238 HJ FCC MALPRACTICE (INCLUDINGIN HB 574)

HB
574

Alaska House of Representatives

file Malpractice

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HUGH MALONE

27 February 19¯6

The Honorable Mike Bradner
Speaker of the House
Alaska State Legislature

Dear Mr. Speaker:

The House Finance Committee has reviewed Article 3 of CSHB 574. This article provides for the establishment of a revolving loan fund in the Department of Commerce and Economic Development, for the purpose of making loans to the medical insurance corporation established in the bill.

The loans would be made by the Department of Revenue from the General Fund. The loans under the section would be at seven percent interest for a maximum period of four years. The maximum that could be borrowed is $5 million. The loans are secured with corporation pledges.

The Committee examined the impact of Article 3 on the State's General Fund cash flow.

Testimony from the Department of Revenue indicates that whatever the amount of any loan, the effect on the General Fund is the same as an appropriation. The money is gone. The Department suggested an appropriation would be a more straightforward approach. Also, since a negative cash flow is projected for the state for a period before June 30, 1977, the amount loaned out will require increased short-term borrowing by the state ($125 million now projected).

The House Finance Committee recommends the loan fund approach. The reasons are:

1) The amount of the loan would be very small compared with existing loan programs, e.g. the V.A. loan program "runs out" of the general fund approximately $4 million per month.

DATA ARE PLURAL

2) Data from the House Judiciary Committee indicates malpractice insurance claims paid in Alaska average less than $500,000 per year, while premiums run in excess of $1 million. Thus the probability of ever using the maximum loan authorization is very small.

3, A loan is much more likely to be repaid than an appropriation and is much less of a subsidy.

I hope the information is useful to the House.

Sincerely,

Hugh Malone

HM/jb

File Malpractice

Malpractice Advisory

A year ago, the malpractice crisis was officially recognized nationwide. The St. Paul (Minn.) Fire and Marine Insurance Company was threatening to leave Maryland and Argonaut Insurance Company was getting ready to pull out of New York. Premiums were doubling and even tripling not only in states like California and Florida where the numbers of suits were multiplying and the dollar amounts of individual awards and settlements were topping $1 million, but also in states like Indiana and North Carolina where suits and high awards were relatively rare. In Michigan, two long-time carriers, Medical Protective and Shelby Mutual, were refusing to write new policies, although they still would insure old customers. It looked like a grim year ahead.

It was, and the outlook for 1976 is worse. St. Paul did, in fact, pull out of Maryland and Argonaut did withdraw from New York. Not only that, but St. Paul has in the past 12 months left 16 other states and Argonaut has pulled out or attempted to leave all states where it was the major carrier, including California, Florida, Idaho, Massachusetts, and Pennsylvania. (It may stay in Hawaii, where it makes a profit.)

MALPRACTICE: GRIM OUTLOOK FOR '76

No doctor can count any longer on finding policies at stable prices

Dr. Hedges at Juneau boat harbor

Several other major insurers, as of January 1975, such as Employers Insurance of Wausau and Lloyds of London, have either voluntarily dropped completely out of the malpractice insurance business or—like Signal Imperial of Los Angeles—have been forced out because of insolvency. About the only big companies writing new policies in more than a single state as 1976 got under way were St. Paul (only in the 33 states that will allow its controversial claims-made form), Medical Protective, Travelers, Hartford, and Aetna.

The list of states with problems either of availability or of exorbitant rates (anything under $10,000 for the highest risk categories is now viewed by many doctors as "cheap") has grown to include all but a handful—specifically Colorado, Georgia, Nebraska, and Oklahoma. Even in these states physicians are uneasy about their future.

Things have gotten so bad for Alaska's 270 physicians that about 30% of them are practicing without malpractice insurance. Doctors in Orange County in southern California are talking of going without insurance en masse if Travelers raises its premiums several hundred per cent this month, rates that would put orthopedists and neurosurgeons in the class paying $36,239. Other southern California doctors have threatened slowdowns if the situation doesn't improve.

Dr. Gary R. Hedges, a Juneau general surgeon who this year is president of the Alaska State Medical Association, says 13 of his city's 16 physicians—including himself—are practicing without professional liability insurance. The only new policies available, he says, are claims-made forms that, unlike St. Paul's, don't even guarantee "tail-end" policies for doctors who retire or switch plans.

"I'm not worse off without any insurance than I'd be with a policy like that," says Dr.

continued

★ = current laws

MALPRACTICE LAWS IN THE 50 STATES AS OF YEAR'S END

(Entries printed in color denote proposed legislation for 1976)

State	Joint Underwriters Association	Self-insurance Plan	State Insurance Fund	Screening Committee or Arbitration (binding, unbinding)	Limit on Doctor's Liability (X 1,000)	MD-financed Catastrophic Fund	Tort Law Changes	Statute of Limitations (years after incident)	Limit on Lawyers' Fees (%)	Study Commission Established	Insurer Reports Claims to State Insurance Commissioner or Board of Medical Examiners	Major Insurance Carrier	Major Carrier's Rates for Orthopedists ($100,000/$300,000) (boldface denotes claims-made) 1/1/75	(1/1/76)	Legislature Meets	Comment
Alabama	★			★			★	2			★	Employers of Wausau	$1,692	($2,606)	5/4/76	Wausau withdrawing July 1977; ISO proposes rates up to $9,000.
Alaska	★		★	★		★	★	3	★[1]	★	★	Continental	$4,172	($4,172)	1/7/76	About 30% of doctors have no policies; individual premiums up to $40,000.
Arizona	★	★		★	★	★	★	2	N.J.[2]	★	★	Travelers	$3,621	($6,521)	1/13/76	Travelers withdrawing April 1976; Imperial in receivership; no other in sight.
Arkansas	★			★	500	★	★	2	N.J.			St. Paul	$1,686	($2,420)	1/12/76	Medical society hearing of more and larger malpractice suits.
California	★	★		★	★[3]		★	3	N.J.		★	Travelers	$7,200	($36,239)[4]	1/5/76	'Cataclysm' (due to price increases) expected in southern Calif. this month.
Colorado	★	★						2		★		Hartford	$3,122	($3,590)	1/7/76	Legislative thrust is strengthening board of medical examiners.
Connecticut					500		★	3	N.J.	★		Aetna	$5,258	($7,511)[5]	2/4/76	Doctors in droves joining medical society, which has state's only insurance plan.
Delaware	★			★			★	3	N.J.		★	Aetna	$6,297	($11,010)[5]	1/13/76	All of state's seven hospitals may lose coverage at end of year.
Florida	★	★		★	100	★	★	4		★	★	Self-insurance plan	$8,243	($8,243)[6]	4/6/76	Argonaut withdraws Jan. 1; self-insurance plan has 2,500 applicants.
Georgia	★			★			★	3		★		St. Paul	$1,530	($1,760)	1/12/76	Situation is stable.
Hawaii	★	★		★			★	6	N.J.	★	★	Argonaut	$5,616	($6,884)	1/21/76	Argonaut wants to remain in Hawaii, only state it makes a profit in.
Idaho	★	★			150[7]		★[7]					St. Paul	$3,748	($2,054)[8]	1/12/76	State court ruled doctor's $150,000 liability limit unconstitutional.
Illinois	★	★		★[7]	500[7]		★	5	★	★		Hartford	$3,468	($5,084)	1/14/76	State court ruled liability limits and screening panels unconstitutional.
Indiana		★	★	★	100	★	★	2	15[9]	★	★	Medical Protective	$2,903	($3,289)	1/5/76	New law hasn't appreciably changed malpractice picture in Indiana.
Iowa	★			★	100	★	★	6	★[1]	★		Medical Protective	$1,935	($3,400)	1/12/76	Medical society wants to strengthen board of medical examiners.
Kansas	★			★	100	★	★	2	N.J.	★	★	Medical Protective	$1,810	($3,070)	1/13/76	Many individual physicians paying close to or in excess of $10,000.
Kentucky	★				100	★	★	5	N.J.		★	Medical Protective	$1,823	($3,304)	1/6/76	Governor's task force will propose comprehensive package of bills.
Louisiana			★	★	100	★	★	3	50		★	Hartford	$1,568	($5,241)	5/10/76	Society agreed Hartford correct when it cancelled policies of five doctors in 1975.
Maine	★			★	100	★	★			★	★	Hartford	$1,737	($4,754)	2/2/76	New doctors must pay up to twice ISO rates; JUA not activated yet.
Maryland	★	★		★			★	3	★		★	Self-insurance plan	$2,273	($5,038)	1/14/76	Self-insurance plan has sold 2,000 policies (there are 5,000 doctors).
Massachusetts	★	★		★	★		★	3	★	★		JUA	$2,657	($4,102)[10]	1/7/75	St. Paul withdrawing coverage from some 4,000 doctors; JUA new carrier.
Michigan		★	★	★			★	2½	N.J.[11]	★	★	Medical Protective	$5,551	($7,863)	1/14/76	ISO has filed new premium rates up to $34,883 for orthopedists.
Minnesota				★[11]			★				★	St. Paul	$2,196	($2,630)	1/26/76	Medical society wants to strengthen board of medical examiners.
Mississippi	★	★		★			★	2				St. Paul	$924	($916)	1/6/76	USF&G charging up to $8,000, apparently to drive doctors to St. Paul.
Missouri	★	★		★	500		★	2	33⅓	★	★	Medical Protective	$2,200	($3,300)	1/7/76	State-sponsored program with Marine Fire

Montana		★[12]						3		★		Aetna	$7,504	($13,287)[5]	1/3/77	Coverage is available although premiums considered high.
Nebraska		★[12]		★			★			★		St. Paul	$2,586	($3,010)	1/6/76	'As of today, there's no crisis,' according to state medical society.
Nevada	★			★	★		★	4	N.J.	★		JUA	$5,130[13]	($7,675)	1/17/77	As many as 25% of Nevada doctors practicing without insurance.
New Hampshire	★			★			★	2		★		Hartford	$486	($1,693)	1/5/77	'Prognosis' a lot better here than in neighboring states.
New Jersey			★	★	500		★	2	N.J.[11]	★		Chubb & Son	$6,325	($8,165)	1/13/76	Still a voluntary insurance market in New Jersey.
New Mexico	★	★		★	100	★	★	3	N.J.			Travelers	$3,315	($5,781)[14]	1/20/76	Travelers, withdrawing March 1, insures 90% of state's doctors (850).
New York	★	★	★	★[11]	★		★	2	N.J.	★		JUA–self-insurance plan	$14,329	($17,195)[4]	1/7/76	Self-insurance company expects to lower rates; already has 15,000 members.
North Carolina	★[7]	★		★	★	★	★	★				St. Paul	$971	($1,251)	1/12/77	Self-insurance plan has 400 of state's 4,700 doctors as members.
North Dakota		★[12]		★	50[18]	★	★	2	15[16]			St. Paul	$1,819	($898)	1/4/77	Some problems insuring new doctors; companies selective.
Ohio	★			★			★	1	33⅓	★		Medical Protective	$5,148	($5,834)	1/1/76	Doctors disappointed tort reforms did not immediately lower premiums.
Oklahoma					150		★	4	N.J.			Ins. Co. of North America	$1,180	($1,594)	1/6/76	Only INA writing policies, but most doctors can buy insurance.
Oregon		★			★[17]	★	★	5	33⅓	★	★	CNA conglomerate	$3,016	($7,240)	1/10/77	Must renegotiate expiring contract with CNA by end of the year.
Pennsylvania	★			★		★	★	4[15]	N.J.	★	★	Medical Protective	$3,035	($5,957)	1/6/76	With $1-million 'umbrella' coverage, some doctors pay up to $18,000.
Rhode Island	★[11]									★		JUA	$1,209	($5,838)	1/6/76	JUA rates considered exorbitant by doctors, but no other policies available.
South Carolina	★			★	★		★	★		★		JUA	$1,010	($1,716)	1/13/76	St. Paul withdrawing; all doctors must buy policies from JUA.
South Dakota	★	★[12]		★			★	2		★	★	St. Paul	$6,428	($2,087)	1/6/76	Medical society fears exclusive JUA would be 'disaster' if imposed.
Tennessee	★	★		★			★	3	33⅓		★	JUA	$3,129	($12,509)	1/13/76	Shelby Mutual leaving, doctors must buy policies now from the JUA.
Texas	★			★	500		★	2	N.J.	★	★	Medical Protective	$4,065	($6,728)	1/11/77	Houston orthopedists buying basic policy from JUA, plus $1-million excess coverage, pays $26,900.
Utah	★				250		★	4		★		Aetna	$6,186	($10,6[illegible]0)[5]	1/12/76	For 1-year extension, Aetna requires medical society support of new laws.
Vermont				★			★	4	N.J.			Aetna	$4,430	($11,925)[5]	1/6/76	Aetna will pull out if new rates not approved; covers 450 MDs (50%).
Virginia	★	★	★	★	100	★	★	2	15[16]	★	★	St. Paul	$2,728	($3,432)	1/14/76	Availability not a problem, but doctors must pay double for $1 million.
Washington	★			★	300		★	2	N.J.		★	Aetna	$6,356	($10,847)[5]	1/12/76	Will try to get mandatory, binding arbitration next year.
West Virginia	★			★	100	★	★	2	N.J.	★	★	Aetna	$6,575	($10,583)[5]	1/14/76	Aetna only company writing new business in the state.
Wisconsin	★			★	200	★	★	3		★		Medical Protective	$2,433	($3,032)	1/20/76	'Over the hump but still an expensive proposition.' Orthopedists pay up to $11,000.
Wyoming	★	★[12]		★	100	★	★	2	N.J.	★	★	Aetna	$1,899	($7,865)[5]	1/27/76	St. Paul pulled out in June but Aetna picked up most of 120 doctors.

[1]Court decides fees. [2]N.J. denotes so-called New Jersey rule, based on a sliding scale. In New Jersey, it is as follows: 40% on first $5,000, 33⅓% on next $45,000, 20% on next $50,000, 10% of anything over $100,000. [3]$250,000 limit on noneconomic damages (pain and suffering). [4]Provides $1 million/$3 million compared with same coverage by Argonaut on Jan. 1, 1975. [5]Aetna's package plan provides $1.25 million/$1.5 million coverage for orthopedists, plus several other features. [6]Provides $500,000 coverage per claim with no aggregate, compared with $100,000/$300,000 by Argonaut on Jan. 1, 1975. [7]Ruled unconstitutional by lower state court. [8]Provides $150,000/$300,000 compared with $100,000/$300,000 by Argonaut on Jan. 1, 1975. [9]On fees collected from catastrophic fund. [10]Rate hearings in late November may result in increased rates by Jan. 1, 1976. [11]Nonstatutory. [12]Five-state regional self-insurance plan proposed. Of these five states only North Dakota has passed law authorizing self-insurance. [13]Imperial's charge on Jan. 1, 1975 for $1 million/$1 million minimum policy it wrote for Nevada orthopedists before going into receivership. JUA rate is for $100,000/$300,000. [14]Provides $1 million/$1 million package compared with $1 million/$1.3 million by Travelers on Jan. 1, 1975. [15]State currently has six-year statute of limitations. [16]Of awards over $100,000. [17]Class 1 and 2: $100,000; Class 3 and 4: $300,000; Class 5 and 6: $500,000. [18] Limit on insurance company liability only.

