

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILE 8672
1758 SCOMM 69: HOUSE LIABILITY INSURANCE TASK FORCE, 1989-1990

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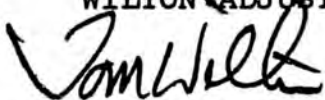
David E. Rogers
February 16, 1990
Page 2

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

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

Sincerely yours,

WILTON ADJUSTMENT SERVICE

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

Tom Wilton
Owner/General Manager

TW/mk

D5K

ALASKA BAR

ASSOCIATION

March 1, 1990

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

Attention: David Rogers, Esq.

RE: Attorney Discipline Dispositions

Dear Mr. Cotton,

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

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

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

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

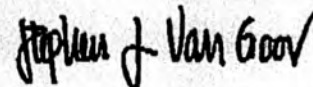
Representative Sam Cotton
March 1, 1990
Page 2 of 2

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

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

Sincerely,

ALASKA BAR ASSOCIATION



Stephen J. Van Goor
Bar Counsel

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

BC108/RF

TABLE 1

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

TABLE 2

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

05

TABLE 3

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

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

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ALASKA STATE LIBRARY

Changes in Medicine Bring Pain to Healing Profession

By LAWRENCE K. ALTMAN
with ELISABETH ROSENTHAL

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

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

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

An Unrecognized Landscape

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

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

Many Doctors Dissatisfied

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

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

Many who study the medical profession believe that doctors brought the changes in the profession on themselves, said Prof. Uwe Reinhardt of Princeton, an expert in health care eco-

Doctors in Distress

First of three articles.

nomics. "Physicians have lived like kids in a candy store," he said. "We, the payers, want the key back."

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

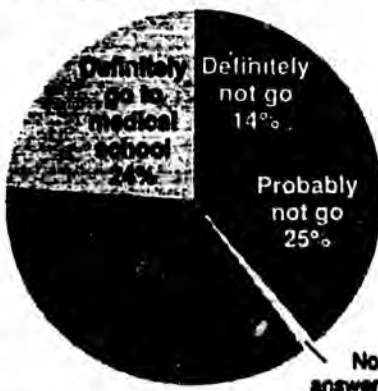
When the A.M.A. newspaper, American Medical News, asked doctors last year to describe how their practices had changed in the 1980's, "The question struck a nerve," the newspaper said. "Dozens of physicians responded with lengthy, heartfelt reflections," many of them expressing frustration with the changes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

Dr. Richard Short, a pediatrician in

Continued on Page 34, Column 1

If They Could Do It Again...

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



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

The New York Times/Feb. 18, 1990

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

LOW TAX PAYMENTS CITED

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

By ROBERT PEAR

Special to The New York Times

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

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

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

New Power for the I.R.S.

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

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

Secretive Nicaraguan Voters

Practice of Medicine Is Undergoing Change, Demoralizing Doctors

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Continued From Page 1

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

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

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

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

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

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

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

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

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

Private Practice

Costs and Trials Of Going It Alone

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

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

Equipping the simplest doctor's office may cost \$20,000 to \$40,000 and for more complicated specialties, like ophthalmology, equipment can cost \$100,000, said George Conomikos, whose firm in Los Angeles advises doctors starting to practice. On top of that, the doctors will be facing annual malpractice premiums that can sometimes exceed \$30,000.

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

Dr. Short, the San Diego pediatrician, who grew up in the 1960's and went into medicine to "make a difference," said in the interview that he closed down his busy pediatrics office in rural Oregon to take a salaried job with a large group in San Diego after office expenses and reimbursement problems rose dramatically. During one two-month period he received no Medicaid payments because the state was out of money for the health care program for the poor. He said a \$20,000 bank loan failed to keep the practice afloat.

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

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



Illustrations by Javier Romero

INCOME

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



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



BY SPECIALTY

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

Surgery	\$307.8
Anesthesiology	\$194.5
Obstetrics/Gynecology	\$180.7
Pathology	\$131.0
Internal Medicine	\$130.9
General Family Practice	\$94.6

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

SPECIALTY

Figures for the 521,328 active, classified physicians with known addresses that the American Medical Association tracked at the beginning of 1989.

WHAT THEY PRACTICE

General
Family
practice
13.3%

PATIENT CARE
15.0%

WHERE THEY PRACTICE





The New York Times/Jack Ryan

Dr. Scott Fox

Ear, nose and throat surgeon

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

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

In five years, there has been a drop of 9,000 in the annual number of applicants for medical school, although the number of applicants rose slightly last year.

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

Little Sympathy for Complaints

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

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

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

More Stringent Oversight Is Seen

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

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

Government Bonus Plan

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

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

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

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

The Money

Lucrative Still, But Not for All

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

Young doctors already face mixed salary prospects. Some big employers like the Kaiser health plans in California and the Health Insurance Plan in New York report that they are having trouble finding young doctors and have thus been forced, repeatedly, to raise the salaries they offer to these doctors. But according to a survey of 470 group practices by the American Group Practice Association, starting salaries for about 1,000 doctors finishing their training dropped almost 5 percent in 1988, the first drop since the association began keeping records in 1966.

