240 HJ FCC MALPRACTICE (INCLUDING HB 574)

(b) Testimony, documents, proceedings, records, and other evidence adduced before a review organization that are otherwise inaccessible under this section may be obtained by a health care provider who claims that denial is unreasonable or may be obtained under subpoena or discovery proceedings brought by a plaintiff who claims that information provided to a review organization was false and claims that the person providing the information knew or had reason to know the information was false.

(c) Nothing in this chapter prevents a person whose conduct or competence has been reviewed under this chapter from obtaining, for the purpose of appellate review of the action of the review organization, any testimony, documents, proceedings, records and other evidence adduced before the review organization.

Sec. 18.23.040. PENALTY FOR VIOLATION. Other than as authorized by sec. 30 of this chapter, a disclosure of data and information acquired by a review committee or of what transpired at a review meeting is a misdemeanor and punishable under AS 11.05.010.

Sec. 18.23.050. PROTECTION OF PATIENT. Nothing in this chapter relieves a person of liability which he has incurred or may incur to a person as a result of furnishing health care to the patient.

Sec. 18.23.060. PARTIES BOUND BY REVIEW. When a review organization reviews matters under sec. 70(5)(H) of this chapter no party is bound by a ruling of the organization in a controversy, dispute or question unless he agrees in advance, either specifically or generally, to be bound by the ruling.

Sec. 18.23.070. DEFINITIONS. In this chapter, unless the context otherwise requires,

(1) "administrative staff" means the staff of a hospital or clinic;

(2) "health care" means professional services rendered by a health care provider or an employee of a health care provider, and services furnished by a sanatorium, rest home, nursing home, boarding home or other institution for the hospitalization or care of human beings;

(3) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.-72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital;

(4) "professional service" means service rendered by a health care provider of the type he is licensed to render;

(5) "review organization" means a hospital governing body or a committee whose membership is limited to health care providers and administrative staff, except where otherwise provided for by state or federal law, and which is established by a hospital, by a clinic, by one or more state or local associations of health care providers, by an organization of health care providers from a particular area or medical institution, or by a professional standards review organization established under 42 U.S.C., sec. 1320(c)(1) et seq., to gather and review information relating to the care and treatment of patients for the purposes of

(A) evaluating and improving the quality of health care [illegible] area or medical institution;

(B) reducing morbidity or mortality;

(C) obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(D) developing and publishing guidelines showing the norms of health care in the area or medical institution;

(E) developing and publishing guidelines designed to keep the cost of health care within reasonable bounds;

(F) reviewing the quality or cost of health care services provided to enrollees of health maintenance organizations;

(G) acting as a professional standards review organization under 42 U.S.C., sec. 1320(c)(1) et seq.;

(H) reviewing, ruling on, or advising on controversies, disputes or questions between

(i) a health insurance carrier or health maintenance organization and one or more of its insured or enrollees;

(ii) a professional licensing board, acting under its powers of discipline or license revocation or suspension, and a health care provider licensed by it when the matter is referred to a review organization by the professional licensing board;

(iii) a health care provider and his patients concerning diagnosis, treatment or care, or a charge or fee;

(iv) a health care provider and a health insurance carrier or health maintenance organization concerning a charge or fee for health care services provided to an insured or enrollee; or

(v) a health care provider or his patients and the federal or a state or local government, or an agency of the

federal or a state or local government;

(I) acting on the recommendation of a credential review committee or a grievance committee.

* Sec. 23. AS 21 is amended by adding a new chapter to read:

CHAPTER 88. HEALTH CARE PROVIDERS INSURANCE.

ARTICLE 1. PURPOSE.

Sec. 21.88.010. PURPOSE OF CHAPTER. It is the purpose of this chapter to provide a means of assuring all health care providers with continuous, affordable and adequate insurance against liability for medical negligence by concentrating all such insurance in one entity [which can negotiate more successfully for insurance from casualty insurers licensed by this state] and to distribute equitably the cost of the insurance among the health care providers insured.

