SB

67

SENATE COMMITTEE REPORT

DATE: 3/2/05

FURTHER:

DATE TURNED
IN TO OFFICE:_____

Judiciary Committee considered SENATE BILL NO. 67

SB 67 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."

and recommends:

[ ] be **replaced** with _____ **CS** _____ (_____)

[ ] adopt **previous** _____ **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

Senate Bill:
[ ] Same Title
[ ] New Title

House Bill:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
		X		
				X
			X	
	X			
CHAIR:	✓			

Sec. ⏩09.55.560⏪. Definitions.

In AS 09.55.530 - ⏩09.55.560⏪,

(1) "health care provider" means an acupuncturist licensed under AS 08.06; an audiologist or speech-language pathologist licensed under AS 08.11; a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; a naturopath licensed under AS 08.45; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist or occupational therapist licensed under AS 08.84; a physician or physician assistant licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; a hospital as defined in AS 18.20.130 , including a governmentally owned or operated hospital; an employee of a health care provider acting within the course and scope of employment; an ambulatory surgical facility and other organizations whose primary purpose is the delivery of health care, including a health maintenance organization, individual practice association, integrated delivery system, preferred provider organization or arrangement, and a physical hospital organization;

(2) "board" means an arbitration board established under AS 09.55.535;

(3) "panel" means an expert advisory panel established under AS 09.55.536;

(4) "professional negligence" means a negligent act or omission by a health care provider in rendering professional services;

(5) "professional services" means service provided by a health care provider that is within the scope of services for which the health care provider is licensed and that is not prohibited under the health care provider's license or by a facility in which the health care provider practices.

Pennsylvania

There Is a Serious Medical Crisis in Pennsylvania

Will your local Pennsylvania hospital's trauma center be open when you have an emergency? Will you be able to find an orthopedic surgeon for your situation? Will your obstetrician still be delivering babies in Pennsylvania when it is time for you to give birth? Almost 17% of Pennsylvania doctors surveyed are leaving the state due to higher malpractice insurance premiums – will your doctor be one of them? The problem is in our courtrooms, but you can help fix it – now.

Dramatic increases in awards for pain and suffering and other non-economic damages have led to enormous increases in your doctors' medical malpractice insurance rates – such stiff increases, many are being forced to stop providing certain kinds of care, some are moving to different states, and some are even getting out of the business altogether. What about your doctor?

All indications are that **the problem is getting worse** – and in the end, everyone in Pennsylvania will suffer as **healthcare for all state residents is at risk**.

- Nearly 17% of doctors in a recent survey in Pennsylvania report moving out of state or reducing their surgical services.
- Brandywine Hospital in Chester County suspended trauma care at its emergency department indefinitely because of the shortage of trauma surgeons to staff the center.

The crisis is particularly acute in specialties such as obstetrics and orthopedic surgery.

- According to an ACOG survey, one in four Pennsylvania OB/GYNs has dropped or is planning to drop obstetrics due to high malpractice costs.
- Frick Hospital in Mt. Pleasant, Pa., reported it would close its obstetrics unit in mid-November 2003.
- Dr. Nicholas A. DiNubile, a prominent Delaware County orthopedic surgeon who treats players for the Philadelphia 76ers and the Pennsylvania Ballet, said last fall he would quit performing surgery Seventeen other surgeons in his practice made the same announcement.

This is a sickness that affects not only individuals who need medical care, but also the economic health of Pennsylvania itself.

Pennsylvania has lost 20,400 jobs since the recent recession ended in November 2001. Job losses have hit the manufacturing sector particularly hard. From 1990 to 2002, Pennsylvania lost 183,600 manufacturing jobs, or 19.4 percent of its manufacturing unemployment. Since the recovery began in November 2001, the state has lost 61,900 manufacturing jobs. Manufacturing jobs have, historically, been the anchor for Pennsylvania's middle class.

The medical liability crisis in Pennsylvania has directly caused job losses because health systems eliminate positions due to increased insurance premiums:

- In April 2002, Albert Einstein Healthcare Network said it was eliminating 179 positions because of the system's sharp rise in malpractice insurance premiums.
- In Bucks County, Doylestown Hospital said it was eliminating 47 full- and part-time positions to help close a $3.5 million budget gap due to the medical center's malpractice insurance rising $3 million.
- Jefferson Health System said it would stop delivering babies at Methodist Hospital in South Philadelphia. The action, prompted by "dramatic increases in malpractice costs," resulted in immediate elimination of 91 full- and part-time positions.

In other economic sectors, the medical crisis hurts Pennsylvania because of increased healthcare costs associated with it. Pennsylvania needs to add jobs and attract new businesses to the state, but this will be difficult with health costs rising. It makes no sense to needlessly increase medical costs to employers through excessive non-economic medical liability awards.

The Rx is simple.

Passing medical liability reform legislation that includes a limit on non-economic damages in medical malpractice lawsuits would reverse these dangerous trends. **Patients would recover all their medical costs and all lost wages** in any malpractice award, but their non-economic damages would be limited. **The U.S. House of Representatives has already approved cush a bill**, but similar legislation is stalled in the U.S. Senate, where it did not receive the 60 votes needed to bring the bill to the floor for consideration.

Pennsylvania's U.S. Senators Santorum and Specter both voted **YEA** to bring S.11, the Patients First act, to the floor for consideration.

February 24, 2004, the U.S. Senate considered a cloture motion that would have allowed further debate on S. 2061 - Healthy Mothers and Healthy Babies Access to Care Act of 2003. Pennsylvania's Senators both voted **YEA**, but the motion did not pass. Regarding the vote, President Bush said, **"I am disappointed that a minority in the Senate has again decided to play politics and block our nation's ability to accomplish medical liability reform."**

April 7, 2004, the U.S. Senate considered a cloture motion that would have allowed further debate on S. 2207 - Pregnancy and Trauma Care Access Protection Act of 2004. Pennsylvania's Senators both voted **YEA**, but the motion did not pass.

Right here, you have all the facts you need to understand this situation and everything you need to take action – now. Contact your U.S. Senators, Senator Santorum and Senator Specter. **Send them an email telling them you want medical liability reform legislation to come to the floor for a vote, and when it does you want them to vote FOR it.**

Tell your U.S. Senators you believe passage of federal medical liability reform legislation that includes an effective cap on non-economic damages is the best way to make Pennsylvania a healthy place for individuals, physicians and renewed economic growth.

Reform needs to be nationwide.

The state constitution of Pennsylvania prohibits a cap on non-economic damages. State legislation is pending that would allow the voters to amend the constitution to allow such a cap, but the earliest a vote could be taken is 2005.

On Thursday, November 4, 2004, President Bush held a press conference outlining his post-election agenda. At the forefront: medical liability reform. He said, "**The new Congress that begins its work next year will have serious responsibilities and**

historic opportunities... We must confront the frivolous lawsuits that are driving up the cost of healthcare and hurting doctors and patients."

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Nebraska Tort Reform Legislation

ISSUE	CURRENT LAW	STATUTORY CITATION and LINK	OTHER PROVISIONS	2003 NEW LAWS and NET EFFECT of LAW CHANGE	2003 BILLS PENDING and CARRIED OVER to 2004
Joint and Several Liability Reform	Abolishes joint and several liability.	Nebraska Statutes 25-21,185.10	Not applicable when two or more defendants act in concert to commit harm.	N/A	N/A
Noneconomic Damage Reform	Limits total amount recoverable from health care providers to $1.25 million.			N/A	N/A
Prejudgment Interest Reform	Sets prejudgment interest rate at 1% above the U.S. Treasury Bill rate.	Nebraska Statutes 45-103.04	Not applicable to actions where the interest rate is specifically provided by law or to a contractually agreed upon interest rate.	N/A	N/A

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Noneconomic Damage Reform

Noneconomic damages include things that do not involve a cash loss and have no precise cash value, such as pain and suffering, emotional distress and loss of consortium or companionship. It is very difficult for juries to assign a dollar value to these losses, particularly with the minimal guidance they are normally given. As a result, these awards tend to be erratic and because of the highly charged environment of personal injury trials, they are often excessive.

The American Tort Reform Association (ATRA) urges states to set statutorily defined dollar limits on the recovery of non-economic damages in all cases.

To date, a total of 23 states (Alaska, California, Colorado, Florida, Hawaii, Idaho, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New Jersey, New Mexico, North Dakota, South Dakota, Texas, Utah, West Virginia, and Wisconsin) have established statutory limitations, ranging from $250,000 to $1,000,000, on the amount of non-economic damages that can be awarded.

STATE	CURRENT LAW	STATUTORY CITATION and LINK	OTHER PROVISIONS	2004 NEW LAWS and NET EFFECT of LAW CHANGE
Alaska	Noneconomic damages may not exceed the greater of $400,000 or injured person's life expectancy multiplied by $8,000.	Alaska Statutes 9.17.010	In personal injury cases involving severe permanent injuries, the limit is increased to the greater of $1 million or injured person's life expectancy multiplied by $25,000.	N/A
California	Limits noneconomic damages in medical malpractice cases to $250,000.	California Civil Code 3333.2	N/A	N/A
Colorado	Noneconomic damages in all civil actions may not exceed $250,000 unless the court finds clear justification to exceed that amount, but in no event no more than $500,000. Amended in 2003 by HB 1186 (1007 (13-21-10.25(1.5)(a)) to provide rules to govern the assertion of claims for exemplary damages by requiring claimants to file an amended pleading and requiring plaintiffs to establish prima facie evidence of a triable issue.	Colorado Revised Statutes 13-21-102.5	N/A	N/A

	Amended further by HB 1007 (13-64-302 (1)(c)) limiting noneconomic damages in medical malpractice cases to $300,000.			
Florida	Establishes limitations on recoverable noneconomic damages in medical malpractice cases.	Florida Statutes XLV 766.118	This statutory limitation applies only to medical malpractice cases with the actual dollar limits further delineated according to whether the claim is brought against a medical practitioner, nonpractitioner or emergency services personnel.	N/A
Hawaii	Limits damages for pain and suffering to $375,000.	Hawaii Revised Statutes 663-8.7	Not applicable to mental anguish, disfigurement, loss of enjoyment of life, loss of consortium or other forms of noneconomic damages.	N/A
Idaho	Limits noneconomic damages involving personal injury to $400,000 with adjustments based on the state's average annual wage adjustments. Amended in 2003 by HB 492 to reduce the cap on noneconomic damages in personal injury cases from $400,000 to $250,000.	Idaho Statutes 6-1603	Not applicable to cases involving willful or reckless misconduct or acts that would constitute a felony.	N/A
Kansas	Limits personal injury damages for pain and suffering to $250,000.	Kansas Statutes 60-19a01	Not applicable to medical malpractice cases.	N/A
Louisiana	Limits total recoveries to $500,000.	Revised Statutes RS 40:1299.42	Applicable only to medical malpractice recoveries. Exclusive of future medical care and related benefits.	N/A
Maryland	Limits noneconomic damages for personal injury cases to $350,000.	Maryland Code 11-108	The limit in wrongful death cases is increased to $500,000 and to $700,000 in cases where there are two or more beneficiaries.	N/A