Average Salary of \$144,700

In 1988, the American Medical Association's annual survey found that the average practicing physician earned \$144,700, but the range was wide and often based on a doctor's specialty or location. While a quarter of all physicians earned more than \$180,000, another quarter earned less than \$80,000.

The survey reported that the average annual income for doctors in the Middle Atlantic states, which it defined as New York, New Jersey and Pennsylvania, was \$134,900, while the average in the New England states was \$133,000.

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

Cont'd on Following Page



PRACTICE

Other patient care 1.0%
Research 3.2%
Administration 2.8%
Teaching 1.5%
Other 0.7%

Source for both charts: American Medical Association

PRACTICE

NUMBER OF DOCTORS

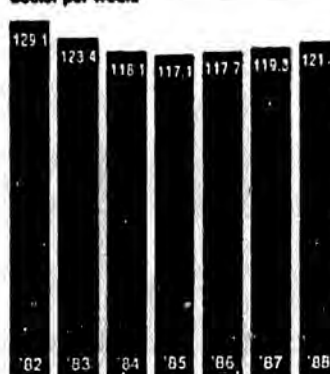
Number of physicians per 100,000 population. Foreign figures are for 1986.



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

PATIENT VISITS

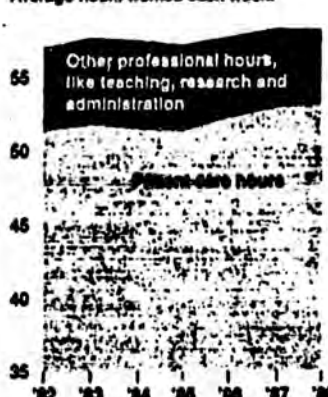
Average number of patient visits per doctor per week.



Source: American Medical Association

HOURS WORKED

Average hours worked each week.

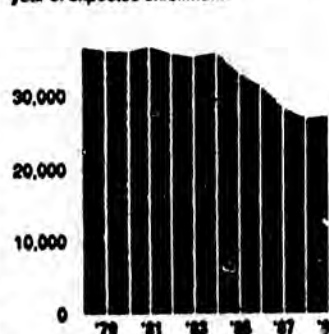


Source: American Medical Association

MEDICAL SCHOOL

APPLICANTS

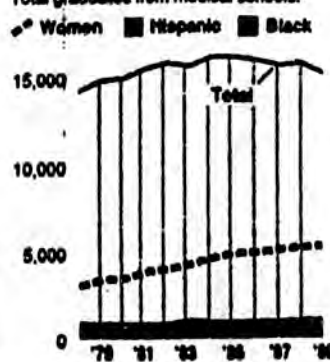
Total applications for medical school, by year of expected enrollment.



Source: Association of American Medical Colleges

GRADUATES

Total graduates from medical schools.



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

DEBT

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



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

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



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

Cont'd From Preceding Page

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

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

"I'm Going to Miss the Income"

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

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

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

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

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

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

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

The Future

White Male Image Gives Way to Diversity

The white male image of medicine is changing at the entering levels of the profession. Indeed, many medical schools would have been in trouble, experts agree, had it not been for the great increase in women and minority members among their students. The number of male applicants to medical school has dropped almost 50 percent since the mid-1970's; in 1985-1986, the medical schools would have been unable to fill their first-year classes if they took only males, even taking every male who applied. For the first time ever, white men that year made up less than half the first-year class.

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

ISSUES

BLACK 3.3% HISPANIC 4.7%



Demographics

Black and Hispanic doctors make up less than 1 percent of American physicians, but the percentage of female physicians has risen rapidly. In 1988, roughly 1 in every 6 American doctors was a woman. Men and women have been applying to medical school in smaller numbers in recent years. Male applicants have dropped 50 percent since the mid-1970's.

Incomes of Male and Female Doctors

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

What the Patient Pays

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

Rural Physicians

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

Respect From Patients

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

The American Medical Association

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



Dr. Richard Short
Pediatrician

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

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

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

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

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

Competition

Now the Doctor Will Call You

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

The number of physicians in the United States today is nearly double that in 1965: 506,000 versus 298,000. The ratio of physicians for every 100,000 people has risen to 237 from 148 in the same period.

Aggressive Business Tactics

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

code thing to tell, and some of the things that can't, but certainly to be frowned upon." But a limited advertising campaign turned his practice around, he said, and he now advertises on billboards, in magazines and on the radio. He also offers financing plans to patients whose health insurance does not cover cosmetic operations.

Hernia Operation Packages

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

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

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

The Training

No Clamor At Schools' Doors

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

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

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

Five years ago, 35,944 college students applied to medical school. Although enrollment has been relatively steady, only 26,915 applied for the 1989-90 freshman class. Fifteen years ago, 1 of every 2.8 applicants was accepted, but today the applicant-to-acceptance ratio is 1.8 to 1.