Hedges, who decided against paying $8,000 for $300,000 maximum coverage in January of last year. A previous $900,000 suit, initiated during a period when he had coverage, has been dropped and—so far—he has had no other malpractice suits lodged against him. He says he informs his patients of his lack of coverage, telling them it's for their benefit as well as his.

"I would have been forced to raise my fees," says Dr. Hedges. And patients paying the higher fees, he maintains, would have assumed his coverage would be sufficient to help them should injury occur. "This would have been doubly misleading," he explains, "because I'm still not sure I'd have coverage" that is either adequate or perhaps even available in the event a patient sued after the coverage expired.

In California, a group of physicians' wives calling themselves Women for Malpractice Reform staged a sleep-in last month at the Sacramento offices of Gov. Edmund G. Brown Jr. to protest rising malpractice rates and demand an emergency session of the legislature to find an acceptable solution to the problem. Roberta Weintraub, wife of Encino, Calif., proctologist Lewis R. Weintraub, presented Governor Brown with 350,000 petitions signed by patients. She declared that 45% of the state's physicians would stop practice if he failed to act.

Early returns indicated that the threatened "slowdown" of southern California doctors would not be effective. Leon Hauck, director of association services of the Hospital Council of Southern California, said only "a few guys" in about ten of southern California's 230 hospitals had taken any action. The job action was predicted to become more widespread once rates increased at the beginning of the year, however.

How bad is the problem nationwide? A 50-state survey by MWN reveals deterioration in almost every state, even in some of those that passed comprehensive malpractice legislation during 1975. Among the states deserted by St. Paul, for example, are two besides Maryland where it was the major carrier with at least 50% of the business—Massachusetts and South Carolina. The firm quit another—Rhode Island—where it had close to half the market. St. Paul was the second largest carrier in Indiana and New Jersey, which have been similarly abandoned.

And premiums indeed have increased. Rates filed by the Insurance Services Organization (ISO) for its member companies have raised the malpractice insurance cost for orthopedists and other high-risk specialists buying $1-million policies (where they can get them) to as much as $10,000 and more in previously "low cost" states like Alabama, Hawaii, Kansas, and Montana. In "expensive" states like California and Michigan, many of the same high-risk specialists pay more than $30,000 for the same policies—again, when they can find them.

Physicians in a few states have experienced little trouble yet with either availability or price of medical malpractice policies. But medical society officials in these states express concern for the future. "We're not at the crisis stage," a Colorado Medical Society spokesman told MWN, "we're at the problem stage." Said an Oklahoma State Medical Association official: "We're doing well, but we're being affected by the national situation." His major concern, he added, was that only one company—Insurance Company of North America—writes malpractice policies in Oklahoma. If it ever decided to pull out, he added, Oklahoma doctors would be in the same pickle as those in dozens of other states.

Last year, some 22 states trying to seize the bull by the horns passed—among other "malpractice" bills—legislation creating Joint Underwriters Associations (JUAs) that would sell malpractice insurance to doctors as a last resort when no other market existed. In fact, JUAs are the only source of malpractice coverage currently in four states—Nevada, Rhode Island, South Carolina, and Tennessee—and compete only with doctors' self-insurance plans in two others, New York and Florida.

Yet even where they are the only game in town, JUAs have been criticized by doctors, primarily for their high rates compared with those the doctors were used to. In Rhode Island, where physicians have had to pay more than quadruple what they previously had been paying, the state's nonstatutory JUA is highly unpopular. The medical society's executive director, Timothy B. Norbeck, told MWN that physicians felt the "rates were exorbitant." He pointed out, however, that high as they were, the JUA rates in Rhode Island were really comparable to those in other northeastern states (see table, pages 72 and 73). Part of the reason for the high rates, he said, was the JUA's requirement for a "stabilization fund" that added about 25% to the first year's basic premiums.

High price, however, is not the only flaw with JUAs. Most of the ones now in operation limit coverage to between $100,000 and $200,000 per claim and from $300,000 to $600,000 aggregate per year, leaving many doctors feeling dangerously exposed. But where nothing else is available, physicians—like beggars—have little choice.

Another problem with JUAs: Where they are authorized, teetering malpractice carriers sometimes use the fact as an excuse to pull out. This apparently was the case in both South Carolina and Massachusetts when St. Paul decided to withdraw, knowing criticism of its departure would be dampened by the existence of an alternative source of malpractice insurance. St. Paul was roundly condemned in Maryland when it threatened to pull out of that state early last year, ultimately delaying its departure several times until another source could be established (the medical society's self-insurance plan). Similarly, Argonaut found itself cast as a villain when it dumped thousands of physicians in New York, California, Florida, and Pennsylvania early last year. (After court suits, it stayed on for a time in those states.)

Another fear of many state medical society officials is that few of the remaining commercial malpractice insurers will return to states that have actually established JUAs—usually for only a two-year period—as an "exclusive market" for professional liability insurance, as have Rhode Island, South Carolina, and Tennessee. This fear prompted Robert D. Johnson, executive secretary of the South Dakota State Medical Association, to oppose crea-

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tion of a JUA in his state. "It could be disastrous to getting private carriers back," he told MWN.

The kind of legislation that state assemblies pass is greatly influenced by what the few remaining malpractice insurers are likely to think of it, whatever its other value in affecting the over-all malpractice situation. The landmark Indiana malpractice law was put together by the state medical society with the help of the state's two major malpractice carriers, St. Paul and Medical Protective. When St. Paul pulled out of the state anyway (after the insurance commissioner turned down its request for permission to sell the claims-made form), the medical society officials were understandably bitter.

In California, assembly speaker Leo T. McCarthy pointed out that before the state's comprehensive malpractice legislation was passed insurance companies had refused to promise how much their premiums would be reduced if specific reforms that the companies had sought were approved by the legislature. This led to a comment from one insurance industry official that "this is the sort of legislator who makes it difficult for insurers to endorse specific tort reform." What the industry wanted, apparently, was less than a *quid pro quo.*

Despite the unequal relationship, medical societies still seek "advice" from insurance companies on malpractice legislation they put together. In a few cases, the insurance firms flatly give medical societies a choice: Push for specific tort reforms (with no promises on rates or availability) or look for another carrier. Aetna, which insures up to 85% of the 1,400 doctors in Utah, told the Utah State Medical Association that its extension of the firm's package plan into 1977 was "contingent on two things," according to Hoyt W. Brewster, the medical society's executive director. "First, we had to pursue programs of physician education. And, second, we had to pursue legislative relief in terms of tort reform." With only 20 days during the short 1976 session to get any legislation through, he told MWN, he is not sure how many of the tort reforms the medical society can persuade the Utah assembly to adopt.

Feeling oppressed both by insurance company dictums and by hasty legislative solutions like JUAs, medical societies in at least ten states either have set up their own self-insurance programs or have received the authority to do so. Of these, self-insurance plans in California, Florida, Maryland, Michigan, New York, and North Carolina have already started selling policies or are building up the necessary capitalization to do so. In Florida, where 2,500 applications have been received to date, rates are the same as those Argonaut charged early last year. Not only that, the plan provides $500,000 coverage per claim—with an unlimited aggregate per year—for the price that Argonaut demanded for $100,000/$300,000 coverage.

In New York, there are already between 15,000 and 16,000 members in the self-insurance plan, which began by charging 20% over Argonaut's fee, then reduced that to 15% when reserves of $26 million were accumulated. The New York self-insurance plan now promises to reduce charges to 10% if—as expected—it builds up $30 million in reserves. In Maryland, on the other hand, even though 2,000 of the state's 5,000 physicians have already signed up with the self-insurance plan, premiums are still more than double what St. Paul was charging early last year.

Perhaps it is significant that in both Florida and New York there is active competition with the medical society's plan; in Maryland, self-insurance is all that is available.

At meeting in Governor Brown's Sacramento offices, Mrs. Weintraub (left, center) of Women for Malpractice Reform presents petitions for special session to deal with soaring rates. Below, Drs. Zorel Paritzky (left) and Stanley Daniels, who has no insurance, carry in half of 350,000 petitions.

Florida's JUA charges 2½ to three times what the self-insurance plan does. In New York, there is, in addition to the self-insurance plan, both a JUA and a state-run insurance fund that seek to sell malpractice policies to doctors. When they all started up at roughly the same time last summer, the three schemes were in hot competition. Recently, New York superintendent of insurance Thomas A. Harnett turned down the JUA's request for rate increases, forcing it to stay roughly at the same premium level as the self-insurance plan.

In Michigan, a similar state insurance fund was put into effect somewhat before the medical society's self-insurance plan got under way. In that case, another group of doctors was involved—the Michigan Physicians Crisis Committee. The organization was formed several years ago to push through the state's comprehensive malpractice law package and has not yet disbanded, somewhat to the consternation of the state medical society. The crisis committee has backed the state fund over the medical society's plan as providing more insurance coverage ($200,000/$600,000 compared with $100,000/$300,000) and criticized the medical society for trying to "cherry pick" the low-risk physicians.

In two areas of the country where individual states have too few physicians to seriously consider a medical society self-insurance plan, groups of states have looked into the possibility of establishing regional self-insurance plans. Nevada sponsored a meeting in Las Vegas recently, inviting all the smaller states of the Far West to discuss one self-insurance plan for all of them. Nebraska similarly sponsored a regional self-insurance plan for five Upper Plains states: Rep. Mary Edelen of South Dakota drafted a joint resolution for presentation to the legislative sessions in Nebraska, Wyoming, Montana, and the Dakotas this year.

Patients' plight is voiced by Gerri Weiss (left) and Janice Oliver whose California OBs, they say, won't deliver without insurance.

And in New England, according to Vermont State Medical Society executive director Getty Page, a third group of smaller states has looked into a similar arrangement, possibly hooking onto the self-insurance plan Massachusetts hopes to set up independently in the next year or so. "I pleaded with Massachusetts to let us come in with them," Page said, "but we'd have to have the same malpractice laws." To that end, the Vermont State Medical Society is introducing a comprehensive package of legislation this year (see table, pages 72 and 73).

The most popular legislative proposals likely to be introduced this year are reforms in the states' tort laws, such as elimination of *res ipsa loquitur*, which puts the burden of proof concerning lack of negligence on the doctor; prohibition of *ad damnum* pleas, which publicize multimillion-dollar lawsuits; institution of a collateral source rule to require deduction of health insurance and other reimbursements from any ultimate judgment; adoption of a local-witness rule that forbids the use of itinerant "experts"; and—most popular of all—setting short (usually two-year) statutes of limitations that begin running from date of injury rather than from date of discovery.

Every state but Colorado and Montana either has already passed more than one of these reforms or will seek to do so when assemblies reconvene. In Colorado, according to a medical society spokesman, the legislative thrust this year will to strengthen the board of medical examiners and tighten up the statute of limitations. In Montana, medical society executive director G. Brian Zins said: "We're studying what other states have done."

Not very surprising is the fact that many of the states in the most trouble intend to be the most active legislatively next year. (Colorado and Montana are in relatively good shape.) One state that has been in trouble all year is Alaska, where doctors at the state's largest hospital—Providence Hospital in Anchorage—refused to perform nonemergency surgery for almost two months when their insurance policies ran out this summer, referring many of their patients to Seattle for operations. The hospital's parent corporation, the Sisters of Providence, found them temporary insurance on September 22.

In response to such situations, the Alaska medical society has sponsored a comprehensive package of laws including creation of both a JUA and a state insurance fund, a constitutional amendment to take physicians' professional liability out of the court system (substituting arbitration), a limit of three years on physicians' liability, and elimination of awards for such noneconomic damages as "loss of consortium" and "pain and suffering." Alaska has already eliminated *res ipsa loquitur*; in fact, it led other states by several years in doing so. But the medical society's efforts last year to put through additional reforms were frustrated. Governor Jay S. Hammond refused to call a special session to deal with the package of new laws that insurance companies were unenthusiastic about and vetoed the only malpractice bill the assembly did manage to pass in 1975—one creating a JUA.

continued

Physicians complain that 'tort reform' brings no relief

Another state in serious trouble—New Mexico, where the major carrier, Travelers (which writes about 99% of the state's malpractice policies), has announced it will pull out on March 1—is also seeking to get a comprehensive package of laws through the legislature this year. A medical society spokesman said in the 30 days, starting January 20, when the state legislature is in session, doctors will attempt to get laws passed both establishing a JUA and authorizing doctors' self-insurance, an Indiana-type law with screening panels, $100,000 limits on physician liability, and a doctor-funded patient catastrophic fund for awards over that amount up to $500,000. In addition, they will seek passage of various tort law changes, including a maximum nine-year statute of limitations for minors (it is currently three years for adults) and a sliding scale of lawyers' contingency fees similar to that in New Jersey.

Many physicians in states that have already passed comprehensive medical malpractice laws, however, are beginning to grumble that nothing seems to have changed—despite their legislative success. "Doctors are disappointed that tort reform didn't result in immediate premium relief," said Ohio State Medical Association executive director Hart F. Page. "I tell them it's like expecting a fever to go down five minutes after giving a patient penicillin."

Still, Page is obviously worried about the law's ultimate effect on the things that count with doctors—availability and price of malpractice insurance. Last year Ohio passed laws that made a provider liable contractually only for written promises, clarified the meaning of "informed consent," and set lawyers' contingency fees at 33⅓%. In addition, the legislature established voluntary binding arbitration, a JUA, and the requirement that malpractice suits be reviewed by the state's medical licensing board. Ohio also has a one-year statute of limitations, about the shortest in the nation.

Even in Indiana, there has been "no appreciable change" in the number or amounts of malpractice suits in the state since July 1, the day the Indiana law went into effect, according to Robert Miller, a vice president of Medical Protective in Fort Wayne, Ind., which now insures about 60% of the state's physicians and probably will pick up most of St. Paul's customers (another 28%) as that firm drops them when policies come up for renewal. The situation in "areas where there was a trend toward high claims continues to deteriorate," Miller said.

The Malpractice Study Commission established by law in Indiana has held several meetings but has not yet proposed further changes in the state's professional liability laws. A medical society spokesman said serious consideration is being given to starting up the self-insurance plan authorized under the 1975 law. And the state insurance commissioner reportedly is reconsidering his opposition to the claims-made policy. It was this opposition that St. Paul says drove it out of the Indiana malpractice insurance market.