ARTICLE 2. INDEMNITY CORPORATION.

Sec. 21.88.020. CORPORATION CREATED. There is created the Alaska Health Care Providers Indemnity Corporation which is a public corporation having a legal existence independent of and separate from the state. Obligations issued by the corporation do not constitute a debt liability or obligation of the state or a pledge of full faith and credit of the state.

Sec. 21.88.030. CORPORATION BOARD OF GOVERNORS. (a) The corporation shall exercise its powers through a board of governors which shall be appointed by the director as provided in (b) of this section.

(b) The appointments to the board of governors shall be Alaska residents as follows:

(1) one member of the Alaska State Medical Association appointed from a list of no less than three persons recommended by the governing board of that association;

(2) one member of the Alaska State Hospital Association

appointed from a list of no less than three persons recommended by the governing board of that association;

(3) ~~three~~ two professionals in the insurance field;

(4) ~~three~~ two persons who are not ~~attorneys~~, health care providers, or ~~representatives of~~ affiliate Local the insurance industry.

(5) One physician from clinical group practice in Ak.

(c) The term of office of each governor is three years, except that the director shall designate three initially appointed governors to serve for one year and two initially appointed governors to serve for two years.

(d) Upon the expiration of the term of a governor, the director shall appoint a successor who shall be from the same class described in (b) of this section as the governor whose term has expired.

(e) Upon a governor's early resignation, death or inability to serve, the director shall appoint a successor from the same class defined in (b) of this section as the terminating governor, who shall serve for the unexpired term.

(f) The director or his designee is not a voting member of the board of governors but shall be notified by the board of and have the right to attend and participate in all meetings and proceedings of the board.

(g) Each member of the board of governors shall be allowed compensation for services and reimbursement for reasonable expenses incurred in attending meetings of the board and transacting corporation business, [as set out in the plan of operation.] $100/day + travel

Sec. 21.88.040. CORPORATION PLAN OF OPERATION. (a) Within 30 days after the effective date of this chapter, the board of governors shall prepare and submit to the director for approval a plan of operation which provides for the fair, reasonable and equitable administra-

for which it is created. The plan and any amendments of it become effective upon the director's approval. If the board of governors has failed to submit a plan of operation, or if at any subsequent time the board of governors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to effectuate the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures by which all the powers and duties of the corporation specified in sec. 50 of this chapter shall be performed;

(2) establish procedures for handling assets and discharging liabilities of the corporation;

(3) establish regular places and times for meetings of the board of governors;

(4) establish procedures for records to be kept of all financial transactions of the corporation, its agents, and the board of governors;

[(5) establish the amount and method of reimbursing and compensating members of the board of governors;]

(6) establish procedures for awarding contracts to carry out the provisions of this chapter;

(7) establish the procedures for issuing contracts of insurance as provided in sec. 50 of this chapter and for the determination of rates;

(8) contain additional provisions necessary or proper for the [illegible] of the corporation.

Sec. 21.88.050. POWERS AND DUTIES OF THE CORPORATION. (a) The

corporation shall

(1) issue to all health care providers who pay the premiums for it a contract on an occurrence basis indemnifying the health care provider and his employees who are health care providers against loss by reason of liability and agreeing to tender on behalf of the health care provider and his employees who are health care providers a defense of the health care provider in a proceeding brought under AS 09.55.530 - 09.55.560; the limit of liability shall be no less than the minimum liability coverage required to be maintained as stated in AS 08.64.215 and AS 18.20.045; the contract shall cover the defense against but need not indemnify a claim for punitive damages; the contract shall cover claims against health care providers

(A) that arise out of professional services performed by the health care provider during the period for which the premium is paid; and, at the option of the health care provider

(B) that arise out of services performed by the health care provider after January 1, 1975 and are filed within three years from the date the services were performed but were not discovered by the health care provider when he chose to take this coverage;