Massachusetts	Limits noneconomic damages in personal injury cases to $500,000.	General Laws of Massachusetts 231 (60H)	Applicable only to medical malpractice cases.	N/A
Michigan	Limits noneconomic damages to $280,000.	Michigan Compiled Laws 600.1483	Applicable only to product liability noneconomic damage cases. The limit is increased to $500,000 for specified types of permanently disabling injuries.	N/A
Mississippi	N/A	N/A	N/A	HB 13a Revises the limitation on noneconomic damages in malpractice actions and provides additional limits on noneconomic damages in all other civil actions.
Missouri	Limits noneconomic damages to $350,000 - to be adjusted annually based on economic price and consumption data.	Missouri Revised Statutes 538.210	Applicable only to medical malpractice cases.	N/A
Montana	Limits noneconomic damages to $250,000.	Montana Code Annotated 2003 25-9-411	Applicable only to medical malpractice cases.	N/A
Nebraska	Limits total amount recoverable from health care providers to $1.25 million.			N/A
New Jersey	N/A	N/A	N/A	AB 50 Implements several reforms relative to medical malpractice, including some addressing availability of liability coverage, noneconomic damages.
New Mexico	Limits total amount of recoverable damages to $600,000.	New Mexico Statutes Annotated 41-5-6	Applicable only to medical malpractice cases. Not applicable to the value of accrued medical care and benefits.	N/A
New York	N/A	N/A	N/A	N/A
North Dakota	Limits noneconomic damages to $500,000.	North Dakota Century Code 32-42-02	Applicable only to medical liability cases.	N/A
Ohio	N/A	N/A	N/A	N/A

South Carolina	N/A	N/A	N/A	N/A
South Dakota	Limits total general damages to $500,000.	South Dakota Codified Laws 21-3-11	Applicable only to medical malpractice cases.	N/A
Texas	Limits noneconomic damages for health care providers to $250,000 and $500,000 for cases with more than one health care provider. Establishes alternative sliding scale limit if the main limit is declared unconstitutional.	Texas Statutes 74.301	N/A	N/A
Utah	Limits noneconomic damages to $250,000 (for actions before arising 7/1/01), $400,000 for actions arising between 7/1/01 and 7/1/02, and adjusted for inflation after 7/1/02.	Utah Code 78-147.1	Applicable only to medical malpractice cases.	N/A
Washington	N/A	N/A	N/A	N/A
West Virginia	Limits noneconomic damages in medical malpractice cases to $250,000 or $500,000 in cases involving wrongful death or permanent disability.	West Virginia Code 55-7B-8	In the event the described limits are determined unconstitutional, maximum noneconomic damages may not exceed $1 million.	HB 2122 Provides medical malpractice reform by limiting liability for certain noneconomic loss.
Wisconsin	Establishes a $350,000 limit on noneconomic damages.	Wisconsin Statutes Annotated 893.55	Applicable only to medical malpractice cases.	N/A

NAMIC does not present the information contained in this report as an exact and absolute portrayal of all tort reform-related laws that have been enacted in every state to date. Rather, it represents a comprehensive listing and summary analysis of the existing laws and recently enacted legislation specifically identified by NAMIC State and Regulatory Affairs staff as generated through its own internal intelligence and legislative and regulatory tracking tools as those which bear direct relevance to the key facets of tort reform NAMIC supports.

This report is for use as a convenient tool for our members, and is not intended, and should not be considered to be, legal advice. Please consult your legal representatives.

City of Bethel v. Peters (09/03/2004) sp-5829

THE SUPREME COURT OF THE STATE OF ALASKA

CITY OF BETHEL,	)	
	)	Supreme Court No. S-10864
Appellant,	)	
	)	Superior Court No.
v.	)	4BE-00-00297 CI
	)	
CATHERINE PETERS,	)	O P I N I O N
	)	
Appellee.	)	[No. 5829 - September 3, 2004]
	)	

Appeal from the Superior Court of the State of Alaska, Fourth Judicial District, Bethel, Leonard R. Devaney, III, Judge.

Appearances: Frank S. Koziol, Law Office of Frank S. Koziol, Anchorage, for Appellant. Christine S. Schleuss, Friedman, Rubin & White, Anchorage, for Appellee.

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

FABE, Justice.

I. INTRODUCTION

This appeal of a jury verdict in a tort suit against the City of Bethel presents the question whether recommendations for action contained in a post-accident report are excludable as subsequent remedial measures under Alaska Rule of Evidence 407, the question whether the superior court properly submitted the issue of severe disfigurement to the jury, and a question

concerning inappropriate arguments during the plaintiffs closing. Because the superior court did not err in its rulings, we affirm the judgment.

II. FACTS AND PROCEEDINGS

A. Factual History

On July 14, 2000, Louise Peters fell in the shower area of Bethels city-owned senior center. She suffered multiple fractures of her right leg. She required surgery in Anchorage to place both internal and external hardware in her leg and for a bone graft. Her recovery involved several return trips to Anchorage to remove the external fixator apparatus and for follow-up exams. Her leg remains bent and her activity has been curtailed.

Following Peterss accident, Louise Charles, the Citys director of senior services, prepared an Accident/Incident Investigation Report, in which she recommended the installation of safety bars in the shower area. Safety bars were later installed. Peters sued the City in December 2000, alleging negligence in its maintenance of the shower.

B. Procedural History

The case was tried before a jury in August 2002. The thrust of Peterss theory of the case was that safety bars in the shower would have prevented the fall and that the City was therefore negligent in failing to install the safety bars before the accident. To this end, Peters introduced into evidence a redacted version of the accident report in which the section detailing the corrective action taken was blacked out. Peterss attorney also questioned Charles and senior center administrative

assistant Bev Bell, asking each whether soon after the accident she thought safety bars should be installed, and whether she had thought of it before the accident. In response to a question about her pre-accident thoughts, Charles volunteered that safety bars had in fact been installed after the accident. In his closing argument, Peterss attorney argued that the City should have known before the accident that safety bars would make the shower area more safe. He mentioned the recommendations Louise Charles made in her report but never discussed the Citys actual installation of the bars after Peterss fall.

In addition to the issues of negligence and contributory negligence, the superior court submitted to the jury, over the Citys objection, the question whether Peters suffered a severe disfigurement. The jury found that the City was eighty-seven percent at fault for the accident and that Peters did suffer severe disfigurement, awarding $575,000 in noneconomic damages. The City appeals from the jury verdict, claiming that Alaska Rule of Evidence 407 should have barred the admittance of the accident report, that the issue of severe disfigurement should not have gone to the jury, and that the courts failure to correct a pair of statements made during Peterss closing argument was plain error.

III. DISCUSSION

A. Standards of Review

The superior courts decision to admit evidence is reviewed for abuse of discretion.1 The correct scope or interpretation of a rule of evidence creates a question of law to which this court applies its independent judgment, adopting the rule most persuasive in light of reason, precedent and policy.2

The superior courts decision whether to give the issue of severe disfigurement to the jury, like the parallel determination of severe emotional distress in an intentional infliction of emotional distress action, is reviewed for abuse of discretion.3 Statements in closing arguments to which opposing counsel made no objection are reviewed for plain error.4

B. The Superior Court Properly Admitted the Recommendation Section of the Post-Accident Report.

Alaska Rule of Evidence 407 provides, in pertinent part: When, after an event, measures are taken which, if taken previously, would have made the event less likely to occur, evidence of the subsequent measures is not admissible to prove negligence . . . . Evidence of subsequent remedial measures is relevant to the question of negligence, but it is excluded in order to encourag[e] defendants to take safety precautions after accidents.5 The City claims that the rule should have barred the admission of the Accident/Incident Investigation Report completed by Louise Charles. The report includes sections headed What Should Be Done? and Corrective Action Taken. The superior court allowed the introduction of the report with the Corrective Action section redacted. In the What Should Be Done? section, which remained intact in the admitted version of the report, Charles wrote that [i]t would be helpful, to elders, if at least 3 more safety bars were installed on the walls in the sauna area and in the bathroom areas. Elders could then support themselves if necessary.

Evidence showing that the City followed Charless recommendation and installed the safety bars is plainly barred by

the rule. The City initially argues that the recommendation for safety bars in the report is this type of evidence and claims that the report reveals the actual safety improvement later installed. But the redacted report only indicated that Charles suggested more safety bars. It did not reveal to the jury that the City followed her advice, and therefore was not excludable as evidence of the installation of the safety bars.6 Rule 407 excludes the challenged section of the report only if the recommendations themselves are covered by the rule.

Our previous cases applying this rule have concerned concrete fixes like placing barriers and flashing lights around a hole where an employee had been injured7 or salting and sanding an allegedly icy walkway after someone had fallen;8 we have never considered whether Rule 407 reaches a section of a post-accident report containing an investigation into an accidents causes or a recommendation for an improvement. Many courts applying analogous rules or evidence have held that the rules scope is limited to improvements actually implemented.9 These courts rely in part on the rules phrase measures are taken, reasoning that [r]emedial measures are those actions taken to remedy any flaws or failures.10 Under this reasoning, an investigation or recommendation is not a concrete action; a report on these activities by itself . . . would not have made the event less likely to occur. 11 These courts therefore do not exclude reports of post-accident investigations and recommendations, often among the best and most accurate sources of evidence and information for injured parties.12

Other courts disagree, holding that evidence of the

parts of a report detailing investigatory findings and recommendations should be excluded as subsequent remedial measures.13 These latter courts rely on the sensible proposition that in many cases, the investigation is the prerequisite to any remedial safety measure.14 They reason that admitting such post-accident evidence would discourage defendants from carefully investigating accidents and considering how to prevent them in the future; they would then be less equipped to make the safety improvements the rule is designed to promote.15 This broader interpretation of the rules exclusionary scope may advance its goals, but it collides with another evidentiary policy, the principle of wide admission of relevant evidence, and with the language of the rule.

Under Rule 402, our Rules of Evidence start from the proposition that all relevant evidence is admissible.16 Rules of exclusion like the one we consider today are merely exceptions to this general rule. Post-accident investigations and recommendations are often relevant to the issue of negligence and, by revealing facts about the causes of an accident and the defendants concerns about it, may be particularly useful to factfinders.17 The general presumption in favor of admissibility strongly suggests, therefore, that such evidence should be admitted, despite any possible disincentive to safety improvements.

Between these two competing policies, the language of the rule favors admissibility. Rule 407 prohibits evidence of measures that have been taken. We take measures to mean concrete actions, and to leave outside the rules prohibition preliminary

investigations and recommendations pointing toward those actions.[18] Even if post-accident investigations and reports were considered measures, the rule would not reach them. The rule excludes subsequent measures that would have reduced the likelihood of the accident if they had been taken previously, meaning before the accident. One cannot investigate an accident before it occurs, so an investigation and report . . . cannot be a measure that is excluded.[19] The language of Rule 407 and the general presumption of admissibility laid down by Rule 402, along with persuasive authority from other courts, compel us to hold that evidence of post-accident investigations and recommendations are not automatically excluded as subsequent remedial measures.[20]

Like all other evidence, investigations and recommendations are subject to the balancing test of Alaska Rule of Evidence 403, which provides that relevant evidence may be excluded if its probative value is outweighed by the danger of unfair prejudice. The relation between admissible investigations and recommendations on the one hand and excluded measures on the other requires particular care in this balancing. If the jury is given evidence of the recommendations but not of the actual fix, there is a danger that jurors may draw the unfair inference that the recommendations were ignored. In deciding whether or not to admit recommendations, the trial court should carefully consider the likelihood of this inference and the prejudice it would cause. In this case, the superior court weighed relevance against prejudice and determined that Charless report, redacted to exclude evidence of the remedial measures taken, was admissible. We find no error in its determination.[21]

C. The Superior Court Did Not Abuse Its Discretion in

Submitting the Question of Severe Disfigurement to the Jury.

