 because of rounding.

the respondents in the survey of the public did not see an advantage of high-volume centers, suggesting a need for education of physicians and the public if a strategy based on the volume of procedures is pursued.

Our results point to a substantial difference between the views of physicians and those of the public on the reporting of medical errors to state agencies, a recommendation embraced by a number of national groups. The public sees reporting as a very effective way of reducing errors and wants these reports to be publicly available. Physicians are more skeptical about this proposal and would prefer that reports be kept confidential.

Finally, the results point to a gap between the views of the public and proposed approaches to preventing medical errors. One of the central statements in the IOM report is that errors should be viewed as due primarily to failures of institutional systems rather than failures of individuals. This is not a premise that the public embraces. The public believes that persons responsible for errors with serious consequences should be sued, fined, and subject to suspension of their professional licenses. Nor do physicians seem to believe that individual health professionals are blameless. A majority of physicians believe that individual health professionals are more likely to be responsible for preventable medical errors than are institutions. Moreover, although few physicians believe that an increase in malpractice suits would be effective in preventing individual errors, many believe that health professionals who make errors with serious consequences should be subject to lawsuits. The results of our surveys show

TABLE 5. RESPONSES TO THE VIGNETTE.*

RESPONSE	OUTCOME WITHOUT HARM			OUTCOME WITH HARM			P VALUE FOR DIFFERENCE IN OUTCOME	
	PHYSICIANS (N=404)	PUBLIC (N=603)	P VALUE	PHYSICIANS (N=427)	PUBLIC (N=604)	P VALUE	PHYSICIANS	PUBLIC
	percent			percent				
Party with "a lot" of responsibility for the error								
Surgeon	90	89	0.67	95	92	0.04	0.006	0.04
Nurse	81	52	<0.001	82	48	<0.001	0.86	0.19
Hospital	42	55	<0.001	48	57	0.01	0.09	0.64
Should be sued for malpractice								
Surgeon	4	30	<0.001	55	69	<0.001	<0.001	<0.001
Nurse	3	12	<0.001	44	21	<0.001	<0.001	<0.001
Hospital	2	22	<0.001	33	44	<0.001	<0.001	<0.001
Should be fined by a government agency								
Surgeon	5	51	0.001	21	65	<0.001	<0.001	<0.001
Nurse	6	26	0.001	18	29	<0.001	<0.001	0.27
Hospital	9	39	0.001	21	50	<0.001	<0.001	<0.001
Should have license suspended								
Surgeon	0	23	<0.001	8	50	<0.001	<0.001	<0.001
Nurse	1	11	<0.001	8	25	<0.001	<0.001	<0.001
Hospital should lose its accreditation	1	11	<0.001	1	15	<0.001	0.73	0.03
Should be required to report the error to the patient or family								
Surgeon	85	95	<0.001	90	95	0.003	0.05	0.60
Nurse	74	67	0.02	70	57	<0.001	0.12	<0.001
Hospital	60	78	<0.001	71	84	<0.001	<0.001	0.005
Should be required to undergo training in the prevention of the type of error that was made								
Surgeon	66	80	<0.001	78	80	0.53	<0.001	0.89
Nurse	71	67	0.17	81	72	<0.001	<0.001	0.05
The hospital should be required to develop systems for preventing similar errors	74	79	0.09	84	84	0.86	<0.001	0.01

*The following vignette was used: "A 67-year-old man goes to the hospital for surgery. He has an allergy to antibiotic drugs, which is noted on his medical record. The surgeon does not notice the information about the allergy and orders an antibiotic to be given at the end of the surgery. A hospital nurse gives the patient the antibiotic." The respondents who received the version that did not involve harm were told, "The patient wakes up with a rash all over his body. The mistake is noticed, the antibiotic is stopped, and the patient fully recovers." The respondents who received the version that did involve harm were told, "The patient wakes up with a rash all over his body and is gasping for air. The mistake is noticed, and the antibiotic is stopped, but the patient stops breathing. Despite every effort, the patient dies."

that the public and, to a lesser extent, physicians hold individual health professionals personally responsible for errors. Although they do support a requirement that hospitals develop systems to prevent future errors, the public is unlikely to support the substitution of a system in which individuals are not subject to sanctions.

The momentum for instituting changes to reduce medical errors is sustained primarily by a range of groups and by the media's interest in the problem — not by practicing physicians or the public. Our findings highlight the issues and potential barriers that national groups such as the IOM, the Leapfrog Group (a consortium of purchasers of health insurance), and the American Medical Association must address if they are to succeed in their efforts to reduce medical errors. Perhaps the most critical issue will be to provide skeptical physicians with scientific proof that the proposed strategies will, in fact, reduce preventable medical errors and the harm they cause.

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LEGISLATIVE RESEARCH REPORT

MARCH 3, 2004

REPORT NUMBER 04.184

PHYSICIANS PRACTICING IN ALASKA

PREPARED FOR REPRESENTATIVE LES GARA

BY PATRICIA YOUNG, MANAGER

You wished to know the number of physicians practicing in Alaska as compared to the population over the last several years. You particularly wished to know if the per capita number of physicians is in a declining trend.

The attached table shows the number of active, state-licensed physicians by year since 1985, as well as the population and the number of practicing physicians per 1,000 residents for each year since that time.[1] As you will see, by this measure, the number of physicians per 1,000 residents has, overall, increased steadily.

We also include a chart prepared by the State Medical Board showing the numbers of physicians as well as other primary health providers since 1985.

I hope you find this information to be useful. Please do not hesitate to contact us if you have questions or need additional information.

[1] These numbers reflect active, state-licensed medical doctors and doctors of osteopathy only. Doctors of podiatric medicine are not included because the numbers of active and inactive practitioners are not separated. We do not include federal physicians; because they are not licensed by the State Medical Board, their annul numbers are far less readily available.

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Alaska Legislature
Legislative Research Services
w3.legis.state.ak.us/Research/research_home.htm

State Capitol
Juneau, AK 99801

State Licensed Physicians and Alaska Population, 1985-2003

Fiscal Year	Population	State Licensed Physicians	State-Licensed Physicians per 1,000 Residents
1985	543,900	815	1.50
1986	550,700	934	1.70
1987	541,300	1,027	1.90
1988	535,000	1,089	2.04
1989	538,900	925	1.72
1990	553,171	1,038	1.88
1991	569,054	1,004	1.76
1992	586,722	1,152	1.96
1993	596,906	1,183	1.98
1994	600,622	1,417	2.36
1995	601,581	1,419	2.36
1996	605,212	1,593	2.63
1997	609,655	1,603	2.63
1998	617,082	1,826	2.96
1999	622,000	1,810	2.91
2000	627,576	2,034	3.24
2001	632,674	1,850	2.92
2002	641,482	2,080	3.24
2003	648,818	2,099	3.24

Notes: Numbers of physicians reflect active state-licensed medical doctors and doctors of osteopathy only; doctors of podiatric medicine are not included because their numbers include both active and inactive practitioners; federal physicians are not included because they are not licensed by the State Medical Board.

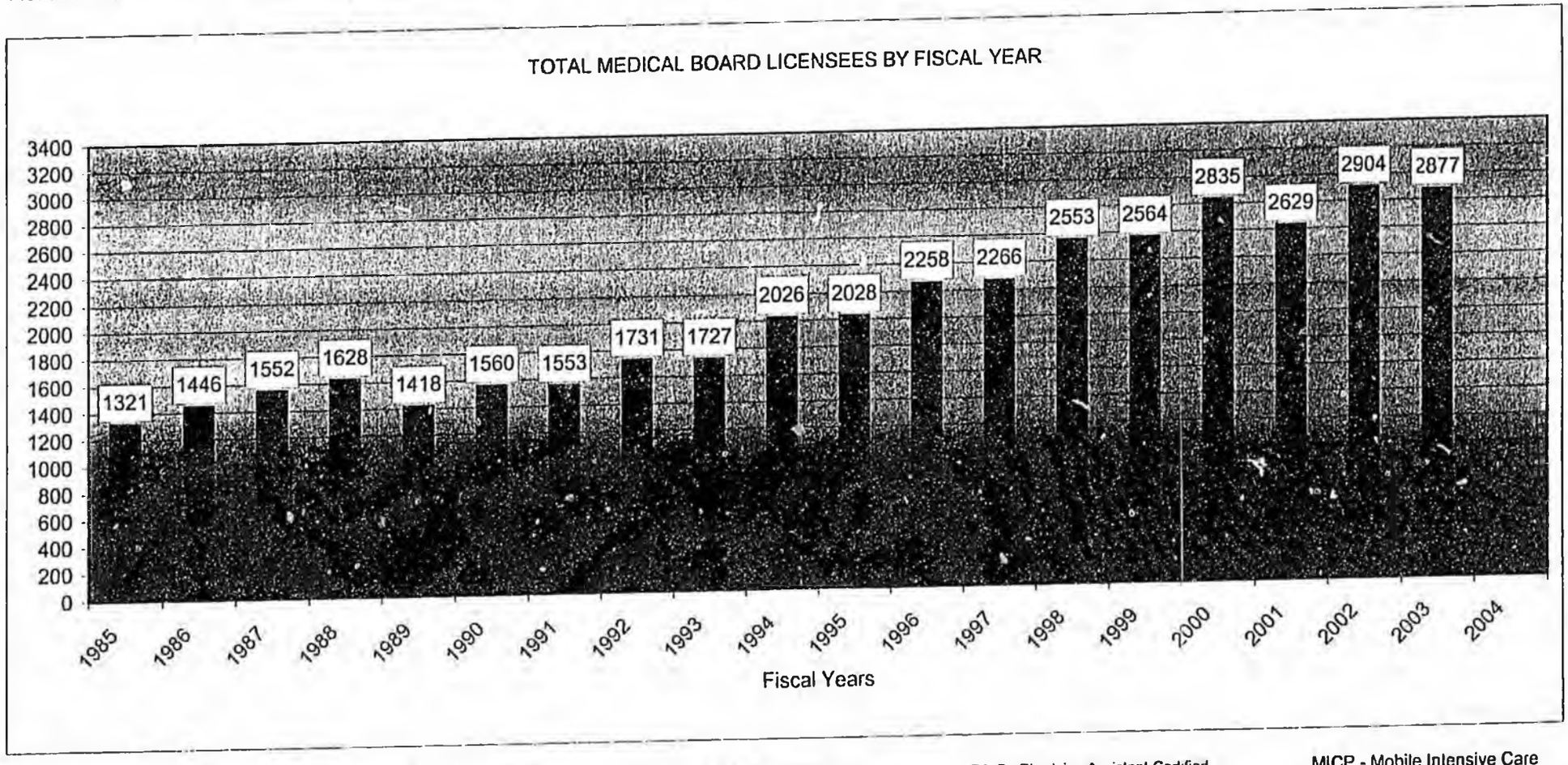
According to the American Medical Association, as reported in "Federal Physicians in 2001," Health Care State Rankings, 2003 (Morgan Quitno Press, 2003, p. 430), in 2001, Alaska had 147 federal physicians.

Population figures for 2003 are provisional.

Sources: Alaska State Medical Board, and Alaska Department of Labor and Workforce Development.

TOTAL PHYSICIANS, PHYSICIAN ASSISTANTS, AND PARAMEDICS BY FISCAL YEAR

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03	FY04
MD/DO Active	815	934	1027	1089	925	1038	1004	1152	1183	1417	1419	1593	1603	1826	1810	2034	1850	2080	2099	
MD/DO Inactive	317	305	279	322	255	254	273	263	243	243	262	262	277	266	300	289	285	268	249	
DPM-Act/Inact	0	11	11	0	0	0	9	11	12	15	13	14	14	15	15	16	16	17	18	
PA-C-Act/Inact	111	111	134	126	138	157	159	186	177	216	200	231	221	255	244	266	245	284	266	
MICP-Active	78	85	101	91	100	111	108	119	112	135	134	158	151	191	195	230	233	255	245	
TOTAL	**1321**	**1446**	**1552**	**1628**	**1418**	**1560**	**1553**	**1731**	**1727**	**2026**	**2028**	**2258**	**2266**	**2553**	**2564**	**2835**	**2629**	**2904**	**2877**	
% Variance from Previous Year	--	+9.4	+7.3	+4.8	-12.9	+10	- .05	+11.4	- .02	+17.3	--	+11.3	.03	+12.6	+.04	+11	-7.8	+10.4	-.09	



MD - Medical Doctor (allopathic)

DO - Doctor of Osteopathy

DPM - Doctor of Podiatric Medicine

PA-C - Physician Assistant-Certified

MICP - Mobile Intensive Care Paramedic

Source: Leslie Gallant, Alaska State Medical Board

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POSITION PAPER ON HOUSE BILL 472/SENATE BILL 319
Alaska Action Trust

INTRODUCTION

In Alaska, to suggest that there is a medical malpractice crisis is at best disingenuous and at worse fraudulent. In short, there is no empirical evidence to support the proposition of a relationship between medical malpractice premiums, medical malpractice litigation and availability of health care providers.

If this proposed legislation passes, you will be responsible for eliminating the ability of stay at home moms and dads, retired or elderly citizens, children, and those with subsistence lifestyles or limited incomes to bring claims against negligent or even reckless doctors or other health care providers. This will be true even when they are blinded, maimed, suffer serious neurological injuries, rendered sexually dysfunctional or even killed by medical malpractice. What makes this proposed legislation even more egregious is that the entire premise for its utility is based upon anecdotal information, unsupported by credible empirical evidence and indeed is contrary to conclusions reached in existing and reliable studies.[1] Even more appalling, there is no corresponding assurance from those most benefited (the insurance industry) that the legislation will have *any* effect whatsoever on medical malpractice rates.

THE HISTORY OF TORT REFORM IN ALASKA

While the following discussion will illustrate the points referenced above, a brief chronological history of similar tort reform efforts in the State of Alaska demonstrates that capping or limiting damages will have absolutely no effect on medical malpractice insurance rates or the availability of medical malpractice insurance to doctors in Alaska or the availability of health care in Alaska.

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[1] Studies repeatedly relied upon by the insurance industry and health care providers pushing similar legislation have been widely discredited. The Milliman report, for instance, relies on data from the National Practitioner Data Bank (NPDP) that has been slammed by the Government Accounting Office (GAO). (*See, e.g.*, GAO: "National Practitioner Data Bank: Major Improvements are Needed to Enhance Data Bank's Reliability," Nov. 2000; Mary Jane Fisher, "GAO Report Slams National Practitioner Data Bank," *National Underwriter*, Jan. 1, 2001). It also fails to adjust any of its figures for medical inflation to offset its conclusion that medical malpractice losses have risen 32% over the last decade in states without caps. When adjusted for 51% in medical inflation for the same time period, paid losses are actually *falling*.

Dating back to 1976 with the passage of A.S. 09.55.548, medical malpractice insurers and health care providers have enjoyed a unique benefit unavailable to other insurers or private citizens. A.S. 09.55.548(b) in effect immunizes these entities and individuals from payment for all past medical expenses incurred as a result of physician and/or health care malpractice paid by private health care plans.

This has resulted in a significant windfall to medical malpractice carriers (and uninsured health care providers) since a private health care plan has no subrogation rights under the statute. The only exception to this windfall is when the collateral source of payment is governmental or quasi governmental such as under Medicare, Medicaid or federal employees who are insured under the federal health care plan. In many cases, this results in savings totaling hundreds of thousands of dollars which are absorbed, unfairly, by other health care plans and ultimately by the citizens of this state through higher health care premiums.

In 1978, again at the urging of medical malpractice insurance carriers and health care providers, the Legislature passed A.S. 09.55.536 requiring the appointment of expert advisory panels in all medical malpractice actions. These panels were appointed by the court and reviewed claims brought by injured Alaskans to determine whether or not malpractice had occurred and, if so, whether the malpractice had caused the patient's injuries. The purported basis for this legislation (as argued by its proponents) was to eliminate or at least minimize frivolous malpractice claims. While the efficacy of the expert advisory panel was always questionable, it has been all but abandoned by health care providers themselves and is no longer requested (it is waived in virtually all cases).

In 1986, the Legislature enacted tort reform legislation placing damage caps on non-economic damage. That legislation capped non-economic damages for injuries that did not result in severe permanent physical impairment or severe disfigurement to $500,000. There was no cap, however, on those injuries that did result in severe permanent impairment or severe disfigurement.

In 1997, sweeping tort law revision was enacted by the Legislature. The previous cap on non-economic damages in cases involving physical injury was reduced to $400,000 (or the injured person's life expectancy multiplied by $8,000) A definitive cap was placed on cases involving severe permanent physical impairment and severe disfigurement of $1,000,000 or the injured persons life expectancy in years multiplied by $25,000. In other words, to exceed the $1,000,000 limitation, a person's life expectancy would have to exceed 40 years.[2]

While the 1997 changes benefited all insurance carriers in the state of Alaska, health

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[2] We mistakenly advised the Committee last week that the cap on non-economic damages was the lesser of $1,000,000 or a multiplier of a person's life expectancy. After reviewing the statute, we realized our mistake. Our oversight underscores the rarity of any claim for non-economic damages exceeding that threshold.

care providers were given additional protection in the form of limiting expert witnesses who could testify on behalf of an injured Alaskan in medical malpractice actions.

A.S. 09.20.185 was enacted requiring that only board certified physicians having expertise and training directly related to the particular field or matter at issue would be allowed to testify regarding standard of care. This requirement is now necessary even though the offending doctor is not board certified in any practice group or specialty. Needless to say, this has made it even more difficult to obtain expert witnesses to testify against offending doctors, particularly since the same doctors belong to national organizations and often know each other personally.

In the face of these sweeping reforms, the insurance industry has repeatedly argued that tort reform benefits policyholders and the public at large. To date, there have been *no* reductions to my knowledge in any insurance rates charged to individual Alaskans. The current legislation that will benefit only health care providers will result in the same outcome. There will be no reduction in health care costs and no reduction in medical malpractice premiums charged in the state of Alaska. As discussed below, this has been repeatedly demonstrated throughout the United States.

THE HISTORY OF MALPRACTICE PREMIUMS IN ALASKA

To best illustrate this point, it is helpful to review the medical malpractice premiums charged in this state dating back to 1993 and compare those to California, the state much touted by the insurance industry because of its previously imposed caps on non-economic damages through the Medical Injury Compensation Reform Act (MICRA). Although the only published premium information readily available deals with the specialties of Internal medicine, General Surgery and OB/GYN, these seem to be the specialties of most concern at least by those physicians and health care providers who testified before the House Judiciary last week.[3]

A cursory review of the premiums charged illustrates the utter lack of credibility of the positions taken by this legislation's proponents. An important thing to remember when reviewing the premiums discussed below is that these are the amounts *charged* by the malpractice carriers. Both NORCAL and MIEC (the current and historical dominant carriers in the Alaska market) give credits back to their insureds. These credits are *not* reported in the data available but it is highly likely that these credits would further substantially reduce the published premiums paid by individual health care providers.[4]

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[3] Medical Liability Monitor [MLM] of Chicago publishes annual rate surveys from premium submissions provided by medical malpractice carriers or obtained directly from state insurance departments throughout the United States.

[4] MLM notes in all of its annual surveys that such credits, discounts and other factors can greatly diminish and sometimes completely offset rate increases. None of the surveys reflect this data, however.

In 1993, NORCAL's premium rates were $12,102 for Internal Medicine doctors, $37,750 for General Surgeons, and $64,518 for OB/GYN's. MIEC's premium rates for the same specialties were $5,487, $19,752, and $32,916 respectively. From 1994 through 1996, NORCAL's rates remained relatively stable. In 1994, MIEC raised its premiums for General Surgeons and OB/GYN's to $38,228 and $63,712 respectively. In 1995, MIEC reduced those rates by about 10 percent.[5]

Between 1997 and 1999, premium rates actually decreased significantly. NORCAL's rates dropped to $8,770 for Internal Medicine doctors, $28,587 for General Surgeons, and $48,706 for OB/GYN's. MIEC reduced its rates to $8,172, $29,420, and $49,032 respectively.[6]

There is no dispute that during this time frame and extending into 2001, most carriers in most states were reducing malpractice premiums because of intense competition in the industry. This competition was reflected in the state of Alaska by the joining of at least two other malpractice carriers to the competitive market.[7] The introduction of new carriers into the competitive market was a national phenomenon. Fierce competition continued to drive down rates for medical professional liability insurance in 1997.[8] In 1999, medical malpractice carriers had been battered from several years of brutal competition, with price cutting the name of the game, even when it meant selling *below* the break-even point.[9]

Back then, leaders in the industry were optimistic that the market would "harden" over the next three years.[10] Then vice president of Florida Physicians Insurance Company, Melodee Dixon, stated, "It will take that amount of time [three years] for claims on policies written at today's grossly inadequate rates to shake out."

Everyone in the industry during this time frame recognized that the amount of

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5 MLM annual surveys for 1993-1995.

6 MLM annual surveys for 1997-1999.

7 Although other carriers may have been in the Alaska market during this time frame, the only entities reporting premiums to MLM appear to be NORCAL, MIEC and joined in 1996 by Physicians Ins. Ex. of Washington and Doctors Co. in 1997. Northwest Physicians Mutual began reporting in 1999. It is unknown when CNA began writing coverage in Alaska.

8 MLM annual survey comments, 1997.

9 "Medical professional liability writers express a very pragmatic, but somewhat optimistic outlook about their market niche. Battered from several years of brutal competition, with price-cutting the name of the game, even when it means selling below the break-even point, these insurers nevertheless think that a market shake-out will come." MLM annual survey, 1999.

10 Market "hardening" is discussed, *infra*.

competition in the industry was causing drastic price cutting and exposing numerous carriers to significant financial risks in the future. These risks were self-inflicted and the resulting losses from malpractice claims were anticipated and predicted by competent actuaries.

The trend of lower malpractice premiums continued through 2000 in the state of Alaska. In 2001, as competition in Alaska and the national market waned, the predicted market "hardening" began to take form. Those carriers that had engaged in risky if not reckless underwriting began to pull out of markets in this state and across the United States. Notwithstanding, the malpractice premium rates in Alaska remained unchanged at MIEC through 2002 and were increased only slightly by NORCAL. In 2001, NORCAL raised its rates to $9,580 for Internal Medicine doctors, $30,872 for General Surgeons, and $52,600 for OB/GYN's.[11]

In 2003, with the market firmly "hardened," the rates from both carriers increased. NORCAL raised its rates for Internal Medicine doctors to $11,209, for General Surgeons to $36,122 and for OB/GYN's to $61,545. MIEC's premium rates were $7,432, $26,748, and $44,580 respectively. Notwithstanding, the premiums charged for 2003 were *less* than those charged by NORCAL for the same practice specialties in 1993, 1994, 1995, 1996 and only slightly higher than those charged in 1997 and 1998. The premium rates charged by MIEC in 2003 were less than those charged by the carrier in 1994, 1995, 1996, 1997, 1998, 1999, and only slightly higher than the premiums charged in 2001 and 2002.[12]

The significance of this rate comparison is even greater when comparing the discounted value of 2003 dollars with the previous years of lower premium rates. In short, these figures reflect an actual *reduction* in malpractice premiums over this time period when viewed in that light without considering the premium credits refunded to health care providers over this same time period. Moreover, when comparing these premiums to the inflation rate of health care costs (and resulting income to physicians), it is clear that these rates have not resulted in *any* increase to the cost of malpractice insurance premiums to health care providers in Alaska through 2003.