Add: and for an additional premium

(2) charge a premium for the protection provided by the contracts issued under (1) of this subsection which shall be determined by the board of governors in accordance with sec. 70 of this chapter and subject to the approval of the director;

(3) comply with or be subject to AS 21.06.090, 21.06.120, 21.06.140, 21.06.160, 21.06.250; AS 21.09.180, 21.09.190, 21.09.200, 21.09.250, 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18, [illegible] of this title;

Insurances be included with [illegible]

(4) carry out the obligations of the contracts issued under

(1) of this subsection by defending all covered claims made against insured health care providers and by paying all liabilities which are finally adjudicated against the insured health care provider or which may in the opinion of the corporation reasonably be expected to be finally adjudicated against the health care provider to the extent of the contract obligation;

(5) provide coverage to health care providers for liability under AS 09.55.530 - 09.55.560 in excess of the minimum limits required for licensure as a health care provider, but limited to $1,000,000 for individual health care providers and $5,000,000 for hospitals, if there is a finding by the director that this coverage is unavailable at a reasonable cost and that this coverage can be made available at a reasonable cost through the corporation; if this paragraph is implemented, each health care provider obtaining excess coverage up to these amounts ~~shall~~ may obtain it from the corporation, and the corporation ~~shall~~ may procure reinsurance for all the risks incurred by contracts issued under this paragraph from the private market.

(b) The corporation may

(1) employ or retain persons, individual or corporate, to discharge its obligations and shall pay, by way of salary, wage, fee, or commission, reasonable compensation for those services; employees of the corporation are not considered state employees;

(2) provide coverage to health care providers for other hazards including malpractice liability insurance for other licensed health care providers employed by the physician or hospital if there is a finding by the director that this coverage is otherwise unavailable by reason of the operation of the corporation;

(3) borrow funds from the revolving loan fund established under sec. 110 of this chapter when necessary for the corporation to

MC: Power to contract for management services.

maintain adequate reserves; loans from the fund shall be repaid within four years after the loan is made at an annual interest rate of seven percent and through prospective rate increases;

(4) negotiate and become a party to those contracts as are necessary to carry out the purposes of the corporation;

(5) sue or be sued in the name of the corporation;

(6) provide risk management + services

(7) perform all other acts necessary and proper to effectuate the corporation.

Sec. 21.88.060. STATISTICS. The corporation shall collect, maintain and report information concerning claims against health care providers. All such information shall be on forms prescribed by the director and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. No less often than annually the corporation shall report to the director, which report shall be kept available to the public, the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to, and the expenses incurred by the corporation during the year. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, no reports which become publicly available may include the names of health care providers or claimants or information that will permit by inference the identity of specific health care providers or claimants. All information shall be made available to the appropriate licensing boards or agencies.

Sec. 21.88.070. RATES. Rates and rating plans used by the corporation for the policies issued shall be determined for each category of health care provider in accordance with all of the following:

(1) rates for physicians ~~shall~~ may be set as a function of the physician's [gross] * medical revenue;

* changed from previous

* perhaps adjusted gross income as reflected in Fed. Tax

(2) rates for hospitals shall be set as a function of the number of permanent beds in the hospital;

(3) a minimum rate may be set for each category of health care provider or discipline or classification within the license category;

(4) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which are actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for claims reported and unpaid, reserves for claims incurred but not reported, and reasonable expenses for the operation of the corporation;

(5) rates may not be inadequate; rates are inadequate if, based on available actuarial data, the premiums to be paid by the health care providers are or may reasonably be expected to be insufficient to pay for losses incurred by the corporation, including claims paid, reserves for claims reported and unpaid, reserves for claims incurred but not reported, and reasonable expenses for the operation of the corporation;

(6) rates shall be adjusted at least as often as annually;

(7) rates for any policy year shall be calculated to include the adjustment for actual experience of the corporation as developed for the preceding four policy years;

(8) in considering losses to be incurred, changes in the law and national, regional and local trends in medical negligence awards may be considered;

(9) income from investment of reserves shall be considered;

(10) disciplines and classifications within the license categories of health care providers shall be considered;

(11) individual risk underwriting factors shall be considered.