Indiana State Medical Association officials, like those in California, Florida, Louisiana, Oregon, and Wisconsin, are anxiously awaiting court judgments on the constitutionality of their "caps" on doctors' liability, which range from maximums of $100,000 to $500,000. Lower courts in two states so far—Idaho and Illinois—have ruled such statutory limits on physician liability to be unconstitutional. In addition, an Illinois circuit court judge recently ruled that the medical review board set up by that state's new malpractice law is unconstitutional. Likewise, a North Carolina superior court judge has ruled unconstitutional his state's reinsurance exchange—a special form of JUA that requires every firm writing property and casualty insurance in North Carolina also to offer physicians' professional liability coverage.

Until the constitutional question of "caps" on doctor liability is settled one way or another, a number of medical societies will not propose liability limits for their 1976 malpractice legislation. In Michigan, for example, a "cap" on doctors' liability was noticeably absent from the medical society's comprehensive package of malpractice legislation—most of which passed the state assembly. Nor will there be such a proposal this year, a medical society spokesman said. "We're waiting to see what's going to happen in Idaho before we try for that," he said. The Idaho Medical Association will appeal to the state's supreme court in an attempt to re-establish its $50,000 limit, according to its new executive director, Don Sower.

The dearth of spectacular improvements in the malpractice situations of states like Indiana and Idaho raises the specter that nothing they can do—nothing at all—can reverse the calamitous situation spreading across the country like a disease. (A spokesman for the California Medical Association describes the prospects for southern California early this year as being "in the nature of a cataclysm.")

Waiting in the wings is the federal government—specifically Sen. Edward M. Kennedy (D-Mass.) with a pocket full of "national" solutions (MWN, May 5, '75, p. 23)—when states try and fail to solve the malpractice crisis themselves. But many physicians consider Senator Kennedy's cures—which would lock them into the PSRO system, among other things—worse than the disease itself. So far, the Ford Administration has held to its original position that the states must first be given the chance to solve their own malpractice problems. In this same spirit, a uniform medical malpractice act is now being put together for all state governments by the National Conference of Commissioners on Uniform State Laws, located in Chicago. But time is clearly running out.

The question remains: If the most comprehensive state laws ultimately fail to have an impact on the availability and price of physicians' professional liability insurance, what good will any kind of state law do, uniform or otherwise? What, then, would be the alternative to one of Senator Kennedy's proposals?

—REGINALD W. RHEIN JR.

file Malpractice

REMARKS BY
ROBERT A. BAILEY
ACTUARY FOR THE CENTRAL OFFICE STAFF
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

RECEIVED

BEFORE THE
LEADERSHIP CONFERENCE OF THE
AMERICAN MEDICAL ASSOCIATION

Chicago, Illinois
January 24, 1976

I appear before you today as th Casualty Actuary for the National Association of Insurance Commissioners. The National Association of Insurance Commissioners (frequently called the NAIC) was organized in 1871. Its membership consists of the chief insurance regulatory authorities of the 54 states and jurisdictions of the United States. As such it is the oldest voluntary association of state officials. I am the director of its statistical program and the individual in charge of the current NAIC malpractice closed claim statistical study.

Today I will describe the statistical programs being conducted by the NAIC to obtain data concerning the medical malpractice problem, and then I will summarize some of the conclusions obtained from the data compiled so far. The views I express here are my own and do not necessarily represent those of the NAIC.

At the NAIC we are familiar with the legislative medical malpractice reforms sponsored by the AMA which were distributed to you shortly after your meeting here a year ago. We have

been keeping track of all the legislation enacted this year in the various states. It is an impressive record and includes a good number of your proposals in various forms. According to our count, 42 states have enacted legislation during 1975 dealing with medical malpractice. 32 of these states have enacted legislation dealing with the immediate problem of assuring availability of medical malpractice insurance. 33 have enacted legislation aimed at reforming the legal system both substantive and procedural. 32 have enacted legislation which focuses on the health care delivery system. And 32 have authorized further studies of the malpractice problem. This reflects unusually widespread legislative concern and activity. The NAIC and others are publishing periodic summaries of the legislation as it is enacted.

As far as we know, much of the heat generated by the medical malpractice controversy centers on medical malpractice insurance and its cost. Actually, however, such insurance - important though it may be - is really the tail end of the kite. The issue had its origin in legal and medical aspects far beyond the control of the insurance business and those of us who regulate it. Furthermore, many of the difficulties have their genesis in inflation, the magnitude of which is largely influenced by national policy. This is an unbelievably complex subject with boundless ramifications. We see no easy

solution to it. The NAIC has made a pioneering contribution to the search for a solution by making available statistics which have been heretofore lacking. But the statistics have not yet pointed the way to a simple overall solution; on the contrary, they simply emphasize how difficult it will be to find one.

The NAIC is obtaining a report on each insurance claim for medical malpractice that is closed on or after last July 1. We expect to continue this program for at least one year. This study is intended to develop data on the costs and causes of medical malpractice claims which can be used to evaluate legislation already enacted, design new remedial legislation and develop programs aimed at preventing medical injuries. This program is under the immediate direction of the NAIC Subcommittee on Professional Liability Insurance, chaired by Commissioner Rawls of Oregon. We plan to publish four summaries of this data during the year of which the first was published last month. These four summaries are available on a subscription basis. I will discuss some of the data in that summary in a moment.

The NAIC has also initiated another statistical program to obtain data on medical malpractice insurance in the annual and quarterly financial statements of insurance companies. This data will show who is writing malpractice insurance

in each state, how much they are writing and what their profits or losses are in each state. It will show trends in how many claims are occurring and trends in how much each claim costs. Much of this data will be available separately for physicians, hospitals and other miscellaneous categories. This data will begin to become available this year as the annual and quarterly financial statements are filed. It will be summarized in various NAIC publications during the year.

Now let us take a look at some of the data we already have to see what answers it has for our problems. It is evident from this first summary of some 4000 closed claims that there are no easy answers. The data shows that the problem is every bit as complex as we suspected and just as serious as we all knew it was.

We have several reports on how long it takes for a claim to be reported after the incident occurs and then, after it is reported, how long it takes to be settled. It takes an average of about one year for claims to be reported, a little longer for serious claims. This average varies some from state to state. About 86% of the claims are reported within two years, and about 98% within four years. Although shortening the statute of limitations may not have a significant effect on the number of claims reported, it may speed up the reporting in some instances. This may help the insurance companies price the insurance with less uncertainty.

After a claim is reported it takes an average of about two years to settle. This varies by state and by size of claim. Claims still unsettled five years after the date of incident involve 10% of the claims by count and 21% by amount. This long delay from incident to settlement, which averages about three years, makes this kind of insurance one of the most difficult to price accurately in advance. This is a guessing game. So many insurance companies have been burned so badly that many have abandoned the field. Recently prices have risen so rapidly there is the possibility that insurers have overreacted. But no one will know for sure until four or five years from now and by then it will be too late to do anything about it.

In response to the high prices and lack of an adequate market for malpractice insurance, many state medical and hospital associations have formed their own insurance company. Having your own insurance company will enable you to reflect your own costs more directly in the price of your own insurance for better or for worse, whichever it turns out. But it is interesting to note that many of the "Doctors Mutuals" do not want to accept all applicants. This, in effect, says to the public that the medical profession wants to allow some physicians to continue practicing that the profession's own insurers are not willing to insure. In turn, this suggests

that some type of review mechanism as to the quality of care rendered be tied into a mutual insurance program where all physicians that pass the review system would be eligible for the insurance program. Those not eligible for insurance would be barred from practicing. In any event, this is food for thought.

The data shows that 86% of the amounts paid are related to claims where the incident occurred in a hospital but only 32% of the amounts paid are paid by hospitals. This, of course, reflects the fact that most of the physicians who practice in a hospital are not employees of the hospital. As a result most of the claims are paid by the physicians. This data indicates that the Virginia proposal of making hospitals responsible for all incidents occurring in the hospital would shift a substantial portion of the cost from physicians to hospitals and at the same time would place the responsibility for a high proportion of all malpractice incidents in the hands of a third party, the hospital, who has some degree of control over who practices in the hospital and how they practice as well as some control over the safety engineering programs in the hospital, where most injuries occur. Such a proposal may create a substantial financial incentive for the hospital to perform an effective review function regarding those who practice in the hospital.

The summary of claims by specialty of physician shows that orthopedists, obstetricians, gynecologists, cardiologists, plastic surgeons and anesthesiologists generate a relatively high volume of claims. But it also shows that the two categories of physicians that generate the largest number of claims, although a relatively lower frequency per physician, are physicians who perform no surgery and physicians who perform only minor surgery. It is evident that all physicians are exposed to the risk of a collectible malpractice claim. The malpractice problem is not confined to a few small types of practice.

There are about twice as many claims against self employed physicians as against those who are members of a professional corporation or partnership. You can probably judge better than I whether this is close to the comparable proportions of physicians in solo and group practice.

The number of claims against physicians who are board certified are about 1 1/2 times the number against physicians who are not board certified. Inasmuch as the number of physicians who are board certified is only about 1 1/4 times the number who are not, it appears that board certified physicians have a slightly higher claim frequency. This probably reflects a more specialized practice and a greater

number of high risk procedures by board certified physicians. In future reports we plan to analyze board certification according to each specialty.

The summary of claims by country of professional education shows that 12% of the claims are against physicians who received their education in a foreign country. The percentage of physicians with a foreign education is considerably greater than their percentage of claims indicating that physicians with a foreign education have a considerably lower claim frequency. Physicians trained in the Philippines had 2% of the claims. Cuba and India each had 1%. Every other country was less than 1/2 of 1%, including Canada, Mexico and England.

The first report contained approximately 1000 claims for which the following items were coded, using the H-ICDA codes: (1) the diagnosis for which treatment was sought, (2) the procedure that caused the injury, and (3) the injury.

The 992 claims for which the diagnosis was coded were scattered over 461 different diagnoses. Even the most frequent diagnosis, delivery, had only about 4% of the claims. There were only 12 diagnoses that had 10 or more of the claims:

38 Delivery without complication

22 Voluntary sterilization

18 Radiologic examination

17 Fracture of upper end of femur

10 Malignant neoplasm of bronchus and lung

10 Malignant neoplasm of breast

14 Acute myocardial infarction

12 Acute appendicitis without peritonitis

13 Acute appendicitis with peritonitis

10 Fracture of tibia and fibula

13 Single, term, hospital birth

12 Family planning for contraception

The 789 claims for which the procedure causing the injury was coded were scattered over 312 different procedures. The most frequent procedure, hysterectomy, had about 4% of the claims. There were only 15 procedures which had 10 or more claims:

13 Operations on spinal cord structures

14 Appendectomy

22 Laparotomy

32 Abdominal hysterectomy, total

11 Dilation and curettage of uterus

19 Cesarean section

19 Reduction of fracture and dislocation

11 Excision of intervertebral disc

13 Inhalation therapy

26 Transfusion of blood and blood components

13 Cast immobilization

17 Administration of anesthetic gas

15 Administration of unspecified drugs

15 Injection of systemic drug

23 Emergency room visit

The 1172 claims for which the principal injury was coded were scattered over 734 different injuries, only six of which, other than nonspecific codes indicating a diagnostic error, had 10 or more claims. The most frequent injury, accidental puncture or laceration,generated about 3% of the claims.

14 Serum hepatitis

22 Cardiac arrest

25 Laceration of face

37 Accidental puncture or laceration

32 Anaphylactic shock

21 Other serum reaction

I have gone into all of this detail regarding the diagnoses, procedures and injuries involved with malpractice claims to show that the problem is widespread and is not isolated anywhere. It appears to involve the entire spectrum of medical care. This in turn suggests we cannot expect to find some panacea for the malpractice problem.

The average amount of indemnity paid per closed claim, counting each defendant separately, was $6672. If the claims closed without payment are excluded, the average per paid

claim was $17,722. If each injury is counted only once regardless of the number of defendants, the average per paid injury was about $20,000. That was for claims closed in 1975 which were incurred, on the average, about three years earlier. The cost of claims occurring now in 1976, which will be paid, on the average, several years in the future, will undoubtedly be much greater.

The cost of a claim varies, of course, according to the severity of the injury. Our summary of closed claims indicates that injuries classified as "permanent minor" had a cost about equal to the overall average. "Permanent significant" claims cost about twice the average, "permanent major" and "permanent grave" cost about seven times the average. "Death" cases cost about 60% more than the average.

Of the claims for which sufficient information was available to ascertain the type of misadventure involved, actual or alleged, 66% involved misadventures in procedures and 34% involved misadventures in diagnosis. 16% involved misadventures in procedures where the procedure was not adequately indicated, was contra indicated, or there was a better alternative. Most of the misadventures in diagnosis were delay in diagnosis or misdiagnosis of an abnormal condition.

I have attempted to summarize for you the data the NAIC is gathering to help us understand the nature of the medical malpractice problem. Data will continue to be compiled to help us measure the effects of the remedial measures that are adopted. Our current problems are serious and may get worse in the short term. But I am confident that our continued search for better solutions for this complex problem will enable us to deal with it in a manner most satisfactory to all concerned.