Under AS 09.17.010(b), a plaintiff in a personal injury or wrongful death action may recover no more than $400,000 in compensation for noneconomic damages. This cap is raised to $1,000,000 if the damages are awarded for severe permanent physical impairment or severe disfigurement.22 Over the Citys objection, the superior court instructed the jury on severe disfigurement. The jury found by special interrogatory that Peters had suffered severe disfigurement and awarded $575,000 in noneconomic damages. The City challenges the superior courts submission of the issue to the jury.

The superior court must make a threshold determination of severe disfigurement before submitting the issue to the jury.23 The court should withhold the issue from the jury if no reasonable juror could find that the plaintiff suffered from severe disfigurement;24 otherwise the question should go to the jury.25 We review this determination for abuse of discretion,26 reversing the superior court only when we are left with the definite and firm conviction, after reviewing the whole record, that [it] erred in its ruling.27 The deferential standard of review and the substantive standard combine to give the City a difficult task in convincing us that the superior court abused its discretion. We will reverse the courts decision to send the question of severe disfigurement to the jury only if we possess a definite and firm conviction that no reasonable juror could think that Peterss injury was a severe disfigurement.28

The first question we must answer is whether evidence concerning the state of Peterss leg before it was fully healed

may play a role in this determination. Peters calls our attention to photographs taken during her recuperation, which lasted several months and involved at least four trips to the Alaska Native Medical Center in Anchorage. The photos show her leg with an array of pins and rods attached. The statute requires severe permanent physical impairment or severe disfigurement to break the damage cap;29 the presence of the word permanent in the impairment clause and its absence in the disfigurement clause of the same statute imply that a severe disfigurement need not be permanent to support damages beyond the cap. However, a reasonable healing period must be allowed before disfigurement may be assessed. Otherwise, a plaintiff might, for example, claim to be disfigured based on his condition immediately after being injured when a wound that will eventually heal completely still appears grisly. Evidence of the plaintiffs injury before this healing period has passed is admissible to the extent that it provides information or inferences about its ultimate condition. It is unclear how the superior court used the various photographs in evidence, but in reviewing its threshold determination, we will only consider evidence of the long-term state of Peterss leg.

The photographs taken after Peterss recovery show her leg bent in a drastic angle at the knee, which itself is marred by significant scarring. Testimony from Peters and her daughter demonstrate that the bend in her leg is constant, if not permanent. Conceding that Peters suffers a disfigurement, the City essentially asserts that it is not severe enough to warrant submitting the question to the jury. The statute does not define

severe disfigurement, and no Alaska cases have dealt with the issue. A disfigurement is [t]hat which impairs or injures the beauty, symmetry, or appearance of a person or thing; that which renders unsightly, misshapen, or imperfect.30 Although Peters notes that her walk is significantly slowed by the injury, that her confidence is shaken, and that she can no longer take part in activities like berry picking or boating, disfigurement concerns the outward appearance of a persons body, not its function.31 We thus consider only the fact that Peterss leg is bent and scarred, not the injurys effect on her ability to walk or take part in other activities.32 Because the definition of disfigurement depends on judgments of a plaintiffs appearance or unsightliness, it must be determined by an objective test gauging the views of the reasonable person. If a reasonable person would see the injury as detracting from the plaintiffs appearance, the injury has caused disfigurement.33 Disfigurement is severe if a reasonable person would find that the injury mars the plaintiffs physical appearance and causes a degree of unattractiveness sufficient to bring negative attention or embarrassment.34 Contrary to the Citys suggestion, a plaintiff is not required to introduce evidence showing how particular people react to the injury; the court and the jury themselves supply the views of the reasonable person.

In making the threshold determination of whether to submit the question of severe disfigurement to the jury, a trial court must balance the twin objectives of restraint and fairness highlighted by the legislatures declaration of the purposes of the tort reform act that included the damage cap: discouraging frivolous litigation . . . without diminishing the protection of

innocent Alaskans rights to reasonable, but not excessive, compensation for tortious injuries.35 The legislature made a policy determination that only those plaintiffs with severe disfigurements should recover beyond the cap. The question should go to the jury whenever the disfigurement could reasonably be characterized as severe. We cannot say that the evidence of Peterss contorted and scarred leg provides us with a definite and firm conviction that no reasonable juror could think it a severe disfigurement. The superior court did not abuse its discretion in submitting the question to the jury.

D. There Was No Plain Error Concerning Peterss Closing Argument.

In his closing arguments, Peterss attorney made two arguments that the City claims warrant reversal. The City did not object to the statements at the time, so the only decision of the trial court available for our review is the courts failure to take corrective action on its own motion. Because the City waived its objections by its silence at trial, we review the trial courts inaction only for plain error.36 [P]lain error exists where an obvious mistake has been made which creates a high likelihood that injustice has resulted.37 Before this court will notice and correct a waived error, the likelihood of injustice must be clear, such that we do not need to speculate on whether the error altered the result.38

The City first claims that Peterss attorney improperly invited the jury to infer liability because Louise Charles, the City director of senior services, rather than the city manager, was Bethels representative at the defendants counsel table. [The city manager]s not sitting there, Peterss attorney said, because

its the belief of the city that youd be much more likely to award damages to Mrs. Peters if the city manager was sitting there. Although the statement is inappropriate and relies on facts that are neither relevant nor admitted into evidence, we will not correct the trial courts failure to take corrective action sua sponte. The Citys claim that the statement created a high likelihood of injustice because Peterss strategy was to absolve[] . . . Charles[] from responsibility and blame is unpersuasive. We cannot determine whether the jury relied on this absolution argument in its verdict without impermissible speculation. There was no plain error in allowing this statement to pass.

In the second incident, Peterss attorney derided the $30,000 damage figure suggested by the Citys attorney in his closing, saying it [m]akes a guy wonder how much Mr. Koziol makes in that year when [Peters is lying] in bed, you know? . . . Its an insult to suggest [$30,000 is] what her injury was. The City asserts that the suggestion about an attorneys salary is so beyond the boundary of reasonable argument as to constitute plain error. We agree that the statement was improper and an undue personal attack on the Citys attorney, and if the City had made a contemporaneous objection, the superior court should have taken corrective action. But the City has not shown that the statement caused a high likelihood of injustice or that the jury would have come to a different conclusion without the inappropriate remark. The superior court thus did not commit plain error in failing to take corrective action in the absence of an objection.

IV. CONCLUSION

For these reasons, the judgment of the superior court

is AFFIRMED.

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1 Hawley v. State, 614 P.2d 1349, 1361 (Alaska 1980).

2 State v. Coon, 974 P.2d 386, 389 (Alaska 1999) (quotation marks and citation omitted).

3 See Wal-Mart, Inc. v. Stewart, 990 P.2d 626, 635 (Alaska 1999) (intentional infliction of emotional distress instruction).

4 See Clary Ins. Agency v. Doyle, 620 P.2d 194, 204 (Alaska 1980).

5 Robles v. Shoreside Petroleum, Inc., 29 P.3d 838, 845 (Alaska 2001); see also Alaska R. Evid. 407, commentary.

6 Cf. Rocky Mountain Helicopters, Inc. v. Bell Helicopters Textron, 805 F.2d 907, 918 (10th Cir. 1986) (holding that post-accident test is not evidence that tested part was redesigned).

7 Exxon Corp. v. Alvey, 690 P.2d 733, 740-41 (Alaska 1984).

8 Agostino v. Fairbanks Clinic Pship, 821 P.2d 714, 716 (Alaska 1991).

9 E.g., McFarlane v. Caterpillar, Inc., 974 F.2d 176, 181-82 (D.C. Cir. 1992); Prentiss & Carlisle Co. v. Koehring-Waterous Div. of Timberjack, Inc., 972 F.2d 6, 9-10 (1st Cir. 1992); Benitez-Allende v. Alcan Aluminio do Brasil, S.A., 857 F.2d 26, 33 (1st Cir. 1988); Rocky Mountain Helicopters, 805 F.2d at 918; Westmoreland v. CBS Inc., 601 F. Supp. 66, 67-68 (S.D.N.Y. 1984); Fox v. Kramer 994 P.2d 343, 350-53 (Cal. 2000).

10 Rocky Mountain Helicopters, 805 F.2d at 918 (emphasis added); see also 2 Jack B. Weinstein & Margaret A. Berger, Weinsteins Federal Evidence 407.06[1], at 407-27 to 407-28 (Joseph M. McLaughlin ed., 2d ed. 2004) (It is only if changes are implemented . . . that the goal of added safety is furthered.) (emphasis added).

11 Benitez-Allende, 857 F.2d at 33 (quoting Fed. R. Evid. 407).

12 Westmoreland, 601 F. Supp. at 68.

13 E.g., Maddox v. City of Los Angeles, 792 F.2d 1408, 1417 (9th Cir. 1986); Martel v. Mass. Bay Transp. Auth., 525 N.E.2d 662, 664 (Mass. 1988).

14 Martel, 525 N.E.2d at 664.

15 See id.

16 United States v. Cruz-Garcia, 344 F.3d 951, 954 (9th Cir. 2003) (discussing Federal Rules of Evidence) (quotation marks omitted); see also Bingaman v. State, 76 P.3d 398, 408 (Alaska App. 2003) (The first governing principle [of Rule 402] is that relevant evidence is presumptively admissible.); Denison v. Anchorage, 630 P.2d 1001, 1003 (Alaska App. 1981) (Rule 402 embodies a basic preference for admission of all relevant evidence . . . .).

17 See Westmoreland, 601 F. Supp. at 68.

18 See Rocky Mountain Helicopters, 805 F.2d at 918; Fasanaro v. Mooney Aircraft Corp., 687 F. Supp. 482, 487 (N.D. Cal. 1988); Weinstein & Berger, supra note 10, 407.06[1], at 407-27 to 407-28.

19 Ensign v. Marion County, 914 P.2d 5, 7 (Or. App. 1996); see also Fox, 994 P.2d at 351.

20 In some cases, a recommendation and a remedial measure may be one and the same, as when the recommendation itself represents a change in policy. E.g., Complaint of Consolidation Coal Co., 123 F.3d 126, 136 n.9 (3d Cir. 1997) (holding that safety alert, . . . designed to alert . . . employees to a potential danger . . . and advise them of measures to avoid this danger . . . . is inherently a subsequent remedial measure). This is not such a case after Charles completed her report and recommendations, the City still had to act to implement her suggestions.

21 Because we hold that Rule 407 does not exclude such recommendations, we do not need to decide whether they could have been admitted for any purpose other than to prove negligence.