(12) see Block arm

Sec. 21.88.080. REQUIRED INSURANCE; CANCELLATION. The corporation shall provide insurance to all health care providers otherwise eligible for licensure under AS 08.64 and AS 18.20. The corporation may provide for installment payment of premiums in which event each installment is due by the date specified. The corporation may cancel any of its policies in the event of nonpayment of any premium or installment on a premium or other charge by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice stating when, not less than 10 days after notice is received by the insured, the cancellation is effective.

ARTICLE 3. LOAN FUND.

Sec. 21.88.110. FUND ESTABLISHED. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) Loans from the fund may be made to the corporation when necessary for the fund to maintain adequate reserves.

(c) Loans from the fund shall be repaid by the corporation within four years at an annual interest rate of seven per cent.

ARTICLE 4. GENERAL PROVISIONS.

Sec. 21.88.300. DEFINITIONS. As used in this chapter,

(1) "corporation" means the Health Care Providers Indemnity Corporation;

(2) "director" means the director of the division of insurance for the State of Alaska;

(3) "fund" means the medical malpractice liability revolving loan fund;

(4) "health care provider" means a physician licensed under AS 08.64 or a hospital as defined in AS 18.20.136, including a hospital or health care facility owned or operated by the state or one or more of

its political subdivisons;

(5) "occurrence basis insurance" is insurance against claims arising during the period of the policy coverage.

* Sec. 24. AS 08.64.365 is repealed.

* Sec. 25. This Act takes effect 30 days after enactment.

HB 574
Med - Malp.
House Judiciary

The Legislature of the State of Alaska
FISCAL NOTE
Second Session - Ninth Legislature

I. REQUEST

Bill Identification: An Act relating to liability for the provision of health care services; changing the Alaska Supreme
Title: Courts Rules of Civil Procedure; and providing for an effective da
Requested by: Fran Ulmer Date:
Return Date Requested: 1-12-76
Agency: Commerce Program: Licensing Professions

II. FISCAL DETAIL

Budget Request Unit(s) Affected: Regulating and Licensing Professions

A. EXPENDITURES: (Thousands of dollars)

	OBJECT	FY 76	FY 77	FY 78	FY 79	FY 80	FY 81
100	PERSONAL SERVICES	0	62.8	69.1	76.0	83.6	91.9
200	TRAVEL	0	5.1	5.6	6.2	6.8	7.5
300	CONTRACTUAL	0	12.9	14.2	15.6	17.2	18.9
400	COMMODITIES	0	1.0	1.1	1.2	1.3	1.4
500	EQUIPMENT	0	14.3	.0	.0	.0	.0
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
	TOTAL	0	96.1	90.0	99.0	108.9	119.7

B. FUNDING: (Thousands of dollars)

GENERAL FUND	.0	96.1	90.0	99.0	108.9	119.7
FEDERAL FUNDS						
OTHER						

C. POSITIONS:

PERMANENT/TEMPORARY	0/0	3/	3/	3/	3/	3/
MAN MONTHS (P./T.)	/	36/	36/	36/	36/	36/

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

AS 08.01.070 (4) empowers the nine Boards subject to this bill "to request, through the Department of Commerce and Economic Development, investigation of violations of their laws and regulations." The above titled bill will make specific the Department's authority and responsibility to conduct such investigations. Additionally, the bill will widen the boards' discipline powers to include limiting or restricting licensee practice. The obvious intent is to reduce the incidence of malpractice actions by empowering the boards to take preventive action.