1975

STATE LEGISLATIVE ACTIVITY

MEDICAL MALPRACTICE

CATEGORY OF LEGISLATION	NUMBER OF STATES
ALL TYPES OF LEGISLATION	42
AVAILABILITY OF INSURANCE	30
REFORM LEGAL SYSTEM	33
REFORM HEALTH CARE DELIVERY SYSTEM	32
AUTHORIZED FURTHER STUDIES	32

CLAIMS REPORTED

WITHIN 2 YEARS	86%
WITHIN 4 YEARS	98%
AVERAGE TIME	1 YEAR

CLAIMS SETTLED

AVERAGE TIME	2 YEARS FROM REPORT 3 YEARS FROM INCIDENT

CLAIMS UNSETTLED AFTER 5 YEARS

BY COUNT	10%
BY AMOUNT	21%

AMOUNTS PAID

INCIDENT OCCURRING IN HOSPITAL	86%
PAID BY HOSPITALS	32%

COUNTRY OF PROFESSIONAL EDUCATION

U.S.A.	88%
FOREIGN	12%

PHILIPPINES	2%
CUBA	1%
INDIA	1%

DIAGNOSIS FOR WHICH
TREATMENT WAS SOUGHT

CATEGORY OF DIAGNOSIS	NUMBER OF CLAIMS
ALL (461 DIFFERENT DIAGNOSES)	992
DELIVERY WITHOUT COMPLICATION	38
VOLUNTARY STERILIZATION	22
RADIOLOGIC EXAMINATION	18
FRACTURE OF UPPER END OF FEMUR	17
MALIGNANT NEOPLASM OF BRONCHUS AND LUNG	10
MALIGNANT NEOPLASM OF BREAST	10
ACUTE MYOCARDIAL INFARCTION	14
ACUTE APPENDICITIS WITHOUT PERITONITIS	12
ACUTE APPENDICITIS WITH PERITONITIS	13
FRACTURE OF TIBIA AND FIBULA	10
SINGLE, TERM, HOSPITAL BIRTH	13
FAMILY PLANNING FOR CONTRACEPTION	12

PROCEDURE CAUSING THE INJURY

CATEGORY OF PROCEDURES	NUMBER OF CLAIMS
ALL (312 DIFFERENT PROCEDURES)	789
OPERATIONS ON SPINAL CORD STRUCTURES	13
APPENDECTOMY	14
LAPAROTOMY	22
ABDOMINAL HYSTERECTOMY, TOTAL	32
DILATION AND CURETTAGE OF UTERUS	11
CESAREAN SECTION	19
REDUCTION OF FRACTURE AND DISLOCATION	19
EXCISION OF INTERVERTEBRAL DISC	11
INHALATION THERAPY	13
TRANSFUSION OF BLOOD AND BLOOD COMPONENTS	26
CAST IMMOBILIZATION	13
ADMINISTRATION OF ANESTHETIC GAS	17
ADMINISTRATION OF UNSPECIFIED DRUGS	15
INJECTION OF SYSTEMIC DRUG	15
EMERGENCY ROOM VISIT	23

ACTUAL AND ALLEGED INJURIES
CAUSED BY MALPRACTICE

CATEGORY OF INJURIES	NUMBER OF CLAIMS
ALL (734 DIFFERENT CATEGORIES)	1172
SERUM HEPATITIS	14
CARDIAC ARREST	22
LACERATION OF FACE	25
ACCIDENTAL PUNCTURE OR LACERATION	37
ANAPHYLACTIC SHOCK	32
OTHER SERUM REACTION	21

AVERAGE AMOUNT OF INDEMNITY

PER CLAIM	$ 6,672
PER PAID CLAIM	$17,722
PER PAID INJURY	$20,000, APPROXIMATELY

SEVERITY OF INJURY	PERCENT OF CLAIMS	PERCENTAGE OF AVERAGE AMOUNT
EMOTIONAL ONLY	10%	8%
TEMPORARY INSIGNIFICANT	12%	10%
TEMPORARY MINOR	29%	29%
TEMPORARY MAJOR	10%	81%
PERMANENT MINOR	10%	101%
PERMANENT SIGNIFICANT	5%	226%
PERMANENT MAJOR	3%	683%
PERMANENT GRAVE	2%	784%
DEATH	19%	163%
ALL	100%	100%

MISADVENTURES IN PROCEDURES	PERCENTAGE OF CLAIMS
NOT ADEQUATELY INDICATED	8%
CONTRA INDICATED	4%
BETTER ALTERNATIVE	4%
DELAYED	6%
IMPROPERLY PERFORMED	39%
NOT PERFORMED	5%
	66%

MISADVENTURES IN DIAGNOSIS	PERCENTAGE OF CLAIMS
DELAY	13%
MISDIAGNOSIS OF ABNORMAL CONDITION	16%
NO ABNORMAL CONDITION	5%
	34%

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99801

M E M O R A N D U M — December 8, 1975

SUBJECT: Governor's Medical Malpractice Commission Proposed Legislation

TO: Rep. Mike Beirne

FROM: Anne Carpeneti

Here follows a summary and critique of the bills proposed by the Governor's Commission.

SUMMARY OF BILL A

* Section 1. Requires the Division of Occupational Licensing to provide investigative staff for health care licensing boards.
-Sec. 13.

* Sec. 2/ Requires that active, licensed chiropractors, dental hygienists, dentists, physicians, nurses, dispensing opticians, optometrists, pharmacists, physical therapists, and psychologists be insured by the Health Care Provider's Indemnity Corporation or another insurer for at least $200,000 per occurrence and $600,000 aggregate per year; allows the licensing board for these health care providers to limit the practice, censure, or require continuing education for licensees.

* Sec. 14. Statement of purpose.

* Sec. 15. Section 15 provides expert advisory panels for malpractice causes of action. Each panel consists of three licensed health care providers in the state. If the sole defendant is a physician, the panel consists of three physicians; other defendants have representatives in their field or specialty on the panel. The selection process for the panel is somewhat similar to the selection of a jury. The panel may compel attendance of witnesses, may compel delivery of medical records, and may examine parties orally and physically. The panel must submit a report to the court within 30 days of being appointed which answers, where possible, questions submitted to it by the parties in addition to the following questions:

(1) Was the claimant adversely affected by the medical services? If so, how?

(2) What was the adverse affect?

(3) What is the prognosis?

(4) How did the medical services alter the natural course of the pre-existing disorder for which the services were originally rendered?

(5) How did the medical condition existing after performance of the medical services differ from the medical condition which might otherwise have been expected?

If the answers to the above questions are not properly the subject of expert opinion, the panel will so state. The report shall also include a record of all evidence considered by the panel. Dissenting reports may be submitted by panel members. No discovery may be taken until the report is complete, absent special circumstances. The report is admissible in the trial of the cause of action, subject to the court's discretion in excluding evidence. The report may be refuted by additional expert testimony, and members of the panel may be cross-examined. Panel members receive travel and per diem from the state.

* Sec. 16. Changes the burden of proof in medical malpractice cases to that of due care under the circumstances in the defendant's field, instead of in the community where the defendant practices, and provides that in cases filed three or more years after the act complained of, the plaintiff must prove negligence by clear and convincing evidence. (The present burden is that of showing negligence by a preponderance of the evidence in all cases.)

* Sec. 17. Provides that damages awarded to the plaintiff in all cases filed three years or more after the cause arose be paid out of the Health Care Providers Late Claims Fund (hereafter Late Claims Fund), which has no right of subrogation against the defendant; provides that the verdict be made according to the category of loss and that future losses be paid periodically rather than in a lump sum; and that damages may not be made for expenses already paid for by collateral sources unless the source is a federal program requiring subrogation.

* Sec. 18. A housekeeping section.

* Sec. 19. Provides that no cause of action against a provider may be based on an oral promise of cure; that a health care provider is not liable for failure to obtain consent of the patient for a procedure unless the plaintiff proves that a reasonable

person would not have consented to the procedure if informed and that the case involved non-emergency or diagnostic procedures; and provides defenses to an otherwise valid claim based on informed consent, for example, if the physician believed that disclosure would adversely affect the patient's condition.

* Sec. 20. Extends the "good samaritan rule" to hospital emergency situations.

* Sec. 21. Requires every licensed hospital to be insured against malpractice by the Indemnity Corporation for at least $200,000 per occurrence and $1,000,000 per year aggregate for every 50 beds.

* Sec. 22. Establishes guidelines for treatment of information presented to review organizations in hospitals; for example, limits liability for defamation of persons furnishing information to review organizations and members and staff of the review organizations to cases involving known falsehood or malice.

* Sec. 23. Section 23 adds a new chapter to Title 21 which creates an Indemnity Corporation, a backup Joint Underwriting Association (JUA), and a Late Claims Fund.

The Indemnity Corporation acts through a board of governors appointed by the governor and consisting of representatives of professional organizations and the insurance field; board members serve three year terms. The board prepares a corporation plan of operation, subject to the approval of the director of insurance, for provision of fair and reasonable malpractice insurance for health care providers in the state. The corporation would have the power to issue policies of insurance, collect premiums, procure reinsurance, hire employees, and perform other functions necessary to operation. A premium tax of 1-1/2 per cent of the total direct premiums collected is levied on the corporation. The corporation is required to insure all licensed providers who pay premiums.

A backup JUA is provided in case the corporation is unable to obtain reasonable insurance for providers in the state. Disability, property, and casualty insurers in the state would be required to participate as a condition of doing business in the state. The JUA would be governed by the corporation's board and operate according to a plan of operation developed by the board, subject to the approval of the director of insurance.

The late claims fund is created to pay all claims based on medical malpractice filed three years or more from the date of occurrence. The director of insurance defends all claims made on the fund, pays claims won against it, sue or be sued in the name of the fund, borrow money for the fund, and other things necessary for the fund. The fund is to be built from annual assessments against health care providers. If the board of the corporation believes that the assessment is not affordable, it shall notify

the legislature, and the legislature may contribute if it chooses. If the legislature does not contribute the assessment remains final. The state is liable for claims against the fund which the fund cannot pay.

SUMMARY OF BILL B

This bill presumes the passage of a constitutional amendment of Article I, Sec. 16 of the Alaska constitution to exempt medical malpractice cases from that section's guarantee of the right to a jury trial in civil cases where the amount in controversy exceeds $250. It establishes a Medical Injury Adjudication Board with 12 members serving five year terms. Three of the members must be physicians, and the remaining may be neither health care providers, attorneys, or persons from the insurance industry. The board hears cases in committees of four members (one of which is a physician). The board is aided by an expert advisory panel, which has the same powers and duties as the advisory panel of Bill A. All medical malpractice causes of action must be filed with the board; dollar amounts for damages may not be specified in the claim. Damages are to be awarded by category of loss and in installments for future damages if the board so decides. Judgments by the board may be appealed to the Supreme Court of Alaska.

JOINT RESOLUTION

The proposed joint resolution exempts medical malpractice cases from Article 1, Section 16 of the Alaska constitution. That section guarantees the right of a jury trial in civil cases where the amount in controversy exceeds $250.

CHANGE IN RULES OF CIVIL PROCEDURE

This proposes a new rule of procedure for appointing an expert advisory panel in medical malpractice cases. It is essentially the same as the provisions in Bill A regarding the expert advisory panel.

COMMENTS ON BILL A

The first issue is whether this approach will solve the physicians' problems in regard to the cost and availability of medical malpractice insurance. One of the more disturbing facts coming to light during the past year is that somewhere between 15 - 20% of the medical malpractice premium dollar goes to injured patients. By adding an additional layer, an expert advisory panel, you may only increase the administrative cost as compared to the payout to plaintiffs recovering verdicts. The rationale, of course, is that if the panel advises that the defendant was not negligent, plaintiffs

will be encouraged to drop the suit or settle for a smaller amount than he would otherwise demand. It assumes that the panel will weed out nuisance suits and lower the legal expenses insurers incur.

The second question is of fairness. Can a panel of health care providers (mainly physicians) be truly unbiased? Physicians have been traditionally unwilling to speak out against their colleagues. Findings of a panel which is supposed to be neutral would probably have a great deal of influence over a factfinder, and the fairness to plaintiffs ought to be considered.

The rationale of requiring the same minimum levels of insurance for all providers (except hospitals) is not clear. It is reasonably certain that a surgeon has a much higher potential liability than, for example, a nurse.

It is wise to allow licensing boards more flexibility in regulating its licensees. It is not clear, however, that requiring that the Division of Occupational Licensing provide investigative staff to the licensing boards gives the boards sufficient resources to thoroughly regulate its licensees.

The fairness of changing the plaintiff's burden of proof to "clear and convincing" in cases filed three years or more after the occurrence ought to be explored. This is a significantly more difficult burden to meet.

The approach to informed consent in the bill is, I believe, weak. The circumstances where a provider need not explain the risks and alternatives to the patient are very broad.

The administration of the Late Claims Fund appears to be rather awkward. If it is determined that the assessment to providers is unaffordable an appropriation from the legislature is requested; if the legislature does not respond, the "unaffordable" assessment is collected anyway. In addition, the bill provides that any excess liability over assets is chargeable to the state; thus, there are no compelling reasons for the fund to be viable anyway.

COMMENTS ON BILL B

The major issue which this bill raises is the wisdom and constitutionality of abolishing the right to a jury trial in medical malpractice cases. The fairness of this approach should be addressed as well as due process and equal protection issues.

The composition of the board also gives rise to questions. Is it reasonable to require that three members be physicians, while attorneys and insurance people are excluded?

Comments on the resolution and the change in the Rules of Court are included in the comments on Bills A and B.

AC:cb

Supplement to the Report to the Legislature
of the State of Alaska on
Medical Malpractice Proposals

by Dr. Herbert S. Denenberg
P. O. Box 146
Wynnewood, Pa. 19096

(Initial Report Dated December 4, 1975 and presented in Juneau, Alaska on December 9 and in Anchorage on December 10, 1975)

February 20, 1976

1. On December 9, 1975, I met in Juneau, Alaska with a group that included Representative Mike Miller, Vice Chairman of the Legislative Council, Senator John Huber, Representative Fred Brown, Representative Larry T. Davis and staff members.

2. The next day I had a series of meetings with various members of the legislature, including Senator Chancy Croft, Senator Jalmar M. Kertulla, Senator Patrick Rodey, Representative Fred Brown, Representative Larry Davis, Representative Samuel R. Cotten, Representative Kathryn Ostrowsky, Representative Charles Parr, and staff members. In addition I talked to members of the Judiciary Committee before their meeting on Rent Control. Those attending, in addition to members of the legislature, included some members of the Governor's Commission on Medical Malpractice and other members of the public.

3. In the course of these meetings, and other informal discussions with members of the legislature, I made a series of comments and recommendations, which do not appear in my report. Some of these additional remarks are briefly summarized here to serve as a supplement to my initial report dated December 4, 1975. I have also included my response to several questions raised by members of the legislature.

4. The law of Alaska should be clarified so any advance payments on malpractice or other claims would not be considered an admission of liability and would be deducted from any final judgment.

Indiana, Louisiana, Nebraska, Nevada and Wisconsin have passed laws relating to this matter. Nebraska (Legislative Bill 560, passed in 1975) provides any advance payment will not be an admission of liability, and further that: "In the event of a trial involving such a claim, the fact that such payments have been made shall not be admissible in evidence or brought to the attention of the jury, and the matter of any credit to be deducted from a judgment shall be determined by a court in a separate hearing or upon the stipulation of the parties."

This should encourage early payment on claims, early settlements, and attempts to minimize damages by early medical treatment. (A similar approach has been suggested in the report on no-fault as to auto liability claims.)

5. Mandatory arbitration should be considered to provide a more economical determination of cases and a sweeping out of some of the flimsy claims. This would not impair the right to trial by jury as there would be a right of appeal de novo to the courts.

6. The Governor's Commission recommended legislation (p.15, sec.9.55.540(c)) subjecting claims more than three years old to a higher standard of proof than would be otherwise imposed on civil claims. This appears to be an unfair and unreasonable requirement, and any attempt to apply such a standard would probably create more confusion and problems than it would dispel.

7. Senator Huber asked me to comment on a provision in the crime compensation act making attorney's fees an addition to any award. This is certainly a sound provision and will help assure that any damages assessed will not be diverted immediately from the purposes for which they are awarded.

Whether this kind of provision is essential depends on the kind of compensation program being considered. For example, in workmen's compensation, the law may be designed to make sure the worker can collect without the need for a lawyer. If this is the case and if the assumption is sound, paying for all attorney fees may simply bring in lawyers needlessly and increase costs.

The National Commission on State Workmen's Compensation Laws had this to say on attorney fees: "An additional question is whether the employee or the employer should pay the employee's attorney's fee. With the adoption of our recommendations for improvements in the delivery system and the adequacy of benefits, it is not unreasonable to hold the employee primarily responsible for any attorney's fees that he incurs. However, States should consider the shifting of these fees to the employer as a form of penalty in those cases in which the employer or his insurer has acted in an unjustified manner."