THE CALIFORNIA EXPERIENCE

Since California's non-economic damage cap legislation seems to be the model being touted by the proponents of this legislation, it is helpful to review the medical malpractice premiums charged in that state.

Between 1991 and 1997 In California, the medical malpractice premiums for internal medicine doctors, general surgeons and OB/GYNs remained relatively constant between 1991 and 1997. The premium rates charged by NORCAL over that time

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11 MLM annual survey 2000-2001.

12 MLM annual survey 2003.

period for Internal Medicine doctors ranged from $5,692 to $9,472, for General Surgeons, $18,916 to $29,440, and for OB/GYN's, from $31,624 to $49,208. MIEC's premium rates were $5,776, $20,792, and between $34,648 and $39,268 respectively.[13]

Of particular note, and as recognized by numerous commentators, the reason for the relative consistency over this time period had little or nothing to do with medical malpractice non-economic damage caps.

In 1975, California enacted the Medical Injury Compensation Reform Act (MICRA) that placed a cap of $250,000 on non-economic damages in medical malpractice actions. MICRA was touted by the insurance industry and health care practitioners as the solution to the "malpractice crisis" and the solution to increasing malpractice insurance rates. By 1988, however, medical malpractice premiums were 190% higher than 1976 levels (40% when adjusted for inflation to 2001 levels).[14]

In 1988 California voters passed Proposition 103, an insurance reform proposal. This proposition roiled back insurance rates 20% and froze rates for one year. It mandated billions of dollars worth of refunds to policyholders and created a system that required approval of insurance rates, allowing the insurance Commissioner to deny rate proposals that were too high or too low to be actuarially justified. It is following this proposition through 1996 that malpractice insurance rates actually stabilized.[15]

Beginning in 1997, insurance rates in California *again* began to increase substantially. In 1997, NORCAL's premium rates for Internal Medicine doctors ranged up to $9,472, for General Surgeons, up to $29,440 and for OB/GYN's, up to $49,208. The rates continued to increase slightly between 1999 and 2001. Since that time, through 2003, the rates have increased to ranges up to $25,178, $58,830, and $77,814 respectively. During this same time period, MIEC's premium rates have increased from their 1996 -- 1998 rates to a range up to $9,305, $27,682, and $50,340 respectively. Accordingly, even with MICRA reform, malpractice rates have steadily *risen* in California and are comparable to or substantially greater than malpractice premium rates charged in this state by the same companies notwithstanding the lack of additional caps on non-economic damages.[16]

THE INSURANCE INDUSTRY ADMITS THAT CAPS WILL NEITHER REDUCE PREMIUMS NOR ARE CAPS RELATED IN ANY WAY TO THE AVAILABILITY OF HEALTH CARE

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13 MLM annual surveys, 1991-1997.

14 *How Insurance Reform Lowered Doctors Medical Malpractice Rates in California*, The Foundation for Taxpayer and Consumer Rights, February 10, 2003, excerpted from N.C. trial lawyers expose on malpractice rates in N.C.

15 *Id.*

16 MLM annual surveys, 1996-2003.

Misinformation regarding the efficacy of caps on non-economic damages and purported decreases in medical malpractice premiums has been disseminated by health care providers and malpractice insurers in other states as well.

In Florida, after pushing through a sweeping medical malpractice bill in August with a promise to reduce ever-increasing insurance premiums for Florida's physicians, malpractice insurance carriers followed up the bill's passage with a request to increase premiums by as much as 45 percent.[17]

In 2003, Oklahoma passed a tort reform bill that included a severe cap on compensation available to certain medical malpractice victims. Following passage of that bill, the insurance company owned by the state medical association requested an astounding 83 percent rate hike which was subsequently approved on the condition that it be phased-in over three years.[18]

In January 2003, Ohio lawmakers enacted a cap on compensation for patients injured by medical malpractice. Almost immediately, all five major malpractice insurance companies in Ohio announced that they would not reduce their rates. One insurance executive predicted his company would seek a 20 percent rate increase.[19]

This should come as no surprise to those familiar with the insurance industry and particularly with malpractice carriers.

Bob White, president of First Professional Insurance Co., the largest medical malpractice insurer in Florida stated that "no responsible insurer can cut its rates after a [medical malpractice tort reform] bill passes."[20] Cliff Webster representing the Washington State Medical Association and Chairman of the Washington Liability Reform Coalition told the Washington State Legislature, House Judiciary Committee in 2003 that "I don't think we would argue that the premiums are likely to go down."[21]

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17 *See, e.g.*, Julie Kay, "Medical Malpractice; Despite Legislation that Promised to Rein in Physicians Insurance Premiums, Three Firms File For Big Rate Increases," *Palm Beach Daily Business Review*, Nov.20, 2003.

18 *BestWire*, Dec. 2, 2003.

19 Laura Bischoff, "Taft Signs Malpractice Reform Bill; Cap on Awards for Pain and Suffering," *Dayton Daily News*, Jan. 11, 2003; Andrew Welsh-Huggins, "Doctors Pushing for Short-Term Relief From Malpractice Rates," *Associated Press*, Jan. 10, 2003; "Despite New Law, Insurance Companies Won't Lower Rates Right Away," *Associated Press*, Jan. 9, 2003.

20 *Palm Beach Post*, Jan. 29, 2003.

21 Testimonial excerpt from testimony before the Washington State Legislature, House Judiciary, Feb. 21, 2003.

Sherman Joyce, President of the American Tort Reform Association candidly acknowledged, "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates."[22] James Robertson, Assistant Vice President and Associate Actuary for SCPIE Indemnity Company (California's second largest medical malpractice insurer) stated "while MICRA was the Legislature's attempt at remedying the medical malpractice crisis in California in 1975, it did not substantially reduce the relative risk of medical malpractice insurance in California." He made that statement in a written response to a question from an administrative law judge overseeing the case in which his company had requested another 15.6% rate hike.

In short, virtually every reliable empirical source underscores the certainty that limiting an injured persons access to the court system for damages has little or nothing to do with insurance premiums for the cost of health care delivery.

In January 2004, the Congressional Budget Office (CBO) concluded that legislation to cap damages in medical malpractice lawsuits would do little to hold down health care spending or eliminate the practice of defensive medicine. Moreover, the report found that medical malpractice insurance premiums have increased in part because of reduced income from insurer investments and short-term factors in the insurance market. The report found that although malpractice insurance premiums are somewhat lower in states with caps on damages, even a large savings in premiums would have a small impact on total health care spending because malpractice insurance costs account for less than two percent of health care spending. The CBO concluded that caps on damages in malpractice suits would not likely end the practice of defensive medicine. That is because physicians who practice defensive medicine may do so less because they fear liability than to generate more income. Equally compelling, the GAO concluded that many reported shortages of health care services [based on these factors] could not be substantiated or did not widely affect access to health care.[23]

In a sweeping and thorough investigation for AIR under the direction of Mr. Robert Hunter (former Federal Insurance Administrator and Texas Insurance Commissioner) it was determined that insurers make most of their profits from investment income. During years of high interest rates or excellent returns in the market, insurance

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22 "Study Finds No Link Between Tort Reforms and Insurance Rates," *Liability Week*, July 19, 1999.

23 *Congress Daily,* Jan. 13, 2004. The same argument of "fleeing" doctors and fear of inability to attract new ones has been completely debunked in Washington. Doctors for Medical Liability Reform claimed that 500 doctors had left the state between 1998 and 2004. They failed to mention, and did not research, however, how many doctors had moved to Washington over the same time frame. According to the 2003 GAO report, there were more doctors per capita in 2001 than in 1998. Moreover, despite arguments to the contrary, there was no indication that health care delivery was being curtailed or eliminated. Carol Ostrom, "Contrary to Ads, Doctors Replaced, Clinics Still Open," *Seattle Times*, Feb. 23, 2004.

companies engaged in fierce competition for premium dollars to invest and maximum returns. They severely under price premiums for policies and insure very poor risks to get premium dollars to invest. This is known as the "soft" insurance market. When the investment climate turns sour, however, the industry responds by sharply increasing premiums and reducing coverage, creating a "hard" insurance market, usually degenerating into a "liability insurance crisis."[24] This is precisely what is proven conclusively by reviewing the comments and premium surveys discussed above.

Moreover, the Hunter report concluded that since the early 1980's, medical malpractice paid claims per doctor has tracked (approximately) medical inflation. In fact, inflation-adjusted payouts for physicians dropped between 2000 and 2002.[25] This data confirms that neither jury verdicts nor any other factor affecting total claims paid by insurance companies that write medical malpractice insurance have had much impact on the system's overall costs over time. Even more compelling, since 1975, the data shows that in terms of constant dollars, per doctor written premiums, the amount of premiums that doctors have paid insurers have gyrated almost precisely with the insurer's economic cycle which is (again) driven by such factors as changing insurance rates, mismanaged business and accounting practices as well as other causes.[26]

MEDICAL MALPRACTICE IN ALASKA – THE REALITY

In summary, what is being touted as a basis for the passage of this legislation is without merit. The following facts underscore why this legislation is bad for Alaskans.

1. Fact: Citizens who are elderly or retired, citizens living a subsistence lifestyle, stay at home parents, and children will be without any legal remedy for even the most egregious instances of medical malpractice. Since they have little or no economic loss, they will not be able to obtain legal counsel to pursue a medical malpractice claim even if they are blinded, crippled, maimed, rendered sexually dysfunctional, or die after a sustained period of suffering. The cost of bringing such claims will easily exceed any potential recovery.

Real-Life Examples:

Linda McDougal -- this is the much-publicized case involving the 46-year-old Navy veteran who underwent a double mastectomy after mistakenly being diagnosed with an aggressive breast cancer. Her pathology results had been mistakenly switched with another woman who in fact had breast cancer. This woman is now horribly scarred for

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[24] Americans for Insurance Reform, Medical Malpractice Insurance: Stable Losses/Unstable Rates in Wyoming, Feb. 2004.

[25] *Id.*

[26] *Id.*

life.

Jennifer -- Jennifer was a beautiful and vibrant 12-year-old Alaskan who was misdiagnosed twice over a three-day period with gingivitis. She was actually suffering from acute leukemia, which was very treatable and survivable but requires a timely diagnosis and urgent medical intervention. This could have been determined with a simple and inexpensive blood test. Unfortunately, given the delay in her diagnosis, she hemorrhaged and died before she could be properly diagnosed. Although this was a clear-cut case of negligence, over $100,000 in out-of-pocket costs were expended before the case settled. Under the proposed legislation, this case could never have been prosecuted and Jennifer, her parents, and three siblings would have been without any remedy at all.

Susan -- Susan was an Alaskan in her early 30's when she was misdiagnosed and refused treatment by several health care providers over a five-day period. Unfortunately, she was suffering from a well-known medical and orthopedic emergency known as cauda equina syndrome. By the time she was finally correctly diagnosed, she had suffered permanent saddle anesthesia (no feeling from her waist to her mid thigh); permanent lower extremity neurological injuries requiring leg braces, and intermittent bowel and bladder dysfunction. Under this legislation, since she could still work at her profession, she would be left with a remedy of $250,000. Despite clear-cut negligence, costs of over $200,000 were expended before settlement was reached.

Traven -- Traven was an adventurous eight-year-old Alaskan boy who sustained lower extremity burns that were entirely survivable and treatable. Unfortunately, due to a series of medical mistakes, he languished for days with an increasingly more severe infection and ultimately lapsed into a coma (with his parents present). He was finally flown to Seattle Children's Hospital where he died. Under this legislation, it would be financially difficult or impossible to bring this claim since his entire family, like Jennifer's above, as well as his estate would be limited to $250,000 in non-economic damages. Although an economic loss to his estate could be claimed, those losses are more difficult to establish for children and are usually so low as to not warrant prosecution of a claim absent non-economic damages.

Mrs. Strong -- Mrs. Strong was a 32-year-old Alaskan mother of two children who was drastically over dosed with a highly caustic chemotherapy drug. The overdose was approximately 8 times what she was supposed to be given and was repeatedly administered over the course of 4 days. She died a horrible death, essentially burning up from the inside out over the course of 6 days. She never had a chance to say goodbye to her children, husband, or her parents. Since she was a mom and essentially out of the work force, she would have had little economic loss and, under this bill, her estate and entire family would be limited to $250,000 in losses.

These are only a few of the many actual cases that we can provide this committee as concrete examples of why this bill works such gross inequities on the innocent people in

correction!!

Americans die annually from medical errors in hospitals. On December 12, 2002, the New England Journal of Medicine reported that 4 out of 10 Americans and 1 out of 3 doctors say that they or their family members have been the victims of a preventable medical error; 10% of doctors say that a family member died as a consequence.[28] How will this legislation address these problems other than to make it financially easier on negligent health care providers and their insurance carriers?

should be 7%

Fact: Repeat offender physicians are responsible for most medical errors. According to a study recently conducted in North Carolina, 3.2% of North Carolina doctors had paid out two or more medical malpractice settlements to patients but were responsible for a total of nearly 42% of all payments reported to the National Practitioner Data Bank.[29] A study conducted by researchers at Vanderbilt University found that doctors with a history of malpractice claims can be expected to have "appreciably worse claims experience" than other doctors in the future.[30] This legislation would protect those health care providers by sharply limiting their exposure for continued malfeasance.

Fact: Medical Malpractice insurance costs are declining as a percentage of physician expenses. A recent USA Today report stated that, on average, doctors currently pay 3.2% of their revenue for medical liability insurance.[31] In 1987, medical malpractice insurance costs were, on average, 12.1% of the physician's total expenses. In the ensuing decade that share was cut in half, falling to less than 7% of total expenses in the late 1990's. Based on the most current statistics available from the American Medical Association, there is a clear and consistent decline in medical malpractice costs as a percentage of a physician's total expenses.[32]

In conclusion, this is without a doubt the most offensive example of self-interest legislation proposed in the last 25 years in Alaska. It is utterly without any reliable factual support for the premise of its proposed utility. It will only serve to benefit the insurance industry and those physicians who engage in negligent and sometimes reckless misconduct. While there are relatively few cases filed in this state alleging medical malpractice, this legislation will severely impact if not entirely eliminate a substantial portion of legitimate and worthy claims. It will leave horrifically injured

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26 *New England Journal of Medicine*, December 12, 2002.

29 *Medical Misdiagnosis in North Carolina*, Public Citizens Congress Watch, April 2003.

30 "Medical Malpractice Experience of Physicians: Predictability or Haphazard?" *Journal of the American Medical Association*, 1989--cited in Medical Misdiagnosis, *Id.*

31 "Hype Outraces Facts in Malpractice Debate," *USA Today*, March 3, 2003.

32 American Medical Association, *Socioeconomic Characteristics of Medical Practice*, 2000 as quoted from N.C. trial lawyer expose.

our State who are the most vulnerable. If you would like to hear about them, please advise and we will provide additional summaries.

Fact: The passage of this legislation will have no impact on medical malpractice premiums in this state and will have no impact on the ability to attract health care professionals to practice here. Other than anecdotal and unsupported comments to the contrary, there is absolutely no evidence to suggest that health care providers stay away from Alaska because of medical malpractice insurance premiums. Indeed, it is considered one of the top 75 places in the United States to practice medicine.[27] This is based in no small part on the lack of managed-care. Further, according to the State Medical Board, the number of medical board licensees has more than doubled since 1985.[28] As discussed above, the argument that the lack of caps discourages doctors from practicing has been posited and rejected by the CBO and others.

Fact: The Institute of Medicine reported three years ago that as many as 98,000 Americans die annually from medical errors in hospitals. On December 12, 2002, the New England Journal of Medicine reported that 4 out of 10 Americans and 1 out of 3 doctors say that they or their family members have been the victims of a preventable medical error; 10% of doctors say that a family member died as a consequence.[29] How will this legislation address these problems other than to make it financially easier on negligent health care providers and their insurance carriers?

Fact: Repeat offender physicians are responsible for most medical errors. According to a study recently conducted in North Carolina, 3.2% of North Carolina doctors had paid out two or more medical malpractice settlements to patients but were responsible for a total of nearly 42% of all payments reported to the National Practitioner Data Bank.[30] A study conducted by researchers at Vanderbilt University found that doctors with a history of malpractice claims can be expected to have "appreciably worse claims experience" than other doctors in the future.[31] This legislation would protect those health care providers by sharply limiting their exposure for continued malfeasance.

Fact: Medical Malpractice insurance costs are declining as a percentage of physician expenses. A recent USA Today report stated that, on average, doctors

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27 Modern Physician, "The List" www.modernphysician.com.

28 Chart "Total Medical Board Licensees by Fiscal Year, 1985-2003. Division of Occupational Licensing

29 *New England Journal of Medicine*, December 12, 2002.

30 *Medical Misdiagnosis in North Carolina*, Public Citizens Congress Watch, April 2003.

31 "Medical Malpractice Experience of Physicians: Predictability or Haphazard?" *Journal of the American Medical Association*, 1989--cited in Medical Misdiagnosis, *Id.*

currently pay 3.2% of their revenue for medical liability insurance.[32] In 1987, medical malpractice insurance costs were, on average, 12.1% of the physician's total expenses. In the ensuing decade that share was cut in half, falling to less than 7% of total expenses in the late 1990's. Based on the most current statistics available from the American Medical Association, there is a clear and consistent decline in medical malpractice costs as a percentage of a physician's total expenses.[33]

Fact: Medical malpractice cases make up a very small percentages of cases filed in Alaska.

Fact: Most medical malpractice verdicts in Alaska are in favor of the defendant doctor. In the history of Alaska there is only one jury verdict against health care providers that was over one million dollars.

In conclusion, this is without a doubt the most offensive example of self-interest legislation proposed in the last 25 years in Alaska. It is utterly without any reliable factual support for the premise of its proposed utility. It will only serve to benefit the insurance industry and those physicians who engage in negligent and sometimes reckless misconduct. While there are relatively few cases filed in this state alleging medical malpractice, this legislation will severely impact if not entirely eliminate a substantial portion of legitimate and worthy claims. It will leave horrifically injured patients and their families with a lifetime of misery, pain, and suffering with no remedy.

There is a substantial statistical chance that this legislation will affect one or more of you or a member of your family on a very personal basis during your lifetime. When you consider that it is estimated by health care safety monitors in Alaska that over 30 percent of providers don't even wash their hands before examining a patient, the chances of negligently passing on infectious disease is very high. [34] At least consider your safety and the safety of others before passing this grossly unfair legislation.

Very Truly Yours,

The Alaska Action Trust
Melissa Fouse, Executive Director

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32 "Hype Outraces Facts in Malpractice Debate," *USA Today*, March 3, 2003.

33 American Medical Association, *Socioeconomic Characteristics of Medical Practice*, 2000 as quoted from N.C. trial lawyer expose.

34 Anchorage Daily News, March 2, 2004, Page D-1 "Patient Power"

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Medical Malpractice Caps

The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage

by

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Table of Contents

Executive Summary 3

Introduction 5

Part 1. The Real Relationship between Caps and Med Mal Premiums 7

Part 2. Other Factors Driving Up Med Mal Premiums 9

Part 3. Conclusions and Recommendations 13

Appendix 1. States with Caps: Median Medical Malpractice Payouts/Premiums 1991 – 2002 16

Appendix 2. States without Caps: Median Medical Malpractice Payouts/Premiums 1991 – 2002 17

Appendix 3. Weakest Medical Malpractice Insurers 18

Appendix 4. Other Studies and Position Statements Published By Participants in This Debate 19

Medical Malpractice Caps

The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage

Executive Summary

Soaring premiums on medical malpractice insurance ("med mal") are a national crisis, invading the practice of medicine, threatening the availability of care, and prompting widespread public outcry. Physicians and the insurance industry place the blame on out-of-control jury awards, and, in response, 19 states have implemented caps on non-economic damages—a key measure now included in various congressional proposals. However, the actual experience of the states with caps does not support these proposals. It shows that:

Caps did reduce the burden on insurers...

- In states with caps, the median payout between 1991 and 2002 was 15.7% lower than the median in states without caps, despite the fact that many states did not impose the caps until late in the 12-year period.
- Moreover, in states with caps, the payouts increased by 83.3% from 1991 to 2002, while the rate of increase in states without caps was 127.9%.

But most insurers continued to increase premiums at a rapid pace, regardless of caps...

- In states with caps, the median annual premium went up by 48.2%, but, surprisingly, in states *without* caps, the median annual premium increased at a *slower* clip—by 35.9%.
- Among the states with caps, only 10.5% experienced flat or declining med mal premiums. In contrast, among the states *without* caps, the record was actually *better*: 18.7% experienced flat or declining premiums.

These counter-intuitive findings can lead to only one conclusion: There are other, far more important factors driving the rise in med mal premiums than caps or med mal payouts. These include:

- The medical inflation rate. In the 12-year period through 2002, medical costs rose 75%.

- The insurance business cycle. The property and casualty industry as a whole suffered an unusually long 12-year "soft" period in the insurance business cycle through 1999, resulting in loose underwriting practices—not enough money in premiums collected to cover anticipated claims. At the end of the cycle, in an attempt to catch up, insurers began to tighten underwriting standards and raise premium rates.

- The need to shore up reserves. Med mal insurers have been consistently under-reserving since 1997—to the tune of $4.6 billion through December 31, 2001. The only way to shore up reserves is to increase premiums.

- A decline in investment income. With falling stock prices and declining interest rates, investment income for the entire property/casualty industry fell 23% in 2001 compared to 2000, and then *another* 2.5% in 2002. Moreover, investment income is particularly critical for lines of business like med mal where the duration of claims payouts typically spans several years.

- Financial safety. Based on the Weiss Safety Ratings, we find that 34.4% of the nation's med mal insurers are vulnerable to financial difficulties (those with a rating of D+ or lower), as compared to 23.9% of the property and casualty industry as a whole. In order to restore their financial health, many med mal insurers will remain under pressure to increase premiums despite new laws to cap payouts.

- Supply and demand. The number of med mal carriers increased until 1997, but has since fallen from 274 in that year to 247 in 2002. Moreover, in certain regions and medical specialties, there is evidence that some med mal insurers have pulled out or discontinued coverage.

Recommendations:

Legislators should put proposals involving non-economic damage caps on hold until convincing evidence can be produced to demonstrate a true benefit to doctors in the form of reduced med mal costs. *Regulators* must review and revise their parameters for approving rate increases. *Insurance companies* must never again allow marketing to divert or pervert prudent actuarial analysis and planning. The *medical profession* must assume more responsibility for policing itself, while states must be more pro-active in reviewing the licenses of individual practitioners. And *consumers* must not relinquish their right to sue for non-economic damages until the medical profession and/or state and federal governments provide more adequate supervision and regulation of doctors, hospitals, and other health care providers.