continued

IV. ATTACHMENTS

Budget forms 12 thru 17

V. DATE: 1-13-76 PREPARED BY: Sharon Andrew, Director

REVIEWED BY:

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

12 New Position Summary

Fiscal Note Attached - An Act relating to liability for the provision of health care services; changing the Alaska Supreme Court Rules of Civil Procedure; and providing for an effective da

CLASSIFICATION TITLE (1)	PRIORITY (2)	PCN (3)	PAY RGE. (4)	MTHLY. SALARY (5)	REVISED PROGRAM NO. (6)	TOTAL POSITION COST (7)	BUDGET YEAR (BY) NO. POS. (8)	NO. MO. (9)	ANNUAL AMOUNT AGENCY MAINTENANCE (10)	ANNUAL AMOUNT AGENCY CHANGE (11)	ANNUAL AMOUNT GOVERNOR (12)
1 Public Protection											
2 General Gov't Unit											
3											
4 Chief Investigator-HCS		new	18G	1852		40,421	1	12		22,224	
5 Benefits @ 21%										4,667	
6											
7 Sp. Investigator-HCS		new	15G	1483		34,573	1	12		17,796	
8 Benefits @ 21%										3,737	
9											
10 Clerk Typist III		new	8G	988		21,266	1	12		11,856	
11 Benefits @ 21%										2,490	
12											
13											
14											
15											
16											
17											
18											
19											
20											
21											
22											
23 SALARIES										51,876	
24 OVERTIME											
BENEFITS										10,894	
26 SUB-TOTAL										62,770	
27 VACANCY									%	5.14 %	%
TOTAL ANNUAL AMOUNT										62,770	
PERMANENT FULL TIME: POSITIONS & (months)									( )	3 (36)	( )
PERMANENT PART TIME/SEASONAL: POSITIONS and (months)									( )	( )	( )
TEMPORARY, FULL TIME EQUIVALENT: POSITIONS & (months)									( )	( )	( )
TOTAL MONTHS										36	

BRU Regulating and Licensing of Professions BRU CODE 08-53-5-07-00-00 REVISED

12 PERSONAL SERVICES NEW POSITION SUMMARY

13 Request for New Positions

POSITION TITLE	RANGE	LOCATION	GOVERNOR
Chief Investigator - HCDS	18G	Anchorage	APPROVED ☐ DISAPPROVED ☐

TYPE OF POSITION (PFT, PPT, SEAS)	NEW	MAINT.	CHANGE	PRIORITY	PAGE/LINE
PFT	RPA		XX		

TYPE OF EXPENDITURE	AMOUNT	FUNDING SOURCE GF	OTHER	RECEIPT CODE	DETAIL OF RELATED EXPENSES
PERSONAL SERVICES	26,891	X			22,224 & 4,667 benefits @ 21%
TRAVEL	2,540				6 trips @ 200 plus 30 p.d. days @ 46.66
CONTRACTUAL	4,400				
COMMODITIES	300				stationary, etc.
EQUIPMENT	6,200				office furnishings, recording equip, vehicle
OTHER					
TOTAL	40,421				BRU COMPONENT

JUSTIFICATION:

Position will establish and direct investigative support section for nine boards in health care delivery service industry. Responsibile for conducting special investigations and directing activities of subordinate staff. Will be under general supervision of licensing violations officer, but remain relatively antonomous in case preparation for administrative action to discipline licensees.