This view of the National Commission is not entirely logical. Even if benefits are adequate, they will be rendered inadequate by deduction of attorney's fees.

The National Commission of Malpractice also considered the question of attorney's fees. It recommended regulating the contingent legal fee by establishing a scale in which the fee decreases as the recovery amount increases (a similar recommendation appears in my earlier report on malpractice).

Here, too, recoveries, if properly determined, will be rendered inadequate by deduction of attorney's fees. However, some believe juries tend to pad awards to cover legal expenses.

Ideally, recovery should include actual damages as well as expenses of litigation. To do so would increase the cost of malpractice insurance. It would also raise the question of charging the plaintiff with the defendant's attorney's fees in cases which the defendant won. All of this would introduce further uncertainties into the litigation process, and perhaps make the right to a day in court even more difficult to obtain.

Although the addition of attorney's fees in another context may be entirely appropriate, it is not clear that in the malpractice field this would be a wise practical measure.

There would be general agreement that requiring the payment of attorney's fees in cases in which there is unreasonable failure to pay benefits (or other unjustified action) is an appropriate measure. This kind of provision can be found in workmen's compensation laws. There, it has practical value, as most cases are clear cut with no room for argument, but in malpractice cases few claims are so clear cut, so the provision would have little practical value.

8. Representative Parr asked me to comment on how the malpractice system could be changed to make it possible for a small but meritorious claim to be collected. In small malpractice claims, it may not pay an attorney to handle the matter on a contingent fee basis. The National Commission on Medical Malpractice found cases in which claimants had to abandon a case which might be worth $10,000 because even such a meritorious case did not offer adequate incentive to an attorney working on a contingent fee basis (See p. 35 of National Malpractice Commission Report).

The only remedy the National Commission could suggest is to establish "public legal assistance mechanisms" or to expand those that already exist "to assure adequate legal representation to persons with small malpractice claims."

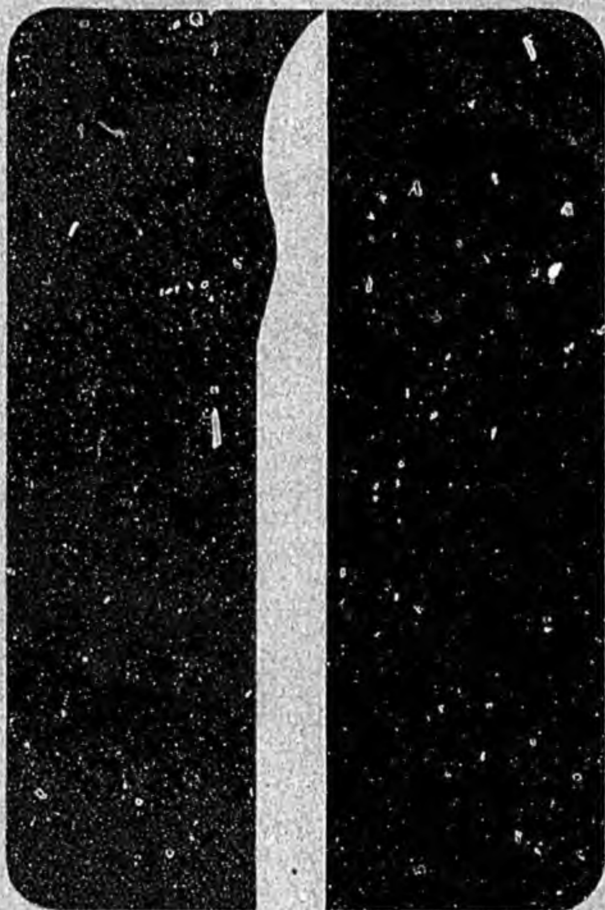
The ready availability of arbitration may somewhat ease the problem. Another suggestion is to establish small claims courts presided over by those technically proficient in the area of medical legal malpractice. In other words, this would be a special small claims court for malpractice claims.

There is probably no good answer for this problem at the present time. Perhaps at one point no-fault malpractice compensation systems will become practical, and enable small meritorious malpractice claims to be adequately compensated.

A shopper's guide to surgery

Fourteen Rules On How To Avoid Unnecessary Surgery

By
HERBERT S. DENENBERG
Pennsylvania Insurance Commissioner



FOREWARD

"Free choice of physician" is frequently invoked by medical spokesmen as the keystone of the U.S. Health System. If this privilege is used wisely, a powerful force could shape an effective, humane and responsive health care system.

"Free choice of physician" is only a hollow slogan for a public unprepared to make an informed and intelligent choice. The ability of the public to make an informed choice of a medical professional has diminished as medicine has become more complex and impersonal. Dissatisfaction and confusion accompany an individual's inability to choose wisely.

Experienced physicians understand that successful health care requires the active cooperation of the patient. The process should start when the patient selects his physician. If a patient enters the system confused, dissatisfied and passive, he often retains these attitudes throughout his treatment.

Commissioner Denenberg's suggestions are practical and easily understood. He has provided a clear Guide to high quality surgical care which encourages patients to become active participants in their treatments.

Leonard Bachman, M.D.
Governor's Health Services Director

PREFACE

Too many people (some say up to two million a year or more in the United States) are subjecting themselves to unnecessary surgery. They often do so without adequate investigation or consideration.

Dr. Paul R. Hawley, a famous medical authority and surgeon, has said: "I shall never cease to be astonished at the number of people who would not invest a penny in any enterprise without full assurance of its safety, yet who will hop on the operating table and permit anyone to cut into their bellies."

Unnecessary surgery takes a needless toll of human lives and generates suffering, disability and expense.

Many studies have documented our national scandel of unnecessary surgery. One of the most noteworthy of these studies was conducted in 1962 to 1964 by the Columbia University School of Public Health and Administrative Medicine. The group surveyed various types of surgery. It found, for example, that of 60 hysterectomies, "1/3 of the patients were operated on unnecessarily and that question could be raised on the advisability of the operation in another 10 percent." Of 13 caesarian sections (delivery of a baby by means of an abdominal operation), there were serious questions about the necessity of surgery in seven cases. There is every reason to believe that the conclusions of the Columbia study are still valid.

A Ralph Nader group in 1971 as well as other independent investigations have reached the same conclusion. Dr. Charles E. Lewis, a Harvard specialist in community health, concluded a 1969 study of the

incidence of surgery with this comment: "The results presented might be interpreted as supporting a medical variation of Parkinson's law: patient admissions for surgery expand to fill beds, operating suites and surgeon's time." And there is an abundance of professional opinion that unnecessary surgery is widespread. Dr. John Knowles, now President of the Rockefeller Foundation in 1972, warned that "incredible amounts of unnecessary surgery are going on"(Baltimore Sun, May 29, 1972, page 4).

This short "Shopper's Guide to Surgery" is intended to give the public some basic rules on how to avoid unnecessary surgery. It is also intended to give the consumer the kind of information he needs to help hold down the cost of health care and to better utilize the health delivery system.

This "Guide" is the fourth in our series; the first was the "Shopper's Guide to Hospitals in the Philadelphia Area"; the second was the "Shopper's Guide to Auto Insurance"; and the third was the "Shopper's Guide to Life Insurance." We also have other "Guides" in preparation, including a "Shopper's Guide to Health Insurance" and a "Shopper's Guide to Homeowners Insurance."

We are also enlisting the aid of others in the preparation of needed consumer Guides. In November of 1971, we ordered Blue Cross of Western Pennsylvania to publish a "Shopper's Guide to Hospitals" for the 29 county area of Pennsylvania it serves. It published such a Guide in June of 1972, entitled "Directory of Hospital Costs and Services in Western Pennsylvania."

Ralph Nader, the leading consumer advocate, has called on other Insurance Commissioners to follow our lead and prepare Guides of their own. We think that's an excellent suggestion. We also think it would be sound for consumer and industry groups to start following suit. It's about time the consumer gets the facts. It's about time we make our free enterprise system of competition work like it's supposed to. It's about time we give the public the facts. We think these "Shopper's Guides" are a step in the right direction.

We know that an informed public will be in a better position to make decisions regarding its own health and welfare. We believe that one of the tasks of government is to inform the public. An informed public will help to prevent abuses that now plague the consumer. These informational Guides, therefore, have an important place in the regulatory processes of government.

Many people contributed suggestions on various drafts of this Guide, most of whom preferred and even demanded that we keep their contributions anonymous. Special thanks are due to Dr. Leonard Bachman, The Governor's Health Services Director, an internationally recognized anesthesiologist; James Mead, Medical Economist of the Pennsylvania Insurance Department; and Rodney F. Pyfer, my Special Assistant.

As future editions of this "Guide" are contemplated, we would greatly appreciate receiving suggestions for improving it.

Herbert S. Denenberg
Pennsylvania Insurance Commissioner

July, 1972

A SHOPPER'S GUIDE TO SURGERY

Some authorities estimate there are as many as 2,000,000 unnecessary surgical operations in the United States each year. How to decide if the surgery you've been asked to undergo fits the category of the 2,000,000 unnecessary operations or the 10,000,000 necessary ones is the purpose of this "Guide."

Don't assume you can place blind trust in our system of medical care. Ralph Nader has pointed out: "Conditions of medical care are often criminally negligent especially for the poor and even at times for the relatively affluent. The endless reports of such conditions by physicians, government investigations and other reliable inquiries and testimony present macabre scenes so repeatedly that they invoke resigned or indifferent responses. The rocketing cost of health care with the advent of socialized payment of physicians' bills through Medicare has not improved the quality of care, but it has enriched the medical profession to an unprecedented degree."

You are placing undue trust in our medical care system if you assume one doctor is as good as another, or that any doctor can provide you with the quality medical care you need. Many doctors, some 15,000 nationally, are licensed but unfit to practice medicine according to conservative estimates, as reported in a 1970 book by Howard R. and Martha E. Lewis called The Medical Offenders. Many doctors may be qualified to render medical care, but may be totally unqualified to perform surgery.

This Guide should help you find a qualified surgeon when you need one. It should also enable you to take other needed steps to avoid unnecessary surgery.

You can't diagnose your own case, but there are some simple rules you can apply to make sure that you really need the surgery that might be prescribed.

Rule 1

Don't go directly to a surgeon for medical treatment. If at all possible, start out by going to a general practitioner or internist. Go to your regular family doctor – a general practitioner or internist – for any initial diagnosis or treatment. Unfortunately, there is a shortage of general practitioners and a surplus of surgeons.

You will also need a general practitioner or internist to treat you after the surgery and to work with your surgeon in providing care both before and after surgery. Everyone should have a family doctor, who is a general practitioner or internist, and you should get one before you're sick. Don't wait until you urgently need one. Select one so he'll be available the minute he's needed. Also, you want him to have time to know you and learn your medical history. Develop a good relationship with a family doctor.

He will then be able to provide you with better care and he'll be more likely to save you from unnecessary surgery.

Most surgeons are competent, conscientious, careful and conservative, as are most other physicians. Some are narrowly trained and tend to do what they are trained to do — operate. A small minority are knife-happy, incompetent and greedy. And there is a tendency for surgeon's to do their thing — which is to perform surgery.

Even in the case of a superb surgeon, a general practitioner or internist can often serve as a countervailing force on any tendency of a surgeon to place too much faith in surgery.

This tendency of medical men (such as general practitioners and internists) to be more conservative than surgeons is documented in Dr. William A. Nolen's best seller, The Making of A Surgeon:

Kevin Jonas (a surgeon) was, naturally, eager to do some heart cases. He would gladly have paid a thousand dollars apiece for potential patients even if he'd have had to steal to get the money, but of course there weren't any for sale. He had to depend on the medical men and they weren't eager to have their patients operated upon. Internists don't take kindly to new surgical procedures; they're from Missouri when it comes to surgical pioneering — as, I suppose, they should be.

Christian Barnard, the famed heart transplanter, in his autobiography, relates how eager he was to find a patient for a heart transplant. "Maybe we were too anxious," he writes. He catalogues his considerable discomfort while eagerly awaiting the first heart transplant operation:

All through the last two weeks of October I kept after Professor Schrire — plaguing him day and night.

The delay and subsequent anxiety caused an alarming flare-up in my arthritis. Both hands and feet began to swell and with such pain I feared it would prevent me from operating when Professor Schrire finally decided to release a patient.

There is some tendency for too much surgery when there are too many surgeons around. It is no mere coincidence that in proportion to population, U.S. surgeons not only are twice as numerous as English surgeons, but also perform twice as many operations.

An authoritative study in 1970 by Dr. John P. Bunker concluded that there is a disproportionately large number of surgeons in the United States and this may lead to some unnecessary surgery. An editorial published in the June, 1972 issue of the Archives of Surgery, a publication of the American Medical Association, confirmed that we have a surplus of surgeons.

Rule 2

Make sure any surgeon that is to perform surgery on you is Board certified. This means his competence as a surgeon has been certified by one of the American Specialty Boards, after a vigorous oral, written and clinical examination. There are about 51,000 surgeons who are Board certified.

One authority, Dr. Robert E. Rothenberg, a well known surgeon, in his book Understanding Surgery, has concluded: "It is safe to say that an American Specialty Board diploma in a doctor's office is almost a guarantee of his efficiency." For some reason, Dr. Rothenberg said nothing of a guarantee of conscience or character. His statement may be too sweeping an endorsement, but a Board certified surgeon is still a sound minimum qualification. It is one important test of a surgeon's ability.

Osteopathic surgeons may be accredited by the American Specialty Board in some states or by their own

American Osteopathic Board of Surgery.

There are competent surgeons who are not Board certified. If you want to use them, you should be careful to check them out all the more carefully by the other rules suggested here.

In some rural areas, Board certified surgeons may not be available. Under these circumstances, the patient may have to travel to a larger city if he cannot otherwise assure himself of the competency of those surgeons available locally.

You can find out for sure if a surgeon is Board certified by calling your local county medical society or using the Directory of Medical Specialists available in most good public libraries.

It pays to look for a competent surgeon. Some reliable experts, including Dr. Paul R. Hawley, have claimed that one-half of the surgical operations in the U.S. are performed by surgeons who are inadequately trained to undertake such surgery. In June of 1972, Dr. Eric W. Fonkalsrud of the editorial board of the American Medical Association's Archives of Surgery, said that about half of the operations in the country are being performed by doctors who are not Board certified surgeons.

One expert, Dr. Harold T. Hyman, in a widely used medical reference book, suggests that the patient not only check out the surgeon but also the anesthesiologist. Others would rely on the surgeon to see that a qualified anesthesiologist is selected for the surgery.

Rule 3

Make sure the surgeon you are to use is a Fellow of the American College of Surgeons (F.A.C.S.). There are about 25,000 surgeons who are designated Fellows. The American College of Surgeons has membership qualifications that keep out the less competent sur-

geons, and the College also stresses programs of continuing education.