Introduction

In the last few years, soaring premiums on medical malpractice insurance ("med mal") have emerged as a national crisis, invading the practice of medicine, threatening the availability of care, and prompting widespread public outcry.

Many doctors, particularly in high-risk specialties, have received renewal notices announcing premium increases of 100% or even 200% over the previous year. Others have simply been dropped by their insurance carriers, forcing them to shop for new med mal coverage, practice without any coverage at all, or stop practicing medicine altogether—all painful alternatives.

The insurance industry places the blame on out-of-control jury awards. In response, legislators in many states, accepting this argument at face value, have implemented tort reform to restrict awards in their states. Their primary vehicle: *Non-economic damage caps,* which limit the awards to an injured patient for intangible injuries, such as pain and suffering. Since 1975, 19 states have implemented these caps[1] at various levels ranging from $250,000 to $1 million, as follows:

State	Cap ($)	Year Adopted
Alaska	500,000	1997[2]
California	250,000	1975
Colorado	250,000	1998
Hawaii	375,000	1976
Idaho	682,000	1990*
Indiana	1,000,000	1990
Kansas	250,000	1994
Louisiana	500,000	1975
Maryland	805,000	1986*
Massachusetts	500,000	1997
Michigan	624,000	1993*
Missouri	547,000	1988*
Montana	250,000	1997
New Mexico	600,000	1996
North Dakota	500,000	1996
Utah	250,000	1996
Virginia	1,000,000	1992
West Virginia	1,000,000	1986
Wisconsin	350,000	1995*[3]

*Caps are adjusted annually for inflation.

[1] The implementation of caps on non-economic damages has no impact on jury awards for actual damages such as medical expenses and loss of income.

[2] Applies to incidents occurring before August 1997. After August 1997: the cap is the greater of $400,000 or life expectancy times $8,000 except in the case of severe disfigurement or physical impairment in which the cap is the greater of $1 million or life expectancy times $25,000.

[3] Applies to damages from all health care providers except in wrongful death cases. Damages in wrongful death are limited to $500,000 for the death of a minor and $350,000 for the death of an adult.

Now, in an attempt to cope with the emerging med mal crisis, the push to impose caps has reached the federal level, with a number of legislative proposals to institute reforms, usually including, as the most salient feature, a $250,000 nationwide cap.

This white paper is not driven by a political ideology or industry-driven self-interest. It is, rather, an objective, data-driven analysis of:

- the real relationship between caps and med mal premiums (Part 1)
- other forces behind rising premium rates (Part 2)
- lessons to be learned from the crisis along with effective long-term solutions (Part 3).

Part 1. The Real Relationship between Caps and Med Mal Premiums

On the surface, the theory behind caps on non-economic damage awards seems logical: caps would limit the payouts by insurers, and the lower payouts, in turn, would naturally enable the insurers to reduce med mal premiums. As we shall demonstrate below, however, in the real world of the med mal insurance business, only the first half of this theory is working.

Caps do reduce the burden on insurers...

Using data provided by the National Practitioner Data Bank, we compared the median payouts in the 19 states with caps to those in the 32 states without caps[4] for the period between 1991 and 2002, with the following results:

- **Payouts reduced.** In states without caps, the median payout for the entire 12-year period was $116,297, ranging from $75,000 on the low end to $220,000 on the high end. In states with caps, the median was 15.7% lower, or $98,079, ranging from $50,000 to $190,000.[5] Since caps in many states were not imposed until late in the 12-year period, this represents a significant reduction.

- **Growth in payouts slowed substantially.** The median payout in the 32 states without caps increased by 127.9%, from $65,831 in 1991 to $150,000 in 2002. In contrast, payouts in the 19 states with caps increased at a far slower pace—by 83.3%, from $60,000 in 1991 to $110,000 in 2002.

In short, it's clear that caps do accomplish their intended purpose of lowering the average amount insurance companies must pay out to satisfy med mal claims.

But insurers continue to increase premiums at a rapid pace, regardless of caps.

Using 1991 to 2002 data published by the Medical Liability Monitor, we examined the median med mal premiums paid by doctors in three high-risk specialties—internal medicine, general surgery, and obstetrics/gynecology. The results:

1. **States with caps had sharper increases in median annual premiums.** Since the insurers in the states with caps reaped the benefit of lower med mal payouts, one would expect that they'd reduce the premiums they charged doctors. At the very minimum, they should have been able to slow down the rate of premium increases. Surprisingly, the data show they did precisely the opposite:

    - In the 19 states with caps, the median annual premium increased by 48.2%, from $20,414 in 1991 to $30,246 in 2002.

[4] For the purposes of this analysis, the District of Columbia is being referred to as a "state" since it effectively operates as such with regard to insurance regulation.
[5] Adjusted for inflation in order to evaluate figures spanning multiple years.

- In the 32 states *without* caps, the median annual premium actually increased at a *slower* pace—by 35.9%, from $22,118 in 1991 to $30,056 in 2002.

Thus, on average, *doctors in states with caps actually suffered a significantly larger increase than doctors in states without caps.*

2. **A smaller proportion of states with caps were able to contain premium increases.** In some states, the median annual premiums remained flat or even declined at various times during the period. Was *this* related to the imposition of caps? In the overwhelming majority of states, the answer is clearly "no." Indeed...

   - Among the 19 with caps, only two states, or 10.5%, experienced flat or declining med mal premiums following the imposition of caps.

   - Meanwhile, among the 32 without caps, the record was actually much better: Six states, or 18.7%, experienced flat or declining premiums.

3. **Premiums in states with caps are more likely to exceed national median.** Focusing on the most recent data, we find that:

   - In 47.4% of the states with caps (9 out of 19), 2002 median premiums were below the national median premium of $30,093.

   - Meanwhile, in 50% of the states without caps (16 out of 32), 2002 median premiums were *below* the national median.

In short, the results clearly invalidate the expectations of cap proponents. To review the surprising facts:

- Insurers in states with caps raised their premiums at a significantly faster pace than those in states without caps.

- Even with the imposition of caps, insurers in nearly nine out of ten states continued to raise rates, while insurers in states without caps were actually *more* likely to hold or cut their premium rates.

- In states with caps, insurers are more likely to charge med mal premiums exceeding the national median than those in states without caps.

These counter-intuitive findings can lead to only one conclusion: There are other, far more important factors driving the rise in med mal premiums than caps or med mal payouts, the subject of the next section.

Part 2. Other Factors Driving Up Med Mal Premiums

We have identified six factors driving up premiums, each of which may be exerting a greater impact on premiums than the presence or absence of caps. These are (1) medical cost inflation, (2) the cyclical nature of the insurance market, (3) the need to shore up reserves for policies in force, (4) a decline in investment income, (5) overall financial safety considerations, and (6) the supply and demand of coverage. We examine each of these factors below.

1. Medical Cost Inflation

The medical inflation rate in the 12-year period was 75%[6] (i.e., $1 of medical expenses in 1991 cost $1.75 in 2002). However, throughout the country, insurers had a general tendency to let their premium increases lag behind the pace of medical inflation. This was most likely due to the extended soft market experienced by the entire property and casualty insurance industry in the 1990s, explained below.

2. The Cyclical Nature of the Insurance Market

The market for property/casualty insurance, including med mal, is historically and fundamentally cyclical, with periods of rising premium rates followed by periods of steady or declining premiums. In the declining portion of the cycle—"a soft market"—insurers relax their underwriting standards and underprice their products in order to retain or gain market share.

The most recent soft market lasted longer than usual—12 years, from 1987 to 1999—probably because of the raging bull market in stocks. Insurers made so much money in their investments they were able to aggressively underprice their policies, deliberately lose money in their underwriting, and still turn a profit overall. As a result, losses in their core operations, more than offset by surging gains from the stock market boom, were largely overlooked by the industry and regulators alike.

All that changed when the stock market boom turned to bust. Property and casualty insurers had to confront the ramifications of their loose underwriting practices: not enough money in premiums collected to cover anticipated claims. That's when they began to seriously tighten underwriting standards and raise premium rates.

3. The Need to Shore Up Reserves for Policies in Force

When insurers write a new policy, they look at past claims experience, make some actuarial assumptions, and place a portion of that policy's premium into a reserve to cover expected future claims. A prudent insurer will make conservative assumptions and err on the side of having more in reserve than it ultimately needs to pay claims. At the end of each year, the insurer then evaluates its reserves for each block of business and determines if a change is warranted to either add or subtract reserves.

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[6] Medical inflation rate: 1991: 8.7%, 1992: 7.4%, 1993: 5.9%, 1994: 4.8%, 1995: 4.5%, 1996: 3.5%, 1997: 2.8%, 1998: 3.2%, 1999: 3.5%, 2000: 4.1%, 2001: 4.6%, 2002: 4.7%.

Data reported to the National Association of Insurance Commissioners (NAIC) show that med mal insurers have been consistently under-reserving since 1997—to the tune of $4.6 billion through December 31, 2001. The under-reserving came to a head in 1999, at the tail end of the soft market. That's when loose underwriting practices caught up with the insurers, as claims rose to a higher level than expected. Thus, even before the bull market ended in the stock market, insurers were coming under increasing pressure to boost their reserves to make up for past shortfalls.

There's only one place these funds could come from—the company's capital; and there was only one way the company could maintain or build its capital—by making more profits. Thus, premium increases were inevitable.

4. A decline in investment income

Until 2000, most of the additional profits insurers needed could be covered by rising investment income and gains from the booming stock market. But during the three-year bear market from 2000 to 2002, as large stock market gains turned to even larger stock market losses, insurers were confronted with double trouble:

- After just one year of premium increases, they still had barely begun to restore their reserves.

- Now, aggravating their difficulties, they also needed to compensate for stock market losses. With falling stock prices and declining interest rates, investment income[7] for the entire property/casualty industry fell 23% in 2001 compared to 2000, and then *another* 2.5% in 2002; and we must assume that med mal insurers suffered a similar decline. Indeed, investment income is particularly critical for lines of business like med mal where the duration of claims payouts typically span several years.

Thus, it was the combination of two powerful forces—under-reserving throughout most of the 1990s *plus* the rapid fall in investment income in the 2000s—that largely drove the unusually rapid premium increases, not only in med mal, but in many other property and casualty lines as well.

5. Financial Safety

If insurers do not replace capital that has been used to shore up reserves, the financial strength of the company deteriorates, ultimately leading to the possibility of financial failure.

The Weiss Safety Ratings measure an insurer's overall financial strength based on evaluations of its capitalization, reserve adequacy, profitability, liquidity, and stability. Among the 2,851 property and casualty insurers reporting to the NAIC, 247 companies wrote at least some med mal policies in 2002, with 90 of these deriving at least 50% of their total premiums from the med mal sector.

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[7] Investment income is defined as capital gains plus interest income.

Within this group of 70, which we define as "med mal insurers," there were a higher-than-average number of vulnerable companies, as compared to the property and casualty industry as a whole (Table 1).

Table 1. Safety of Insurers: Med Mal vs. All Property and Casualty Insurers

Weiss Safety Rating Category	2003 All P&C Insurers	2003 Med Mal Insurers
Secure	76.1%	65.5%
Vulnerable	23.9%	34.4%

"Secure" includes companies rated A (Excellent), B (Good), and C (Fair).
"Vulnerable" includes those rated D (Weak) and E (Very Weak)

What progress have med mal insurers made in restoring their financial health by raising premiums? So far, none: Despite higher premiums since 1999, there has been no improvement in the financial safety of the med mal insurers. Quite to the contrary, the proportion of insurers in the "vulnerable" category has increased since 1999 (Table 2).

Table 2. Safety of Med Mal Insurers: 2003 vs. 1999

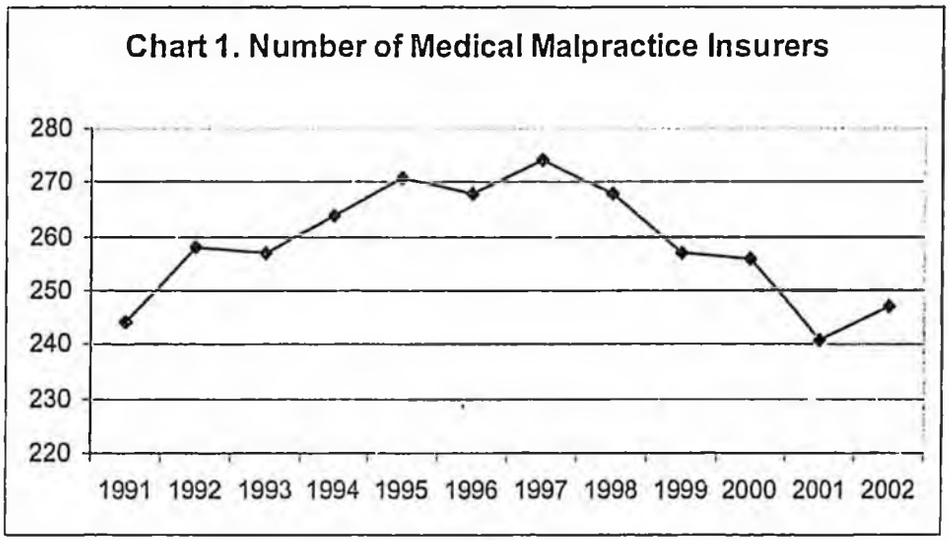
Weiss Safety Rating Category	2003 Med Mal Insurers	1999 Med Mal Insurers
Secure	65.5%	69.0%
Vulnerable	34.4%	31.0%

Thus, in order to restore their financial health, *many med mal insurers will remain under pressure to continue to increase premiums despite any new laws that are enacted to cap individual payouts.*

6. The Supply and Demand of Coverage

Press reports have highlighted the plight of physicians around the country who are closing up shop because their med mal insurer is pulling out of the local market.

To help determine if this is an industry-wide problem, for each year between 1991 and 2002, we counted the number of insurers that are writing new med mal policies and/or renewing existing policies (Chart 1).



The number of carriers providing med mal coverage nationwide increased from 244 in 1991 to a peak of 274 in 1997. Since 1997, however, the number of carriers declined steadily to a low of 241 in 2001, recovering slightly to 247 in 2002.

Compared to 1991, therefore, there has actually been a modest *increase* in the number of med mal carriers—from 244 to 247.

However, doctors are currently feeling the pressures of diminished supply reflected in the declining trend since 1997. Moreover, in certain regions and in certain medical specialties, there is abundant anecdotal evidence that certain med mal insurers have pulled out or discontinued coverage.

Part 3. Conclusions and Recommendations

There is no doubt that the implementation of non-economic damage caps has resulted in lower claim payouts for insurers. For caps to be considered successful, however, the lower payouts would need to translate into lower med mal premiums for medical professionals. Unfortunately, that has not been the case due to the continuing presence of other, far more significant factors driving premium rates higher.

Indeed, the 1991 to 2002 data indicate that the presence of caps may be *inversely correlated* to med mal premium levels. We have no data to pinpoint the reasons for this perverse result and therefore can only speculate as to what they may be. Some possibilities include:

- Legislatures in states with a preponderance of unprofitable med mal insurers may have been among those that were most pressured by those insurers and their lobbyists to impose caps. Meanwhile, states that have not imposed caps so far may be those in which med mal insurers were relatively less desperate to begin with. Insurers in states with caps may have *already* been on the path toward faster rate increases even before the caps were legislated, and the changes in the legislation may have merely been a symptom of—not an impediment to—this trend.

- Once caps were imposed, regulators in those states may have been somewhat more liberal in allowing rate increases, making the false assumption that caps alone would sooner or later help to correct the imbalances in the marketplace.

Furthermore, med mal insurers have also had to deal with the added burden of high medical inflation, which directly impacts their claims experience. By the end of the soft market in 2000, these insurers found themselves in a position where claims costs had increased, but premium income had not even kept pace with inflation.

All of these forces led to an inevitable increase in the med mal premiums insurers charge to doctors and other medical professionals. But despite the increase in revenue, the med mal insurers as an industry have continued to weaken financially and remain weaker than the overall property/casualty insurance industry.

In summary, we believe the broad market forces prevailing in the property/casualty industry have driven—and continue to drive—med mal premiums up, evidently overwhelming any reduction in jury awards.

Thus, by focusing on caps as a solution...

- The insurance companies and their supporters are diverting the public's attention away from long years of mismanagement by an industry that continually allowed actuarial prudence to take a back seat to marketing strategy.

- The insurers, insurance regulators and insurance legislators are avoiding a much-needed post-mortem on what really went wrong in the property and casualty industry

in general and in the med mal sector in particular. Was it prudent to rely so heavily on investment income while underwriting income stayed chronically in the red? Did industry decision makers get caught up in the stock market euphoria like nearly everyone else?

- Worst of all, many companies and legislators are using the insurance crisis opportunistically to push tort reform. However, tort reform, to be productive, merits more pondered and balanced debate based on its own merits, independent of the insurance crisis.

We recommend the following steps:

First, *legislators* must immediately put on hold all proposals involving non-economic damage caps until convincing evidence can be produced to demonstrate a true benefit to doctors in the form of reduced med mal costs. Right now, consumers are being asked to sacrifice not only large damage claims, but also critical leverage to help regulate the medical profession—all with the stated goal that it will end the med mal crisis for doctors. However, the data indicate that, similar state legislation has merely produced the worst of both worlds: The sacrifice by consumers *plus* a continuing—and even worsening—crisis for doctors. Neither party derived any benefit whatsoever from the caps.

Second, *regulators* must review and revise their parameters for approving rate increases. The big lesson to be learned from the past decade is that it's dangerous to count on volatile investments—especially common stocks—to compensate for poor operations.

For many years, we have warned that rather than evaluating the property and casualty business based on total profits (including investment income), the focus should be on underwriting profits and losses, independent of investment income.[8] Had our warnings been heeded, premium rate increases may have risen gradually over time, rather than jumping suddenly during an already-painful bear market.

Third, *insurance companies* must never again allow marketing to divert or pervert prudent actuarial analysis and planning. Consumers and medical professionals can accept rate increases provided they are spread out evenly over time, and provided they are given good value for their premium dollars in terms of claims paying ability and stability. They cannot accept rate increases that are designed to cover up, or compensate for, serious mismanagement.

Fourth, *the medical profession* must assume more responsibility for policing itself, while states must be more pro-active in reviewing the licenses of individual practitioners who have a significantly higher-than-average number of claims against them in their specialty, in proportion to their level of activity. These individuals

[8] "Property & Casualty Insurers Cashing in on Wall Street Windfalls to Offset Underwriting Losses," February 28, 1997. "Property and Casualty Insurers Suffer 40% Decline in Net Income in 1994," April 18, 1995.

greatly increase the risk associated with their specialties, pushing med mal premiums up for all doctors in that sector. States must also make major strides to share data on high-risk doctors. At the very minimum, they must cease licensing doctors who have lost their licenses in other states, often due to high-cost medical mistakes.

Fifth, *consumers* must not relinquish their right to sue for non-economic damages until the medical profession and/or state and federal governments provide more adequate supervision and regulation of doctors, hospitals, and other health care providers.

The imposition of caps will not make a significant dent in the problem, and may even have adverse impacts. It is no substitute for longer-term, fundamental solutions that address the actual factors behind the med mal crisis.

Appendix 1

States with Caps:
Median Medical Malpractice Payouts/Premiums 1991 - 2002

State	Year Imposed	Amount of Cap ($000)	1991 Median Payout ($)	2002 Median Payout ($)	% Change 1991 to 2002	1991 Median Premium ($)	2002 Median Premium ($)	% Change 1991 to 2002
Alaska	1997	500	125,000	165,000	32.0	N/A	27,940	N/A
California	1975	250	31,700	67,500	112.9	20,354	30,430	49.5
Colorado	1998	250	25,000	100,000	300.0	22,678	33,651	48.4
Hawaii	1976	375	30,000	250,000	733.3	23,334	25,756	10.4
Idaho	1990	682	22,000	100,000	354.5	N/A	14,199	N/A
Indiana	1990	1,000	35,000	50,000	42.9	N/A	22,886	N/A
Kansas	1994	250	75,000	103,765	38.4	14,669	23,335	59.1
Louisiana	1975	500	65,000	100,000	53.8	20,291	37,280	83.7
Maryland	1986	605	75,000	180,000	140.0	24,193	34,771	43.7
Massachusetts	1997	500	100,000	250,000	150.0	N/A	30,246	N/A
Michigan	1993	624	60,000	77,000	28.3	65,946	68,225	3.5
Missouri	1988	547	80,000	162,500	103.1	25,999	38,759	49.1
Montana	1997	250	30,000	100,000	233.3	18,697	27,011	44.5
New Mexico	1996	600	100,000	110,000	10.0	N/A	67,161	N/A
North Dakota	1996	500	57,500	75,000	30.4	N/A	16,238	N/A
Utah	1996	250	20,000	115,000	475.0	20,474	37,290	82.1
Virginia	1992	1,000	50,000	200,000	300.0	16,497	21,343	29.4
West Virginia	1986	1,000	100,000	140,465	40.5	N/A	56,989	N/A
Wisconsin	1995	350	90,000	256,357	184.8	18,111	17,213	-5.0
Total			60,000	110,000	83.3	20,414	30,246	48.2

Source: Compiled and analyzed by Weiss Ratings, Inc. from data supplied by Medical Liability Monitor and the National Practitioners Data Bank

Appendix 2

States without Caps:
Median Medical Malpractice Payouts/Premiums 1991 - 2002

State	1991 Median Payout ($)	2002 Median Payout ($)	% Change 1991 to 2002	1991 Median Premium ($)	2002 Median Premium ($)	% Change 1991 to 2002
Alabama	75,000	200,000	166.7	25,629	23,490	-8.3
Arizona	66,875	169,240	153.1	37,601	38,571	2.6
Arkansas	72,495	125,000	72.4	10,422	16,384	57.2
Connecticut	66,663	250,000	275.0	29,198	40,146	37.5
Delaware	73,539	150,000	104.0	N/A	24,731	N/A
District of Columbia	172,000	162,500	-5.5	28,085	40,871	45.5
Florida	95,000	162,500	71.1	43,600	95,474	119.0
Georgia	75,000	175,000	133.3	27,998	30,093	7.5
Illinois	115,000	320,000	178.3	39,260	49,948	27.2
Iowa	41,250	102,500	148.5	21,140	18,607	-12.0
Kentucky	48,258	49,000	1.5	23,666	44,834	89.4
Maine	75,000	250,000	233.3	22,118	18,583	-16.0
Minnesota	45,000	125,000	177.8	8,117	10,142	25.0
Mississippi	45,000	131,500	192.2	19,726	30,871	56.5
Nebraska	39,000	131,250	275.0	N/A	14,710	N/A
Nevada	32,500	175,000	438.5	24,988	59,776	139.2
New Hampshire	50,000	250,000	400.0	N/A	27,157	N/A
New Jersey	75,000	210,000	180.0	20,162	38,307	90.0
New York	75,000	200,000	166.7	48,026	50,970	6.1
North Carolina	72,000	195,000	170.8	11,294	31,687	180.6
Ohio	24,667	137,500	457.4	31,450	52,764	67.8
Oklahoma	50,000	97,000	94.0	9,137	12,766	39.7
Oregon	65,000	95,000	46.2	17,268	26,711	54.7
Pennsylvania	100,000	200,000	100.0	11,433	71,260	523.3
Rhode Island	62,500	125,000	100.0	N/A	27,922	N/A
South Carolina	59,475	100,000	68.1	12,984	21,337	64.3
South Dakota	25,000	150,000	500.0	9,618	13,853	44.0
Tennessee	58,750	110,000	87.2	15,601	30,018	92.4
Texas	70,347	150,000	113.2	27,945	55,951	100.2
Vermont	42,500	40,865	-3.8	N/A	15,690	N/A
Washington	40,000	150,000	275.0	18,158	23,100	27.2
Wyoming	80,000	125,000	56.3	22,758	39,829	75.0
Total	65,831	150,000	127.9	22,118	30,056	35.9

Source: Compiled and analyzed by Weiss Ratings, Inc. from data supplied by Medical Liability Monitor and the National Practitioners Data Bank

Appendix 3

Weakest Medical Malpractice Insurers

Company	2002 Total Med Mal Premium ($000)	2002 Total Premium ($000)	Weiss Safety Rating
Academic Health Professionals Insurance	16,484	16,484	E
American Association of Orthodontist RRG	4,505	4,506	D
American Excess Insurance Exchange RRG	33,682	39,747	E
American Physicians Assurance	170,440	230,224	D
American Physicians Insurance Exchange	34,887	34,887	D
Campmed Casualty & Indemnity of MD	3,750	7,237	E+
Commonwealth Medical Liability Insurance	29,648	29,893	D+
Delaware Professional Insurance	732	732	E+
Eastern Dentists Insurance RRG	6,961	7,314	D
Franklin Casualty Insurance RRG	19,377	19,377	D-
Hanys Insurance	74,529	76,260	D+
Hospital Casualty	22,637	26,112	E
Hospital Underwriting Group	22,620	22,776	E
Lion Insurance	51	86	D+
MCIC Vermont RRG	155,021	162,325	D
MedAmerica Mutual RRG	7,838	7,838	D+
National Guardian RRG	7,422	7,422	E
New England Medical Center of VT	1,166	1,166	D-
Northwest Physicians Mutual Insurance	33,094	33,200	D+
OHIC Insurance	136,926	151,597	D
PACO Assurance	3,171	3,172	D+
Physicians Liability Insurance	40,626	75,071	E+
Physicians Reciprocal Insurers	185,333	186,924	E+
Physicians Reimbursement Fund	2,193	2,193	E+
Preferred Physicians Medical RRG	24,906	24,905	D+
Princeton Insurance	240,266	374,811	D
SCPIE Indemnity	100,198	101,675	D+
Texas Hospital Insurance Exchange	7,304	14,009	D-
Tri Century Insurance	24,238	24,238	D+
VHA Risk Retention Group	29,071	30,616	D-
Virginia Health Systems Alliance	12,058	12,242	E

A = Excellent; B = Good; C = Fair; D = Weak; E = Very Weak

Source: Weiss Ratings, Inc.