Some Schools Recruit

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

At the University of Massachusetts at Amherst, the number of seniors applying to medical school dropped to 109 in 1989-90 from 269 five years ago. The high cost of medical school, along with "horror stories" about malpractice suits and the grueling lives of doctors played a part, said W. Brian O'Connor, a zoology professor who advises pre-medical students.

"It's not very attractive," he said. "They have to go to school for four years, and three years of residency, and then the 80- to 85-hour work weeks they associate with a physician — it doesn't leave much for personal and family life."

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

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

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

The Little Progress

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

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

More Stress for Women

Medicine is particularly stressful for women, said Dr. Davidson, in addition to the biases, there are the added pressures of the family and the home, she said. Studies show that 75 percent of married female doctors perform all their household work. More than half of female physicians suffer a major depression sometime during their career and the divorce rate for the group is 48 percent higher than that of women in general, Dr. Davidson said.

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

Health Groups Attract Women

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

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

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

NEXT: The loss of autonomy.

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

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

THE NATION'S BILL

ITS GROWING SHARE OF THE G.N.P.

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

WHERE IT GOES

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



Sources: Department of Health and Human Services (share of G.N.P.), American Medical Association (where it goes)

BAROMETERS OF HEALTH

INFANT MORTALITY RATE



IN COMPARISON

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



LIFE EXPECTANCY

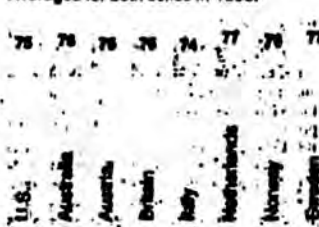
At birth, in years. Men Women



Sources: American Medical Association

IN COMPARISON

Averages for both sexes in 1988.



Sources: Compiled by the Population Reference Bureau

Charts by Anna Cronin

"All the News
That's Fit to Print"

The New York

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NEW YORK, MONDAY, FEBRUARY

Many in Medicine See Rules Sapping Profession's Morale

By LISA BELKIN

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

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

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

Chained by 'Munchkins'

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

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

Doctors In Distress

Second of three articles.

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

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

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

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

Continued on Page A13, Column 1



A protester using an iron rod to break a window at the pr

In Pretoria, Last Throes Of Marxism?

By CHRISTOPHER S. WREN
Special to The New York Times

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

The party finds itself defending an ideology that is collapsing across East-

Jeering R To Demo

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

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

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

By ELIZABETH KOLBERT

STATE LIBRARY

Many Doctors Seeing Increase of Regulation As Professional Malaise

Continued From Page A1

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

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

"Accountants leave, lawyers leave, businessmen walk away from their jobs," said Bruce C. Viadeck, the president of the United Hospital Fund, a philanthropic and research organization in New York City that specializes in health-care matters. "The fact that a 56-year-old guy who's been doing well decides he doesn't want to buck the bureaucracy anymore, that's to be expected."

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

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

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

unnecessary procedures at hospitals having high rates.

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

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

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

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

Who Decides?

Doctors Debating The Insurers

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

Dr. Rosenthal is currently debating with Medicare about \$2,000 in care for a patient last spring. The elderly man was admitted to the hospital with a broken hip and then suffered numerous complications, including pneumonia and an instance of cardiac arrest.

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

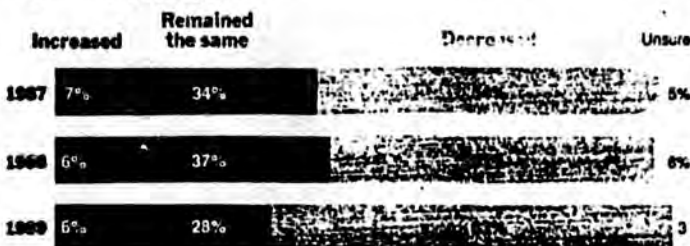
The Government and insurance companies frequently stipulate minimum requirements for certain operations: for example, in some states a patient's airway must be 80 percent



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

Feeling a Loss of Control

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



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

Having Some Second Thoughts

Doctors were asked whether they would go to medical school if they were in college now. Some doctors who

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

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

The Consequences

Many Are Leaving In Frustration

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

Dr. Sennett graduated from Yale Medical





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

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

The autonomy of doctors eroded slowly for nearly two decades, but after 1963 the pace increased when the Government adopted a system that broke down all known diagnoses into 467 subgroups and set a price that Medicare would pay for each. The price for each type of care in these Diagnostic Related Groups is based on the expected average cost in the region for the care. Regardless of what the care really costs, that is all a doctor or a hospital will receive from Medicare.