22 AS 09.17.010(c).

23 Cf. Meidinger v. Koniag, Inc., 31 P.3d 77, 87 (Alaska 2001) (The trial court must make a threshold determination whether the severity of the emotional distress and the conduct of the offending party warrant an instruction on intentional infliction of emotional distress.) (quotation marks omitted).

24 See Nelson v. Progressive Corp., 976 P.2d 859, 868 (Alaska 1999) (upholding directed verdict that no severe distress occurred because no reasonable jury could make the requisite finding); Teamsters Local 959 v. Wells, 749 P.2d 349, 358 n.14 (Alaska 1988) (upholding determination that severe distress was established as a matter of law where a reasonable jury would not have differed); State, Dept of Corrections v. Johnson, 2 P.3d 56, 64 (Alaska 2000).

25 See Wal-Mart, Inc. v. Stewart, 990 P.2d 626, 635 (Alaska 1999) (If reasonable jurors could differ as to whether the evidence adduced at trial would satisfy [the elements of the tort of intentional infliction of emotional distress (IIED)], the superior court is required to submit the IIED claim to the jury.) (quotation marks omitted).

26 See id.

27 Samaniego v. City of Kodiak, 80 P.3d 216, 218-19 (Alaska 2003) (quotation marks omitted).

28 See Wal-Mart, 990 P.2d at 635.

29 AS 09.17.010(c).

30 Blacks Law Dictionary 420 (5th ed. 1979).

31 See Nelson v. Myers, 381 N.W.2d 407, 408 (Mich. App. 1985) (Whether an injury amounts to a permanent serious disfigurement depends on its physical characteristics rather than its effect on the plaintiffs ability to live a normal life.) (quotation marks omitted).

32 An injurys effect on a plaintiffs abilities is properly the subject of an instruction on severe permanent physical impairment, also under AS 09.17.010(c). In the present case, the superior court refused to give such an instruction, a decision Peters does not challenge.

33 Cf. Tuhy v. Schlabsz, 574 N.W.2d 823, 825 (N.D. 1998) (holding that scar that could not be seen by trial court upon close observation of plaintiffs lip was not serious and permanent disfigurement); Smith v. Higgins, 810 S.W.2d 710, 712 (Ky. 1991) ([A]ny scar capable of ordinary perception or which produces ongoing personal discomfort constitutes disfigurement.); Kanaziz v. Rounds, 395 N.W.2d 278, 281 (Mich. App. 1986) (holding scar that is not immediately and readily noticeable is not permanent serious disfigurement).

34 Cf. Falcone v. Branker, 342 A.2d 875, 880 (N.J. Super. Law Div. 1975) (holding that to qualify as permanent significant disfigurement, a facial scar has to mar the natural expression so as to attract attention and should be materially disfiguring); cf. also, e.g., McCabe v. Boyce, 770 N.Y.S.2d 495, 497 (N.Y. App. Div. 2003) (reversing determination that very, very slight scar was significant disfigurement); Waldron v. Wild, 468 N.Y.S.2d 244, 247 (N.Y. App. Div. 1983) (A disfigurement is significant if a reasonable person viewing the plaintiffs body in its altered state would regard the condition as unattractive, objectionable or as the subject of pity or scorn.) (quotation marks omitted); Beazley v. Pierce, 19 Pa. D. & C.3d 729, 733; 1981 WL 743 at **4 (1981) (requiring more than a trifling mark discoverable only on close inspection for an injury to qualify as cosmetic disfigurement [which] is permanent, severe and irreparable).

35 Ch. 26, 1(1), SLA 1997 (Alaska Statutes, Temp. & Special Acts & Resolves 1997).

36 5, 800 (Alaska 1996) (quotation marks omitted).04 (Alaska 1980).

37 State Farm Mut. Auto. Ins. Co. v. Weiford, 831 P.2d

1264, 1270 (Alaska 1992) (quotation marks and citation omitted).

38 Jaso v. McCarthy, 923 P.2d 795, 800 (Alaska 1996) (quotation marks omitted).

24-LS0393\G
Bullock
2/2/05

CS FOR SENATE BILL NO. 67( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR SEEKINS

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:

SHORT TITLE. This Act may be known as the Alaska Medical Injury Compensation Reform Act of 2005.

*** Sec. 2.** AS 09.55 is amended by adding a new section to read:

Sec. 09.55.549. Limitation on damages. (a) Notwithstanding AS 09.17.010, noneconomic damages for personal injury or death based on the provision of services by a health care provider may only be awarded as provided in this section.

(b) In an action to recover damages for personal injury or wrongful death based on the provision of services by a health care provider, damages may include both economic and noneconomic damages.

New Text Underlined [DELETED TEXT BRACKETED]

(c) Damage claims for noneconomic losses shall be limited to compensation for pain, suffering, inconvenience, physical impairment, disfigurement, loss of enjoyment of life, loss of consortium, and other nonpecuniary damage, but may not include hedonic damages.

(d) The damages awarded by a court or a jury under (c) of this section for all claims including a loss of consortium claim 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) Multiple injuries sustained by one person as a result of a single course of treatment shall be treated as a single injury for purposes of this section.

(f) In this section,

(1) "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, and includes past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, burial expenses, loss of use of property, cost of replacement or repair, loss of employment, and loss of business or employment opportunities;

(2) "hedonic damages" means damages that attempt to compensate for the pleasure of being alive.

*** Sec. 3.** 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 and to malpractice claims that are subject to an agreement to arbitrate initially filed on or after the effective date of this Act.

*** Sec. 4.** This Act takes effect July 1, 2005.

ALASKA STATE SENATE

Session:
State Capitol
Juneau, Alaska 99801-1182
(907) 465-2327
(907) 465-5241 Fax

Interim:
119 N. Cushman, Suite 201
Fairbanks, Alaska 99701
(907) 456-8161
Senator_Ralph_Seekins@legis.state.ak.us

Senator Ralph Seekins
District D

Senate Bill 67 Sponsor Statement

"An Act relating to claims for personal injury or wrongful death against health care providers."

Senate Bill 67 amends AS 09.55 by adding a new section (.549). This section places a $250,000 limit on non-economic damage awards where health care providers render services. This bill intends to alleviate a growing, two-pronged, crisis in Alaska's health care industry — the dearth of liability insurance carriers and the declining number of *practicing* physicians.

Liability insurance is one of life's absolute necessities. As drivers, we are required to have liability coverage before we get behind the wheel. As homeowners we understand the protection liability insurance provides. Now imagine if Allstate, State Farm and GEICO found the Alaska market litigiously perilous and decided to pull up stakes. What would rates do?

Health care providers, too, understand the necessity of liability coverage. The fact is, in today's world no commercial enterprise dares "go bare." But where our state's health care industry is concerned, the lack of carriers is not hypothetical — it is a reality. Medical malpractice insurance companies have found Alaska uneconomic and have left the market. This has created much uncertainty and opened the door to higher rates across the board.

These added costs of doing business are, of course, paid by every Alaskan needing medical care. But there is a much more serious problem — that being a critical shortage of physicians. The fact is, Alaska ranks near the bottom in the number of physicians per capita. Over half of Alaska's physicians exceed the age of 50. Furthermore, it gets continually more difficult to recruit new entries when other states have capped non-economic damages at or near $250,000.

The bottom line? Despite all our natural assets, Alaska is viewed as an undesirable place for medical insurance carriers to do business and, as a result, for physicians to set up shop.

This is, unquestionably, a complex issue. Yet, other states have effectively placed an upper limit on non-economic damage awards thereby providing a stable, predictable and insurable climate. Senate Bill 67 follows this national trend.

It's important to note that this legislation does not alter awards for quantifiable damages such as lost wages and medical expenses and does not affect awards for gross negligence or reckless behavior. Furthermore, it is not intended to be a silver-bullet solution to an entire range of issues facing our health care industry today. However, it does provide a step in the right direction in terms of stabilizing the medical insurance market here in Alaska and boosting our efforts to attract the next generation of physicians.

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 67
(S) Publish Date: 3/2/05

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 and Workers' Compensation
Sponsor Senator Seekins
Requester Senate Labor and Commerce
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 the Alaska Medical Injury Compensation Reform Act of 2005 to uncodified law of the State of Alaska. It also 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.

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

Prepared by: Kathryn A. Daughhetee, Director
Phone 465-3673
Division Administrative Services
Date/Time 2/4/05 11:26 AM
Approved by: Kathryn Daughhetee for Gregg D. Renkes, Attorney General
Date 2/4/2005
Agency Department of Law

(Revised 12/2003 OMB)

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: SB 67
(S) Publish Date: 3/2/05

Revision Date/Time (Note if correction):
Dept. Affected: Commerce

Title: Claims Against Health Care Providers
RDU: Occupational Licensing (117)
Component: Occupational Licensing
Sponsor: Seekins
Requester: Senate Labor & Commerce
Component No.: 2360

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
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 (1156)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1156 - Receipt Supported Services						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2005) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

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

Prepared by: Jennifer Strickler, Administrative Manager
Phone (907) 465-2144
Division: Occupational Licensing
Date/Time 2/4/05 5:59 PM
Approved by: Edgar Blatchford
Date 2/4/2005
Agency: Commerce, Community, and Economic Development

(Rev 1dc 9/23/2004 OMB)

For SB 67

Alaska State Medical Association

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

February 8, 2005

Honorable Con Bunde and
Senate Labor and Commerce Committee
Alaska State Senate
State Capitol, Room 506
Juneau, AK 99801

Re: SB 67 – Medical Liability Reform

Dear Senate Bunde and Senate Labor and Commerce Committee Members:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily interested in ensuring that Alaska's citizens have access to high quality health care. ASMA strongly supports SB 67, which provides for meaningful medical liability reform and urges you to support it as well.

SB 67 establishes a $250,000 maximum for the unquantifiable damages known as non-economic damages. Non-economic damages are also known as "pain and suffering" damages. SB 67 does not limit the quantifiable economic damages such as lost wages, and post and future medical care costs. (SB 67 defines economic damages, which are not currently defined in Alaska statutes.)

ASMA asserts that enactment of SB 67 will provide for equitable and more predictable settlements in medical injury cases. The result will be a more stable professional liability insurance marketplace and, most importantly, will help us recruit physicians to help fill our chronic shortage of physicians.

The American Academy of Actuaries[1] has stated that medical liability reform establishing a $250,000 limit is imperative in stabilizing the physician professional liability insurance marketplace. A recent study[2] of medical students found the legal environment and the availability of affordable liability insurance plays a major part in a graduate's decision as to where to set up practice.

Access to medical services is limited in much of the state. Alaska has one of the smallest numbers of physicians per capita in the country. An American Medical News story pertaining to the special Medical payment reform for Alaska noted our precarious situation: "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…only six states had a lower doctor to patient ratio."[3] This data indicates that to reach the national average, Alaska would need about 500 more actively practicing physicians. This determination is future substantiated in Molly Southworth, MD, July 2004 Masters of Public Health Thesis, titled "Alaska's Physician Workforce: An Overview, a Summary of Training Background, and the Impact of the WWAMI Program".[4] Exacerbating the problem is the aged physician workforce. ASMA's database shows nearly 50% of our physician workforce over age 50. Dr. Southworth's Thesis[5] as well as Leslie Gallant of the State Medical Board[6] further validates that fact. The Providence Alaska Medical Center confirmed in its 2002 study that physicians in its service area were getting older and highlighted immediate acute shortages in psychiatrists, surgeons, and general internists, among

others.[7] In 2002, the total shortage identified in primarily the Anchorage bowl area totaled about 200. The Providence study was updated for 2005 and projected the physician workforce needs to 2009.[8] The Shortage in 2005 is still at around 200, with a projected shortage in 2009 of 261.