Appendix 4

Other Studies and Position Statements published by Participants in this Debate

"Florida's Medical Malpractice Insurance Crisis: An Examination of Strategic Public Policy Issues." The Florida Center for Public Policy and Leadership at the University of North Florida. March 2003. This study is currently being updated, but will be available at http://www.unf.edu/thefloridacenter/press_room/index.shtml when complete.

"Hype Outraces Rates in Malpractice Debate; Degree of Crisis Varies Among Specialties and From State to State." *USA Today*. March 4, 2003.
http://www.usatoday.com/news/nation/2003-03-04-malpractice-cover_x.htm

"Medical Malpractice Analysis." Milliman USA on behalf of Florida Hospital Association. November 7, 2002.
http://heal-fl-health-care-pdf.netcomsus.com/resources_MillimanUSAstudy.pdf

"Medical Malpractice Insurance: Stable Losses/Unstable Rates." Americans for Insurance Reform. October 10, 2002.
http://www.insurance-reform.org/StableLosses.pdf

"Medical Malpractice: Questions and Answers." American Trial Lawyers Association.
http://www.atla.org/ConsumerMediaResources/Tier3/press_room/FACTS/medmal/icqanda.aspx

"Premium Deceit: The Failure of 'Tort Reform' to Cut Insurance Prices." Center for Justice & Democracy. July 29, 1999; reissued February 12, 2002.
http://www.insurance-reform.org/PremiumDeceit.pdf.

"President's Medical Malpractice Plan Based on Biased, Inaccurate Information; CFA Identifies Insurer Practices as Cause of Soaring Rates." Consumer Federation of America. July 31, 2002.
http://www.consumerfed.org/073102medmalrelease.html.

"Update on the Medical Litigation Crisis: Note the Result of the 'Insurance Cycle'." U.S. Department of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy. September 25, 2002.
http://www.aspe.hhs.gov/daltcp/reports/mlupd2.htm.

Statement by the Physician Insurers Association of America. January 29, 2003.
http://www.thepiaa.org/publications/pdf_files/January_29_Piaa_Statement.pdf.

Americans for Insurance Reform - Fact Sheet

California Restrictions On Malpractice Victims Have Not Affected Malpractice Premiums

Premium Data Shows California Law Is No Model For The Nation

Data released today by two consumer groups show that California's 22-year experience with the nation's most draconian limits on the rights of medical malpractice victims has failed to slow premium increases for doctors and hospitals. In fact, over the last decade, the average malpractice premium in California has grown more quickly than it has in the nation overall.

The California-based Foundation for Taxpayer and Consumer Rights and New York-based Center for Justice & Democracy (CJ&D) hired nationally recognized actuary J. Robert Hunter, former Texas Insurance Commissioner and Federal Insurance Administrator under Ford and Carter, to compare national malpractice premium trends to those in California. Hunter found that from 1991 to 2000, malpractice premiums in California have stayed close to national premium trends. The 2000 average premium per doctor in California was only 8.2 percent below that of the nation ($7,200.61 vs. $7,843.75) while the average malpractice premium in California between 1991 and 2000 actually grew more quickly (3.5 percent), than it did in the nation overall (1.9 percent.) According to Hunter, "there is not much difference in the rates or the rate of change between California and the nation based on the latest decade of experience."

In the mid-1970s, California enacted severe laws restricting the rights of patients who have been injured by malpractice, allowing them to recover no more than $250,000 in noneconomic compensation no matter how egregious the malpractice or serious the injury. The medical establishment is campaigning to spread this severe cap on damages not only to other states, but to the entire nation in recently introduced federal legislation (H.R. 4600), arguing falsely that this cap has kept premiums dramatically downward.

"If there are savings to limiting the rights and recovery of innocent victims of dangerous and culpable doctors, then insurers have not passed them on to physicians," said Jamie Court, executive director of the Foundation for Taxpayer and Consumer Rights. "California is a failed model for the national restrictions being proposed on patients. California patients have been denied adequate compensation and representation for their injuries, and California doctors have seen almost no premium savings. Only the insurers have gotten rich in the good times."

"This study disputes one of the most sensationalized fictions driving the movement to limit lawsuits against malpracticing doctors and hospitals – the notion that California's brutal restrictions on patients' rights, enacted in the mid-1970s, have slowed the growth of malpractice premiums," said CJ&D Executive Director Joanne Doroshow. "In fact, the opposite has happened. Over the last 10 years, California's premiums have grown faster than the nation's.

"This analysis has, for the first time, exposed as an insidious public relations scam the notion that California's cruel law has controlled the growth of malpractice insurance premiums. This law has had terrible consequences for many innocent people, while doing nothing to improve the affordability of liability insurance for doctors."

Year	California number of Doctors in State	U.S.A. Number of Doctors	California Med Mal Premium Earned (in thousands)	U.S.A. Med Mal Premium Earned (in thousands)	Average Med Mal Premium per Doctor in California	Average Med Mal Premium per Doctor in U.S.A.
1991	76043	631400	529056	4862170	6957.33	7700.62
1992	76367	652100	526496	5138395	6894.29	7879.77
1993	76411	670300	563004	5174055	7368.10	7719.01
1994	77311	684400	576771	5931898	7460.40	8667.30
1995	78169	720300	597660	6080639	7645.74	8441.81
1996	79048	737800	610003	5992394	7716.87	8121.98
1997	80341	756700	628858	5917038	7827.36	7819.53
1998	81762	777800	652801	6195047	7981.72	7963.81
1999	82872	797600	611785	6155241	7382.29	7717.20
2000	84675	812800	609712	6375401	7200.61	7843.75
1991 to 2000 percent change					3.5	1.9
1991 to 2000 percent change (annualized)					0.4	0.2

Sources:

Doctors USA: Statistical Abstract of the United States;

Doctors CA: California Department of Consumer Affairs;

Earned Premiums: NAIC Report On Profit By Line By State

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(AIR is a project of the Center for Justice & Democracy)

Americans for Insurance Reform

"PROTECTING THE INNOCENT, NOT WRONGDOERS"

Medical Malpractice Insurance: Stable Losses/Unstable Rates 2003

***** NEWLY UPDATED STUDY BASED ON 2002 DATA*****

November 2003

Introduction and Summary of Findings

In October 2002, Americans for Insurance Reform (AIR), a coalition of over 100 consumer groups around the country, produced for the first time a comprehensive study of medical malpractice insurance from the 1970s through 2001. The study, *Stable Losses/Unstable Rates*, examined what insurers have taken in and what they've paid out over the prior 30 years. AIR found that the amount medical malpractice insurers paid out, including all jury awards and settlements, directly tracked the rate of medical inflation. On the other hand, medical insurance premiums charged by insurance companies have not corresponded to increases or decreases in payouts. Rather, they have risen and fallen in sync with the state of the economy reflecting gains or losses experienced by the insurance industry's market investments.

Now, AIR has added to this analysis newly-released insurance data from the year 2002, the year when many doctors around the country began experiencing sharp increases in insurance rates. Insurers told doctors that these premium increases were necessary because payouts and costs had dramatically risen. The data, however, does not support this view. Instead, 2002 reflects exactly the same trends as those of prior years.

This new study makes two major findings:

- First, contrary to what the insurance and medical lobbies have alleged, the years 2001 and 2002 saw no "explosion" in medical malpractice insurer payouts or costs to justify sudden rate hikes. In fact, rather than exploding, inflation-adjusted payouts per doctor dropped from 2001 to 2002. Payouts (in constant dollars) have been essentially been flat since the mid-1980s.

- Second, medical malpractice insurance premiums rose much faster in 2002 than was justified by insurance payouts. The 2002 hike is similar to the rate hikes of the past, which occurred in the mid-1980s and mid-1970s and were not connected to actual payouts. Rather, they reflect a weakened economy and losses experienced by the insurance industry's market investments and their perception of how much they can earn

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on the investment "float" (which occurs during the time between when premiums are paid into the insurer and losses paid out by the insurer) that doctors' premiums provide them.

Background

The nation's insurance companies are advancing a legislative agenda to limit liability for doctors, hospitals, HMOs, nursing homes and drug companies that cause injury. Federal and state lawmakers and regulators (and the general public) are being told by medical and insurance lobbyists that doctors' insurance rates are rising due to increasing claims by patients, rising jury verdicts and exploding tort system costs in general.

The insurance industry argues and, worse, convinces doctors to believe that patients who file medical malpractice lawsuits are being awarded more and more money, leading to unbearably high losses for insurers. Insurers state that to recoup money paid to patients, medical malpractice insurers are being forced to raise insurance rates or, in some cases, pull out of the market altogether.

Since insurers say that jury verdicts are the cause for the current "crisis" in affordable malpractice insurance for doctors, the insurance industry insists that the only way to bring down insurance rates is to limit an injured consumer's ability to sue in court.

Insurance rates for doctors have skyrocketed twice before: in the mid-1970s and in the mid-1980s, each "crisis" occurring during years of a weakened economy and dropping interest rates. Each of these periods was followed by a wave of legislative activity to restrict injured patients' rights to sue for medical malpractice. Medical and insurance lobbyists told legislators that changes in tort law were needed to reduce medical malpractice insurance rates.

However, history shows that the insurance industry has not cut, and has no plans to cut, insurance premiums as a consequence of tort restrictions. The American Insurance Association (AIA) and representatives of the American Tort Reform Association (ATRA) have already gone on record admitting this, with the AIA stating on March 13, 2002, "[T]he insurance industry never promised that tort reform would achieve specific premium savings."

The Center for Justice & Democracy's 1999 study, *Premium Deceit —the Failure of "Tort Reform" to Cut Insurance Prices*, found that tort law limits enacted since the mid-1980s have not lowered insurance rates in the ensuing years. Some states that resisted enacting any "tort reform" experienced low increases in insurance rates or loss costs relative to the national trends, and some states that enacted major "tort reform" packages saw very high rate or loss cost increases relative to the national trends. In other words, there was no correlation between "tort reform" and insurance rates.

More recently, Weiss Ratings, an independent insurance-rating agency in Palm Beach Gardens, Florida, found that between 1991 and 2002, states with caps on noneconomic damage awards saw median doctors' malpractice insurance premiums rise 48 percent -- *a greater increase than in states without caps*. In states without caps, median premiums increased only 36

percent. Moreover, according to Weiss, "median 2002 premiums were about the same" whether or not a state capped damage awards.

In January 2003, Ohio lawmakers enacted a cap on compensation for patients injured by medical malpractice. Almost immediately, all five major medical malpractice insurance companies in Ohio announced they would not reduce their rates. One insurance executive predicted his company would seek a 20 percent rate increase.

In Mississippi, lawmakers enacted a cap on medical malpractice verdicts in October 2002. Four months later, investigative news articles reported that surgeons still could not find affordable insurance and that many Mississippi doctors were still limiting their practice or walking off the job in protest.

Nevada also enacted a severe cap on compensation in 2002. Within weeks of the law's enactment, two major insurance companies proclaimed that they would not reduce insurance rates for at least another year to two, if ever. The Doctor's Company, a nationwide medical malpractice insurer, then filed for a 16.9 percent rate increase. Two other companies filed for 25 percent and 93 percent rate increases.

The "liability insurance crises" of the mid-1970s and mid-1980s were ultimately found to be caused not by legal system excesses but by the economic cycle of the insurance industry. Just as these liability insurance crises were found to be driven by this cycle and not a tort law cost explosion as many insurance companies and others had claimed, the "tort reform" remedy pushed by these advocates failed.

As this study confirms, it will fail again.

The 2003 Study

AIR, under the direction of actuary J. Robert Hunter (Director of Insurance for the Consumer Federation of America, and former Federal Insurance Administrator and Texas Insurance Commissioner), has produced a comprehensive study of medical malpractice insurance, examining specifically what insurers have taken in and what they've paid out, in constant dollars, over the last 30 years through 2002. AIR examined everything that medical malpractice insurers have paid in jury awards, settlements and other costs over the last three decades, and compared these actual costs with the premiums that insurers have charged doctors, as well as with the economic cycle of the insurance industry.

This AIR study explores whether or not there is, as the insurance industry claims, an explosion in lawsuits, jury awards or tort system costs justifying an increase in insurance premium rates, or whether premium increases simply reflect the economic cycle of the insurance industry, driven by interest rates and investments.

The Insurance Industry's Economic Cycle

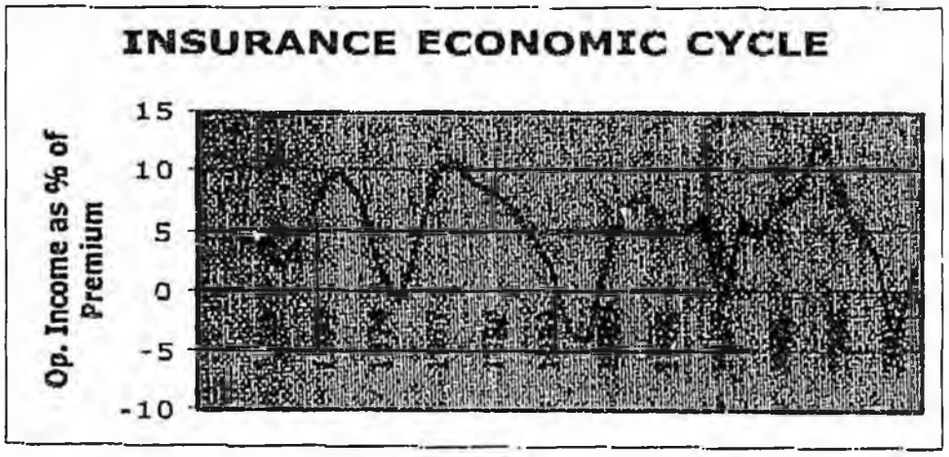
Insurers make most of their profits from investment income. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium dollars to invest for maximum return. Insurers severely underprice their policies and insure very poor risks just to get premium dollars to invest. This is known as the "soft" insurance market.

But when investment income decreases — because interest rates drop or the stock market plummets or the cumulative price cuts make profits become unbearably low — the industry responds by sharply increasing premiums and reducing coverage, creating a "hard" insurance market usually degenerating into a "liability insurance crisis."

A hard insurance market happened in the mid-1970s, precipitating rate hikes and coverage cutbacks, particularly with medical malpractice insurance and product liability insurance. A more severe crisis took place in the mid-1980s, when most liability insurance was impacted. Again, in 2002, the country experienced a "hard market," this time impacting property as well as liability coverages with some lines of insurance seeing rates going up 100% or more.

The following Exhibit shows the national cycle at work, with premiums stabilizing for 15 years following the mid-1980s crisis. (The 1992 data point was not a classic cycle bottom, but reflected the impact of Hurricane Andrew and other catastrophes in that year.)

Exhibit 1. The Insurance Cycle



Prior to late 2000, the industry had been in a soft market since the mid-1980s. The strong financial markets of the 1990s had expanded the usual six- to-ten year economic cycle. No matter how much they cut their rates, the insurers wound up with a great profit year when investing the float on the premium in this amazing stock and bond market. (The "float" occurs during the time between when premiums are paid into the insurer and losses paid out by the insurer —*e.g.*, there is about a 15 month lag in auto insurance and a 5 to 10 year lag in medical

malpractice.) Further, interest rates were relatively high in recent years as the Fed focused on inflation.

But in 2000, the market started to turn with a vengeance and the Fed cut interest rates again and again. This took place well before September 11th. The terrorist attacks sped up the price increases, collapsing two years of anticipated increases into a few months and leading to what some seasoned industry analysts see as gouging.[1] However, the increases we are witnessing are mostly due to the cycle turn, not the terrorist attack or any other cause. This is a classic economic cycle bottom.

Smoking Guns

AIR tested two hypotheses advanced by the insurance industry: First, if large jury verdicts in medical malpractice cases or any other tort system costs are having a significant impact on the overall costs for insurers' and are therefore the reason behind skyrocketing insurance rates, then losses per doctor should be rising faster than medical inflation over time. Second, if lawsuits or other tort costs are the cause of rate increases for doctors -- rather than decreasing interest rates and other economic factors -- those losses should be reflected in rate increases in line with such losses, not in ups and downs that instead reflect the state of the economy, the well-documented insurance economic cycle (Exhibit 1), interest rates, the stock market or the level of insurers' investment income.

AIR finds both hypotheses are completely false, demonstrated by Exhibits 2 and 3 below. First, these charts show that since 1975, medical malpractice paid claims per doctor have tracked medical inflation very closely (slightly higher than inflation from 1975 to 1985 and flat since). In other words, payouts have risen almost precisely in sync with medical inflation. Moreover, contrary to what the insurance and medical lobbies have alleged, the years 2001 and 2002 saw no "explosion" in medical malpractice insurer payouts or costs to justify sudden rate hikes. In fact, rather than exploding, inflation-adjusted payouts per doctor *dropped* from 2001 to 2002. These data confirm that neither jury verdicts nor any other factor affecting total claims paid by insurance companies that write medical malpractice insurance have had much impact on the system's overall costs over time.

Second, while payouts closely track medical inflation, medical malpractice premiums are quite another thing. They do not track costs or payouts in any direct way. Since 1975, the data show that in constant dollars, per doctor written premiums — the amount of premiums that doctors have paid to insurers — have gyrated almost precisely with the insurer's economic cycle, which is driven by such factors as insurer mismanagement and changing interest rates, not by lawsuits, jury awards, the tort system or other causes. Moreover, medical malpractice insurance premiums rose much faster in 2002 than was justified by insurance payouts. This hike is similar to the rates hikes of the past, which occurred in the mid-1980s and mid-1970s and were not connected to actual payouts.

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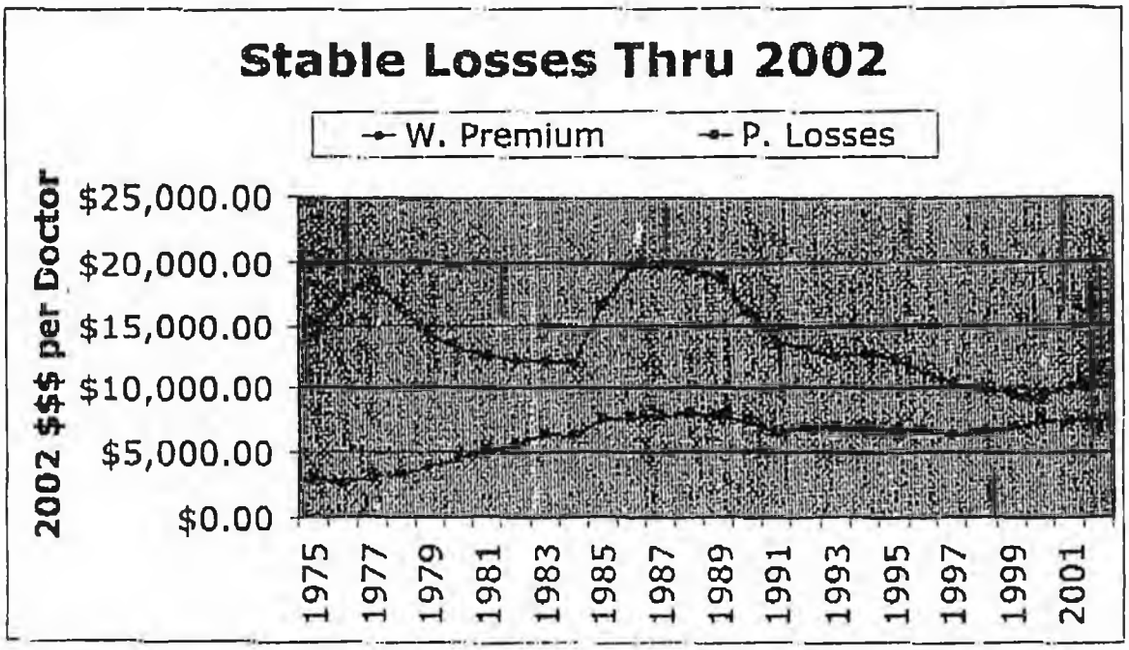
[1] "[T]here is clearly an opportunity now for companies to price gouge – and it's happening.... But I think companies are overreacting, because they see a window in which they can do it." Jeanne Hollister, consulting actuary, Tillinghast-Towers Perrin, quoted in, "Avoid Price Gouging, Consultant Warns," *National Underwriter*, January 14, 2002.