This is not an infallible rule, of course, but it is one that is well worth applying in selecting any surgeon.

You can check as to whether any surgeon is a Fellow of the American College of Surgeons in the same fashion as you check to see if he is Board-certified – consult the Directory of Medical Specialists or call your local county medical society. You can also write directly to the American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.

The equivalent organization for Osteopaths is the American College of Osteopathic Surgeons located at 1550 South Dixie Highway, Suite 216, Coral Cables, Florida 33146.

Rule 4

Even if your family doctor and surgeon agree that surgery is necessary, consider getting an independent consultation or opinion before subjecting yourself to surgery.

Consultations, according to some studies, reduce operations by as much as 20 to 60 percent. You may be in that 20 to 60 percent. And you have a right to seek consultation.

As one expert, writing under the pseudonym of Dr. Lawrence P. Williams, says in a book entitled How to Avoid Unnecessary Surgery:

The old saying, two heads are better than one, is as true in medicine as anywhere else – possibly even more so, for conscientious doctors have found out that in order to present a problem case to another doctor, they must first review and organize the facts of the case. This in itself often makes the problem

clearer. A second independent surgeon, moreover, may consider certain aspects of the condition quite differently, throwing a new light on the problem. The chance that other factors pertaining to the surgery will be brought out is greater with a consultation.

The second doctor must be truly independent. He should not be part of a 'you-scratch-my-back-I'll-scratch-your-back' arrangement. The second surgeon should be told his opinion is being sought but he will not do the surgery if it is necessary. This removes any financial incentive for him to suggest surgery.

You may want to select the second surgeon on your own, or perhaps get recommendations from your family doctor or surgeon.

When a consultation is to be rendered, the first surgeon ordinarily briefs the second one on the case and his tentative diagnosis and recommendation.

Some would prefer a totally independent opinion rather than an independent consultation, with the second surgeon working on his own and being unaware of the conclusions of the first surgeon. This may remove any tendency to be too quick about going down the wrong path with the first surgeon.

One well-known surgeon suggested that the best way to avoid unnecessary surgery is to get three independent opinions without advising any of the three surgeons involved about the conclusions of the other two.

How many consultations and opinions you should have depends on the facts and circumstances of each case. The need for additional consultations and opinions is a matter which you can discuss with your own doctor and surgeon. In some clear cut cases (pardon this figure of speech), no consultation will be necessary at all. And of course, there may be need for emergency surgery – as, for example, after an auto accident or in the event of a ruptured

appendix — when there may not be sufficient time to follow the rules suggested here.

If a doctor refuses to seek consultation upon request, he is violating the ethical rules of the medical profession. For example, Section 8 of the American Medical Association Principles of Medical Ethics states:

A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical care may be enhanced thereby.

Look out for a doctor or surgeon who is afraid of consultation or becomes angry or disturbed at the prospect of consultation. Drop a doctor or surgeon who can't accept another expert's consultation graciously. As between your doctor's or surgeon's ego and your health, opt for the latter.

If a doctor improperly refuses consultation, you can report his refusal to the county medical society for possible disciplinary action, as well as to Vincent J. Fumo, Acting Commissioner of the Bureau of Professional and Occupational Affairs, 279 Boas Street, Harrisburg, Pennsylvania 17120 (Phone 717/787-2100).

Rule 5

Make sure any surgery is performed in an accredited hospital and, if possible, select a hospital that gives staff privileges (i.e., the right to practice in the hospital) to both your doctor and surgeon. The Joint Commission on Accreditation of Hospitals (J.C.A.H.). certifies that institutions it accredits meet certain minimum requirements designed to assure quality patient care. The standards of the J.C.A.H. are not notably high but they do disqualify the least adequate hospitals and the out-and-out "butcher shops."

Osteopathic hospitals may be accredited by their own

group — the American Osteopathic Association or by the J.C.A.H.

About a fourth of the nation's hospitals are not accredited by the J.C.A.H. or the American Osteopathic Association, but almost all of the better hospitals are. There are about 1,600 unaccredited institutions out of a total of about 7,000 short-term hospitals.

The address of the Joint Commission on Accreditation of Hospitals is 645 North Michigan Avenue, Chicago, Illinois 60611. The address of the American Osteopathic Association is 212 East Ohio Street, Chicago, Illinois 60611.

Another method of assuring quality hospital and surgical care is to make sure the hospital you go to is affiliated with a medical school, and your doctor and surgeon are on the staff of that hospital. Medical school hospitals and their affiliates have a reputation for excellence, and for keeping their medical staffs on the ball.

Rule 6

Don't push a doctor to perform surgery on you. If you insist on surgery, even if it is unnecessary, you are likely to find a surgeon willing to perform it.

There are "overtreaters" who are willing to perform unnecessary surgery, so don't ask for trouble.

As Howard R. and Martha E. Lewis note in their book, The Medical Offenders:

The patients whom overtreaters sell most successfully are neurotic women. A gynecologist new to this country observed: 'In Europe it is all the doctor can do to persuade a woman to have a needed operation. In America it is difficult to dissuade her from having an unnecessary one."

Some women have had six, nine, or 16 major operations in search of relief from their anxiety, malaise, and all-around misery of emotional immaturity.

One doctor has suggested that females are subjected to unnecessary surgery more often than males because of the male dominance of the medical profession. Dr. Francis S. Norris, a surgical pathologist, substantiates this point of view by citing a 1969 Surgeons' Cancer Conference at which it was agreed that surgeons think twice about orchidectomy (surgical removal of a testicle), but rarely hesitate to remove an ovary.

Occasionally a surgeon is overheard to say: "Surgery was unnecessary, but if I didn't do it, someone else would. And at least I did a good job." Don't be so eager for surgery that you prescribe your own unnecessary operation.

Rule 7

Make sure your doctor and surgeon explain both the alternatives to surgery and the possible benefits and complications of surgery.

Any doctor or surgeon should do so and you'll be able to make a more intelligent decision on surgery when you have the facts. As a matter of fact, a doctor that fails to disclose the risks of surgery may open himself up to a malpractice suit. Under the legal doctrine of informed consent, a patient who has not been fairly advised about the risks of surgery has not legally consented to it. He may, therefore, sue any doctor for malpractice who operates on him without fairly disclosing the risks incurred.

All kinds of possible complications may arise from surgery. One expert, Dr. Robert E. Rothenberg, in his book <u>Understanding Surgery</u>, lists five complications:

(1) Pneumonia, once feared, now largely controllable by antibiotics.
(2) Embolism (blood clot).
(3) Postoperative shock.
(4) Wound infections.
(5) Postoperative hemmorhage and wound rupture.

Another serious complication that should be mentioned is cardiac arrest.

The risks of surgery depend on many factors such as age, physical condition, and the nature of the operation to be performed. Such risks are always there and you're entitled to know precisely what they are. Despite all the advances in surgery, one out of every 650 will not come through surgery alive, according to Dr. Rothenberg. That's an average figure, so the expected mortality for any given operation may be much lower or higher.

It is true that some minor procedures involve only slight and almost negligible risk. The uncomplicated removal of a wart without the need for general anesthesia is a good example. If general anesthesia, which involves loss of consciousness, must be used, there is always significant risk. Death and complications from anesthesia are among the most serious risks arising from surgery. Any time general anesthesia is to be used, even an operation that merely involves a surface procedure without cutting into a body cavity, there is a significant risk.

As general anesthesia involves significant risk, it is preferable to have it administered by a physician anesthesiologist who is a specialist, or under his supervision by a certified, trained nurse anesthetist. It is a good idea to be sure the hospital you go to uses a physician anesthesiologist.

Perhaps the best definition of major surgery that puts the risk involved in true perspective is the one that goes like this: If it involves you, it may be minor surgery. If it involves me, it's major surgery.

You should also know what the alternatives to surgery are, such as diet in the case of a peptic ulcer. Surgery is typically a last resort, and you should be as sure as you can that you've explored all treatment short of surgery. Needless to say, you should know the benefits of the proposed surgery. You can hardly judge the risk or even the need for surgery without a clear picture of its likely benefits. Of course, if it is clear that surgery is needed, it should not be delayed to the point where further harm may result.

Rule 8

Frankly discuss the fee for surgery with your doctor. You should know what the surgery is going to cost. Furthermore, most surgeons prefer that the patient understand the cost of surgery in advance. So, forget all about the mistaken notion that it's somewhat improper to inquire about the cost of surgery.

Any surgeon worth his scalpel will gladly discuss fees. If he is not willing to do so, then he doesn't know much about his obligation to the patient and the patient's right to know. Under Phase II of the Federal Wage-Price Stabilization Program, every doctor must post a notice that a record of all his fees is available on demand.

Under Pennsylvania Blue Shield Plans A and B, if your income is under certain specified amounts, the surgeon must accept the fee scheduled in your policy as full payment. If your income is above these limits, the surgeon may charge more than the scheduled amount. (The income limits for Plan A are $2,500 for an individual and $4,000 for a family. Under Plan B, the income limits are $4,000 and $6,000 respectively.)

Be sure you know all costs involved – the surgeon's fees, any fees for his assistant, the anesthesiologist's fees, those of the hospital, special nursing care, your own physician's fees, and any other costs.

This discussion of fees will have several important incidental advantages. It gives you a better idea of the nature of the surgery.

It also may suggest improper arrangements between the surgeon and others. If the assistant's fee is much beyond 20 percent of the surgeon's fee, that may suggest fee-splitting. For example, if the assistant is also a referring doctor, a high assistant's fee may suggest "fee-splitting," a form of unethical kickback to the doctor from the surgeon. Don't put yourself in the hands of a surgeon or doctor that engages in such unethical activity. So, politely question any excessive fees to the surgeon's assistant if fee-splitting is suggested. According to the Lewis' book, The Medical Offenders, fee-splitting is especially widespread in Pennsylvania.

Rule 9

Check the surgeon out with those who know him or have used him. This includes other patients as well as associates of the surgeon.

You might want to check on his background in the Directory of Medical Specialists. What school did he go to? Where did he take his residency? How long has he practiced, etc?

One good way to find the best surgeon is to find out who doctors use when they need surgery for themselves or their families. The greatest compliment to a surgeon is when he is used by a doctor or his family.

Check the surgeon out yourself. You've got to have confidence in him. You don't have to like him, but you should have confidence in him – or find another surgeon.

Rule 10

Make sure the surgeon knows and is willing to work with your general practitioner or internist. To assure

complete, continuous and quality care, close cooperation between the surgeon and your doctor is vital.

If they can't work as a team, you may be the loser.

Rule 11

Consider a surgeon who is part of a group practice, and preferably a group that includes internists, surgeons and other specialists. This involves doctors who work together on all their cases, and freely consult and communicate with each other. With a group practice, you are more likely to have a doctor available at all times who is familiar with your case and you have the built-in benefits of consultation.

Some patients are critical of group practice, however, if they get a feeling that they are being passed from one doctor to another.

Group practice takes many forms. It includes partnerships of many kinds, private clinics, and groups sponsored by labor and management.

One type of group practice is the Health Maintenance Organization (HMO). In most HMO's, the surgeon's income does not depend on the number of operations he performs. Under the HMO concept, doctors, including surgeons, are paid as much for keeping you well as they are for treating you when you are sick.

A good HMO performs about 50 percent less surgery on its patients than a health insurance plan which compensates doctors on a per case basis. As a result, membership in a good HMO may help save you from unnecessary surgery.

Rule 12

Select a surgeon who is not too busy to give patients enough time and attention. Surgeons who handle too

many cases are bad news for the patient for obvious reasons.

The best surgeons are likely to be busy. But the "best" surgeon who must rush through an operation and must hurry past his patients is not likely to get good results. To say haste makes waste is a gross understatement when discussing surgery.

It may be difficult for you to decide if a surgeon is too busy. You can get some feel for this by observing how crowded his waiting room is and how much time he is willing to spend with you.

Rule 13

Be especially on guard if some of the operations that are most often unnecessarily performed are proposed for you. These include hysterectomies, hemmorhoidectomies, and tonsillectomies. These operations have been referred to as "remunerectomies" by some cynics (a fancy Greek derivative from the word "remuneration"). One doctor, Norman S. Miller of the University of Michigan, coined the term "hip-pocket hysterectomies" because the "only benefactor is the surgeon's wallet." (Evening Bulletin, June 8, 1972, page 25.)

Rule 14

The patient, not the doctor or surgeon, is supposed to, and is entitled to make the decision on whether to have surgery. Listen to the experts. But remember, it's still your decision. You're entitled to have the facts you need and you're entitled to decide whether or not to go ahead with the surgery.

As the title of the television show goes – "THIS IS YOUR LIFE."

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Reprinted by Blue Cross in the interest of keeping the consumer informed on matters relating to the health care community.

Ambassadors

Fairbanks Memorial Hospital

1650 Cowles St.
FAIRBANKS, ALASKA 99701

OPERATED BY
LUTHERAN HOSPITALS AND HOMES SOCIETY
FARGO, NORTH DAKOTA 58102

January 28, 1976

Representative Terry Gardner
Judiciary Committee
Pouch V
Juneau, Alaska 99811

Dear Mr. Gardner:

In response to a letter from Mike Bradner, I would like to submit the following comments on the Governor's basic package on malpractice legislation. I hope the legislature will be convinced of its importance to the people of the State. I believe the package as presented is a compromise and not totally acceptable to any one group. It is more than likely to create considerable debate and I would therefore like to express some feelings to the members of your committee for them to consider in the debate.

First, I believe that any system which is evolved should guarantee the people just compensation for medical injuries sustained. But justice is no longer served by placing the entire financial burden of such compensation on the accused. In the past, this risk of financial ruin has been spread out through the use of insurance. The question now is whether or not the three hundred physicians and eighteen hospitals can continue to bear the full cost of this burden through insurance. I am told that twelve to fifteen percent of the premiums paid are actually delivered to the injured party. The remainder goes for legal and court costs, insurance administrative cost, investigative and case preparation cost, etc. On this basis, if we can expect $1,500,000 in claims in the coming year, $10,000,000 would have to be generated in premiums to cover the expected claims. Can this burden be placed entirely on the physicians and hospitals who will pass these costs on to the people or must we seek alternatives? We certainly should make the system more efficient.

Secondly, I believe that in order to make the above guarantee, it will be necessary to guarantee malpractice "coverage". Does the State have a responsibility here? I believe that it does, if only inasmuch as it licenses physicians and hospitals and offers to the public that these licensees have at least met minimal qualifications.

Probably one of the most controversial aspects of the package, as presented, is the compulsory nature of contributions to the Medical Indemnity Corporation as a requirement for licensure. If it is <u>truly</u> necessary to have the total health care industry as contributors in order to obtain this "coverage", then this requirement should remain. We <u>must</u> have the coverage. No amount of limitation of awards or decrease in the statute of limitations will encourage an immediate

inrush of insurance companies to pick up the business. An interesting offshoot of the compulsory nature of this contribution might be the incentive it gives to peer review for risk identification.