The recruitment challenge is the main reason medical liability reform is so important to Alaska. Unfortunately, the state does not have the capacity to "grow" its own physicians. Alaska has no medical school, and of the small number of students graduating annually from the WWAMI program, some do not return to practice. Likewise, the state's lone residency training program is small. Alaska is, and will continue to be a net imported of doctors. As such, we have to compete with other states facing physician shortages, a competition that is influenced significantly by the state's medical-legal practice environment.

ASMA asserts that SB 67 is a critical element in helping us improve our practice environment so as to help in physician recruitment. Well trained physicians in sufficient numbers are ASMA's greatest concern so that all Alaskans have access to high quality care when it is needed. Alaskans need and deserve local health care without having to be flown out of state for treatment.

ASMA urges you to support SB 67.

Sincerely,

Paul Worrell, MD

By: Paul Worrell, MD President
For: The Alaska State Medical Association

cc: Senator Ralph Seekins
Senator Ben Stevens
Senator Johnny Ellis
Senator Bettye Davis

Footnotes:

① Issue Brief, American Academy of Actuaries, "Medical Malpractice Tort Reform: Lessons from the States", Fall, 1996, p. 4.
② "AMA Survey: Medical Students' Opinions of the Current Medical Liability Environment: American Medical Association Division of Market Research and Analysis, November 2003.
③ "Medicare Law Aims to Bring Alaska Physicians in from the Cold." AM News, 1/19/2004.
④ "Alaska's Physician Workforce: An Overview, A Summary of Training Backgrounds, and the Impact of the WWAMI Program", Molly B. Southworth, MD, 7/2004, Masters of Public Health thesis, pp 26-33.
⑤ See Southworth ④, pp 12-14.
⑥ "Shingle Shortage?", Anchorage Daily News, Ann Potempa, 9/3/2002
⑦ "Physician Workforce Analysis", Providence Health System Alaska, November 2002, pp 17-18.
⑧ "PAMC Physician Supply and Physician Need Estimate: Summary", Providence Alaska Medical Center, February 2005.

Richard L. Hutchison, M.D., F.A.C.S.
Plastic & Reconstructive Surgeon

1919 Lathrop Street • Suite 101 • Fairbanks, AK 99701-5956 • (907) 451-8775

Senator Ralph Seekins
State Capitol, Room 125
Juneau, AK 99801-1182

Dear Senator Seekins:

Thank you for introducing SB 67, "Alaska Medical Injury Compensation Reform Act of 2005".

I strongly support the passage of this bill.

The availability of affordable medical liability insurance is increasingly becoming a problem in the State of Alaska. If this trend continues, the quality and access to health care in our state will be harmed.

Passage of similar reform bills in other states have yielded direct benefit for the overall population and has allowed both primary care and specially physicians to continue to practice efficient and effective medicine. The similar reform bills have not limited the ability of patients to seek legal redress when warranted.

Please work towards the passage of this bill. In both urban and rural areas, our state has a physician shortage. Passage of SB 67, in addition to allowing Alaskan physicians to continue to practice, will help in recruiting much needed new physicians.

Let me know if you have any questions or desire additional information.

Sincerely,

Richard L. Hutchison, M.D., F.A.C.S.

NFIB
The Voice of Small Business®

ALASKA

National Federation of Independent Business

Statement of Support for SB 67

Medical Liability Reform

February 9, 2005

The Alaska Chapter of the National Federation of Independent Business has 2,500 members, making it the largest small-business advocacy group in the state.

This legislation provides an award limit of $250,000 for non-economic damages for personal injury claims against health care providers. NFIB/Alaska fully supports this legislation. It is important to emphasize that this in no way limits economic damages which include past and future losses for wages or employment opportunities and costs for past and future health care services and products. The limit is for non-monetary losses such as pain and suffering.

Alaska's current law sets a $400,000 non-economic damage limit with higher awards available for serious injuries. This has effectively eliminated the hard cap since all injuries are argued to be serious.

Other states have seen positive results by limiting the amount awarded for pain and suffering. According to a study conducted by the RAND Corporation, a California-based research organization, the State of California's medical liability law which includes a $250,000 cap on non-economic damages has reduced awards by an average of 30 percent. Their law also limits payment to plaintiffs' lawyers, which have dropped 60 percent.

NFIB and other business groups support medical liability reform across the nation because of the rising costs of health care and access to health care for their employees. The medical liability crisis is estimated to add between 5 and 9 percent to the overall health-care costs in the United States. The skyrocketing costs of medical liability insurance have caused a crisis in many states with the loss of doctors willing to do business in their state. Due to the uncertainty in Alaska's liability insurance market young physicians have better choices than Alaska and it is difficult to attract new doctors. As in some other states, Alaska needs to work to change that.

Vote YES on Senate Bill 67

Submitted by Thyes Shaub on behalf of NFIB/Alaska.

National Federation of Independent Business – ALASKA
217 Second St., Suite 206 • Juneau, AK 99801 • 907-463-5118 • Fax 907-463-5128 • www.NFIB.com

February 10, 2005

Senator Ralph Seekins

Re: **Support for Senate Bill 67**

Dear Senator Seekins;

Thank you for your efforts to control the unending exponential increases in health insurance premiums. I know this step is not going to completely fix the problem, but it is a step.

I own a retail clothing and footwear store in Juneau. We have always provided health insurance benefits for our employees, but soon we will not be able to cover our employee's insurance needs if every year I receive a premium increase of on average 15%. We have had to increase deductibles and self-insure to make up the difference to employees if they have a big claim. This cannot continue forever, soon we'll run out of tricks.

I feel like we have been more than doing our part to control costs. Now it is time for the other parties involved to do their part. I understand completely both the economic and the non-economic side of this equation and it's effects on the worker and their family as my wife suffered a serious back injury many years ago while on the job. The current situation is out of control.

Good luck in your quest. Part of the problem is the people fighting the battle are "well heeled" enough to not have the problem of covering rising premiums be real enough for them, among other things...

Regards,

Ron Flint

Ron Flint
President, The Nugget Alaskan Outfitter

Richard L. Hutchison, M.D., F.A.C.S.

Plastic & Reconstructive Surgeon

1919 Lathrop Street • Suite 101 • Fairbanks, AK 99701-5956 • (907) 451-8775

Senator Ralph Seekins
State Capitol, Room 125
Juneau, AK 99801-1182

Dear Senator Seekins:

Thank you for introducing SB 67, "Alaska Medical Injury Compensation Reform Act of 2005".

I strongly support the passage of this bill.

The availability of affordable medical liability insurance is increasingly becoming a problem in the State of Alaska. If this trend continues, the quality and access to health care in our state will be harmed.

Passage of similar reform bills in other states have yielded direct benefit for the overall population and has allowed both primary care and specially physicians to continue to practice efficient and effective medicine. The similar reform bills have not limited the ability of patients to seek legal redress when warranted.

Please work towards the passage of this bill. In both urban and rural areas, our state has a physician shortage. Passage of SB 67, in addition to allowing Alaskan physicians to continue to practice, will help in recruiting much needed new physicians.

Let me know if you have any questions or desire additional information.

Sincerely,

Richard L. Hutchison, M.D., F.A.C.S.

Member of the American Society of Plastic & Reconstructive Surgeons
Board Certified by the American Board of Plastic Surgery
Fellow American College of Surgeons

ages. By 1986, moreover, 10 states had followed California's lead and placed caps on noneconomic damages.

How successful have all these reforms been? That question has fueled endless debate, complicated by the fact that, in at least 14 states, courts have overturned tort measures on constitutional grounds. (Tort-reform challenges are pending in three other states.)

Critics say the surviving reforms have failed to

Here are the 22 states that cap noneconomic damages. For a more-comprehensive description of your state's cap, check with your medical society.

State	Cap amount	Year enacted
Alaska	$400,000 (Or life expectancy calculation, whichever is greater; rises to greater of $1 million or life expectancy calculation for severe injury.)	1997
California	250,000	1975
Colorado	300,000	1998 (amended 2003)
Florida	500,000 (May be increased to $1 million under certain conditions.)	2003
Hawaii	375,000	1976
Idaho	253,321*	1990 (amended 2003)
Kansas	250,000	1994
Maryland	635,000*	1986 (amended 1994)
Massachusetts	500,000	1997
Michigan	366,000* (There's a $653,500 limit for cases involving paralysis due to brain or spinal cord injury, impairment of cognitive capacity, or loss of reproductive ability.)	1993
Mississippi	500,000	2004
Missouri	565,000*	1988
Montana	250,000	1997
Nevada	350,000 (Cap may be raised in certain circumstances.)	2002
North Dakota	500,000	1996
Ohio	250,000 (Or three times economic damages, whichever is greater, up to a maximum of $350,000 for cases with single plaintiff or $500,000 for those with multiple plaintiffs.)	2002
Oklahoma	300,000	2003, 2004
South Dakota	500,000	1976
Texas	250,000	2003
Utah	430,000*	1996 (amended 2001)
West Virginia	250,000* (Rises to $500,000 in cases involving wrongful death, permanent and substantial physical deformity, and other serious injuries.)	2003
Wisconsin	432,352* (Doesn't apply to wrongful death cases, which carry different caps.)	1995

*Adjusts for inflation

Sources: Weiss Ratings, AMA, and National Conference of State Legislators

ALASKA ACTION TRUST
813 WEST THIRD AVENUE
ANCHORAGE, ALASKA 99501

INFORMATION IN OPPOSITION TO SENATE BILL 67

I. POSITION PAPER

II. CHART: CALIFORNIA PREMIUMS ARE HIGHER THAN STATES WITHOUT CAPS

III. DOCTORS DON'T LIKE CALIFORNIA

IV. MEDICAL MISCALCULATION CREATES DOCTOR SHORTAGE

V. CHART: ALASKA NPDB REPORTS 1999-2003

VI. CHART: NUMBER OF OBGYN PHYSICIANS IN ALASKA

VII. CHART: DO CAPS DRAW OB/GYN PHYSICIANS TO A STATE?

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POSITION PAPER ON SENATE BILL 67
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 rolled 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