In sum, the results of AIR's analysis illustrated in Exhibits 2 and 3 are startling; premiums rise and fall with the insurance industry's economic cycle, as illustrated in Exhibit 1, but losses paid do not.

Exhibit 2



Sources:
A.M. Best and Co. special data compilation for AIR, reporting data for as many years as separately available; U.S. Bureau of the Census, 1975[2]; Inflation Index: Bureau of Labor Statistics, 1975 (1985 estimated). See Exhibit 3 for underlying data.

Definitions:

- **"W. Premium," "DPW" or "Direct Premiums Written"** is the amount of money that insurers collected in premiums from doctors during that year.
- **"P. Losses," or "Paid losses"** is what insurers actually paid out that year to people who were injured —all claims, jury awards and settlements —plus what insurance companies pay their own lawyers to fight claims.[3]

[2] We calculate the paid losses on a per doctor basis to remove from the trend we are studying the effect of the ever increasing number of doctors in America. We acknowledge that the number of doctors includes a certain number of doctors that are retired or otherwise not in the medical malpractice system, but since we are interested in overall loss trends over time, and since the percentage of doctors in that category should not vary much year to year, this fact should not significantly impact our results.

[3] "Paid losses" are a far more accurate reflection of actual insurer payouts than what insurance companies call "incurred losses." Incurred losses are not actual payouts. They include payouts but also reserves for possible future claims – *e.g.*, insurers' estimates of claims that they do not even know about yet. While incurred losses do exhibit more of a cyclical pattern, observers know that this is because in hard markets, as we are currently experiencing,

Exhibit 3

Year	Direct Premiums Written (thousands)	Direct Losses Paid (thousands)	Loss Ratio	Number Doctors in USA (active)	Medical Care Inflation (CPI-U)	Direct Premiums Written per doctor	Direct Losses Paid per doctor	Year	Direct Premiums Written per doctor 2002 Dollars	Direct Losses Paid per doctor 2002 Dollars
1975	865,208	190,867	0.221	366,425	47.3	$2,361.21	$520.89	1975	$14,307.06	$3,156.17
1976	1,187,978	188,545	0.159	378,572	51.7	$3,138.05	$498.04	1976	$17,395.85	$2,760.91
1977	1,423,091	248,969	0.175	381,969	56.8	$3,725.67	$651.80	1977	$18,798.90	$3,288.86
1978	1,412,555	294,456	0.208	401,364	61.3	$3,519.39	$733.64	1978	$16,454.42	$3,430.03
1979	1,405,991	391,800	0.279	417,266	66.9	$3,369.53	$938.97	1979	$14,435.09	$4,022.55
1980	1,493,543	521,849	0.349	435,545	74.5	$3,429.14	$1,198.15	1980	$13,191.82	$4,609.27
1981	1,616,470	665,570	0.412	444,899	82.1	$3,633.34	$1,496.00	1981	$12,683.50	$5,222.34
1982	1,815,056	847,543	0.467	462,947	91.9	$3,920.66	$1,830.76	1982	$12,226.99	$5,709.41
1983	2,033,911	1,079,862	0.531	479,440	100.1	$4,242.26	$2,252.34	1983	$12,146.18	$6,448.76
1984	2,282,590	1,197,979	0.525	511,090	106.4	$4,466.12	$2,343.97	1984	$12,029.98	$6,313.74
1985	3,407,177	1,556,300	0.457	514,000	113.1	$6,628.75	$3,027.82	1985	$16,797.52	$7,672.62
1986	4,335,863	1,709,883	0.394	519,411	121.6	$8,347.65	$3,291.97	1986	$19,674.65	$7,758.86
1987	4,751,084	1,905,491	0.399	534,692	129.9	$8,941.75	$3,563.72	1987	$19,728.30	$7,862.67
1988	5,166,811	2,128,281	0.412	549,160	138.2	$9,408.57	$3,875.52	1988	$19,511.55	$8,037.08
1989	5,500,540	2,273,628	0.413	559,988	148.5	$9,822.60	$4,060.14	1989	$18,957.29	$7,835.93
1990	5,273,360	2,415,117	0.458	572,660	161.9	$9,208.54	$4,217.37	1990	$16,301.21	$7,465.70
1991	5,043,773	2,423,418	0.480	594,697	176.2	$8,481.25	$4,075.05	1991	$13,795.27	$6,628.31
1992	5,228,362	2,808,838	0.537	605,685	189.4	$8,632.15	$4,637.46	1992	$13,062.16	$7,017.40
1993	5,469,575	3,028,086	0.554	619,751	201.1	$8,825.44	$4,885.97	1993	$12,577.68	$6,963.30
1994	5,948,361	3,174,987	0.534	632,121	210.4	$9,410.16	$5,022.75	1994	$12,818.21	$6,841.83
1995	6,107,568	3,326,846	0.545	646,022	219.8	$9,454.12	$5,149.74	1995	$12,327.34	$6,714.81
1996	6,002,233	3,556,151	0.592	663,943	227.8	$9,040.28	$5,356.11	1996	$11,373.77	$6,738.63
1997	5,864,218	3,587,566	0.612	684,605	234.4	$8,565.84	$5,240.34	1997	$10,473.42	$6,407.35
1998	6,040,051	3,957,619	0.655	707,000	242	$8,543.21	$5,597.76	1998	$10,117.70	$6,629.42
1999	6,053,323	4,446,975	0.735	720,900	251.1	$8,396.90	$6,168.64	1999	$9,584.03	$7,040.75
2000	6,303,206	4,988,474	0.791	737,500	261.4	$8,546.72	$6,764.03	2000	$9,370.66	$7,416.11
2001	7,288,933	5,424,197	0.744	755,000	273.1	$9,654.22	$7,184.37	2001	$10,131.45	$7,539.51
2002	8,928,252	5,806,463	0.650	780,000	286.6	$11,446.48	$7,444.18	2002	$11,446.48	$7,444.18

insurers will increase reserves as a way to justify price increases. In fact, the current insurance "crisis" rests significantly on a jump in loss reserves in 2001. Historically, reserves have been later "released" to profits during the "softer" market years. For example, according to a June 24, 2002, *Wall Street Journal* front page investigative article, St. Paul, which until 2001 had 20 percent of the national med mal market, pulled out of the market after mismanaging its reserves. The company set aside too much money in reserves to cover malpractice claims in the 1980s, so it "released" $1.1 billion in reserves, which flowed through its income statements and appeared as profits. Seeing these profits, many new, smaller carriers came into the market. Everyone started slashing prices to attract customers. From 1995 to 2000, rates fell so low that they became inadequate to cover malpractice claims. Many companies collapsed as a result. St. Paul eventually pulled out, creating huge supply and demand problems for doctors in many states. Christopher Oster and Rachel Zimmerman, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal*, June 24, 2002.

Stable Losses/Unstable Rates 2003, Page 7.

A Word About Loss Ratios

Loss ratios are the percent of premiums that insurers pay out in claims. These ratios will drop during hard market years reflecting sudden rate hikes, as they did during the years 1985-1987, and again in 2002, which this study shows. Otherwise, they tend to trend up as insurers cut premiums during the soft market.

Exhibit 3 shows this precise phenomenon of steadily increasing loss ratio between 1988 and 2001. This simply demonstrates the insurance cycle at work, which is the point of this study. Insurers did not respond to higher loss ratios during these years by raising rates because they were making significant money from investments. In fact, during the soft market, insurers are expected to take a larger underwriting loss (a combined loss ratio over 100 percent) than during the hard market as they benefit from more investment income during these times. As we show, when this income drops, insurers will then raise rates and loss ratios will also drop. This is indeed what is now happening.

Conclusion

Like the 2002 study, *Stable Losses/Unstable Rates,* this updated version analyzes what medical malpractice insurers have taken in and what they've paid out over the last 30 years, including jury awards, settlements and other costs. Its findings are startling. While insurer payouts directly track the rate of medical inflation, medical insurance premiums do not. Rather, they rise and fall in relationship to the state of the economy. Not only has there been no "explosion" in lawsuits, jury awards or any tort system costs at any time during the last three decades, but the astronomical premium increases that some doctors have been charged during periodic insurance "crises" over this timeperiod are in exact sync with the economic cycle of the insurance industry, driven by interest rates and investments. In 2001, rates began to spike, but payouts dropped. In other words, insurance companies raise rates when they are seeking ways to make up for declining interest rates and market-based investment losses.

CENTER FOR JUSTICE & DEMOCRACY
CJ&D
WHITE PAPER

Number 9 ❖ April 2003

WHERE'S THE CRISIS?

HAS AMERICA BEEN DUPED BY THE AMA?

*By Emily Gottlieb and Joanne Doroshow**

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"Fighting to protect the right to jury trial and an independent judiciary for all Americans."

* Deputy Director and Executive Director, Center for Justice & Democracy

SUMMARY

The American Medical Association, a lobby group that is pushing for liability limits for doctors in approximately 18 states as well as Congress, continues to release "surveys" of its members in support of its campaign. The most recent survey was issued on April 3, 2003. According to the AMA, these states are experiencing "liability crises," necessitating laws that severely limit compensation for the families of those killed or injured by medical malpractice..

What the AMA consistently fails to disclose is that numerous local news outlets have released evidence over the past year that not only fails to support the AMA's allegations of a lawsuit "crisis" in these states, but actually contradicts it. Moreover, within the last year three of these states – Nevada, Mississippi and Ohio – gave the AMA what is asked for by enacting caps on damage awards; in each case, doctors are still struggling to find affordable insurance.

This is not to deny that some doctors in some states (but not all) are being hit with sudden insurance rate hikes. But as the state Attorneys General put it some 17 years ago in what has sadly become a entirely predictable and recurring insurance phenomenon, "The facts do not bear out the allegations of an 'explosion' in litigation or in claim size, nor do they bear out the allegations of a financial disaster suffered by property/casualty insurers today. They finally do not support any correlation between the current crisis in availability and affordability of insurance and such a litigation 'explosion.' The available data indicate that the causes of, and therefore solutions to, the current crisis lie with the insurance industry

itself." *Current Crisis of Unavailability and Unaffordability of Liability Insurance* (Boston, Mass.: Ad Hoc Insurance Committee of the National Association of Attorneys General, May, 1986).

The following states have been identified as "liability crisis" states by the AMA (defined as rising claims, skyrocketing awards and fleeing doctors) in the group's push for a cap of $250,000 on non-economic damages. Yet a simple scan of local media stories, which report on what local courtroom and medical data actually show, establishes the following:

- **Arkansas:** No evidence damage awards are rising (because no entity compiles these records)
- **Connecticut:** Little change in number of lawsuit filings for a decade; numbers of neurosurgeons and OB/GYN's increasing
- **Florida:** Jury awards have dropped as state has grown; number of claims and payouts steadily falling
- **Georgia:** Number of claims paid is down 25 percent; doctors win 85 percent of time
- **Illinois:** Number of claims steady throughout the 1990s; 76 percent dismissed without payment
- **Kentucky:** Doctors per capita increasing faster than the nation
- **Mississippi:** State gaining doctors; only four states grew faster in physician population; cap passed in 2002 but doctors still can't find affordable insurance
- **Missouri:** Number of claims fell 29 percent since 1987.
- **New Jersey:** Lawsuits down 16 percent since 1997; less than 10 percent of doctors experiencing large rate increase
- **Nevada:** Number of doctors increased 41 percent since 1992; cap passed in 2002 but insurers haven't reduced premiums
- **New York:** Number one in nation for per capital surgical specialists: number three for OB/GYN's; largest insurer denied rate hike
- **North Carolina:** Number of doctors up 41 percent since 1992
- **Ohio:** Number of case filings equal to 1995; juries ruled for patients less than half as often as in 1995; cap passed in 2003 but insurers haven't reduced premiums
- **Oregon:** Cases against doctors decreased from 2000 to 2001
- **Pennsylvania:** Jury awards are dropping; million dollar awards down for second straight year
- **Texas:** Claims falling since 1999
- **Washington:** Little change in lawsuits filed; number of million dollar awards same as in 1999
- **West Virginia:** Claims down since 1993; amount paid to settle claims constants since 1993

State Breakdown

Arkansas

"Have civil damage awards, on average, actually been going up in Arkansas over the years? It's hard to say, because ***no one entity in Arkansas is compiling records*** on all of them. The

Arkansas Administrative Office of the Courts collects data on court cases throughout the state, but individual counties' reporting has been sporadic over the years." (emphasis added). Laura Kellams and Michael Rowett, "Tort-reform bills in spotlight State, national lawmakers debate limits on some lawsuits," *Arkansas Democrat-Gazette*, March 2, 2003.

Connecticut

"In 2002, 368 medical malpractice lawsuits were filed in Connecticut, according to the State Superior Court in Hartford. ***That number changed little during the past 10 years***, from a low of 272 in 1991 to 1992 to a high of 389 in 1998 to 1999." In 2001 781 OB-GYNs were licensed to practice in Connecticut. In 2003, *the number had increased* to 819. ***For neurosurgeons, the trend is the same***: 96 neurosurgeons were licensed to practice in 2001, 108 in 2003." (emphasis added) Jane Gordon, "Doctors Upset Over Malpractice. Patients Are, Too," *New York Times*, March 23, 2003.

Florida

"A Gannett News Service analysis of state and federal insurance payment records shows ***little to no increase in the payments insurance companies made to victims of medical malpractice in the past five years.*** In fact, Gannett found, ***the amount of medical malpractice awards reported to Florida regulators has dropped as the state has grown.***... Florida's average malpractice award in 2001 was $219,122 - less than the national average of $219,461.... For the past five years, national records show, the state's total malpractice awards have increased at a rate of just 1 percent a year. A comparable state database of malpractice payouts shows ***malpractice awards those same years dropping an average of 3 percent a year.... The average jury award*** - which insurance companies say drives them to agree to higher settlement amounts - ***has dropped every year since 1999*** and is now $326,070, Gannett analysis shows. (emphasis added) Paige St. John, "Malpractice crisis questioned," *News-Press* (Fort Myers, FL), March 26, 2003.

"A Florida Today examination of court records and state and national insurance data found ... ***The number of malpractice claims paid per capita in Florida has decreased steadily since 1995***, state insurance records show. Floridians today get money in malpractice cases at their lowest rate since 1984.... ***Total payouts by malpractice insurers statewide have dropped an average of 2 percent a year every year since 1997.***" (emphasis added) John A. Torres, "House passes malpractice cap," *Florida Today*, March 14, 2003.

Georgia

"Last year only five Georgia patients were paid more than $2 million, according to the National Practitioner Data Bank. The database also says that ***the number of medical malpractice claims paid in Georgia has gone down 25 percent since 1999.***" (emphasis added) Barnini Chakraborty, "Doctors, lawyers argue over malpractice caps," *Chattanooga Times Free Press* (Tennessee), March 10, 2003. A study published in 2000 in the *Georgia Law Review* of a half dozen Georgia counties found that tort filings are actually lagging behind Georgia's population growth.... Overall, the plaintiffs prevailed in a little more than half of the jury trials. But in medical malpractice trials by jury, the ***doctors won roughly 85 percent of the time***. (emphasis added). Don Schanche Jr., "Storm brews

in Ga. over malpractice; Sharply rising insurance expenses cause some doctors to drop services," *Macon Telegraph*, December 30, 2002.

Illinois

In Illinois, ***the number of malpractice claims stayed about even over the course of the 1990s.*** ... Payouts to people who sued both doctors and hospitals jumped sharply in the early 1990s, but they've held relatively even since then. ... ***76 percent of malpractice claims were dismissed without payment in 1999.***" (emphasis added). Editorial, "Ups And Downs," *St. Louis Post-Dispatch*, February 3, 2003, part 1 of a 2 part series entitled, "Malpractice Insurance: Q & A."

Kentucky

"[T]he number of ***doctors per person in Kentucky has increased faster than in the rest of the nation since the early 1980s.***" Gideon Gil, "2003 Kentucky General Assembly; Study: Jury award limits wouldn't cut doctors' premiums," *Courier-Journal* (Louisville, KY), February 25, 2003. "In 2001, 69 malpractice suits went to trial in Kentucky, according to the Kentucky Trial Court Review. Plaintiffs won only 19. And just six plaintiffs won $1 million or more." John Cheves and Karla Ward, "Ob/Gyn, Bye Patient Illustrate Problem," *Lexington Herald-Leader*, February 4, 2003.

Mississippi.

"Medical groups have claimed doctors are fleeing Mississippi, relocating to states with more stable legal climates. So far, the numbers don't bear that out. In fact, ***the state has gained 564 doctors over the past five years.*** The state Medical Association has said the growth in doctors lags behind the state's population growth. But while Mississippi still ranks last in the nation in the number of doctors per capita, it has made dramatic gains since 1995. ***Only four states have grown faster in physician population***: Alabama, Alaska, Arkansas and South Dakota. (emphasis added). Joey Bunch, "Crisis or PR campaign?; Pro and con forces seek to win hearts and minds of Mississippians," Biloxi Sun-Herald, August 11, 2002.

In October 2002, lawmakers limited jury awards for non-economic "pain and suffering" damages to $500,000. Despite enactment of the cap, premiums continued to skyrocket and, for some doctors, coverage is still unavailable at any price. See., e.g., Ben Bryant, "Tort reform has done little to ease malpractice crisis," *Biloxi Sun-Herald*, February 2, 2003.

Missouri

"[Gov. Bob] Holden's insurance report, a four-month study of the medical malpractice market, said ***that litigation that resulted in a cash payment had dropped 42 percent from 1988 to 2001,*** and that ***the number of claims overall had fallen from 2,244 to 1,599, or 29 percent, since 1987.*** (emphasis added). Deslatte Aaron, "Malpractice rates gain Holden's attention," *Springfield News-Leader*, February 7, 2003. "In Missouri, the number of malpractice claims actually dropped over the course of the 1990s. ...In Missouri, average payments to patients who sued doctors rose 23 percent from 1992 to 2001. But that was less than the 26 percent rise in the consumer price

index." Editorial, "Ups And Downs," *St. Louis Post-Dispatch*, February 3, 2003, part 1 of a 2 part series entitled, "Malpractice Insurance: Q & A." In 2001, "fewer malpractice claims were filed against Missouri doctors than in 2000. That was about half as many as the number filed in 1987...[P]ain and suffering awards, which Missouri caps at $540,000, averaged only about $84,000.... Yet malpractice insurance premiums are going through the roof here." Editorial, *St. Louis Post-Dispatch*, October 11, 2002.

New Jersey

"Patients filed 1,656 lawsuits [in 2001] - a 16 percent decrease from 1997, when 1,971 were filed, according to figures from the Administrative Office of the Courts." (emphasis added). Wendy Ruderman, "Untangling the knots of medical malpractice; N.J. legislators must do right by doctors, insurers, lawyers and patients. A bill could come this month," *Philadelphia Inquirer*, February 19, 2003. The Administrative Office of the Courts "reported that out of 205 medical malpractice cases that went to trial in 2002, plaintiffs prevailed in only 54, or 26 percent. Of those, the average award was $300,000 for economic and noneconomic damages combined." Michael Booth, "Medical Malpractice Reform Measure Fails as Neither Side Wants To Bend," *New Jersey Law Journal*, February 13, 2003. From January through August 2002, ***less than 10 percent of medical malpractice policyholders experienced large rate increases.***" (emphasis added). "N.J. Regulators Say Few Providers Faced Large Med-Mal Premium Hikes," *BestWire*, January 27, 2003.

North Carolina

Doctors are not fleeing North Carolina. Instead, ***the state has seen a 41 percent increase in the number of physicians since 1992.*** "Doctors' need for bill challenged," *Raleigh News Observer*, April 8, 2003. "Average malpractice payouts in North Carolina have increased 69 percent over the past 10 years. But spending on national health care services has risen 87 percent over the same period, according to Kaiser Family Foundation." Sarah Avery, Matthew Eisley and Jean Fisher, "Malpractice fight brews," *News Observer* (Raleigh, NC), March 30, 2003.

Nevada

"State researchers found ***fewer doctors leaving Nevada due to rising insurance premiums than doctors' advocates reported.*** Thirty-five of the 4,700 medical doctors in Nevada closed their practices, 12 retired and six stopped practicing obstetrics, according to a study by the state legislative research division.... 'I was shocked to read the statistics,' Assembly Majority Leader Barbara Buckley, D-Las Vegas, told the *Las Vegas Review-Journal*. 'Certainly the impression we've been given was inaccurate.' (emphasis added). "State study says fewer doctors leaving Nevada than reported," *Associated Press*, February 28, 2003.

In the summer of 2002, Nevada enacted a $350,000 cap on non-economic compensation in most medical malpractice cases. Within weeks of the law's enactment, two major insurance companies – American Physicians Assurance and the Medical Liability Association of Nevada – proclaimed that they would not reduce insurance rates. American Physicians Assurance, the primary insurer for Las Vegas obstetricians, said that it had no plans to lower premiums for

several years, if ever. Bob Byrd, chairman of the Medical Liability Association of Nevada, said, "We're not lowering rates anytime soon." In January 2003, The Doctors Company filed for a 16.9 percent rate increase, shortly after two other companies filed for 25 percent and 93 percent rate increases, according to the Nevada State Division of Insurance. Joelle Babula, "Medical liability company requests premium increase," *Las Vegas Review-Journal*, February 11, 2003; Joelle Babula, "Medical Liability Laws: Doctors remain unsatisfied," *Las Vegas Review-Journal*, January 27, 2003; "Deliveries In Limbo: Women search for care," *Las Vegas Review-Journal*, January 10, 2003; Lawrence Messina, "Wise mulls trauma care solutions amid Nevada reports," Associated Press, October 7, 2003; Joelle Babula, "Obstetricians say problems remain," *Las Vegas Review-Journal*, October 1, 2002; Joelle Babula, "State insurance program holds off on lowering rates," *Las Vegas Review-Journal*, August 14, 2002; Joelle Babula, "Medical Malpractice: Insurer has no plans to lower costs," *Las Vegas Review-Journal*, August 10, 2002.

New York

The number of physicians practicing in New York State has skyrocketed and is increasing at a rate faster than the national average. ***New York ranks first in the nation in surgical specialists, which are most likely to be sued, and third in the nation in the number of OB/GYN's per capita, well ahead of California (ranked 27th).*** When compared to the region, only Connecticut (ranked 2nd) is ahead of New York State in the number of ob gyns per capita. *First Do No Harm: A Consumer Response to the Medical Lobby's Campaign to Limit The Legal Rights of Injured Patients*, NYPIRG et at., (September 2002) (emphasis added). In July 2002, ***New York's largest medical malpractice insurer was denied its requested premium increase,*** with State Insurance Superintendent Gregory Serio stating, "I don't think there is any further need for more rates at this point."