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

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

These changes, and others, have led to more sophisticated, and more public, ways to rate the performance of hospitals and individual doctors. In March 1968, the Federal Government for the first time released the mortality rates of Medicaid patients in hospitals nationwide. Last year, New York State began compiling statistics on the rates of Cesarean sections at hospitals and trying to reduce the number of the expensive and often

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

The Government and insurance companies frequently stipulate minimum requirements for certain operations: for example, to see a state a patient's airway must be 90 percent obstructed to warrant a tonsillectomy. Surgeons must often obtain approval from insurance companies or Government agencies before starting a case.

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

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

The H.M.O.'s

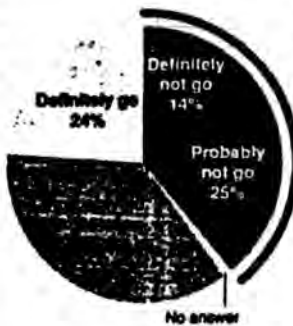
Controls Within the Profession

While most of the wrath of today's doctors is directed at outside regulators from the Government and private insurers, they also complain of internal controls. Health maintenance organizations, which are groups of doctors who accept a yearly fee from an employer or individual in exchange for nearly unlimited health care, are becoming more numerous and more complicated. In 1970 there were 37 H.M.O.'s enrolling 3 million people. This January, there were 907 serving 32.5 million, or nearly 13 percent of the population.

H.M.O.'s regularly issue lists comparing their physicians for the time spent with patients and the amount of medications prescribed — with the clear message that those highest on the list are a financial drain on the group. All care beyond the flat fee paid for a

Having Some Second Thoughts

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



From a survey of 1,004 doctors interviewed by telephone in January and February 1968. The survey was conducted by the Gallup Organization for the American Medical Association.

Why Not?

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

The New York Times/Feb. 16, 1968. Illustration by Jovon Samuels

The Bureaucracy

The Paperwork Grows Rapidly

Both a cause and a consequence of the growing number of players in the health industry is a growing number of administrators. An American Hospital Association booklet lists 200 health-care careers, and 52 of those are administrative. Similarly, a study by the Journal of Internal Medicine found that the numbers of health administrators increased nearly fourfold between 1970 and 1968, while the number of doctors increased by half.

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

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

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

The growing bureaucracy also brings more paperwork, another source of frustration. Dr. Robert and Dr. Dennis Wagner are brothers and have been practicing in Shiner, Tex., with a population of 2,360 for nearly 30 years. They say they no longer enjoy it and spending 40 percent of their time on paperwork is one of the reasons why.

They recently bought a \$75,000 computer

patient is absorbed by the organization, while all unused fees are profit.

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

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

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

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

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

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

Some Point to Massachusetts as Extreme of Regulation

By ELISABETH ROSENTHAL

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

But many say the good intentions have backfired. The American Medical Association estimates that more than 10 percent of doctors in private practice have left the state since 1965; the figure may be as high as 30 percent in some specialties, although a special state commission says the figures are difficult to determine.

Doctors say three laws make practice in Massachusetts financially difficult:

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

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

3. Retroactive malpractice payments. This state's Joint Underwriting Association lost money through much of the 1970's and early 1980's, and doctors are paying extra premiums to make up for these losses. According to Medical Economics magazine, a urologist was charged \$16,000 for 1969 insurance and \$15,000 in retroactive premiums.

With doctors' incomes in Massachusetts running 15 percent below the national average, many doctors are leaving.

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

Last year Massachusetts convened a spe-

cial commission to study the problem.

Dr. Sennett graduated from Yale Medical School in 1963, worked as a doctor briefly, then joined Aetna Life and Casualty in Middletown, Conn., in July. "I did my residency at a time when Medicare D.R.G.'s were being implemented," he said. "I saw doctors under increasing obligation to justify their decisions to people who didn't understand and certainly were not interested in learning."

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

Other frustrated doctors are staying, some because they cannot afford to leave. One 26-year-old New York-area obstetrician says she has soured on her profession because "the Government and the malpractice lawyers are always looking over your shoulder."

She has thought of such alternatives as starting her own medical-transcription service, pursuing a business degree or becoming a professional musician. But if she does any of these things she will have to pay about \$78,000 for a "malpractice tail" to keep her covered until the statute of limitations runs out on claims over cases she has handled.

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

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

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

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

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

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

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

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

NEXT: A changing relationship

COMPLIMENTS OF THE
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As the costs of paying for the apartment go up. And when costs go up, values tend to sink.

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

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

assessments on the 10 percent of homes to 8 percent a year or 20 percent over five years, while allowing much larger increases on co-ops, condominiums and rental buildings.

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

Continued on Page B3, Column 1

Wariness Is Replacing Trust Between Healer and Patient

By GINA KOLATA

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

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

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

'Most Doctors Mean Well'

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

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

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

Opinion polls indicate that doctors

Doctors in Distress

Last of three articles.

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

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

Continued on Page D15, Column 1

By HENRY KAMM

Special to The New York Times

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

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

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

No Longer Brothers?