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 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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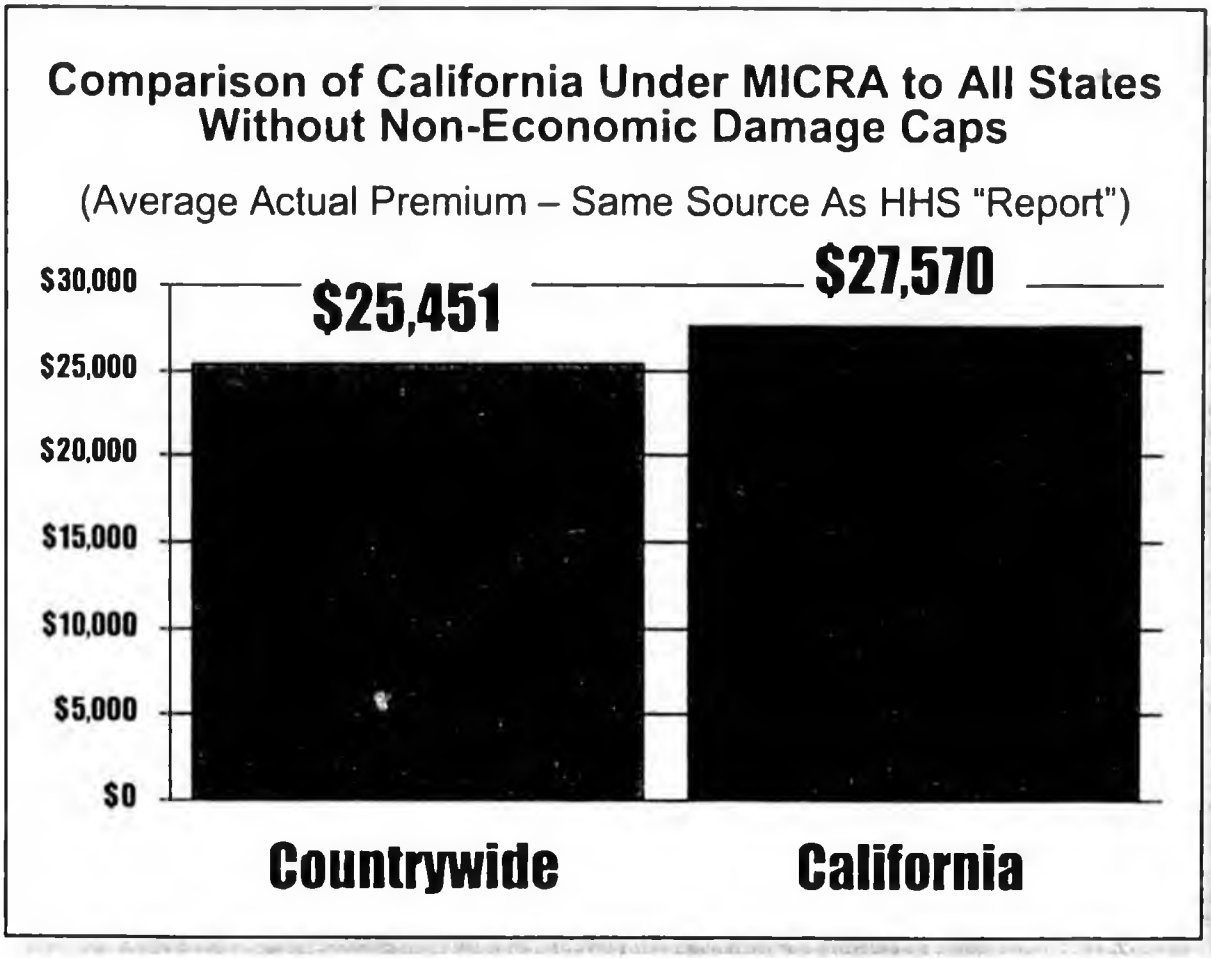
32 "Hype Outraces Facts in Malpractice Debate," *USA Today*, March 3, 2003.

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"

Medical Malpractice Caps

California Rates Are Higher Than States Without Caps



- **California Has The Most Restrictive And Severe Medical Malpractice Caps In The Country**
- **The Source Used By The HHS "Report" Indicates That Premiums Are 8% Higher**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

SOURCE: Medical Liability Monitor, 2001. Dollar values represent the combined average of all premiums presented for OB/GYNs, Internists, and General Surgeons among the selected states, 2000-2001. Texas, Maine and New Jersey have caps that apply only in cases of wrongful death. If these states are added, the average rises to $26,105 and California premiums are 6% higher than the countrywide average.

Doctors Don't Like California

Census Bureau Says Doctors Are Fleeing California

The U.S. Census Bureau reports that over the past decade, California has fallen from eighth to 12th place in the nation in per capita ratio of doctors to population.
http://www.ama-assn.org/sci-pubs/amnews/pick_00/bibf0814.htm#08144

California Newspaper Says Doctors Fleeing California

California doctors are heading for small towns in such states as Texas, Alabama and North Carolina where doctors say they have considerably more control over their medical decisions, get paid a fair fee for their services and can afford to live comfortably. Of those doctors not clearing out of the area, a good number are retiring early or changing professions.
(Importantly: Texas, Alabama and North Carolina all do not have any caps on noneconomic damages)

http://www.svcn.com/archives/saratoganews/01.17.01/cover-0103.html

Study Shows New Doctors Don't Want To Go To California

Indicators of significant physician dissatisfaction with medical practice and physician flight from California are dramatic. There appear to be widespread problems recruiting new physicians.

California Medical Association. 2001 Physician Survey Findings. "And Then There Were None." page III

California Doctors Wouldn't Choose California Again

Indicators of significant physician dissatisfaction with medical practice and physician flight from California are dramatic. There appear to be widespread problems recruiting new physicians. Only a third of physicians would still choose to practice in California if they had to do it over today.

California Medical Association. 2001 Physician Survey Findings. "And Then There Were None." page III

California Facing A Doctor Shortage Crisis

Negative career, professional and economic pressures in the California health care system are having the ultimate impact of causing physicians to leave medicine and creating barriers for others to practice in the state. If these trends bear out, California will face a dire situation that will parallel the current nursing shortage

California Medical Association. 2001 Physician Survey Findings. "And Then There Were None." page 18.

Doctors Don't Like California

Many Doctors Fed Up And Quitting Their Practice

CMA (The California Medical Association) has for the past several years received serious and substatntial reports from physicians and patients about access to care problems. Within the physician grapevine, discontent among doctors is widely expressed. Hundreds of physicians throughout the state report their plans to quit practice in California

California Medical Association. 2001 Physician Survey Findings. "And Then There Were None." page 18

OB/Gyns Fed Up

The Santa Rosa OB/Gyn medical Group lost two of its five practitioners. Among them was Dr. Thomas Garrett, who said, It was slowly becoming more difficult to be a good, caring physician.

California Medical Association. 2001 Physician Survey Findings. "And Then There Were None." page 18

Medical Care Delayed In California Because Of Crisis

Dr. Harvey Cohen, chairman of the Department of Pediatrics at Stanford University School of Medicine, describes shortages in numerous pediatric specialties. This doesn't mean the patient doesn't get care, he said. It means they may have to wait three months or longer for an appointment.

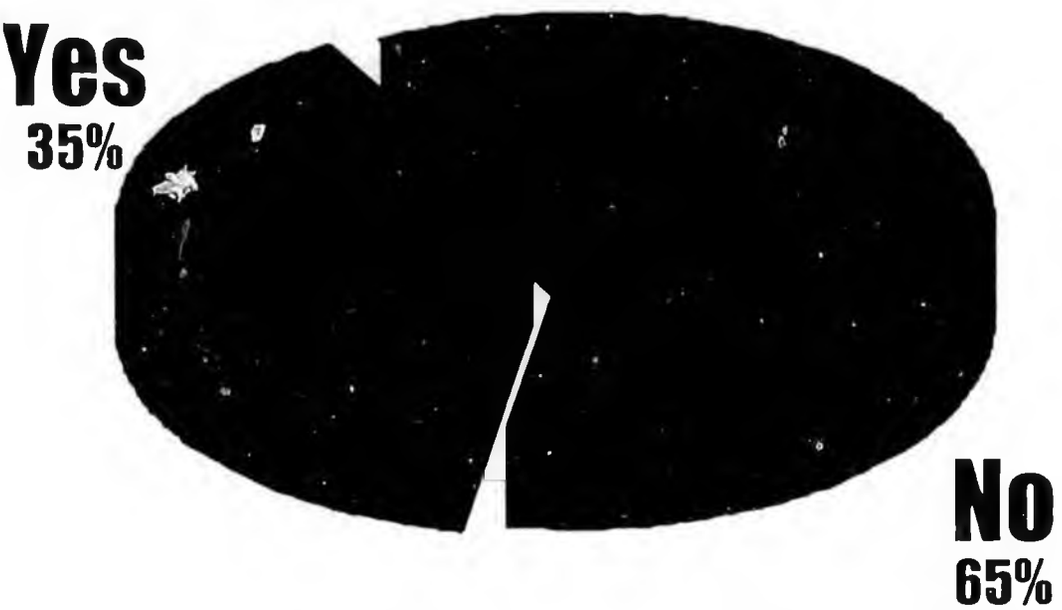
California Medical Association. 2001 Physician Survey Findings. "And Then There Were None." page 18

Medical Malpractice Insurance

Are Doctors In California Happy There?

Would You Choose California Again?

Asked Of California Doctors - 2001



- **Only About A Third Of Current Doctors Would Choose To Practice In California Again**
- **MICRA Hasn't Made California Desirable To Docs**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

•Source: American Medical Association. And Then There Were None: The Coming Physician Supply Problem. Page 20.

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Medical miscalculation creates doctor shortage

After a glut was predicted a decade ago, the number of physicians isn't keeping up with the demands of a wealthy, aging population

By Dennis Cauchon
USA TODAY

TALLAHASSEE, Fla. — Retired fisherman Billy Bodiford was diagnosed with prostate cancer in October. The doctor who found the cancer is the only urologist available in Taylor County, Fla. (pop. 19,200) — and he visits just one day a month.

The doctor sent Bodiford from his hometown of Perry to Tallahassee 50 miles away for surgery. "You can't get the type of operation I needed in my town," says Bodiford, 68, who was hospitalized for six days in December and is feeling better.

Bodiford experienced what many Americans may soon face: a shortage of physicians that makes it hard to find convenient, quality health care. The shortage will worsen as 79 million baby boomers reach retirement age and demand more medical care unless the nation starts producing more doctors, according to several new studies.

The country needs to train 3,000 to 10,000 more physicians a year — up from the current 25,000 — to meet the growing medical needs of an aging, wealthy nation, the studies say. Because it takes 10 years to train a doctor, the nation will have a shortage of 85,000 to 200,000 doctors in 2020 unless action is taken soon.

The predictions of a doctor shortage represent an abrupt about-face for the medical profession. For the past quarter-century, the American Medical Association and other industry groups have predicted a glut of doctors and worked to limit the number of new physicians. In 1994, the *Journal of the American Medical Association* predicted a surplus of 165,000 doctors by 2000.

"It didn't happen," says Harvard University medical professor David Blumenthal, author of a ***New England Journal of Medicine*** article on the doctor supply. "Physicians aren't driving taxis. In fact, we're all gainfully employed, earning good incomes, and new physicians are getting two, three or four job offers."

The nation now has about 800,000 active physicians, up from 500,000 20 years ago. They've been kept busy by a growing population and new procedures ranging from heart stents to liposuction.

But unless more medical students begin training soon, the supply of physicians will begin to shrink in about 10 years when doctors from the baby boom generation retire in large numbers.

"Almost everyone agrees we need more physicians," says Carl Getto, chairman of the Council on Graduate Medical Education, a panel Congress created to recommend how many doctors the nation needs. "The debate is over how many."