Ohio

A 2002 *Cleveland Plain Dealer* analysis of malpractice suits found that "***the number of malpractice cases filed in 2001 was almost the same as in 1995. Last year, juries ruled in favor of injured patients less than half as often as they did in 1995, court records show.*** A smaller percentage of their verdicts involved million-dollar awards than in 1995, and the total for all verdicts was 28 percent lower last year." (emphasis added). Roger Mezger, "Pattern lacking in insurance rate hikes; PD analysis finds no tangible crisis in malpractice suits," *Plain Dealer*, October 20, 2002. "An exhaustive study of Franklin County cases by Ohio State law professors cast serious doubt on massive jury awards. It showed 114 medical malpractice cases going to trial in 12 years, 30 percent won by the plaintiffs, with a median jury award of $198,000 – well below the $300,000 cap on non-economic damages in a pending Ohio Senate bill. Four of the five highest awards were reduced by the trial judge or on appeal." Leigh Allan, "Cries For Tort Reform All Wet," *Dayton Daily News*, September 17, 2002.

Legislation capping non-economic damages in medical malpractice cases at $500,000, with a $1 million cap for catastrophic injuries, was signed into law in January 2003. After the caps were signed into law, all five major medical malpractice insurance companies in Ohio – American Physicians Assurance, the Doctors Company, GE Medical Protective, Medical Assurance and the Ohio Hospital Insurance Co. – said they had no plans to reduce their rates because of the legislation and that premiums could even rise." Laura A. Bischoff, "Taft Signs Malpractice Reform Bill; Cap on awards for pain and suffering," *Dayton Daily News*, January 11, 2003; Andrew Welsh-Huggins, "Doctors

pushing for short-term relief from malpractice rates," *Associated Press*, January 10, 2003; "Despite new law, insurance companies won't lower rates right away," *Associated Press*, January 9, 2003; Spencer Hunt, "Docs look for insurance cure," *Cincinnati Enquirer*, November 26, 2002.

Oregon

"Statistics from the Oregon Board of Medical Examiners show ***332 malpractice cases against doctors in 2000, which decreased to 302 cases in 2001.***" (emphasis added). Susan Tom, "Obstetricians play safe, avoid suits," *Statesman Journal* (Salem, OR), July 9, 2002.

Pennsylvania

"Across Pennsylvania, ***the number of medical-malpractice awards for $1 million or more is down for the second year in a row.... The overall amount of those big jury awards is dropping too.*** So far, juries have awarded $69 million in the first eight months of this year. In 2000, the total was $415 million. ... In Philadelphia, patients still lose 60 percent of all malpractice trials, but that is much better than suburban counties, where patients lost 80 percent of the time or more." (emphasis added). Josh Goldstein, "Medical lawsuit payouts still high; Philadelphia awards and settlements made up nearly half of the $348 million paid out by a state fund," *Philadelphia Inquirer*, September 22, 2002.

Texas

"The Office of Court Administration has recorded a steady drop in the number of personal injury lawsuits not involving a motor vehicle, the category that would include medical malpractice: from 31,050 suits in 1994-95 to 19,590 in 2000-2001....***[State Board of Medical Examiners] statistics do show a shrinking number of claims since 1999, when the number spiked at 5,715.*** Of the 4,445 claims closed that year, 617 resulted in payments, the average being $208,592. In 2001, 4,083 claims were filed, but only 1,088 were closed. Of the 23 closed with payments, the average amount was $267,253.... The Texas Department of Insurance showed a 4 percent increase in claims since 1996, according to an Austin America-Statesman report, far short of the surge in insurance rates." (emphasis added). Editorial, "Premium importance," *Fort Worth Star-Telegram*, March 24, 2003.

Washington

According to the state's Medical Quality Assurance Commission, in 2002, "there were 11 malpractice payments of $1 million or more – exactly the same number as in 1999." Carol M. Ostrom, "Arguments, facts behind malpractice debate Q&A," *Seattle Times*, February 21, 2003. "The insurance premium rate increases are coming despite ***little change in the number of malpractice suits filed each year against doctors in the state.***...According to a report by Physicians Insurance, a self-funded mutual company operated by doctors that provides malpractice insurance for about two-thirds of the state's doctors, the frequency of claims per 100 insured clinics and physicians averaged 6.3 in 1990, then rose to 10.7 in 1995, but has since declined. In 2002, the claim frequency per 100 insured doctors was 6.2." (emphasis added). Julia Anderson, "Tort & Retort:

Doctors say they're dogged by rising costs of premiums and jury awards, while attorneys say it's not their fault," *The Columbian* (Vancouver, WA.), February 9, 2003.

West Virginia

"The number of claims against the state's doctors since 1993 has decreased and the amount of money spent to settle the claims has not changed, according to board of medicine records." (emphasis added). Joy Davis, "Doctor dilemma; The Medical Malpractice Debate," *Charleston Gazette*, December 1, 2002. "Board of Medicine records show that the number of malpractice claims filed against doctors licensed in West Virginia dropped between 1992 and 2000." Lawrence Messina, Caution advised amid medical malpractice debate, *Associated Press*, November 18, 2002. ***"The average West Virginia payout from 1999 to 2002 was less than the national average and lower than 27 states and the District of Columbia. ... A Gazette analysis, meanwhile, said the number of claims against the state's doctors since 1993 has decreased and the amount of money spent to settle the claims has not changed."*** Joy Davis, "Putting a price on pain; State struggles to keep doctors, patients happy," *Charleston Gazette*, November 17, 2002. "Reporter Lawrence Messina combed through thousands of records of claims from the Board of Medicine. He found that the number of claims has been decreasing, and that the amount of money paid to settle claims has remained relatively constant since 1993.... He also found that less than one-fifth of the number of doctors licensed in the state had ever been sued for malpractice, and less than 4 percent of the doctors in the state were sued in any given year." Dan Radmacher (editorial), "Malpractice diagnosis incorrect," *Charleston Gazette*, August 23, 2002. "[Lawrence] Messina found that jury awards in West Virginia had fluctuated, but generally held steady between 1993 and 2000. The number of claims filed each year actually decreased. Messina found this out by examining Board of Medicine records that insurance companies are required to file. He looked at nearly 2,300 resolved claims." Dan Radmacher (editorial), "AP article misses malpractice mark," *Charleston Gazette*, July 26, 2002.

Americans for Insurance Reform

"PROTECTING RIGHTS, NOT WRONGS"

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MYTHBUSTER

THE LIABILITY INSURANCE CRISIS — DÉJÀ VU ALL OVER AGAIN

In the mid-1980s, during this country's last liability insurance "crisis," great pressure was brought to bear on state legislatures to restrict the rights of innocent Americans to be compensated for their injuries and to hold wrongdoers accountable in court. Lawmakers in some 46 states succumbed to this pressure and passed "tort reforms" after being told by insurance companies and others that this was the only way to reduce skyrocketing insurance rates.

They were responding to news reports like these, virtually identical to reports of today:

- "An American Medical Association official says escalating costs of medical malpractice insurance are increasing health-care costs for the public and forcing doctors to curtail some services." *Baton Rouge Morning Advocate,* **May 31, 1986.**

- "Doctors are threatening to quit practicing some specialties or move out of the state while South Florida hospitals and trauma centers have threatened to shut down or have curtailed services." *St. Petersburg Times,* **May 7, 1987.**

- "Busloads of physicians from around [New York] state will travel to Albany on Wednesday, May 21, to rally for legislative reform of the state's medical liability system." *PR Newswire,* **May 19, 1986.**

- "Doctors and hospitals in [West Virginia] have been saying for weeks that they would have to close their doors at the end of this month when three major insurance companies planned to cancel malpractice insurance coverage for most of the state's medical providers." *Washington Post,* **May 24, 1986.**

- "Hundreds of doctors, especially those in high-risk specialties like obstetrics and orthopedics, refused to accept new patients last February when a state Insurance Division decision opened them up to massive retroactive premium increases." *The Record (New Jersey),* **July 24, 1986.**

Eventually, a few years after the mid-1980s insurance crisis, the insurance cycle flattened out, rates stabilized and availability improved everywhere – until now, over a decade later. The flattening of rates had nothing to do with tort law restrictions enacted in particular states, but

rather to modulations in the insurance cycle everywhere. In 1991, for example, Washington's insurance commissioner Dick Marquardt concluded in a report that it was "impossible to attribute stable insurance rates to tort-law changes or the damages cap," since rates also improved in states that did not pass tort reform.

Have we learned nothing from the past? The "liability insurance crisis" of the mid-1980s was ultimately found to be caused not by legal system excesses but by the economic cycle of the insurance industry.

Just as the liability insurance crisis was found to be driven by this cycle and not a tort law cost explosion as many insurance companies and others had claimed, the "tort reform" remedy pushed by these advocates failed.

It will fail again.

Only effective insurance reforms will stop these cyclical insurance crises.

- **Volcanic eruptions in insurance premiums for doctors have occurred three times in the last 30 years – in the mid 1970s, again in the mid-1980s, and now today.** The cause is always the same: a severe drop in investment income for insurers compounded by pricing errors in prior years.

- **Each time, insurers have tried to cover up their mismanaged underwriting by blaming lawyers and the legal system.** To buy this position, one would have to accept the notion that trial lawyers or juries were particularly aggressive in the mid-1970s, then non-aggressive for a decade, then aggressive in the mid-1980s, non-aggressive for 17 years and are now aggressive again. This is ludicrous.

- **Reinsurers historically have targeted medical malpractice lines for rate hikes,** dictating premium increases even for doctor-owned mutual insurance companies that should be independent of the profit considerations that motivate pricing decisions by the rest of the industry.

- **The insurance industry has not cut, and has no plans to cut, insurance premiums as a consequence of tort restrictions.** The American Insurance Association (AIA) and the American Tort Reform Association (ATRA) have already gone on record admitting this, with the AIA stating on March 13, 2002, "[T]he insurance industry never promised that tort reform would achieve specific premium savings."

- **The Center for Justice & Democracy's 1999 study, *Premium Deceit —the Failure of "Tort Reform" to Cut Insurance Prices*, found that tort law limits enacted since the mid-1980s have not lowered insurance rates in the ensuing years.** Some states that resisted enacting any "tort reform" experienced low increases in insurance rates or loss costs relative to the national trends, and some states that enacted major "tort reform" packages, like New York, saw very high rate or loss cost increases relative to the national trends. In other words, there was no correlation between "tort reform" and insurance rates.

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10 Things You Should Know About ... MEDICAL MALPRACTICE

1. Insurance companies are paying victims of medical negligence on average approximately $30,000. Average payouts have stayed virtually flat for the last decade.[1]

2. Medical malpractice costs, as a percentage of national health care expenditures, are at an all time low, 0.55 percent.[2]

3. According to the National Academy of Sciences, up to 98,000 people are killed each year by medical errors in hospitals – far more than die from car accidents, breast cancer or AIDS.[3]

4. Total national costs (lost income, lost household production, disability and health care costs) of negligence in hospitals are estimated to be between $17 billion and $29 billion each year.[4]

5. Eight times as many patients are injured by medical malpractice as ever file a claim; 16 times as many suffer injuries as receive any compensation.[5]

6. According to the National Center for State Courts, between 1992 and 2001, medical malpractice filings per 100,000 population have only fluctuated minimally, with an overall 1 percent decrease in per capita filings.[6]

7. Injured medical malpractice patients win before juries in only 23 percent of cases[7]; in 1992, the rate was 7.5 percent higher at 30.5 percent.[8] Only 1.1 percent of medical malpractice plaintiffs who prevail at trial are awarded punitive damages.[9]

8. According to studies in several states, there is no correlation between where physicians decide to practice and state liability laws or insurance rates.[10]

9. Tort law limits do not lower insurance rates; states with little or no tort law restrictions have experienced approximately the same changes in insurance rates as those states that have enacted severe restrictions on victims' rights.[11]

10. Numerous hospital and medical procedures have been made safer as a result of lawsuits, including anesthesia procedures, catheter placements, drug prescriptions, hospital staffing levels, infection control, nursing home care and trauma care.[12]

###

NOTES

[1] "New Study Shows Average Medical Malpractice Payout Over Last Decade Only $28,524; New Data Reveals Same Trends in 2001," Americans for Insurance Reform, News Release, January 23, 2003.

[2] *Ibid.*

[3] Kohn, Corrigan, Donaldson, Eds., *To Err is Human; Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, DC (1999).

[4] *Ibid.*

[5] Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990).

[6] *Examining the Work of State Courts, 2002; A National Perspective from the Court Statistics Project* (2003), p. 28. This finding is based on medical malpractice data from 17 states.

[7] *Examining the Work of State Courts, 2001; A National Perspective from the Court Statistics Project* (2001), p. 94.

[8] "Tort Trials and Verdicts in Large Counties, 1996," U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, NCJ-179769 (August 2000), p. 9.

[9] *Ibid* at 7.

[10] Wlazelek, Ann, "Doctors' ad campaign baseless; They're not fleeing Pa., but malpractice straits create 'hostile' climate," *Morning Call*, March 24, 2002; "Doctors not leaving Pittsburgh despite costly insurance," *Associated Press*, November 12, 2001; Goldstein, Josh, "Recent Census of Doctors Show No Flight from Pennsylvania," *Philadelphia Inquirer*, October 2, 2001; Leonard, Martha, "State has seen sharp increase in number of doctors," *Sunday Gazette Mail*, February 25, 2001; Kinney and Groufein, "Indiana's Malpractice System: No-Fault by Accident," 54 *Law & Contemp. Probs.* 169, 188 (1991), cited in Galanter, Marc, "Real World Torts," 55 *Maryland L. Rev.* 1093, 1152-1153 (1996); Kinney, "Malpractice Reform in the 1990s, Past Disappointment, Future Success?" 20 *J. Health Pol. Pol'y & L.* 99, 120 (1996), cited in Galanter, Marc, "Real World Torts," 55 *Maryland L. Rev.* 1093, 1152 (1996).

[11] Martin D. Weiss, Melissa Gannon and Stephanie Eakins, *Medical Malpractice Caps: The Impact of Non-Economic Damage Caps on Physician Premiums, Claim Payout Levels, and Availability of Coverage*, Weiss Ratings, Inc. (2003); J. Robert Hunter and Joanne Doroshow, *Premium Deceit: The Failure of "Tort Reform" to Cut Insurance Prices*, Center for Justice & Democracy (1999).

[12] Meghan Mulligan and Emily Gottlieb, *Lifesavers: CJ&D's Guide to Lawsuits that Protect Us All*, Center for Justice & Democracy (2002).

From: "Neil Ferstand" **Wednesday, January 14, 2004**

Health Care Marketplace

Capping Awards in Medical Malpractice Lawsuits Would 'Do Little' To Slow Health Spending, CBO Report Says

Legislation to cap damages in medical malpractice lawsuits would "do little to hold down health care spending" or eliminate the practice of "defensive medicine," according to a Congressional Budget Office report released last week, *CongressDaily* reports (*CongressDaily*, 1/13). The report found that malpractice insurance premiums have increased in recent years in part because insurers have experienced increases in claims costs, as the amounts of damage awards in malpractice lawsuits have increased. However, the report found that malpractice insurance premiums also have increased because of reduced income from insurer investments and short-term factors in the insurance market. The report found that although malpractice insurance premiums are lower in states with caps on damages in malpractice lawsuits, "even large savings in premiums" would have a small impact on total health care spending because malpractice insurance costs account for less than 2% of spending (CBO report, 1/8). In addition, the report found that a cap on damages in malpractice lawsuits would not likely end the practice of "defensive medicine" -- in which physicians order more procedures and tests than are medically necessary to avoid malpractice lawsuits -- because "physicians who practice defensive medicine may do so less because they fear liability than to generate more income," *CongressDaily* reports (*CongressDaily*, 1/13). The report did not reach a conclusion on whether caps on damages in malpractice lawsuits affect access to health care. According to the report, although the General Accounting Office confirmed cases in which access to emergency surgery and newborn delivery was reduced in "scattered, often rural areas where providers identified other long-standing factors that affect the availability of services," the GAO also found that many reported shortages of health care services "could not be substantiated" or "did not widely affect access to health care" (CBO report, 1/8).

Medical Errors

The CBO report also found no evidence that the current medical liability system prevents medical errors, a claim that some opponents of caps on damages in malpractice lawsuits have made (*CongressDaily*, 1/13). The report said that the medical liability system may not prevent medical errors because health care providers are "generally not exposed to the financial cost of their own malpractice" and because "very few medical injuries ever become the subject of a tort claim" (CBO report, 1/8).

http://www.kaisernetwork.org/daily_reports/print_report.cfm?DR_ID=21678&dr_cat=3

"YOU KNOW HOW I SAID WE NEEDED TORT REFORM? NOW THAT WE'VE GOT IT, WE'D LIKE A GIANT RATE INCREASE AS WELL" – INSURANCE INDUSTRY OF AMERICA

Predictions that skyrocketing medical-malpractice-premiums costs for doctors would drop after state lawmakers capped jury awards a year ago appear premature... Premiums are expected to rise this year, in some instances as much as 40 percent, and doctors are closing shop and moving from the state.
("Doctors still closing shop and voting with their feet," T.C. Brown, Cleveland Plain Dealer, February 20, 2004)

"Based on the trends of frequency and severity of medical-malpractice claims that we see in Florida right now, we will need to ask for some kind of rate increase."
Dean Davidson, spokesman for MedPro, Florida's third largest med mal carrier, explaining the company's desire for a 19.4% rate increase just three months after passage of Florida's new medical malpractice law. ("Insurer wants malpractice rate increase," Orlando Sentinel, October 7, 2003)

"[T]ort reform does not provide a magical 'silver-bullet' that will immediately affect medical malpractice insurance rates."
(Medical Assurance Co. of Mississippi, September 2002)

"No, we're not telling you that."
Patricia Costante, chairman and CEO of the MIIX Group of Insurance Companies, replying to a question inquiring whether her company would not raise premiums if caps were enacted. (Meeting of the New Jersey Assembly Joint Committee of Banking & Insurance and Health & Human Services on Medical Malpractice, June 3, 2002)

"I don't like to hear insurance-company executives say it's the tort system – it's self inflicted.'"
Donald J. Zuk, Chief Executive of SCPIE, a leading malpractice insurer in California, (Wall Street Journal, June 24, 2002). A year later SCPIE lobbied the insurance commissioner unsuccessfully for a 15.6% rate increase.

"While MICRA was the legislature's attempt at remedying the medical malpractice crisis in California in 1975, it did not substantially reduce the relative risk of medical malpractice insurance in California."
(James Robertson, actuary and assistant VP for SCPIE, in written testimony to the California Insurance Commissioner, lobbying for the 15.6% rate increase)

"The cap (on non-economic damages of $250,000) will not lower premiums. One of the reasons premiums won't go down is that even if non-economic damages are capped, the loss for economic losses-medical costs for example-are still in this current environment escalating at medical inflation that is running in the double digits- I forget exactly what it was last year. So, even if you were to cap non-economic damages, the economic damages would still cause acceleration in the premiums- so, in fact they will not go down. I want to clarify: I misspoke, and said we thought premiums would go down."
WA State Medical Association and insurance industry lobbyist Cliff Webster, answering a question regarding the effect of proposed caps on premiums. (Washington State House Judiciary Committee, February 21, 2003)

"We strongly believe there is good reason to hope that the worst soon will be in the past, but we realize that optimism —however well-founded—has little power to mitigate the current situation."
Jerome M. Buckley, CEO and Chairman of Colorado's COPIC, explaining away a 14.2% rate increase in 2003 and projected 13.82% rate increase for 2004 by blaming the legal environment. Colorado passed its most significant tort reforms in 1988. (COPIC Topic, No.88 October 2003)

"[A]ny limitations placed on the judicial system will nave no immediate effect on the cost of liability insurance for health care providers."
(Final Report of the Insurance Availability and Medical Malpractice Industry Committee, a bi-partisan committee of the West Virginia Legislature, issued January 7, 2003)

"It will take several years for the effects of the new legislation to be felt."
Robert Byrd, Chairman of the Medical Liability Association. ("Doctors Still Wait to See Premium Improvement in Nevada," Best's Insurance News, August 20, 2002)

Farmers Insurance has "suffered significant underwriting losses" recently and plans to refocus on its core lines of home, business, auto and life insurance.
Farmers Insurance Group spokeswoman Michelle Levy, explaining the decision to quit the medical malpractice business in California despite three decades with a $250,000 cap. ("Farmers Insurance Exits Malpractice Arena," AP, September 24, 2003)

"We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates."

St. Paul's found "a total effect of about 1% savings" from Florida's 1986 tort reforms, but that even this 1% might be inflated. St. Paul concluded that "the noneconomic cap of $450,000, joint and several liability on the noneconomic damages, and mandatory structured settlements on losses above $250,000 will produce little or no savings to the tort system as it pertains to medical malpractice."
Conclusion of a St.Paul study of the projected effect of Florida's tort reforms, which included a $450,000 cap, on recently closed cases. (St. Paul Fire & Marine Ins. Co., Medical Professional Liability, State of Florida, 1986)

"Given that liability losses constitute such a low proportion of business owners' losses, GA feels it is prudent to continue with its original proposal of a 10 percent increase in base rates."
General Accident Insurance Company. (The Seattle Times, July 1, 1986). The Times went on to write that "the highly touted tort-reform legislation enacted by the Legislature early this year is not lowering liability-insurance rates as promised, according to preliminary filings made with the state insurance commissioner."