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

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

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

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

Commitment Was An

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

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

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

In his speech, Mr. Modrow that East Germany could

Continued on Page A10, C



INSIDE

New Bishop for Brooklyn

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

Selma Still Smolders

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

Airlines Bet on Expansion

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

Heart Surgery and the Mind

Romanian Leader Warns of Tough New Measures Against Demonstrators

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

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

Business Taps the East Bloc's Intellectual Resources

Physicians and Patients Are Frequently Sharing Mistrust and Wariness

Continued From Page A1

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

The poll also found that 26 percent of Americans say they respect doctors less now than they did 10 years ago. The most frequent reasons they cited were that doctors were "in it for the money" or lacked concern for their patients.

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

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

The Causes

Distrust at 2 Ends Of the Stethoscope

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



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

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

Patient Pressure for Tests

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

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

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

Masterminding the Treatment

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

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

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

"You Can't Depend on Doctors"

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



The New York Times/Rick Freedman

Dr. Brenda Magauran stitching an accident victim's head in the emergency room at Parkwood Hospital in New Bedford, Mass. When Dr. Magauran entered practice he thought he

would have long-lasting relationships with his patients. But after discovering that, in general surgery programs, he would be on 24-hour call, he switched to emergency room practice.

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

Thinking About Free Time

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

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

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

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

The Results

The Public Image

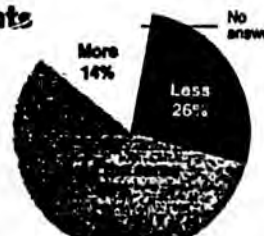
Percentage of respondents agreeing with each statement.

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



The Respect of Patients

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



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



Dr. Stephen Brommer
Internist, New Haven, Conn.

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

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

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

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

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

Suits Emotionally Devastating

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

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

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

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

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

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

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

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

"You Can't Depend on Doctors"

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

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

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

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

The Loss

Relationships Are Impersonal

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

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

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

Long Relationships Are Rare

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

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

"When I look back at what I did before, I say, 'How did I ever live like that?'" he said.

"People respect my evenings now. Before, no matter how educated my patients were, if they had a little problem they did not feel bad about bothering you."

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

The Results

Image of Medicine As Just a Business

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

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

Like Finding an Auto Repair Shop

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

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

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

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

'Realm of a Medical Industry'

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

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

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



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



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

Less Respect Because...

They are in it for the money	25%
They lack rapport/concern/interest	17%
They don't take time for patients	15%
I have had a bad personal experience	13%
More Respect Because...	
They are more educated/knowledgeable	20%
I'm older/I need them more now	15%
They are doing a good/better job	13%
They have more pressures/challenges	11%

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

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

A.M.A. Is Splintered by Challenges

By LAWRENCE K. ALTMAN

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

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

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

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

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

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

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

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

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

General Support for the Plan

The association supported the system in general.

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

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

D5j

M E M O R A N D U M

December 1, 1989

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

TO: Representative Sam Cotten

FROM: John B. Gaguine
Legislative Counsel

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

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

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

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

D52

NATIONAL SOCIETY OF PROFESSIONAL ENGINEERS



February 27, 1990

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

Dear Mr. Speaker:

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

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

Sincerely,

A handwritten signature in cursive script, appearing to read "M. Bayers", is positioned above the typed name.

Margaret E. Bayers
Director
Professional Engineers in Education

enclosures

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

CORRECTION

**THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY**

D5j

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Representative Sam Cotten
Page 2
December 1, 1989

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

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

If I may be of further assistance, please advise.

JBG:lmb
L8/074

D52

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enclosures

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

RETURN TO: _____



GLOSSARY OF INSURANCE TERMS

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

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

GLOSSARY

Calendar/Accident Year

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

Capacity

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

Case Estimates (Reserves)

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

Claim Expense

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

Claims-made Insurance

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

when the coverage commences. (See Retroactive Coverage.)

Closed Without Payment (CWP)

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

Combined Ratio

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

Compensatory Damages

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

Earned Premium

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

Excess of Loss Reinsurance

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

Exclusions

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

Expense Only Claim

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

Frequency

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

**Glossary
of
Terms**

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

Incurred But Not Reported Reserves (IBNR)

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

Incurred Loss

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

Indemnity Payment

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

Loss Development Factor

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

Occurrence Insurance

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

Paid Claim Count

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

Paid Expense

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

Permissible Loss Ratio

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

Policyholder Surplus

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

Premium

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

Premium Available for Losses (Net Premium)

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

Program Year

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

Punitive Damages

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

Pure Premium

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

Rate

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

Reinsurance

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

Reported Claims Count

The total of all claims reported to the insurance company.