BRU: Regulating and Licensing of Professions BRU CODE 08-53-5-07-00-00 REVISED _____

13 PERSONAL SERVICES REQUEST FOR NEW POSITION

13 Request for New Positions

POSITION TITLE	Special Investigator-Health Care Delivery Service	RANGE	15G	LOCATION	Anchorage	GOVERNOR
TYPE OF POSITION (PFT, PPT, SEAS)	PFT	NEW	X	MAINT.		APPROVED / DISAPPROVED
		RPA#		CHANGE	X	PRIORITY ____ PAGE/LINE ____

TYPE OF EXPENDITURE	AMOUNT	FUNDING SOURCE GF	FUNDING SOURCE OTHER	FUNDING SOURCE RECEIPT CODE	DETAIL OF RELATED EXPENSES
PERSONAL SERVICES	21,533				17,796 plus 3737 benefits @ 21% 6 trip
TRAVEL	2,540				@ 200 plus 30 p.d. days @ 46.66 stationary
CONTRACTUAL	4,100				etc.
COMMODITIES	200				of c. furnishings, vehicle, recording equ
EQUIPMENT	6,200				
OTHER					
TOTAL	34,573				BRU COMPONENT

JUSTIFICATION: Under supervision will conduct investigations in health care delivery service industry to prepare and compile evidence necessary to sustain license discipline actions.

BRU: Regulating & Licensing of Professions BRU CODE 08-53-5-07-00-00 REVISED ____

13 PERSONAL SERVICES REQUEST FOR NEW POSITION

13 Request for New Positions

POSITION TITLE	RANGE	LOCATION	GOVERNOR
Clerk Typist III	8G	Anchorage	APPROVED ☐ DISAPPROVED ☐

TYPE OF POSITION (PFT, PPT, SEAS)	NEW	MAINT.	CHANGE	PRIORITY	PAGE/LINE
PFT	X		X		

TYPE OF EXPENDITURE	AMOUNT	FUNDING SOURCE: GF	OTHER	RECEIPT CODE	DETAIL OF RELATED EXPENSES
PERSONAL SERVICES	14,346	X			11,856 + 2490 benefits @ 21%
TRAVEL	0				ofc space telephone and vehicle
CONTRACTUAL	4,400				100 sq. ft. ofc, phone, IBM type + maint.
COMMODITIES	500				agent stationary etc.
EQUIPMENT	2,020				ofc. furnishings & dictaphone
OTHER					
TOTAL	21,266				BRU COMPONENT

JUSTIFICATION: Position will provide general clerical support for two full time staff investigators in health care delivery service industry.

BRU: Regulating & Licensing of Professions BRU CODE 08-53-5-07-00-00 REVISED

13 PERSONAL SERVICES REQUEST FOR NEW POSITION

14. Travel

CODE	TRAVEL CLASSIFICATION	PRIOR YEAR (PY) ACTUAL	CURRENT YEAR (CY) AUTHORIZED	BUDGET YEAR (BY) AGENCY Maintenance	AGENCY Change	AGENCY Request	GOVERNOR'S BUDGET
200	TOTAL TRAVEL				5.1		
210/220	FIELD/ADMINISTRATIVE TRAVEL						
	IN-STATE TRANSPORTATION				2.4		
	IN-STATE PER DIEM				2.7		
	OUT-OF-STATE TRANSPORTATION						
	OUT-OF-STATE PER DIEM						
230	CONVENTIONS AND MEETINGS						
	IN-STATE TRANSPORTATION						
	IN-STATE PER DIEM						
	OUT-OF-STATE TRANSPORTATION						
	OUT-OF-STATE PER DIEM						
920	INTER-AGENCY TRANSFERS (Non-Add)						

EXPLANATION:

Two investigators in health care delivery services. Case load average = 23 1/2 per man, 75% of which are in local area.

12 trips per year at average of $200.00 = $2400.00
12 trips, average 5 p.d. days @ $44.66 = $2680.00