In asking for a 22% rate increase following passage of tort reform in Washington State, including a cap on all damage awards, the company said, "our proposed rate would not be measurably affected by the tort reform legislation."
Allstate Insurance Company of Washington State, (The Seattle Times, July 1, 1986)

After enactment of the 1986 Washington tort reforms, St. Paul said that the limit on plaintiffs' lawyers fees "probably will have no effect on loss costs," and that "a 'cap' can become a target in smaller dollar cases, thus actually working to increase costs. We do not have the data that would allow us to project the actual probable effect in either direction."
(Letter from Richard W. Tongen, Executive Vice President, St. Paul Fire and Marine Ins. Co., to Richard G. Marquardt, Washington Insurance Commissioner, June 12, 1986)

After the 1986 Washington tort reforms, the Great American West Insurance Company said that on the basis of its own study, "it does not appear that the 'tort reform' law will serve to decrease our losses, but instead it potentially could increase our liability. We elect at this point, however, not to make an upward adjustment in the indications to reflect the impact of the 'tort reform' law."
(Letter from Kevin J. Kelley, Director of Actuarial for Great American West Insurance Company, to Norman Figon, Rate Analyst, Washington Insurance Department, April 23, 1986)

Sherman Joyce, President of the American Tort Reform Association, ("Study Finds No Link Between Tort Reforms and Insurance Rates," Liability Week, July 19, 1999)

"Insurers never promised that tort reform would achieve specific premium savings . . ."
(March 13, 2002 press release by the American Insurance Association)

"The conclusion of the study is that the noneconomic cap . . .[and other tort 'reforms'] will produce little or no savings to the tort system as it pertains to medical malpractice."
(Internal documents citing a study written by Florida insurers regarding that state's omnibus tort "reform" law of 1986 - Medical Professional Liability, State of Florida, St. Paul fire and Marine Insurance Company, St. Paul Mercury Insurance Company)

"[M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and 'I've never said that in 30 years."
(Victor Schwartz, General Counsel, American Tort Reform Association, Business Insurance, July 19, 1999)

"[The insurance industry now says [tort reform] measures will have no effect on insurance rates. We have been disappointed by the response of the insurance industry. The reforms we passed should have led to rate reductions because we made it more difficult to recover, or set limits on recovery. But this hasn't happened."
(Connecticut State Lawmaker, UPI, March 9, 1987)

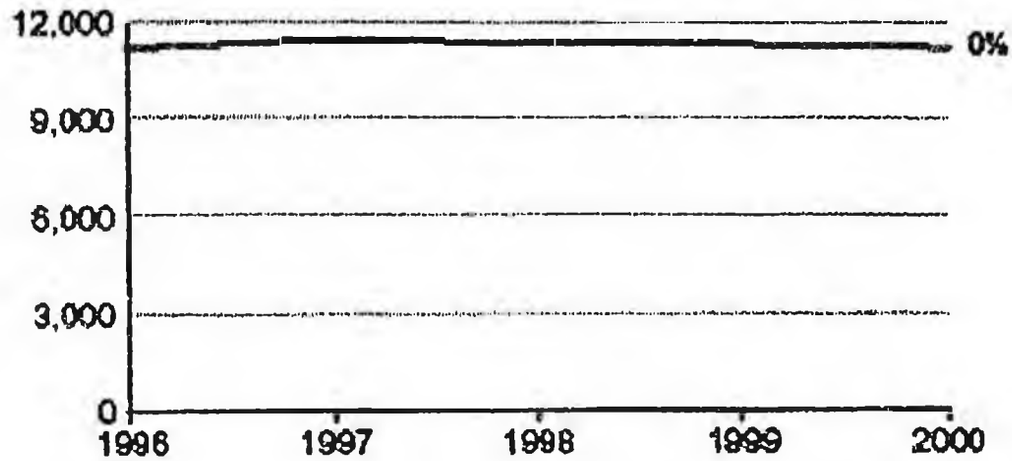
"[W]e believe the effect of tort reform on our book of business would be small. ... [T]he loss savings resulting from the non-economic cap will not exceed 1% of our total indemnity losses. . . [I]n our sample of liability claims, no claim was found that would have been affected by the joint and several restriction." And any savings due to alternative payment methods would be "negligible."
(Letter from Robert J. Nagel, an Assistant Vice President at State Farm, to Ray Rather, Kansas Insurance Department, Oct. 21, 1986)

"[T]he review of the actual data submitted on these cases indicated no reduction of cost."
Conclusion of an Aetna study of the projected effect of Florida's tort reforms, which included a $450,000 cap, on recently closed cases. (Aetna Casualty & Sur. Co., Commercial Ins. Div., Bodily Injury Claim Cost Impact of Florida Tort Law Change, Aug. 8, 1986)

Medical Malpractice Insurance

Are Malpractice claims increasing?

Medical Malpractice Filings in 14 States, 1996-2000



The National Center For State Courts Says NO

"Between 1996 and 2000, medical malpractice data were available from 14 states. The chart clearly shows that there has been no change in the volume of medical malpractice cases in the last five years. Although filings crept up slightly (2.5 percent) in the first year, this increase was subsequently erased by a slow, steady decrease over the four remaining years" (page 31).

National Center For State Courts, Courts Statistics Project. 2002. Available online at http://www.ncsconline.org/

HEALTHCARE

- Main Page
- Press Releases
- In the Media
- Factsheets
- Reports
- Medical Malpractice Stories
- HMO Arbitration Abuse Report
- Casualty of the Day

OTHER TOPICS

- Corporate Accountability
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- Citizen Advocacy
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home / healthcare / factsheets

FACTSHEET

Five Dangerous Myths About California's Medical Malpractice Restrictions

Myth#1: Legal Restrictions on Victims Lowered California Doctors' Malpractice Premiums.

Facts: Californians enacted the strongest insurance rate regulation in the nation in 1998 through insurance reform Proposition 103 (Prop 103), a ballot initiative passed by the voters and authored by FTCR president Harvey Rosenfield. This law resulted in a rate freeze, a rate rollback, and stringent regulation that reduced premiums in all lines of insurance -- including medical malpractice.

In 1975, California enacted a series of legal restrictions on injured patients -- the Medical Injury Compensation Reform Act (MICRA). Data from the National Association of Insurance Commissioners, summarized in graphs linked to below show that:

- Overall, California medical malpractice premiums increased dramatically during the first thirteen years with MICRA and substantially decreased after voters' approved Proposition 103. (See graph)
- Medical malpractice premiums remained extremely volatile after MICRA and did not stabilize until Prop 103 imposed rate regulation in 1988.
- In 1986, after a decade of MICRA, California was once again mired in an insurance crisis, with medical malpractice premiums rising at a rate of 26% annually, faster than premiums rose nationally during the same period. In fact, the year MICRA's cap of damages was upheld in court (1985), California malpractice premiums increased by 20% and the following year rates jumped an additional 40%.
- Conversely, after three years of insurance regulation under Prop 103, medical malpractice rates had fallen by more than 20%. During the first decade of regulation, premiums were down by 7% and, if we adjust for inflation, medical malpractice premiums are down by 35% since the enactment of regulation.

- California medical malpractice premiums tracked closely with national trends until Proposition 103 set California apart, by statutorily requiring lower insurance rates. (See graph)

Former Governor Jerry Brown, who signed the MICRA law, stated seventeen years later (on June 13, 1993) that he would not recommend it for the nation because in the interlude he "witnessed yet another insurance crisis and found that insurance company avarice, not utilization of the legal system by injured consumers was responsible for excessive premiums." "Saddest of all," Brown continued, is "the arbitrary and cruel effect upon victims of malpractice." (Read Brown's full statement)

Myth #2: Injured patients are still able to hold wrongdoers legally accountable because only "non-economic" damages are capped -- compensation for those damages not measured by wage loss, medical bills, or other tangible economic measures.

Facts: Only those patients with large wage loss or medical bills are typically able to find attorneys in California. Most medical malpractice victims cannot. For example, injured patients who, as a result of medical negligence, lose their fertility or are severely disfigured typically cannot prove "economic" damage. Similarly, the death of a child or senior citizen typically does not result in "economic" damage because there is no basis for wage loss or measuring medical bills. In these types of California cases, there is typically no legal accountability for wrongdoers

The situation stirred well-known insurance defense attorney Robert Baker, who defended malpractice suits for more than twenty years, to tell Congress about the problem. "In my view, these malpractice reforms have aided insurance companies and physicians, but have, to a significant extent, been detrimental to person injured by medical negligence," Baker testified before the House Judiciary Committee in 1994 on behalf of the American Board of Trial Advocates (ABOTA). "As a result of the caps on damages, most of the exceedingly competent plaintiff's lawyers in California simply will not handle a malpractice case.

"There are entire categories of cases that have been eliminated since malpractice reform was implemented in California. The victims of cases that have a value between $50,000 and $150,000 are basically without representation. As an example, incidents of failure to diagnose an appendicitis still occur, but suits are not filed to any extent in California."

Soon after the testimony, Baker's major clients -- the HMO Kaiser Permanente and malpractice insurer The Doctors' Company -- fired him. (Read Baker's full statement)

Legal fees and expenses are not added on to the "economic" damage award, so they must be subtracted from the capped "non-economic" damages portion. This makes expensive cases without significant economic damage components not viable for attorneys.

Myth #3 A one-size-fits-all cap on compensation is fair to patients who can receive "unlimited" economic damages.

Facts: Economic damages cannot always be anticipated. California juries are not informed of the cap on non-economic damages, so they are often not careful about apportioning economic damages. In one famous case, for example, Harry Jordan, a Long Beach man, was hospitalized to have a cancerous kidney removed but the surgeon took out his healthy kidney instead. A jury awarded Jordan more than $5 million dollars, but the judge was required to reduce the verdict to $250,000 due to California's cap on "non-economic" damages - plus a mere $6,000 in "economic costs". Jordan, who lived for years on 10% kidney function, could no longer work, though the jury (which lawfully can not be notified about the "non- economic" cap) did not take this into account. Jordan's court costs -- not including attorney fees -- amounted to more than $400,000 and his medical bills, that arose after frequently being denied by insurers, totaled more than $500,000. He paid $1700 per month in health insurance.

The stories of other patients victimized by California's restrictions can be found in FTCR's testimony before Congress.

Read a letter from members of California's Congressional Delegations critical of MICRA.

Myth #4: Malpractice damage caps are about doctors vs. lawyers .

Facts: Malpractice caps are about patients vs. reckless HMOs and managed care corporations.

Twelve years old today, Steven Olsen is blind and brain damaged because, as a jury ruled, he was a victim of medical negligence when he was two years old. He fell on a stick in the woods while hiking. Under the family's HMO plan, the hospital pumped Steven up with steroids and sent him away with a growing brain abscess, although his parents had asked for a CAT scan because they knew Steven was not well. The next day, Steven Olsen came back to the hospital comatose. At trial, medical experts testified that had he received the $800 CAT scan, which would have detected a growing brain mass, he would have his sight and be perfectly healthy today.

The jury awarded $7.1 million in "non-economic" damages for Steven's avoidable life of darkness and suffering. However, the jury was not told of the two decade old restriction on non-economic damages in the state. The judge was forced to reduce the amount to $250,000. The jurors only found out that their verdict had been reduced by reading about it in the newspaper. Jury foreman Thomas Kearns expressed his dismay in a letter published in the San Diego Union Tribune.

"We viewed video of Steven, age 2, shortly before the accident. This beautiful child talked and shrieked with laughter as any other child at play. Later, Steven was brought to the court and we watched as he groped, stumbled and felt his way along the front of the jury box. There was no chatter

or happy laughter. Steven is doomed to a life of darkness, loneliness and pain. He is blind, brain damaged and physically retarded. He will never play sports, work, or enjoy normal relationships with his peers. His will be a lifetime of treatment, therapy, prosthesis fitting and supervision around the clock. . . Our medical-care system has failed Steven Olsen, through inattention or pressure to avoid costly but necessary tests. Our legislative system has failed Steven, bowing to lobbyists of the powerful American Medical Association (AMA) and the insurance industry, by the Legislature enacting an ill-conceived and wrongful law. Our judicial system has failed Steven, by acceding to this tilting of the scales of justice by the Legislature for the benefit of two special- interest groups. . .. I think the people of California place a higher value on life than this."

In 2001, Steven had 74 doctor visits, 164 physical and speech therapy appointments, and three trips to the emergency room. And his parents say that was a good year because Steven was not hospitalized. Steven's mother Kathy had to leave her job because caring for Steven is a full time job. She has to struggle constantly with the school district for Steven to receive special education classes. One day, Steven ate part of a light bulb, not an uncommon problem for children with brain injuries. He has to be watched constantly. Insurance executives that seek to limit jury awards for the individual's pain and suffering claim society must do so to save money. Yet these executives typically make millions every year without any of Steven Olsen's pain and suffering. Limiting their responsibility for the pain of individuals reduces not only the corporation's accountability, but the worth of the individual to that of a mere object.

Kathy Olsen said this about Steven: "It has been 10 years ago this month when Steven came home from a 5-month life changing stay at the hospital. He was only 2 years old. When he went into the hospital no one asked his party affiliation. He was a casualty of the system. The system that he had no say in. Which lawmakers were looking out for him? Now with all his disabilities he will never see, do things that the average person gets to do in their lifetime, or vote in an election. Please look out for all the Steven Olsens in this great country. Don't let this happen over and over again."

Myth #5 Defensive medicine is always bad, significantly drives up the costs of medicine and results from doctors facing full legal accountability.

Facts: In the managed care age, the financial incentives point the other way -- to less caution, not more. Proponents of limiting victims' rights claim that doctors' fear of lawsuits, so called defensive medicine, is driving them to perform unnecessary tests and procedures.

The Congressional Office of Technology Assessment foresaw this trend in July 1994, reporting that less than 8 percent of diagnostic procedures are likely to be caused by conscious concern about malpractice liability. "Defensive medicine is not always bad for patients," the agency stated. "Malpractice reforms that remove incentives to practice defensively, without differentiating between appropriate and inappropriate defensive medicine, could also remove a deterrent to providing too little

care at the very time that such mechanisms are needed."

###

▲ back to top

Alaska Action Trust

P.O. Box 102323 • Anchorage, Alaska 99510
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(907) 258-4040 • FAX (907) 258-8751

TELECOPIER COVER SHEET

TO:

Lesil McGuire / 907-465-6592
Les Gara / 907-465-3518

FROM:

Donna J. McCready / Alaska Action Trust – Board Member

INTERNAL USE:

March 3, 2004
Number of Pages (including cover sheet): 28
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Alaska Action Trust

P.O. Box 102323 • Anchorage, Alaska 99510
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March 3, 2004

VIA FACSIMILE

Chair Lesil McGuire and
Committee Members
House Judiciary Committee

Re: HB 472 – Examples of Cases Where Rule 82 and Rule 79 Judgments Were Sought Against Plaintiffs in Medical Negligence Cases

Dear Madam Chair and Members of the House Judiciary Committee:

At the hearing last Wednesday, February 25, 2004, you requested information regarding Rule 82 judgments against plaintiffs in medical negligence cases. This letter responds to that request.

Rule 82 is the Court Rule that allows a prevailing party to obtain a judgment for a portion of his or her legal fees against the losing party. Rule 79 allows the assessment of certain costs against a losing party. The threat of fees and Rule 79 costs being assessed against a plaintiff at the end of a case is a tremendous disincentive to a plaintiff to go to trial because, unlike insured defendants, if the plaintiff loses they have to pay fees and costs out of their own pockets, facing the prospect of bankruptcy in many cases. Because costs and fees are generally quite high in medical negligence cases, judgments for costs and fees in malpractice cases can be a significant threat to a plaintiff.

The summary of cases below and attached judgments[1] show that Rule 82 and Rule 79 are in fact used against patients/plaintiffs who are not prevailing parties in medical malpractice cases.

The following cases were brought to my attention during the last week. <u>There are undoubtedly other cases that have not been brought to my attention where judgments were sought and obtained by medical care providers and their insurers against patients who were not the prevailing party in a medical malpractice action. The following are simply examples of such cases.</u>

[1] Where possible, I have attached a copy of the actual judgment to this letter.

In the two cases cited by the sponsor of HB 472, **Marsingill v. O'Malley**, 3AN-95-9909 Ci, and **Korman v. Mallin**, 3AN-90-3486 Ci, defendants obtained judgments against the plaintiffs. In **Marsingill** the judgment for costs and fees was **$87,964.34** and in **Korman** the judgment for fees was **$3,931.00**. [Both judgments are attached.]

In **Kathleen Castle, as personal representative of the Estate of Wesley K Johnson, individually and as next best friend to Kirsten Johnson vs. Greg McCarthy, et al.**, 3AN-97-1836 Ci, there was a judgment entered against the plaintiffs in the amount of **$149,258.17** in favor of the defendants for costs and fees. The plaintiff filed Chapter 7 Bankruptcy and ultimately the defendants received **$37,500.**

In **Moffitt v. Kralick, M.D. and John C. Godersky, M.D.**, 3AN-93-9935 Ci, Dr. Godersky was awarded costs in the amount of $24,490.16 and fees in the amount of $49,757.70. Dr. Kralick was awarded $30,053.73 in costs against Moffitt and $56,322.50 in fees. The final judgment for the total costs and fees against Moffitt in favor of his doctors was **$160,624.09**. [Judgments attached.]

In **Freitas v. Alaska Radiology Assoc., Inc., et al.**, 3AN-99-100664 Ci, the defendants obtained a judgment in the amount of **$51,454.90** against the plaintiff who was dying from breast cancer and her husband. [Judgment attached.]

In **Snyder v. Jon F. Lieberman, M.D., et al.**, 4FA-98-3245 Civ., defendants were awarded $16,425.63 in costs and $39,142.35 in fees for a total of **$55,567.98**. [Judgment attached.]

In **Johnson v. George Siegfried, M.D.**, Dr. Siegfried was awarded $14,270.13 in costs and $28,113.60 in fees for a total of **$42,383.73**. [Judgment attached.]

In **Elgedawi v. Wrigley**, 3AN-01-7057Ci, Dr. Wrigley obtained a judgment against his patient for **$41,524.47**. [Judgment attached.]

In **Griffin v. George Siegfried, M.D.**, 3AN-97-2981Ci, Dr. Siegfried obtained a judgment against his patient for fees in the amount of $26,527.20 and costs in the amount of $12,113.74 for a total award of **$38,640.94**. [Judgment attached.]

In **Giordano v. Valley Hospital Association**, 3PA-96-860 Ci, Valley Hospital was awarded costs and fees in the amount of **$29,779.31** plus post-judgment interest on the unpaid balance. [Judgment attached.]

In **Thibault v. Mark Zimmerman, M.D.**, 3AN-93-11357 Ci, Dr. Zimmerman obtained a judgment in the amount of $8,969.25 for costs and $19,825.00 for fees, for a total of **$28,794.25** against Thibault. [Judgment attached.]

In **Johnson v. Douglas Smith. M.D. and Kathleen Fields**, 3AN-93-2919Ci, defendants were awarded costs in the amount of $3,979.08 and fees in the amount of $15,846.45, for a total award of **$19,825.53**. [Judgment attached].

In **Grummett v. Olsen**, 1JU-98-00384 Ci, the defendant doctor obtained an award against the plaintiff for fees and costs and the plaintiff was then forced to file for bankruptcy protection.

In **Sweet v. Sisters of Providence**, 893 P.2d 1252 (Alaska 1995), the defendants obtained a judgment against the plaintiffs as well.

I sincerely hope this information is helpful to the committee.

Very truly yours,

ALASKA ACTION TRUST

Donna McCready, Board Member

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

VICKI MARSINGILL and PAUL MARSINGILL, Wife and Husband,

Plaintiffs,

v.

JAMES O'MALLEY, M.D.,

Defendant.

Case No. 3AN-95-9909 Civil

FINAL JUDGMENT

On June 30, 2000, the jury rendered its special verdict, finding that defendant James O'Malley, M.D., was not negligent in the above-styled action. In accordance with the jury's finding,

IT IS HEREBY ORDERED that final judgment be entered in favor of defendant James O'Malley, M.C., and against plaintiff Vicki Marsingill for attorney's fees in the amount of $51,160.57 11/22/00 FAX entered pursuant to Alaska R. Civ. P. 82, and taxable costs of $36,803.84 11/22/00 FAX pursuant to Alaska R. Civ. P. 79, for a total judgment of $87,964.34 11/22/00 FAX against plaintiff Vicki Marsingill and in favor of Dr. O'Malley. The total judgment shall bear interest at the rate of 10.5 percent per annum from the date of entry of this judgment until completely satisfied.

JUL 24 2000

DELANEY, WILES, HAYES, GERETY, ELLIS & YOUNG, INC.
SUITE 400
[illegible] 9TH AVENUE
ANCHORAGE, ALASKA
(907) 279-3581

DATED at Anchorage, Alaska, this 26th day of August, 2000.

Peter A. Michalski
Superior Court Judge

Final Judgment on behalf of James O'Malley, M.D., having been served by mail and received on the _____ day of July, 2000, at _____ o'clock ____.m., is:

_____ Approved as to form (initial)

_____ Disapproved as to form (initial)

_____ Acknowledged as to date and hour

Robert H. Wagstaff
Attorney for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of this document was mailed/hand delivered on the 28th day of July, 2000, to:

Robert H. Wagstaff
425 "G" Street, Suite 610
Anchorage, Alaska 99501

Kathy K. Conger
32033

I certify that on 8-28-00 a copy of the above was mailed to each of the following at their addresses of record: R Wagstaff H Lazar

Secretary/Deputy Clerk

Resent to Wagstaff Lazar 11/22/00 SB

DELANEY, WILES, HAYES, GERETY, ELLIS & YOUNG, INC.
SUITE 400
101 ST 3RD AVENUE
ANCHORAGE, ALASKA
(907) 278-9881

1803

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

APR 09 1992

JULIE KORMAN,

Plaintiff,

vs.

ROBERT E. MALLIN,

Defendant.

Case No. 3AN-90-3486 Civil

ORDER GRANTING ATTORNEY'S FEES

Upon the motion of Robert Mallin, M.D., defendant, for an award of attorney's fees, pursuant to Civil Rule 82, and this court having considered the memorandum, affidavit, and exhibits submitted in support of the motion, and the documents filed in opposition thereto, and this court having found that Robert Mallin, M.D. is the prevailing party herein and entitled to an award of reasonable attorney's fees incurred in his defense herein,

IT IS HEREBY ORDERED that Robert Mallin, M.D. shall recover $ 3931.00 in attorney's fees pursuant to Civil Rule 82, which sum shall be endorsed upon the judgment previously entered in his favor.

It is this court's considered view, that the forementioned sum properly serves to advance the purposes of Civil Rule 82 in view of the issues in this proceeding, the amount of plaintiff's

damage claims, and the legal work required to prepare the defense of Dr. Mallin's behalf.

DATED at Anchorage, Alaska, this 9th day of April, 1992.

Superior Court Judge

SMC:lsd
3b0976.Ord

I certify that on 4-9-92 a copy of the above was mailed to each of the following at their addresses of record:

Secretary

Webb
Ray

HAGANS, BROWN GIBBS & MORAN
ATTORNEYS AT LAW
SUITE 1000
ANCHORAGE, AK 99501
(907) 274-7686

Anchorage Recording Dis· ict

Return to:
Matthew K. Peterson
Clapp, Peterson & Stowers
711 H Street, Suite 620
Anchorage, Alaska 99501-3442
Tel: (907) 272-9272
Fax: (907) 272-9586

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

BERNIE W. MOFFITT, JR.,

Plaintiff,

vs.

LOUIS L. KRALICK, M.D. and JOHN C. GODERSKY, M.D.,

Defendants.

Case No. 3AN-93-9935 Civil

FINAL JUDGMENT

This matter, having been tried before a properly empaneled jury and the jury having returned its verdict in favor of Dr. Godersky and against Plaintiff, Bernie W. Moffitt, Jr., on December 15, 1995;

IT IS HEREBY ORDERED as follows:

1. Final judgment in favor of John C. Godersky, M.D. shall be and hereby is entered. All claims of plaintiff Bernie W. Moffitt, Jr. against Dr. Godersky are DISMISSED WITH PREJUDICE.

2. Dr. Godersky is awarded his costs pursuant to Alaska Civil Rule 79 in the amount of $ 24,490.16 (3/19/96)

Exhibit A
Page 1 of 13

3. Dr. Godersky is awarded his attorney fees pursuant to Alaska Civil Rule 82 in the amount of $49,757.70 (8-13-96 MSD)

ORDERED, ADJUDGED AND DECREED this 24 day of January, 1996.