On the subject of risk identification, I believe that it is necessary only to beef up the powers and immunities of the Medical Board and to provide for a natural flow of information from the medical societies, hearing committees, expert advisory panels, etc. I would recommend against establishing a branch of government concerned with risk identification as I believe such already exist in the Medical Board.

In summary, I support the recommendations of the Advisory Committee and ask the legislature to consider that this package was an effective compromise reached in the fall of 1975. If any changes are to be made, in the light of new information, please "don't throw the baby out with the bath water".

Sincerely,

ROGER F. HARDING, M. D.
Fairbanks Memorial Hospital

RFH:nw

RECOMMENDATION OF GOVERNOR'S COMMISSION ON MALPRACTICE

RECOMMENDATION #1: The liability of the health care provider should terminate three years after occurrence (two years statute of limitations and one year limit on discovery). Any reported case after the third year ought to become the responsibility of a special fund and not the liability of the health care provider.

RECOMMENDATION #2: Any award to which the injured patient is entitled should be reduced by all available collateral sources such as private, group or governmental medical or disability benefits whether contributory or noncontributory, except life insurance, by including the introduction into evidence of the items of damage compensated by collateral sources, except federal programs which by law must seek subrogation.

RECOMMENDATION #3: Medical professionals should be immune from liability to a person who is not his patient for administering emergency medical care where the giving of immediate aid appears to be the only alternative to death or serious bodily injury or harm.

RECOMMENDATION #4: The law should provide that no promise to achieve a certain medical result is valid unless that promise is in writing signed by the health care provider.

RECOMMENDATION #5: The definition of medical negligence be improved by adopting a national standard of acceptable medical care in lieu of a local community standard, limiting the standard to that at the time of the act, and imposing the standard appropriate under all circumstances under which the health care provider was acting.

RECOMMENDATION #6: Cases brought more than three years after the date of the incident alleged to cause the loss complained of must be proven by evidence that is clear and convincing.

RECOMMENDATION #7: There be enacted provision for appointment of ad hoc medical expert panels composed of at least one physician and two health care providers of the same discipline as the health care provider charged, impanelled after filing of an action and prior to any pretrial proceedings to initiate an investigation of available evidence and report to the parties its findings as to medical facts.

RECOMMENDATION #8: The findings of the expert medical panel be admissible as evidence and the panelists subject to cross-examination in any subsequent trial.

RECOMMENDATION #9: There be established a medical adjudication board consisting of nine citizens of the State who are neither health care providers nor legal professionals, nor insurers, and three physicians appointed by the Governor, and one Superior Court judge assigned by the court. This board would be the exclusive tribunal for medical negligence cases.

RECOMMENDATION #10: The legislature enact a joint resolution for the amendment of Article I, Section 16 of the Alaska State Constitution, permitting the legislature to consider an alternative system of adjudicating medical negligence claims which may be a substitution for trial by jury.

RECOMMENDATION #11: Provisions be made to authorize and administer the awards of future income and continuing medical care to be paid periodically rather than in a lump sum.

RECOMMENDATION #12: Jury and board awards shall be rendered by category of loss.

RECOMMENDATION #13: Create a Health Care Providers Indemnity Corporation, a public corporation, which would be regulated by the Director of Insurance as a domestic property and casualty insurer and which would be a mandatory and exclusive source of minimum limits of medical malpractice insurance for all health care providers for the losses reported within the first three years after occurrence.

RECOMMENDATION #14: The corporation may contract with servicing carriers for administrative and claims services and seek contracts of indemnity from admitted carriers retaining for itself no insurable risk.

RECOMMENDATIONS #15: The rates for coverages provided by the corporation should be developed based on Alaska's experience and retrospectively adjusted over a four year period such that each category of health care providers would fully pay for all losses and expenses incurred in the programs yielding an appropriate profit to the indemnity carrier.

RECOMMENDATION #16: The corporation provide coverage retroactively to January 1, 1975 with appropriate additional premiums for those health care providers which had no insurance during that period.

RECOMMENDATION #17: A joint underwriting association should be authorized to be implemented upon a finding by the Director of Insurance that indemnity at a reasonable rate is not available from a private carrier.

RECOMMENDATION #18: The joint underwriting association should be composed of all property, casualty and disability insurers and all health care service contractors.

RECOMMENDATION #19: Create a late claims fund which shall be funded by assessments against all health care providers in amounts determined by the Director of Insurance after public hearing as necessary to actuarially carry all fund liabilities and guaranteed by the State to the extent necessary to cover actuarial deficiencies. There should also be provision for the legislature to reduce the assessment of health care providers upon a finding that the assessment is unaffordable.

RECOMMENDATION #20: Legislation should be enacted which will require the maintenance of separate, specific and detailed statistical information on malpractice claims. Authority should be exercised by the Director of Insurance to more deliberately regulate policy forms and rates for this line.

RECOMMENDATION #21: The proposals of this Commission should inure to the benefit of, and be binding upon all licensed in the State as hospitals, as defined in AS 18.20.130 chiropractors, dental hygenists, dentists, physicians, osteopaths, chiropodists, nurses, opticians, pharmacists, physical therapists, psychologists and psychological assistants.

RECOMMENDATION #22: There should be a legislatively prescribed procedure for informing the patient of the consequences of a procedure and obtaining the consent to perform it and also setting forth the conditions pursuant to which consent is implied or not required.

RECOMMENDATION #23: The appropriate licensing boards should be authorized to render disciplinar sanctions against health care providers other than license suspension. The boards should be abl to reprimand, censure, place on probation, restrict practice by time, specialty, procedure or facility or to require continuing education or retraining.

RECOMMENDATION #24: The appropriate licensing board should have authority to require more relevant and more frequent reports on healthcare practices by and from its licensees. Persons reporting should have immunity from defamation actions based on reports made to licensing boards to officially constituted service committees of hospitals and professional organizations.

RECOMMENDATION #25: The legislature appropriate such additional funds as are needed to properly staff the health care licensing boards with investigative and administrative personnel.

RECOMMENDATION #26: Provision should be made for more effective loss control by all health care providers but with specific attention to identified problem areas.

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

M E M O R A N D U M   February 18, 1976

SUBJECT: Medical Malpractice Premiums by Alaskan Physicians

TO: The Honorable Terry Gardiner

FROM: Louise Crane
Research Analyst

The Division of Insurance, Department of Commerce and Economic Development has, at the request of the Legislative Affairs Agency, conducted an individual policy survey of the medical malpractice premiums of Alaskan physicians by polling each broker who markets medical malpractice insurance in Alaska. This information has been compiled as to total premiums, total premium by speciality and average premium by speciality.

The attached letter from Richard L. Block, Director of Insurance, also includes information you requested in a letter of January 30th concerning the impact of premiums if an absolute statute of limitations was adopted.

The Legislative Affairs Agency had requested the release of the information on several occassions within the past week. However, the Director of Insurance was out-of-town, and his staff was reluctant to release the compiled information without the Director's editorial review. This Agency received the attached report at 9:30 a.m., February 18, 1976.

LC:cw

ATTACHMENT

STATE OF ALASKA

JAY S. HAMMOND, Governor

DEPARTMENT OF COMMERCE &
ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE / POUCH D— JUNEAU 99801

February 17, 1976

Terry Gardiner, Representative
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Gardiner:

In response to your request for current statewide premium levels for Medical Malpractice Insurance I am pleased to provide you with the attached schedule.

Bear in mind that this is not entirely reflective of actual premiums paid for the following reason:

1. The figures used are for basic limits of $200-600,000.00 of liabiliaty. Most physicians who purchase insurance also purchase excess liability, probably to $1,000,000.00 for which there is an additional charge.

2. Some of the policies included in this survey are on a claims made form and in order to obtain protection for claims made during a tail period, an additional charge will have to be made at a later date. Those charges are not included in the premium figures.

The fact that some of the policies reported are on claims made form and some are on occurrence form tends to also distort the picture.

Finally, many of the physicians are insured under a very favorable program offered to the American Group Practice Association. In order to show this spread of premiums in each class, the attached chart has a column for the low and the high premiums which were reported to us.

You also asked what the difference would be in premium level should the Medical Malpractice Insurance Commission's proposals be adopted. The most frank answer I can give is, I don't know. Perhaps it would be helpful for you to consider the following points:

1. Under the Commission's recommendation there would be two charges:

   A. A charge for coverage of claims reported within three years. Since the coverage provided is similar to that provided under the Lloyd's claims made form with three years of automatic tail protection and similar to the Shand Morahan program which provides three years tail protection upon the payment of a specified additional charge, that the Lloyd's premium or the Shand Morahan premium with additional charge will provide some indication of current premium levels for the coverage provided by the M.I.C.

   B. The charges to support the late claims fund will probably key off of some of the Closed Claims Survey Information which shows that approximately 6% to 10% of the dollars which have been paid out have been with respect to claims reported after 36 months after date of occurrence.

2. The Commission's recommendation requires the rate to be based on Alaska experience which means that if a lower than average number of claims were reported, this should be reflected in the lower than average premium level. We are currently obtaining a list of currently outstanding claims and claims which have been closed. It would appear that the total cost of all claims averaged over any four year period, is currently less than the present premium level, that is to say, the Alaskan experience has been more favorable than is indicated by the cost of the increasing rates. Any new rate will have to allow for the potential for increased frequency and larger size of losses that could be anticipated as Alaskans become more aware of the malpractice situation and the propensity to file a suit is increased but as the rating mechanism is rolled forward over the four year period, past history would suggest that the factors causing substantial rate increases in other states would not be present in the State of Alaska.

3. The Insurance Service Office which promulgates rates for its member carriers, indicated at the Malpractice Insurance Commission hearings in Anchorage, and frankly in more recent discussions, maintained, that were they to make a new filing of rates for their members, based on Alaskan experience, the rates would be lower than they have been in the past because of the favorable claim experience.

4. The present rates reflect expense factors, many of which will not be present in the mechanisms proposed by the Commission. Some examples are:

   A. Taxes are reduced by 1 1/2% of the total premium.

   B. Producer costs (agency and brokerage commissions) would be substantially reduced, I would estimate by 5 to 20% of the total premiums.

   C. General and overhead expenses can conceivably be substantially reduced but it is difficult to estimate by how much at this time.

   D. If the Commission's proposals concerning tort reform is adopted, it is believed that defense costs will be materially reduced.

   E. Because the program will be reinsured as a separate entity it is expected that reinsurance costs will be higher than they would be if the program were insured by a national carrier as part of an overall program but this could be offset by the fact that on a long term basis, reinsurance costs are a function of experience and if the experience is good the cost for reinsurance will be reduced even for a small sized book of business.

You have asked by your letter of January 30th, what the impact of premiums would be if we adopted an absolute statute of limitations similar to that enacted in California, Florida, Indiana, and Oregon. Carriers will anylize the effect of that law probably taking into account three considerations.

1. The current loss development data available suggests that approximately 6% of the indemnity paid is in respect to claims which were reported over three years after date of occurrence with respect to adults and 18% with respect to minors. These figures are not large, suggesting that the concern of the carriers and the dramatically increased bulk reserves to cover these losses might be partially unwarrented.

2. At the same time those figures reflect experience on cases which were reported in prior periods and closed after July 1, 1975 and prior to the close of the reporting period for the December 1975 N.A.I.C. Closed Claims Survey Report. It is reasonable to expect that wider knowledge of the malpractice suit remedy will result in more law suits and thus a larger

share of late claims which will tend to justify higher bulk reserves thus an absolute limit on time in which to file a suit could have a substantial favorable impact on costs beyond the amount indicated in subparagraph 1 above.

3. The principle concern which carriers will continue to harbor is whether such a statute is an unconstitutional infringment of the right of due process. Until that matter is finally determined by a e U.S. Supreme Court opinion, the carriers will remain concerned notwithstanding the enactment of such a State law, and will establish reserves to cover the eventuality that valid claims could be filed after the running of the statute.

It could be concluded that the enactment of a statute of limitations law would certainly not cause an increase in rates and might in future years as experience develops cause the rates to be reduced.

Yours cordially

Richard L. Block
Director

PRESENT PRIMARY MALPRACTICE COST ESTIMATES

SPECIALTY	CLASS	HIGH PREMIUM	LOW PREMIUM	AVERAGE PREMIUM	NO. DOCTORS AVERAGE DERIVED FROM	TOTAL DOCTORS	TOTAL PREMIUM
General Surgery	4*	12,084	2,463	7,509	7	48	$360,432
Family Practice	1	3,909	625	1,446	22	155	224,130
Orthopedic Surgery	6*	14,501	2,363	12,084	11	25	302,100
Ophthalmology	3*	9,126	1,478	4,851	4	20	97,020
OB GYN	5*	3,918	2,955	9,126	6	34	310,284
Otolarngology	4*	7,509	6,219	7,509	3	12	90,108
Internal Medicine	1	4,851	484	1,111	14	60	66,660
Radiology	2	17,464	484	4,138	8	14	57,932
Pediatrics	1	1,478	484	1,050	10	40	42,000
Pathology	1	4,162	2,605	3,383	2	12	40,608
Urology	3*	2,238	1,970	4,851	2	6	29,106
Neurologist	1	550	550	550	1	8	4,400
Acupuncture	1	1,019	1,019	1,019	1	1	1,019
Anesthesiology	6*	12,084	7,500	12,084	1	14	169,176
Plastic Surgery	5*	9,126	2,955	9,126	class 5 av.	3	27,378
Psychiatry	1	1,101	484	1,035	" 1 "	29	30,015
Dermatology	1	1,101	484	1,035	" 1 "	4	4,140
						485	$1,856,508

*Average for this class not credible or available. Utilize current available premium shown as average.

Average Premium 3,830

Block

STATE OF ALASKA

JAY S. HAMMOND, Governor

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE / POUCH D — JUNEAU 99801

February 18, 1976

Alaska State House of Representatives
Judiciary Committee
In Session
Juneau, Alaska

Attention: Terry Gardiner, Chairman

Dear Representatives:

Re: Committee substitute for HB 574

I have reviewed what I believe is the last available draft of the above referenced measure. I would suggest that the following technical changes be made:

1. In subparagraph 8 of the several statutes requiring insurance for a health care provider it is provided that the Commissioner of Commerce and Economic Development may require all persons licensed to obtain the insurance required. This is essentially a determination involving knowledge of the markets, underwriting requirements, rates and trends in the insurance industry and falls within the special purview of the Director of Insurance. I believe that in all of those sections the Director of Insurance whould be substituted for the Commissioner of Commerce and Economic Development. This recommended change is endorsed by the Commissioner of Commerce and Economic Development.

   Adopted

2. On page four, line three, I recommend that there be added as follows:

   "...in the required amounts[.] <u>issued by the Health Care Provider Indemnity Corporation</u>."