Reserve Premium

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

Retroactive Coverage

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

Severity

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

Ultimate Loss

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

Underwriting Expense

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

Underwriting Profit (Loss)

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

Written Premium

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

RETURN TO: _____



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

INSURANCE

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

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

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

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

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

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

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

POLLUTION

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

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

**Pollution/
Asbestos**

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

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

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

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

ASBESTOS

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

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

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

LIABILITY

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

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

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

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

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

RISK IDENTIFICATION

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

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

RISK ANALYSIS/ASSESSMENT

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

1. **Capability and Capacity** — The best opportunity to manage risks occurs before a commission is accepted. The first task involves an examination of your firm's capabilities and capacity to perform the required services.
 - a. Do you have appropriate experience with this type of project and with rendering the services that will be required?
 - b. Will consultants be required? Are qualified consultants available to you?
 - c. Do you have the capacity for this project? What is the workload forecast? If additional hiring will be required, will you be able to hire qualified employees in sufficient number? Will the firm be able to assimilate the required new hires without straining management controls?
2. **Client** — Given the very competitive nature of practice within the design professions, client evaluation has had little or, at best, a very low priority in determining whether or not to seek or accept a particular commission. Proper risk assessment must, however, include an evaluation of the client. Time and effort spent on client evaluation is an important element in risk management. Some things to look for and evaluate include:
 - a. Other projects — Has your relationship with this client been good, bad or indifferent on other projects? Does the client have confidence in you and you in him? If a new client, what is his reputation in dealing with other design professionals?
 - b. Solvency — Is the client financially strong? If you require indemnity from the client, will the client be in a position to honor the agreement when the time comes?
 - c. Site — Have you visited the site? Does the client control the site?
 - d. Target — Has the client already been identified as a polluter? Is governmental action against the client pending or imminent?
 - e. Public relations — How is the client perceived by the community? Is there likelihood of adverse public reaction to the project?
 - f. Sincerity — Is the client making a serious effort to abate, eliminate or avoid a problem? Is the client merely trying a "bandaid" approach?
 - g. Access — Is the client providing you with free access? Is there full disclosure? Is the client responding to your inquiries with prompt and candid answers?
 - h. Attitude — How much site monitoring will the client undertake? Will proper operation be maintained?
 - i. Technical expertise — Does the client have in-house design and/or construction capabilities?

If so, how will this affect your independence in rendering your services?
 - j. Future business potential — Is there the potential for future commissions from this client? For a continuing professional relationship?
3. **Project** — Looking closely at the project itself can be revealing as to the probability of loss.
 - a. Degree of difficulty — Are the project requirements unique, complex, or do they border on the "state of the art"?
 - b. Controlling regulations — Will the operations be subject to governmental controls and reporting requirements? Are there any unusual codes, statutes or ordinances?
 - c. Budget — Is the proposed budget realistic in terms of the project requirements? Are funds readily available or definitely committed?
 - d. Time — Is the time schedule realistic?
 - e. Funding — What is the source of the client's funding? Are necessary funds likely to be available when required to maintain the progress of the project? Are there any funding contingencies?
4. **Contract** — Since the starting point for determining the design professional's duty is the contract you sign with your client, great care should be taken in assessing the responsibilities enumerated therein.
 - a. Authority — Does the proposed contract grant authority to carry out your responsibilities?
 - b. Scope of services — Are they clearly defined? Be alert to nebulous requirements, such as "as necessary" or "as required."
 - c. Limitation — Does the proposed contract include objectionable responsibilities such as direction, control or supervision of the *Work*?
 - d. Multi-phase — Will you have responsibility for more than one phase, e.g., study, identify and design?
 - e. Indemnity — Is the client attempting to shift its responsibility by requiring indemnity? Remember, the client "owns" the pollutant and should, therefore retain the liabilities associated with it.
 - f. Vicarious liability — Must the firm hire others for whom it will be responsible? If so, who has the right of selection?
5. **Compensation** — Is the proposed fee appropriate to the scope of services to be provided and the probable liability risk? Just as insurance companies require the payment of a premium before accepting risk, so should the design professional require a fee commensurate with any risks.²
 - a. Profit — What is the profit potential? *Losses are paid out of profit.*

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

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

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

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

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

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

INDEMNIFICATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

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

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

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

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

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

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

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

Appendix A

Notice Sent to Firms Insured in VOSCO/CNA Program

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

POLLUTION

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

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

ASBESTOS

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

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

Appendix B

ASBESTOS EXCLUSION

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

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

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

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

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

All other provisions of this policy remain unchanged.

Appendix C

POLLUTION EXCLUSION

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

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

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

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

Additional Definitions

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

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

All other provisions of this policy remain unchanged.

RETURN TO: _____



HOW YOUR PROFESSIONAL LIABILITY INSURANCE PREMIUM IS DETERMINED

By JAMES C. FARBER

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

INTRODUCTION:

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

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

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

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

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

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

BILLINGS:

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

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

**Your
Policy
Rating - III**

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

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

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

LOCATION:

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

TYPE OF SERVICES:

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

CLAIMS EXPERIENCE:

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

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

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

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

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

FACTORS YOU CAN CONTROL:

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

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

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

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

CONCLUSION:

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

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

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



QUALITY ASSURANCE CHECKLIST

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

I CLIENT SELECTION

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

II SELECTION OF CONSULTANTS

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

III PERFORMANCE BY STAFF MEMBERS

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

IV CONTRACT DOCUMENTS

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

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

V SPECIFICATIONS

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

struction Documents Phase.