Getto's advocacy of more doctors is remarkable because his advisory committee and its predecessor have been instrumental since the 1980s in efforts to restrict the supply of new physicians. In a new study sent to Congress, the council reverses that policy and recommends training 3,000 more doctors a year in U.S. medical schools.

Even the American Medical Association (AMA), the influential lobbying group for physicians, has abandoned its long-standing position that an "oversupply exists or is immediately expected."

"The truth is, we don't know if there's a shortage of physicians," says AMA President John Nelson, a Salt Lake City obstetrician. "It looks like there are enough physicians for the short term, but maybe we need more because of the aging population."

The United States dramatically expanded the number of doctors being trained in the 1960s and 1970s, creating two new physicians for every one that retired, says Richard Cooper,director of the Health Policy Institute at the Medical College of Wisconsin.

But the production of new doctors has changed little since 1985. Today, new physicians roughly equal the number of doctors retiring. Within a decade, baby boom doctors licensed in the 1960s, 1970s and 1980s will retire in large numbers that will outstrip the 25,000 new doctors produced every year, Cooper says.

The effective number of physicians will fall even more, Cooper says, because doctors work shorter hours today. "The public expects good, innovative health care, but we're not producing enough physicians to provide it," Cooper says.

The marketplace doesn't determine how many doctors the nation has, as it does for engineers, pilots and other professions. The number of doctors is a political decision, heavily influenced by doctors themselves.

Congress controls the supply of physicians by how much federal funding it provides for medical residencies — the graduate training required of all doctors.

To become a physician, students spend four years in medical school. Graduates then spend three to seven years training as residents, usually treating patients under supervision at a hospital. Residents work long hours for $35,000 to $50,000 a year. Even doctors trained in other countries must serve medical residencies in the USA to practice here.

Medicare, which provides health care to the nation's seniors, also is the primary federal agency that controls the supply of doctors. It reimburses hospitals for the cost of training medical residents.

The government spends about $11 billion annually on 100,000 medical residents, or roughly $110,000 per resident. The number of residents has hovered at this level for the past decade, according to the Accreditation Council for Graduate Medical Education.

In 1997, to save money and prevent a doctor glut, Congress capped the number of residents that Medicare will pay for at about 90,000 a year. Another 20,000 residents are financed by Veterans Affairs and Medicaid, the state-federal health care program for the poor. Teaching hospitals pay for a small number of residents without government assistance.

Medicare, which faces enormous financial pressure in coming decades, already spends 3% of its budget training physicians and may not have the resources to spend more.

Cooper says the nation needs 200,000 more physicians because aging and wealthy countries demand more health care.

The portion of U.S. income spent on health care rose from 8.8% in 1980 to 15.4% in 2004 and will reach 18.7% in 2014, according to Medicare estimates. That means more doctors are needed, whether it's for hip replacements or prescribing new drugs.

Demographic changes in the medical profession also contribute to the need for more physicians. Nearly half of new physicians are women, and studies show they work an average of 25% fewer hours than male physicians, Cooper says.

Physicians older than 55 work about 15% less than younger doctors. And medical residents have been limited to 80-hour weeks since 2003, ending decades of 100-plus-hour weeks.

Most worrisome, the retirement of baby boom physicians means the number of doctors will start falling just as the first baby boomer turns 70 in 2016, says Ed Salsberg, a workforce specialist at the Association of American Medical Colleges.

The United States stopped opening medical schools in the 1980s because of the predicted surplus of doctors.

The Association of American Medical Colleges dropped this long-standing view in 2002 with the statement: "It now appears that those predictions may be in error." Last month, it recommended increasing the number of U.S. medical students by 15%.

Florida State University's College of Medicine, the first new medical school since 1982, will graduate its first class this year. Arizona, Nevada, California and Florida are considering opening additional medical schools. Other states are considering expanding theirs.

Florida State won approval from the state Legislature to become the nation's 126th medical school by emphasizing family practice and other specialties needed in rural areas and inner cities, where the doctor shortage is already acute.

Florida State medical student Shannon Price, 34, plans to return to her hometown of Perry when she becomes an obstetrician in 2010. She knows firsthand how having too few doctors hurts Perry.

The only person in her family to attend college, Price worked in a munitions factory after high school. Laid off, she went to junior college, then became a nurse.

"People go without health care in my hometown," she says. "Women go five or six years without Pap smears. We'd deliver babies in the emergency room. My family didn't go to the doctor, other than occasional visits to the health department."

Doctors' Memorial Hospital in Perry is paying Price's medical school tuition to encourage her return. "She could go anywhere she wants in the country yet she wants to come back here," hospital administrator Rick Brown says. "We appreciate that."

Because physicians are affluent and in short supply, they tend to locate where they want to live — not, as McDonald's or a Chinese restaurant might, where the most customers are.

Jackson Hospital, a 120-bed hospital in Marianna, Fla., a town of 6,200 an hour west of here, needs a urologist, a radiologist, an ear, nose and throat specialist and a gynecologist. "It's supply and demand, and it's hard to get doctors here," hospital administrator Charles Ellis says.

Particularly scarce are old-fashioned specialists — general surgeons, radiologists, anesthesiologists — who have a wide range of duties. Jackson Hospital has one radiologist who does the work of two or three doctors. He works 15 to 18 hours a day.

New radiologists are not very interested in traditional radiology, Ellis says. They prefer cutting-edge radiology using catheters to treat cancer, blood clots and other problems, which is more lucrative and has predictable hours.

"It's hard to find a radiologist and orthopedic surgeon who want to focus on broken bones, especially at 3 a.m.," Ellis says. "But that's what we need."

Some medical policy specialists say the USA doesn't have too few doctors, just poor distribution of them.

"We have more and more physicians taking care of fewer and fewer patients," says Kevin Grumbach, chairman of family and community medicine at San Francisco General Hospital.

He says doctors gravitate to high-paying practices — such as sports medicine and total body scans — that serve the wealthy and well-insured at the expense of Medicare patients and others.

"It's wrong to think that we can produce more physicians and have them trickle down to where they are needed," says Grumbach, who favors a government-run, national health care system. "Investing billions of dollars to produce more doctors is a foolish way to spend money."

Others worry that more physicians will drive up the cost of medical care, not make it cheaper and more accessible. Physicians will order more tests, more procedures and more drugs — without improving the nation's health, they say.

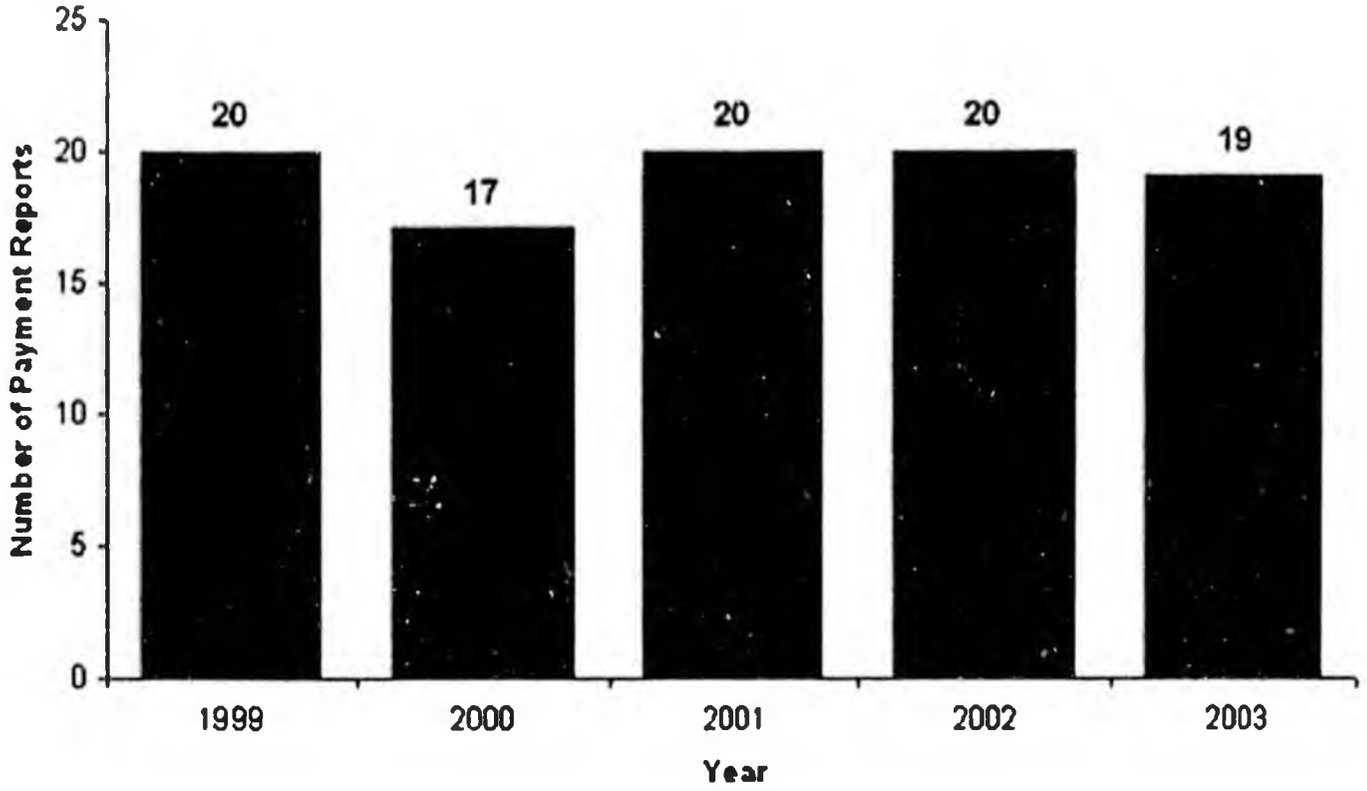
"Doctors create their own demand," says physician Don Detmer, co-chairman of an Institute of Medicine committee that, in 1996, recommended cuts in funding for medical residents. "If we produce an abundance of doctors, there's little incentive for the system to become more efficient." The Institute of Medicine is an independent group created by Congress for advice on medical issues.

But Cooper, a former medical school dean, says it's foolish to limit doctors as a way to control health care costs. "Doctors don't drive medical costs," he says. "Sickness does.

"We face at least a decade of severe physician shortages because a bunch of people cooked numbers to support a position that was obviously wrong," Cooper says. "This is a desperate situation. And we need to act now because it takes a long time to train a doctor."