   This recommendation is made to be sure that all physicians are insured in the corporation even though they are insured through an employers policy. This means that if the hospital procures insurance from the Health Care Provider Indemnity Corporation and covers its physicians, the physician has satisfied his insurance requirement. On the other hand if the physician is employed by a corporate employer, the only way that the provision could be satisfied is if the corporate employer purchased malpractice insurance for the physician through Health Care Providers Indemnity Corporation.

   OK

3. Page 10. It was intended by the Malpractice Commission that the expert advisory panel be composed of health care providers That is not specifically required in the existing section. I would suggest that lines 15, 16, and 17 be amended as follows:

   "...professional services by a health care provider, the court shall establish [a three person] an advisory panel of three health care providers in accordance with this section."

4. Page 12. The measure prohibits consultation among the partys counsel and the advisory panel except through ordinary discovery proceedings. This clearly defeats the purpose of having the advisory panel. As written the section would prohibit the panel from interviewing or discussing the matter with the defendant doctor and would require that depositions and interrogatories be used to extract information. It is the purpose of the advisory panel to eliminate the expense of these discovery proceedings, not to encourage it. I would suggest that nothing is served by prohibiting communications with the advisory panel and thus subsection (g) should be stricken.

5. Section 09.55.550 would strike the words "BY A PREPONDERANCE OF THE EVIDENCE", and refer instead to Section 09.55.540. This latter section contains no statement as to the quantum of proof required to make a case. There seems to be lack of unanimity what quantum of proof is required, but I certainly believe that justice is better served if the Legislature will finally determine the quantum of proof and state it in a statute clearly. It could be stated either in Section 540 or Section 550.

   I would still commend substantively, that with respect to cases reported longer than three years after incident, the quantum of proof should be "clear and convincing" and the quantum of proof for other cases should be "by a preponderance of evidence."

6. Page 13. I believe that awards for loss of future earnings should be permissive and not mandatory, thus the word "shall" in line 27 should be changed to "may".

7. On page 14, line 1, there is reference to the concept of increasing the award by an interest rate factor. It is unclear whether it is intended to provide for an escalation in the value of the periodic payment to cover inflation or whether it is trying to define the discount factor in establishing

a reserve for fixed periodic payments. If the desire is to protect against inflation then I would suggest that the language be amended as follows:

> "...periodic payments rather than by a lump sum payment; however the amount of periodic payment shall be increased annually in the same proportion as annual increases in the consumer price index for the community in which the claimant resides."

On the other hand, if the application of a discount factor is the objective, then the following language should be used:

> "...periodic payments rather than by a lump sum payment: however, any part of the award which is paid on periodic basis shall be reserved as an actuarialy calculated annuity utilizing tables and rates for annuity reserves currently approved by the Division of Insurance.

8. The provision in the subrogation section is impossible of implimentation. On page 14, line 11 it provides that evidence of collateral sources are admissable after the fact finder has rendered its award. Presumably the fact finder is a jury and once a jury has rendered its award there is no opportunity to present additional evidence. I would suggest the most workable solution is to strike from line 13, the language "after the fact finder has rendered its award."

9. Page 16, line 21 should be amended to read:

> "...liability per year of not less than one million dollars plus an additional twenty thousand dollars for each bed over fifty beds for which the hospital is licensed."

10. Page 25, line 16. retroactive insurance provision should be changed to read as follows:

> "...(B) that arise out of services performed by the health care provider after December 31, 1974 for any period in which the health care provider had no malpractice insurance except that coverage will not be provided for a claim already filed or of which the health care provider has or reasonably should have had notice at the time retroactive insurance is purchased."

11. I believe that the rating provision should be amended in order to make the charges to physicians track as closely as possible with the intended controll costs intended by the Commission. That may by accomplished within the context of current insuring structures in this measure by amending the rating law as follows.
Page 28, line 10:

"...unpaid, reserves for claims incurred during the policy period but not reported but reasonably expected to be reported within three years after the date of incident ~~and~~ reasonable..."

Adopted

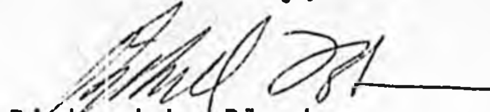
The same change should take place in lines 16 and 17. Also change reserve requirement p25

There should be added an additional factor in establishing the rate as follows:

Adopted

"(12) an amount sufficient to repay any loan obligation".

Yours cordially,



Richard L. Block
Director

BOARD OF GOVERNORS
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AREA CODE 907/272-7469
MARY F. LAFOLLETTE, EXECUTIVE DIRECTOR AND BAR COUNSEL

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January 22, 1976

RECEIVED
JAN [illegible]
Office of Chief Justice
Supreme Court of Alaska
Juneau

Honorable Robert Boochever
Chief Justice
Alaska Supreme Court
Pouch "U"
State Court and Office Building
Juneau, Alaska 99811

Re: Expert Medical Panel Proposed For Use In Medical Malpractice Cases

Dear Mr. Chief Justice:

The court has asked for the Alaska Bar Association's comments concerning the use of expert medical panels in medical malpractice cases as proposed by the Governor's Task Force. My response is necessarily a qualified one to the extent that it must be noted that there is by no means unanimity on this subject among Alaska's lawyers. However, with the assistance of the Alaska Bar's Special Committee on Medical Malpractice, chaired by Anchorage attorney, Joe Young, we have the following comments concerning that proposal:

Perhaps the most important objection to the proposed panel is directed at the underlying premise, i.e., that a jury of lay persons is unable to understand the type of medical evidence presented in a medical malpractice case. That premise is fallacious at best. Any attorney who has ever been involved in a personal injury case requiring the use of medical testimony can attest to the ability of a jury to comprehend and evaluate such testimony. Most physicians demonstrate remarkable skill as witnesses in terms of their ability to reduce complex medical terminology to succinct explanatory remarks. To the extent that the proposed expert medical panel finds its genesis in the notion that jurors are simply not able to grasp the complexities of medical testimony, it is not well founded.

As to the suggestion that such panels are necessary because the parties are too often led down the primrose path to misguided litigation by their own biased medical experts, there is some room for discussion. While it may be true that in a few instances parties (and their attorneys) may be misled by their own overzealous experts, there is no evidence that this has occurred in Alaska. Responsible counsel will consult with independent experts in an effort to determine the validity of a potential malpractice claim.

It is possible that a voluntary screening panel plan such as that used in Arizona or Colorado might be of some utility in weeding out nonmeritorious claims. I am enclosing copies of both the Pima County (Arizona) and Colorado plans. Neither of those measures features a panel comprised solely of members of the medical profession. Those plans do perform a public service to the extent that they may tend to discourage pursuing a suit which is clearly without merit and to the extent that they provide patients with relatively small claims an economical forum for evaluation of their cases. Unfortunately, these plans have not been successful in reducing professional liability insurance rates.

There is a more technical objection to the use of an expert medical panel as proposed by the task force which must be given at least passing mention. Based on the information available to us, it appears that the panel would be free to accept evidence without regard to strict legal standards relating to admissibility. The panel would be free to incorporate such evidence into its findings and that evidence would in turn be admissible without further foundation or qualification. That prospect should prove frightening to doctor and patient alike.

The cost factor of medical malpractice litigation is likely to increase substantially if an expert medical panel plan is implemented. In order to gain an initial advantage at trial from the use of favorable medical panel findings, both parties would have to prepare for hearings before the panel in the same manner as if they were going to trial. In effect, the parties would be put to the added and unnecessary expense of trying their case twice. From the bar association's point of view, it is difficult to see how either the medical profession or the public would be well served by such an inherently expensive procedure.

There is an additional legal objection to the use of a medical expert panel which is simply that the proposal appears potentially violative of Article 1, §1 of the Alaska Constitution which provides in part that "all persons are equal and entitled to equal rights, opportunities, and protection under the law". It is my understanding that a compulsory screening panel plan was struck down on equal protection grounds in Tennessee. The possibility that this proposal may suffer from similar constitutional infirmities cannot be ignored.

A careful review of the Task Force's findings provides no empirical data from which it is possible to infer that the creation of a medical expert panel is either necessary or desirable. Indeed, there is no evidence to suggest that juries are somehow incapable of properly resolving these cases.

In its present form, the expert medical panel bears little resemblance to the voluntary screening panel proposed by the Alaska Bar nearly five years ago. That plan had the virtue of being optional and at least paid lip service to the notion that objectivity in the review of such matters should and could be maintained. The panel proposed by the task force would consist of one physician and two other health care providers of the same health care provider charged. Thus, in the instance of a malpractice claim against a physician, the expert panel would be composed entirely of physicians. While we may all be convinced of the integrity of the physicians elected for service on such a panel, the appearance of impropriety may be raised merely by the panel's composition.

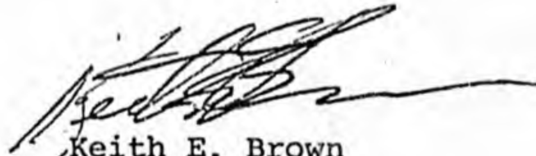
I wish I could report that the Alaska Bar Association has devised a means by which the current medical liability insurance crisis could be resolved. Unhappily, that is not the case. Despite the high quality of medical care rendered to Alaskans, the sad fact is that we are simply the tip of the proverbial iceberg, controlled in this case by events of national magnitude. While I have not been shown any accurate figures relating to premium/loss ratio in Alaska, I would estimate that the premium revenue far outstrips the relatively few losses paid out for medical maloccurrences. Alaska's physicians are being asked to pay for a national loss experience and are probably paying the price of the losses of the insurance industry in the stock market.

As things presently stand, a workable joint underwriting association bill seems to have the greatest possible chance to stabilize the current insurance picture. I should add that in all likelihood the bar's own insurance problems will follow closely on the heals of those currently confronting the medical profession. Our own arrangements for a group E & O policy has given us a considerable amount of information relating to cancellations by a number of carriers previously writing E & O coverage in Alaska. Premiums are going up, and will continue to escalate; moreover, and it is almost inevitable that members of the bar will be relegated to purchasing "claim made" as opposed to the more desirable "per occurrence" coverage. With that thought in mind, I believe that the organized bar is sympathetic to the plight of the medical profession. But, I trust that when our turn comes we will not be advancing our own proposal for a "legal expert board".

It is possible that a voluntary arbitration plan similar to that now offered in Michigan might prove to be of some benefit, but a consideration of such alternatives is beyond the scope of this letter. Suffice it to say that from the bar's point of view and, I expect, from the public's, the proposed medical expert panel has nothing to commend it.

If the bar can be of any assistance to the court, please contact me.

Very truly yours,



Keith E. Brown
President

KEB:wj

Enclosures

cc: Joe Young
BOG Members
Mary LaFollette

Mandatory group ~~Opt~~ in insurance for other groups
1. Director has hearing then Mandatorily includes a group
He uses a standard of impairment of delivery of that healthcare system to the public

Expert Advisory panel of 3 Mandatorily appointed by court — No list or challenge procedure — ~~Appointees from profession the case involves~~ Judge has discretion on composition only limit to health care provider
~~eliminate "Alaska" ~~from~~ residency~~
~~Add language "when possible select Alaskan Health~~

Change "health care provider"
to "Medical Care provider"

Paar

John Hedland

large settlements not the problem

high cost of experts for cases

3

HEW defense att receive more legal fees

System designed to require a lot of legal work

Expert Advisory Board - Report to court

What is cheaper about Advisory Board ?
Is the problem jurors don't have enough info ?
Why is a 3rd opinion better ?
What if Advisory Board is split ?
What happens to att fees + court costs in cases now ?

Const Amend would allow Adjudication Board

Expand Small Claims Court set-ups

What is cheaper about Adj. Board over Jury
What really is so expensive about Jury

Mandatory arbitration is farther from Jury type system - No judge present

if not Mandatory have 2 courts
What about pre-liminary hearings + Grand Jury
Penalize for loss in appealing - Test strength of case

loser pays costs

Original sponsor: Rules Committee by request of the Governor

IN THE HOUSE BY THE JUDICIARY COMMITTEE

CS FOR HOUSE BILL NO. 574

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to liability for the provision of health care services; changing the Alaska Supreme Court's Rules of Civil Procedure; and providing for an effective date."

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

* Section 1. AS 08.01.050 is amended by adding a new paragraph to read:

(19) provide investigative services to the boards established under chs. 20, 32, 36, 64, 68, 71, 72, 80, 84, and 86 of this title, for the purpose of assisting those boards in matters of professional discipline.

* Sec. 2. AS 08.20 is amended by adding new sections to read:

Sec. 08.20.115. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for chiropractic malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for chiropractors is impairing the delivery of chiropractic services to the public.

In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice chiropractic should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 3. AS 08.32 is amended by adding new sections to read:

Sec. 08.32.015. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if the person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for dental hygienists is impairing the delivery of dental hygienists' services to the public.

Sec. 08.32.165. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 160 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice dental hygiene should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 4. AS 08.36 is amended by adding new sections to read:

Sec. 08.36.115. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for dental malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for dentists is impairing the delivery of dentist services to the public.

Sec. 08.36.325. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 320 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice dentistry should be limited or conditioned or the practitioner disciplined, the board may censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 5. AS 08.64 is amended by adding new sections to read:

Sec. 08.64.215. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance issued by the Health Care Providers Indemnity Corporation against liability to patients for medical malpractice in limits of not less than

$200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development or his designee may waive the requirement in (a) of this section for a person if that person furnishes satisfactory evidence of his having other insurance providing coverage in amounts not less than those specified in (a) of this section. No waiver granted under this subsection may extend beyond the normal expiration date of the person's insurance policy or January 1, 1977, whichever occurs first.

Sec. 08.64.312. CONTINUING EDUCATION REQUIREMENTS. (a) The board shall promote a high degree of competence in the practice of medicine by requiring every physician licensed in the state to fulfill continuing education requirements.

(b) Before a license may be renewed the licensee shall submit evidence satisfactory to the board of his successful completion of 15 hours of continuing education annually in medicine as prescribed by regulations of the board. Courses approved by the board shall include, but are not limited to, review courses and instruction on new techniques and developments in medicine.

(c) The board may exempt a physician from the requirements of (b) of this section upon an application by him giving evidence satisfactory to the board that he is unable to comply with the requirements because of extenuating circumstances. However, no person may be exempted from more than 15 hours of continuing education in a five year period.

Sec. 08.64.325. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 330 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice under this chapter should be limited or condi-

tioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 6. AS 08.68 is amended by adding new sections to read:

Sec. 08.68.165. INSURANCE REQUIRED. (a) To be eligible for an active license as a nurse under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for nurses is impairing the delivery of nurse services to the public.

Sec. 08.68.275. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 270 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice nursing should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 7. AS 08.71 is amended by adding new sections to read:

Sec. 08.71.085. INSURANCE REQUIRED. (a) To be eligible for an