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

VI USE OF MATERIALS AND EQUIPMENT

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

VII CONSTRUCTION PHASE SERVICES

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

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

VIII BUILDING CODES AND ZONING RESTRICTIONS

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

IX OCCUPATIONAL SAFETY AND HEALTH ACT

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

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

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

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

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

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

**PRESENTATION GUIDE
FOR
“PROFESSIONAL LIABILITY”**

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

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

A PRESENTATION KIT FOR "PROFESSIONAL LIABILITY"

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

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

CONTENTS

This presentation kit contains the following materials:

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

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

PART ONE: (22 minutes)

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

PART TWO: (18 minutes)

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

PART THREE: (16 minutes)

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

SUGGESTIONS ON HOW TO PRESENT "PROFESSIONAL LIABILITY"

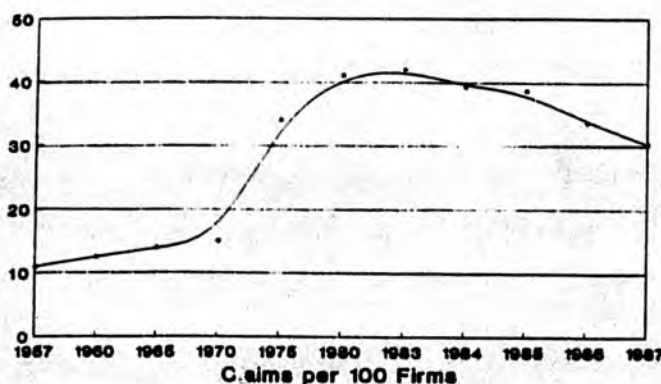
1. To be most effective, the video should be viewed in a group and discussed with the guidance of a moderator. However, if necessary, the tape is straightforward enough to be viewed and reviewed independently using an adaptation of this discussion guide.
2. Because the entire tape runs nearly an hour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

BACKGROUND FOR DISCUSSION MODERATOR

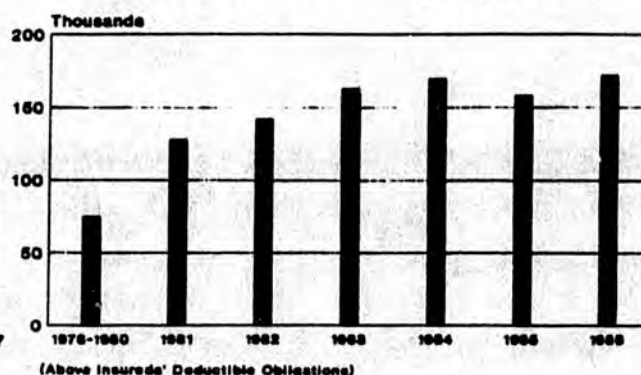
Update on Statistics

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

Frequency of Claims



Average Paid Claim Value
Claims with Indemnity Payments



Current data (5/11/89) indicate:

FREQUENCY OF CLAIMS* PER 100 FIRMS = 30.3%

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

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

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

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

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

UPDATE ON CURRENT MAJOR SOURCES OF PROBLEMS

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

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

DISCUSSION QUESTIONS FOR MODERATOR

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

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

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

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

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

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

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

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

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

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

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

5. What did they do right ?

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

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

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

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

SUMMARY

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

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

REMEMBER: THE BEST DEFENSE IS GOOD PRACTICE.

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

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

"PROFESSIONAL LIABILITY"

Discussion Questions for Videotape

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

D.6

DAVID E. ROGERS

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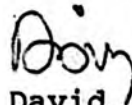
907-586-2366
FAX 907-586-6959

March 19, 1990

Hi.

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

Your friend,


David

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

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

5. CLAIMS EXPERIENCE - Preliminary Findings: *WJ*

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

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

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

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

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

file D.7

Alaska State Legislature



Speaker of the House of Representatives

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

Official Business

Memorandum

TO: Liability Insurance Task Force Members

FROM: Representative Sam Cotten *SC*
Chairman

DATE: April 2, 1990

RE: Task Force

=====

Enclosed are the following:

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

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

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

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

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

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

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

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

MR. ADLER: Thank you.

MR. SAMP: Thank you.