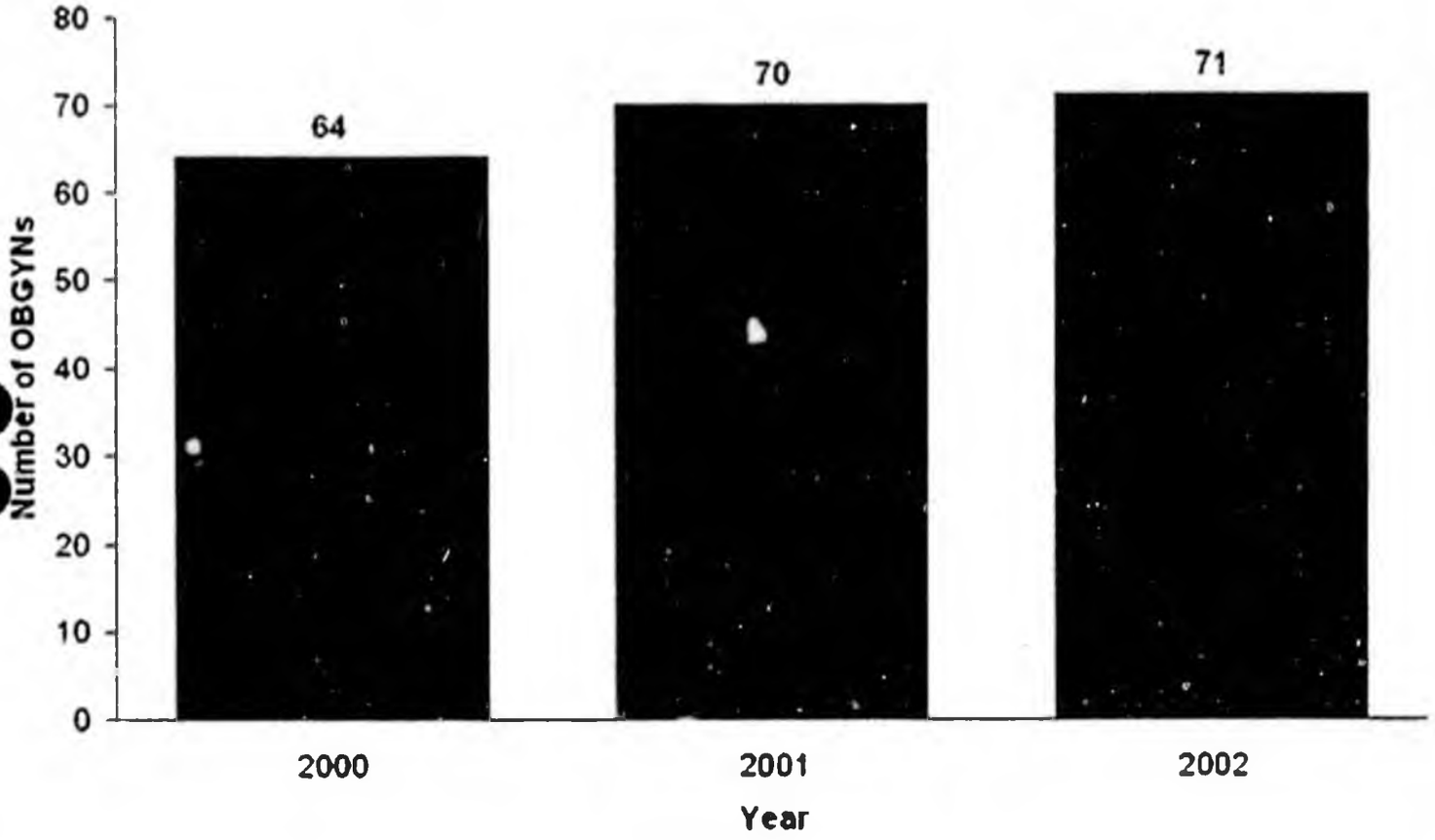
Find this article at:
http://www.usatoday.com/printedition/news/20050303/1a_cover03.art.htm

Number of Alaska Medical Malpractice Payments Reported to the National Practitioner Data Bank



Source: National Practitioner Data Bank Annual Report 2003

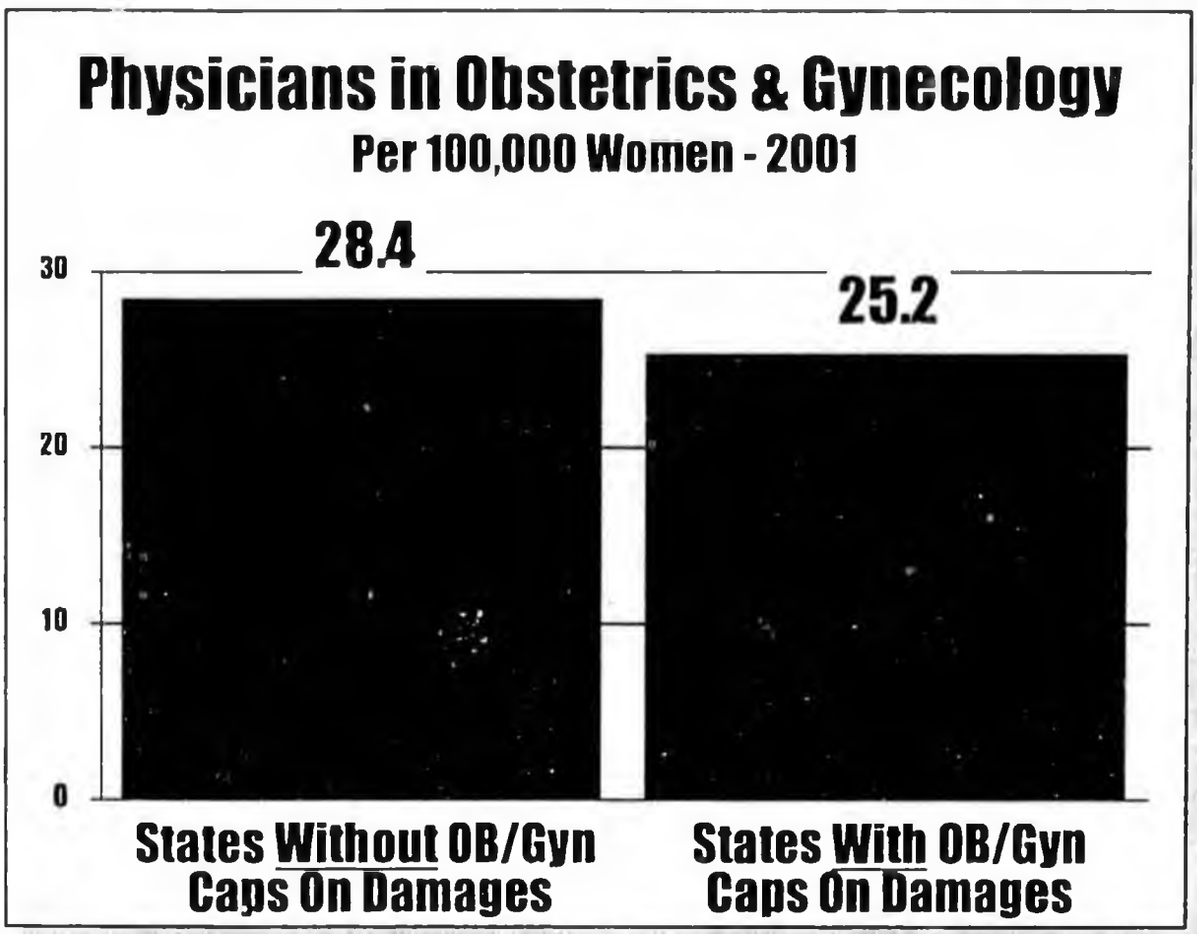
Number of OBGYNs in Alaska



Source: American Medical Association, "Physician Characteristics and Distribution in the U.S." (2003-2004 edition)

Obstetrics & Gynecology

Do Caps Draw OB/Gyn Physicians To A State?



- **There Are 12.7% More OB/Gyn Physicians Per 100,000 Women In States Without OB/Gyn Caps**
- **Caps Do Not Attract Doctors**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

Source: Health Care State Rankings 2003. Morgan Quitno Press. (http://www.statestats.com). The following states were classified as having caps that affect medical malpractice cases broadly in 2001: AK, CA, CO, FL, HI, ID, IN, KS, LA, MD, MA, MI, MO, MT, NE, NM, ND, SD, UT, VA, WV, WI. Maine and New Jersey are excluded because their caps only affect cases of wrongful death.

Jeanne Ostnes

From: Donna J. McCready [djm@anchorlaw.com]

Sent: Wednesday, March 16, 2005 4:15 PM

To: Sen. Gene Therriault

Cc: Joseph Balash; Donna J. McCready

Subject: SB 67 - Bill that would cap non-economic damages in medical malpractice cases

Dear Senator Therriault,

I met with you briefly last year in Juneau on SB 319, which has been reintroduced this year as SB 67. This bill would cap non-economic damages in medical malpractice cases at $250,000. I just learned this afternoon that this bill is being brought up again tomorrow morning before the Senate Judiciary. As a concerned citizen, an attorney, and a member of the Alaska Action Trust, I am writing in opposition to the bill. I am writing to you individually because I believe that you really care about what is best for Alaskans and I think you care about the truth.

First, we already have caps on non-economic damages: $400,000 for physical injury and $1,000,000 for severe permanent physical injury.

Second, passing legislation capping non-economic damages in medical malpractice cases only hurts Alaskan individuals most seriously injured by malpractice and only protects the few physicians who cause the most serious harm through negligence or recklessness. The legislation primarily protects insurance companies. Imagine, a child who, because his physician had been up most of the night drinking, dies during a surgical procedure performed negligently by that physician who is hung over. If non-economic damages are capped at $250,000 the parents of that child would be unable to gain access to our court system and to justice because no attorney or family could afford to bring such a case. The life of a child does not, in an economist's eyes, have much economic value. And because the cost of pursuing medical malpractice cases is so high (mainly because you have to have expert physicians hired from the lower 48) and so time consuming (doctors and their insurers generally are not interested in settling until significant discovery takes place) no attorney that I know of could pursue such a case.

Which brings me to my third point – the folks who will essentially be denied access to justice if this legislation passes will be those to whom economists do not assign a high economic value: stay-at-home parents, the retired, the elderly, children.

I have talked about who will be hurt by this legislation – individual Alaskans who do not have a well-heeled lobby on their side. My question is who benefits from this legislation? The answer is the insurance industry. Doctors will not benefit from this legislation because it has already been shown that their premiums will not stay the same or be reduced if such legislation passes. This is borne out by the experience in the states where a $250,000 cap has been passed. It would be interesting to have members of the insurance industry testify under oath about the effect of such legislation on malpractice premiums and numbers of physicians practicing in a state where the $250,000 cap has been passed. There is no evidence that malpractice premiums are connected to malpractice suits – especially in Alaska. There is no data to support that doctors are not coming to Alaska because we cap damages at $400,000 and $1,000,000 (for severe permanent physical injury) as opposed to $250,000. In fact, according to the AMA, the number of physicians has increased steadily in this State since 1999. The National Practitioner Data Bank Annual Report for 2003 shows that the number of malpractice payments in Alaska has remained steady between 1999 and 2003 (there were reports of 20 malpractice payments in 1999, 2001, and 2002 and 19 payments in 2003). There is no crisis.

I have the following questions:

Why has Mr. Hove stated during the March 8th hearing before Senate Judiciary that the bill does not affect awards for gross negligence and recklessness when the bill does in fact apply to cases of gross negligence and recklessness?

Why did Senator Seekins, during the March 1st hearing before Labor and Commerce, say that the $1,000,000 cap would still apply for severe injuries when that is not what the bill says?

How is it that you can sue for the loss of enjoyment of life but not for "hedonic" damages?

Again, who really is benefiting from this legislation and who stands to lose if it is passed?

Thank you. I would appreciate that opportunity to discuss this with you further.

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