Peter Michalski
Superior Court Judge

96-044267
18.CC
ANCHORAGE REC. DISTRICT
REQUESTED BY Clapp, Peterson & Stowers
'96 SEP 10 AM 9 08

I CERTIFY THAT ON 3/19/96
A COPY OF THIS DOCUMENT WAS
MAILED/HANDED TO: Luce, Esq.
Lamb, Esq.
Peterson, Esq.
Secretary/Deputy Clerk

I certify a copy of this document was mailed/hand delivered to:
Lamb, Hensley, Luce
Date: 12/22/95 By: KLA

I certify that on 1-30-96
a copy of the above was mailed to each of the following at their addresses of record: Dekney, Wiles, Hayes/Gerety & Ellis
Clapp, Peterson & Stowers
Secretary/Deputy Clerk

I hereby certify that this is a true and correct copy of the original on file in my office.
ATTEST:
Clerk of the Trial Courts at Anchorage
By: Deputy
Date: 1/30/96

Exhibit A
Page 7 of 13

AUG 7 1996
DELANEY, WILES, HAYES, GERETY, ELLIS, INC.

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

BERNIE W. MOFFITT, JR.,

Plaintiff,

vs.

LOUIS L. KRALICK, M.D., and JOHN C. GODERSKY, M.D.,

Defendants.

Case No. 3AN-93-9935 Civil

Filed in the Trial Courts
STATE OF ALASKA THIRD DISTRICT
JAN 30 1996
Clerk of the Trial Courts
By _____ Deputy

I certify that on 8-6-96 a copy of the above was mailed to each of the following at their addresses of record: Luce Lamb Peterson
Secretary/Deputy Clerk

I CERTIFY THAT ON 3/19/96 A COPY OF THIS DOCUMENT WAS MAILED/HANDED TO: Luce, Esq. Lamb, Esq. Peterson, Esq.
Secretary/Deputy Clerk

DELANEY, WILES, HAYES, GERETY ELLIS, INC.
SUITE 400
100. WEST 3rd AVENUE
ANCHORAGE, ALASKA
(907) 279-3581

FINAL JUDGMENT

THIS MATTER having been tried before a jury between November 27 and December 14, 1995, and the jury having returned a special verdict on December 15, 1995, with a finding of no negligence by either defendant, the court pursuant to Alaska R. Civ. P. 58 hereby enters final judgment in favor of the defendant Louis L. Kralick, M.D.

Defendant Louis L. Kralick, M.D., pursuant to Alaska R. Civ. P. 79, is awarded costs in the amount of $ 30,053.73 (3/19/96) and, pursuant to Alaska R. Civ. P. 82(b)(2), is awarded attorneys' fees in the amount of $ 56,322.50, for a total judgment in favor of defendant Louis L. Kralick, M.D., and against plaintiff Bernie Moffitt, Jr., in the amount of $ 86,376.23. This judgment shall bear interest on the total amount at the rate of 10.5 percent per annum.

DATED at Anchorage, Alaska, this 29th day of January, 1996.

I certify that on 1-30-96 a copy of the above was mailed to each of the following at their addresses of record: Delaney, Wiles, Hayes, Gerety + Ellis
Secretary/Deputy Clerk Peterson + Shaved

Peter A. Michalski
Superior Court Judge

Exhibit A

Matthew K. Peterson, Esq.
Clapp, Peterson & Stowers, LLC
711 H Street, Suite 620
Anchorage, Alaska 99501-3442
Telephone: (907) 272-9272
Telecopier: (907) 272-9686

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

DONNA MAE FREITAS and DANIEL FREITAS, husband and wife,

Plaintiffs,

vs.

ALASKA RADIOLOGY ASSOC., INC. and JANICE M. ANDERSON, M.D.;

Defendants.

Case No.: 3AN-99-10664 Civil

FINAL JUDGMENT

Upon a jury verdict dated April 16, 2001, finding no negligence on the part of defendants;

IT IS ORDERED that judgment is entered as follows:

1. Defendants Alaska Radiology Assoc., Inc. and Janice M. Anderson, M.D., shall recover from and have judgment of dismissal with prejudice of all claims raised by Plaintiffs against them, and judgment shall be entered against Plaintiffs, Donna Mae Freitas and Daniel Freitas, jointly and severally, as follows:

a. Attorney's Fees $ 31,811.40
Date Awarded: 12/18/01
SK 2/14/02 Judge: TAN

b. Costs $ 19,643.50
Date Awarded: 2/14/02
SK 2/14/02 Clerk: Brenda Axtell

c. **TOTAL JUDGMENT:** $ 51,454.90 SK 2/14/02

d. Post-Judgment Interest Rate: 9.0 %

May 17/01
Date

Tan Sen Kwong
The Honorable Sen K. Tan
Judge of the Superior Court

Certificate of Service:

I hereby certify that a copy of this document was mailed ✓, faxed ____, hand delivered ____ on April 25, 2001, to the following:

Paula M. Jacobson, Esq.
Attorney at Law
604 West 2nd Ave.
Anchorage AK 99501

Sidney Stillerman Royer
Schroeter, Goldmark & Bender
500 Central Building
810 Third Avenue
Seattle WA 98104

By: Dana Thornton

I ~~certify~~ that on 5-17-01 a copy of the above was mailed to each of the following at their addresses of record.
Jacobson Peterson
E Mueller
Secretary/Deputy Clerk

Re Mailed 2/15/02 SK

CLAPP PETERSON & STOWERS, LLC
1503 College Road, Suite 200
Fairbanks, AK. 99709-4175
Tel: (907) 479-7776
Fax: (907) 479-7966

Filed in the Trial Courts
STATE OF ALASKA, FOURTH DISTRICT

JAN 4 2001

Clerk of the Trial Courts
By_____Deputy

SUPERIOR COURT FOR THE STATE OF ALASKA
FOURTH JUDICIAL DISTRICT AT FAIRBANKS

JAMES M. SNYDER and BECKY SNYDER, husband and wife,

Plaintiffs,

vs.

JON F. LIEBERMAN, M.D., TANANA VALLEY CLINIC LIMITED PARTNERSHIP; and TANANA VALLEY MEDICAL-SURGICAL GROUP, INC.,

Defendants.

Case No. 4FA-98-3245 CIV
ABA No. 6903004

FINAL JUDGMENT

IT IS ORDERED that judgment is entered as follows:

1. Defendants Jon F. Lieberman, M.D., Tanana Valley Clinic Limited Partnership, and Tanana Valley Medical-Surgical Group, Inc. shall recover from and have judgment against Plaintiffs, James M. Snyder and Becky Snyder, jointly and severally, as follows:

a. Principal Amount $_____

b. Prejudgment Interest on $_____

(computed at the annual rate of _____%

from _____ to date of judgment) $_____

c. Sub-Total: $_____

d. Attorney's Fees $ 39,142.35

Date Awarded: 3-6-01

Judge: STEINKRUGER

e. Costs $ 16,425.63

Date Awarded: 3.7.01

Clerk: Linda Bree
Chief Deputy

f. TOTAL JUDGMENT: $_____

g. Post-Judgment Interest Rate: _____%

Post-judgment interest shall accrue at the legal rate of interest from December 14, 2000 until the judgment is paid in full.

1/4/00
Date

Niesje J. Steinkruger
Superior Court Judge

I certify that a copy of this document was served via:
(X) First Class Mail
( ) Hand-Delivery
( ) Facsimile
to the following listed individuals:

Matt O'Meara, Esq.
Kenneth L. Covell, Esq.

Date: 12/8/03 By: Bobbi Godwin

I certify that a copy of the foregoing was distributed via:
( ) U.S. Postal Svc Chris Hicks, O'Meara
( ) Other
HAND DELIVERY Covell
( ) Courier Svc
( ) Pick Up Bin
( ) Fax
( ) Other
By: Date: 12-8-03
Item (w/o amounts)

REDISTRIBUTION
I certify that on 3.9.01 CP-S-Hicks-cert.
copies of this form were sent to O'meara
Clerk: DP-COVELL
w/copies of Final

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

Filed in the Trial Courts STATE OF ALASKA, THIRD DISTRICT SEP 28 1994 Clerk of the Trial Courts By

DEBRA L. JOHNSON,

Plaintiff,

vs.

GEORGE E. SIEGFRIED, M.D.,

Defendant.

Case No. 3AN-89-3903 CI

FINAL JUDGMENT

Upon verdict of a properly impanelled jury, dated September 1, 1994, in favor of George E. Siegfried, M.D., Defendant, and against Debra L. Johnson, Plaintiff, following jury trial which commenced on August 18, 1994, judgment shall be and hereby is entered as follows:

1. All claims of Plaintiff Debra L. Johnson as against George E. Siegfried, M.D. are dismissed with prejudice.

2. George E. Siegfried, M.D. is the prevailing party in the litigation.

3. George E. Siegfried, M.D. shall be and hereby is awarded his costs in the amount of $14,270.13 (1/25/95).

4. George E. Siegfried, M.D. is hereby awarded his attorney fees in the amount of $28,113.00.

ORDERED, ADJUDGED, AND DECREED this 28 day of Sept., 1994.

The Honorable Peter A. Michalski
Judge of the Superior Court

I CERTIFY THAT ON 1-25-95 A COPY OF THIS DOCUMENT WAS MAILED/HANDED TO: Gemminger, Esq. Peterson, Esq./Colbo, Esq.
Secretary/Deputy Clerk

Re-sent 6-1-95

HUGHES THORSNESS GANTZ POWELL & BRUNDIN
ATTORNEYS AT LAW
509 WEST THIRD AVENUE
ANCHORAGE, ALASKA

Final Judgment

ATTEST: I certify that this is a true and correct copy of the original on file in my office.
Clerk of the Trial Courts at Anchorage
By: Deputy 6/6/95

I certify that on 9-28-94 a copy of the above was mailed to each of the following at their addresses of record: Pettley/Von Gemminger/Peterson

Exhibit A
Page 3 of 13

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

ELSAID ELGEDAWI,

Plaintiff,

vs.

JOHN B. WRIGLEY, M.D.,

Defendant.

Case No. 3AN-01-7057 CI

JUDGMENT

The above-entitled matter having come on regularly before this court for trial on the 16th day of July, 2003 for jury trial, plaintiff being present and through counsel, Charles W. Ray, Jr., and defendant being present and through counsel, Keith E. Brown, the jury having heard the testimony and evidence presented at trial and having entered a verdict in favor of defendant, judgment is hereby rendered in favor of defendant dismissing the plaintiff's cause of action with prejudice; costs incurred in the amount of $3410.97 9/17/03 SJA; and attorney's fees pursuant to Civil Rule 82 in the amount of $38,113.50, for a total judgment of _____ Dollars ($41,524.47) 9/17/03 SJA, on which interest shall accrue at the rate of 10.5 % per annum from Sept. 4, 2003 until paid in full.

LET EXECUTION ISSUE.

DATED this 4th day of Sept., 2003.

Honorable John Reese
Superior Court Judge

I certify that on 9/10/03 a copy of the above was mailed to each of the following at their addresses of record:

Ray/Reese

Deputy/Clerk/Law Assistant

Resent 9/17/03

AUG 07 2003

Law Offices
BROWN, WALLER & GIBBS
A Professional Corporation
821 N Street, Suite 202
Anchorage, Alaska 99501-3285
(907) 276-2050

COUNSEL OF RECORD

CASE NO. 3AN-01-07057 CI

KEEP ON TOP OF FILE

NAME	MAILING ADDRESS & PHONE NUMBER	FOR WHOM
Charles W. Ray	711 "H" Street, Suite 310	PLT
	Anchorage AK. 99501	
	(907) 274-4839/ph 277-9414/fax	
KEITH E. BROWN	821 N Street, suite 202 99501 276-2050	Δ
	276-2051/fax	
PTCF GRANTED 6/13/03	JUTM 7/14/03	

TF-900 (3/00)(5 ½ X 8 ½)(canary cdsk) ~~TFAR 4/29/02~~ ~~TJETR 12/9/02~~ vacated LJ 9-19-01 BA
K 12/5/02 SCTT 12-16-02 ~~S/C 3/14/02~~ vacated ~~PTCF 12/2/02~~ T/S 7/14/03

OTHER CIVIL

- ☐ Foreclosure (FOR)
- ☐ Injunctive Relief (INJ)
- ☐ Quiet Title (QIT)
- ☐ Other (OCI). Please describe: _____

- ☐ Administrative Appeal (ADR)
- ☐ Minor Settlement (MIN)

2. If you checked a box in the first column, fill in the name of each defendant below, one name per line. (Not required if this is a fast track case.)

Name of Defendant	Appearance	Answer	Request for Entry of Default	Notice of Dismissal by Plaintiff	Confession of Judgment
John B. Wrigley, M.D.	☒	☒	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

☐ Defendant list continued on back.

Clerk Instructions: First be sure all defendant names are listed if the case is subject to Rule 16(b) (i.e., listed in column one of section 1 and not fast track). Then check the appropriate box when one of the listed documents is filed or when a defendant appears in a court hearing. When there is a check beside the name of each defendant, set the case for a Pretrial Scheduling Conference.

Matthew K. Peterson, Esq.
Clapp, Peterson & Stowers, LLC
711 H Street, Suite 620
Anchorage, Alaska 99501-3442
Telephone: (907) 272-9272
Telecopier: (907) 272-9586

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

MARK S. GRIFFIN,

Plaintiff,

vs.

GEORGE E. SIEGFRIED, M.D.,

Defendant.

Case No. 3AN-97-2981 Civ.

FINAL JUDGMENT

Upon verdict of the duly and properly impaneled jury, dated August 10, 2000, and a finding by said jury of no negligence on the part of Dr. Siegfried, defendant herein, the Court hereby orders that judgment shall be entered as follows:

1. All claims raised by plaintiff Mark Griffin, as against George Siegfried, M.D., shall be and hereby are DISMISSED WITH PREJUDICE.

2. Dr. Siegfried shall be and hereby is awarded his attorney's fees incurred in the defense of the action in the amount of $ 26,527.20 AR 1/8/01, pursuant to Alaska R. Civ. 82.

Exhibit A
Page 4 of 13

3. Dr. Siegfried shall be and hereby is awarded his costs pursuant to AR 1/8/01 Alaska R. Civ. P. 79, in the amount of $ 12,113.74.

ORDERED, ADJUDGED and DECREED this 30 day of August, 2000.

By: _____
Honorable Eric T. Sanders
Judge of the Superior Court

Certificate of Service:

I hereby certify that a copy of this document was mailed ✓, faxed ___, hand delivered ___ on August 10, 2000, to the following:

Larry Caudle, Esq.
2525 Blueberry Road, Suite 201
Anchorage, Alaska 99503

By: _____

✓ I certify that on 8/30/00 a copy of the above was mailed to each of the following at their addresses of record:

K Sims
Secretary/Deputy Clerk

CAUDLE/PETERSON

Resent 1/9/01

002072
PALMER
RECORDING DISTRICT

18 cc

2001 JA 17 PM 12:15
REQUESTED BY
Northrim Bank

Exhibit A
Page 5 of 13

I certify that this is a true and correct copy of the original on file in my office.
ATTEST:
Clerk of the Trial Courts at Anchorage
By: _____ 1/12/01
Deputy Date

AFTER RECORDING, RETURN TO:
MATTHEW PETERSON, ESQ (1926-160)
CLAPP PETERSON & STOWERS LLC
711 H ST STE 620
ANCHORAGE AK 99501-3442

FOR RECORDING IN THE
PALMER RECORDING DISTRICT
THIRD JUDICIAL DISTRICT
STATE OF ALASKA.

Craig F. Stowers, Esq.
Clapp, Peterson & Stowers, LLC
711 H Street, Suite 620
Anchorage, Alaska 99501-3442
Telephone: (907) 272-9272
Facsimile: (907) 272-9586

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT PALMER

KATHERINE GIORDANO

Plaintiff,

vs.

VALLEY HOSPITAL ASSOCIATION, INC., an Alaska corporation,

Defendant.

Case No. 3PA-96-860 CI

CORRECTED
JUDGMENT

This matter was tried before a properly impaneled jury, with trial commencing May 19, 1999. A verdict was rendered in favor of defendant Valley Hospital Association and against plaintiff Katherine Giordano on May 28, 1999.

THIS COURT ORDERS AS FOLLOWS:

1. Judgment is entered in favor of Valley Hospital Association and against plaintiff Katherine Giordano.

2. Pursuant to Alaska R. Civ. P. 79, Valley Hospital Association shall be awarded its costs in the amount of $6,836.31.

3. Pursuant to Alaska R. Civ. P. 82, Valley Hospital Association shall be awarded its attorney fees in the amount of $22,943.00.

Valley Hospital Association is awarded costs and attorney fees against Katherine Giordano in the amount of $29,779.31.

Further, the Court awards Defendant Valley Hospital Association post-judgment interest on the unpaid balance of the judgment at the statutory rate of seven and one-half percent (7.5%) per annum from July 20, 1999, the date of this Court's entry of judgment in favor of Valley Hospital Association, until the date of satisfaction of the entire judgment.

DATED: 11/30/99

Eric Smith

The Honorable Eric Smith
Judge of the Superior Court

Certificate of Service:

I hereby certify that a true and correct copy of the foregoing was mailed X, faxed ____, hand delivered ____ on November 10, 1999, to the following:

Benjamin I. Whipple, Esq.
14001 W. Arctic Ave.
Palmer, AK 99645

By: Diane L. Burger

I certify that on 12-2-99
a copy of this document was sent to:
☐ CSED ☒ Attorney(s) of Record A. Powers Whipple
☐ Plaintiff ☐ Defendant
☐ Other ____
at the address(es) of record.
Rec'd Jnl ____ Date ____ Deputy Clerk

Exhibit A
Page 1 of 13

Matthew K. Peterson, Esq.
Clapp, Peterson & Stowers
711 H Street, Suite 620
Anchorage, Alaska 99501-3442
Tel: (907) 272-9272
Fax: (907) 272-9586

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

JEAN THIBAULT,

Plaintiff,

vs.

MARK ZIMMERMAN, M.D.,

Defendant.

Case No. 3AN-93-11357 Civil

FINAL JUDGMENT

Pursuant to verdict of a properly impaneled jury on July 11, 1996, in favor of Mark Zimmerman, M.D. and against plaintiff Jean Thibault, the Court hereby ORDERS as follows:

Final Judgment shall be and hereby is entered in favor of Dr. Zimmerman and against Ms. Thibault on all claims.

Plaintiff's complaint is dismissed with prejudice.

Dr. Zimmerman is awarded his costs pursuant to Alaska Civil 79 in the amount of $8,969.26 cmm. and his attorney fees pursuant to Alaska Civil Rule 82 in the amount of $19,825.00 cmm 10-14-96.

Exhibit A
Page 4 of 13

ORDERED, ADJUDGED AND DECREED this 13 day of August, 1996 at Anchorage, Alaska.

Brian C. Shortell
SUPERIOR COURT JUDGE

Received this 22nd day of July, 1996.

Approved as to form: _____

Disapproved as to form: ✓

STEPOVICH, KENNELY & STEPOVICH
Attorneys for Plaintiff

Ted Stepovich

I certify that on 8/14/96 a copy of the above was mailed to each of the following at their addresses of record: Stepovich / Peterson

Secretary/Deputy Clerk

RESENT 10-14-96 CORRECTION

Certificate of Service:

I hereby certify that a copy of this document was mailed ____, faxed ____, hand delivered X on July 30, 1996, to the following:

Ted Stepovich, Esq.
Stepovich, Kennelly & Stepovich, P.C.
733 W. 4th Avenue, Suite 401
Anchorage, Alaska 99501

By: L. Jones

MKP/dlj:pldg final judgment.doc

Exhibit A
Page 9 of 13

NOS Shortleff

AUG 23 1996

Craig F. Stowers, Esq.
Clapp, Peterson & Stowers
711 H Street, Suite 620
Anchorage, Alaska 99501-3442
Tel: (907) 272-9272
Fax: (907) 272-9586

FILED
STATE OF ALASKA
THIRD DISTRICT
96 AUG 16 PM 2:52
CLERK OF TRIAL COURTS
BY _____
DEPUTY CLERK

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

BARRY VINCENT JOHNSON,

Plaintiff,

vs.

DOUGLAS C. SMITH, M.D. and KATHLEEN FIELDS,

Defendants.

Case No. 3AN-93-2919 Civil

FINAL JUDGMENT

Pursuant to verdict of a properly impaneled jury on August 12, 1996, in favor of Defendants Douglas Smith, M.D. and Kathleen Fields and against plaintiff Barry Johnson, the Court ORDERS as follows:

Final Judgment is entered in favor of Douglas Smith, M.D. and Kathleen Fields, and against Barry Johnson on all claims.

Plaintiff's complaint is dismissed with prejudice.

Dr. Smith and Ms. Fields are awarded their costs pursuant to Alaska Civil 79 in the amount of $ 3,979.08 (csm 9-16-96), and their attorney's fees pursuant to Alaska Civil Rule 82 in the amount of $ 15,846.45 (10/4/96 BS).

Exhibit A
Page 10 of 13

ORDERED, ADJUDGED AND DECREED this 22 day of August, 1996 at Anchorage, Alaska.

Brian C. Shortell
SUPERIOR COURT JUDGE

Received this 15 day of Aug, 1996 at 4:15 a.m./p.m.

MALONEY & HAGGART
Attorneys for Plaintiff

Dennis Maloney

I certify that on 8/22/96 a copy of the above was mailed to each of the following at their addresses of record: Maloney/Holmes

Secretary/Deputy Clerk

CFS/dlj:pldg judgment.doc

Exhibit A
Page 11 of 13

Date 10-7-96 To: Clapp, Peterson & Stowers

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

BARRY VINCENT JOHNSON,

Plaintiff,

vs.

DOUGLAS C. SMITH, M.D. and KATHLEEN FIELDS,

Defendants.

Case No. 3AN-93-02919 Civil

FILED IN THE TRIAL COURTS
State of Alaska Third District

OCT 07 1996

Clerk of the Trial Courts

By _____ Deputy

ORDER

Defendants' motion for attorneys' fees is GRANTED. Defendants are awarded $15,846.45 pursuant to Civil Rule 821(b)(2). This figure has been added to the final judgment.

DONE this 7th day of October, 1996, at Anchorage, Alaska.

BRIAN SHORTELL
Superior Court Judge
Third Judicial District

I certify that on 10/8/96 a copy of the above was mailed to each of the following at their addresses of record: Stowers / Maloney

Secretary/Deputy Clerk

Exhibit A
Page 12 of 13

Subject: HB 472 names
Date: Tue, 24 Feb 2004 15:00:23 -0900
From: Jeff Logan <jefflogan@gci.net>
To: vanessa_tondini@legis.state.ak.us, josh_applebee@legis.state.ak.us

Vanessa,

The list of people who want to testify on HB 472 tomorrow:

In person:

Jim Jordan, Executive Director, Alaska State Medical Assn.

Dr. Alex Malter, President, Alaska State Medical Assn.

Mike Haugen, Executive Director, Alaska Physicians and Surgeons.

On Teleconference:

Dr. George Rhyneer, Alaska Heart Institute

Dr. John Duddy, President, Alaska Physicians and Surgeons

Dr. Mark Withrow, Kodiak Island Clinic

Dr. Richard Cobden, Tanana Valley Clinic

Ron Neupauer, MIEC (Medical Indemnity Exchange of California)

There you have it.

JL