FOCUS - NEGLIGENT TREATMENT

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

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

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

MAC NEIL/LEHRER NEWSHOUR

Wednesday, February 28, 1990

WNET, New York, New York

SHOW #3678

ANCHORS:

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KWAME HOLMAN, NEWS MAKER
(Interview with Defeated Pres. Ortega)

**FOCUS - EXXON - FACING
CHARGES:**

ROBERT ADLER, Environmental Lawyer

**RICHARD SAMP, Washington Legal
Foundation**

**FOCUS - NEGLIGENT
TREATMENT:
(Medical Malpractice Debate)**

**DR. DAVID AXELROD, New York Health
Commissioner**

DR. HARVEY WACHSMAN, Malpractice Lawyer

TRANSCRIPT BY:

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commissioned the Harvard Report today and is one of the leading proponents of the no fault insurance solution. Harvey Wachsman is a physician and practicing lawyer. He is president of the American Board of Professional Liability Attorneys. He's on the faculty of Brooklyn Law School and the University of South Florida College of Medicine.

Dr. Axelrod, what is the surprising finding in your study, the large amount of negligence, or the small amount of claims?

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

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

DR. AXELROD: That is correct.

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

DR. AXELROD: Yes.

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

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

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

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

MR. MAC NEIL: How does that come about?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. MAC NEIL: No fault --

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

the law. That is the most difficult thing for a malpractice lawyer who's capable to prove in any case. No patient will ever be able to prove it by themselves.

MR. MAC NEIL: In other words, this is just giving the doctors immunity because you'll never pay anybody because the doctors will never admit if they review themselves or a committee reviews them, they'll never admit that there was malpractice.

DR. AXELROD: But we've confused two very different things. We've confused physician discipline and deterrence with an equitable system for compensation for medical injury. Both Dr. Wachsman and I would agree that there needs to be a better disciplinary system. I do not believe that there is any data that would suggest that the existing malpractice system represents an effective deterrent. That was one of the elements of the Harvard study and I think that there is, if any presence of deterrence, it's very limited.

MR. MAC NEIL: But his point is that the system you're proposing would represent no deterrence at all.

DR. AXELROD: Oh, no, oh, no, hardly.

MR. MAC NEIL: I mean, he instances no compensation for birth damaged babies under the Virginia's no fault system and the inability of patients in New Zealand under their system to gain any admission of malpractice.

DR. AXELROD: Well, there's, I don't want to get into other systems, because I think that there are complexities about the New Zealand system which has been in place for 15 years that, in fact, has not had an effective deterrent system. The Virginia system has been in place for one year in which there has been any experience, and I don't know that that is an appropriate time frame in which to judge the effectiveness of the program. What I think you have to do is identify the fact that we have not been as good as we think we have been with respect to oversight of physicians. I think that there needs to be a whole new arena in which we evaluate the effectiveness of the oversight of government, the failures of the existing physician peer review process, the failures of the hospital review process, but I think that the most important thing of all that will challenge the effectiveness of any malpractice system, any no fault system even, will be the new information that is emerging. One of the major revolutions that has occurred is the availability of information with respect to outcome, with respect to procedures within institutions, procedures done by physicians. I am firmly convinced that it is the public, it is the advocacy of the public, it is the public requesting information that is going to change the medical practice in the most imaginative way possible.

MR. MAC NEIL: I'm sorry, gentlemen, but that is the end of our time. Thank you both for joining us.

RECAP

MR. LEHRER: Again, the major stories of this Wednesday, Nicaragua's Sandinista government declared a unilateral cease-fire in the war against the contras. On the Newshour, Pres. Ortega said if the contras refuse to disband, he will do what is needed to defend his nation. And after five previous attempts, NASA successfully launched the space shuttle Atlantis. Good night, Robin.

MR. MAC NEIL: Good night, Jim.
That's the Newshour tonight and we will be back tomorrow night. I'm Robert MacNeil. Good night.

PATIENTS, DOCTORS, AND LAWYERS:
MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION
IN NEW YORK

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

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

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

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

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

ACRONYMS

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

PREFACE

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

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

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

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

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

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

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

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

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

EXECUTIVE SUMMARY

Introduction

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

The Study had four principal components:

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

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

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

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

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

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

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

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

The nature of adverse events

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

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

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

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

3. Economic Consequences of Medical Injury

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

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

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

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

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

4. Malpractice Litigation and Deterrence

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

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

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

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

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

Alaska State Legislature

D.8



Speaker of the House of Representatives

Official Business

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

Memorandum

TO: Liability Insurance Task Force

FROM: Rep. Sam Cotten
Chairman

DATE: April 12, 1990

RE: Harvard Study Materials

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

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CORRECTION

**THIS DOCUMENT
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GLOSSARY, continued

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

SUIT - litigation in court

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

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

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

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

ACRONYMS

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

PREFACE

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

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

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

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

Consultants to the project included:

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

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

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

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

Members of the Medical Practice Study office who provided

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

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

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

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

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

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

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

EXECUTIVE SUMMARY

Introduction

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

The Study had four principal components:

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

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

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

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

The following summarizes some of our methods and major findings.

1. The incidence of adverse events

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

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

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

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

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

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

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

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

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

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

Risk factors

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

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