BRU Regulating and Licensing of Professions BRU CODE 08-53-5-09-00-00 REVISED

15 Contractual Services

CODE	CONTRACTUAL SERVICES CLASSIFICATION	PRIOR YEAR (PY) ACTUAL	CURRENT YEAR (CY) AUTHORIZED	BUDGET YEAR (BY) AGENCY Maintenance	AGENCY Change	AGENCY Request	GOVERNOR'S BUDGET
300	TOTAL CONTRACTUAL				12.9		
310	COMMUNICATION SERVICES				2.7		
320	PRINTING AND ADVERTISING				.2		
330	RENTS AND UTILITIES				4.8		
340	REPAIRS, SERVICES AND ALTERATIONS				.5		
350	TRANSPORTATION OF THINGS				.3		
360A	EQUIPMENT RENTAL-HIGHWAY WORKING CAPITAL FUND				2.4		
360B	EQUIPMENT RENTAL-WORD PROCESSING				.0		
360C	EQUIPMENT RENTAL-OTHER				2.0		
370	INSURANCE AND BONDING				.0		
380	PROFESSIONAL FEES AND SERVICES				.0		
390	OTHER				.0		
930	INTER-AGENCY TRANSFERS (Non-Add)				.0		

EXPLANATION:

310: 3 telephones, monthly phone charge and long distance
320: printing and advertising
330: rents and utilities - 400 sq. ft. @ 1.00 per foot per month
340: maintenance on equipment
350: transportation of recording equipment, records, etc.
360A: 2 vehicles at approximately $100.00 per month per car
360C: IBM memory typewriter @ 165.00 per month

	CLK/TYP III	Chief Inves.	Sp. Invest.
310:	.7	1.0	1.0
320:	.0	.2	.0
330:	1.2	1.8	1.8
340:	.5	.0	.0
350:	.0	.2	.1
360A:	.0	1.2	1.2
360C:	2.0	.0	.0

BRU: Regulating and Licensing of Professions BRU CODE 08-53-5-07-00-00 REVISED

16 Commodities

CODE	COMMODITIES CLASSIFICATION	PRIOR YEAR (PY) ACTUAL	CURRENT YEAR (CY) AUTHORIZED	BUDGET YEAR (BY) AGENCY Maintenance	AGENCY Change	AGENCY Request	GOVERNOR'S BUDGET
400	TOTAL COMMODITIES				1.0		
410	CLOTHING						
430	FOOD FOR HUMAN CONSUMPTION						
440	FUEL (OTHER THAN FOR MOTOR VEHICLES)						
450	MAINTENANCE & CONSTRUCTION MATERIALS						
460	MOTOR VEHICLE,PARTS,SUPPLIES & ACCESSORIES						
470	PROFESSIONAL & SCIENTIFIC SUPPLIES						
480	STATIONERY AND OFFICE SUPPLIES				1.0		
490	OTHER SUPPLIES,MATERIALS AND PARTS						
940	INTER-AGENCY TRANSFERS (Non-Add)						

EXPLANATION:

office supplies for three staff positions

BRU Regulating and Licensing of Professions BRU CODE 08-53-5-07-00-00 REVISED

17 Equipment

CODE	EQUIPMENT CLASSIFICATION	PRIOR YEAR (PY) ACTUAL	CURRENT YEAR (CY) AUTHORIZED	BUDGET YEAR (BY) AGENCY Maintenance	AGENCY Change	AGENCY Request	GOVERNOR'S BUDGET
500	TOTAL EQUIPMENT				14.3		
510	VEHICLES, BOATS, AIRPLANES				9.4		
520	OFFICE FURNITURE AND EQUIPMENT				4.0		
530	EQUIPMENT PECULIAR TO THE PROGRAM				.9		
560	SHOP AND MAINTENANCE EQUIPMENT						
590	OTHER EQUIPMENT						
950	INTER-AGENCY TRANSFERS (Non-Add)						

EXPLANATION:

ITEM NO.	DESCRIPTION OF ITEMS REQUESTED	EQUIP. CODE	NO. OF UNITS	UNIT COST	REPLACEMENT	NEW
1	executive desk	520	2	240		480
2	credenza	520	3	240		720
3	bookcase	520	3	90		180
4	[illegible] chair	520	3	125		370
5	executive chair	520	2	180		360
6	secretarial desk	520	1	285		285
7	secretarial chair	520	1	80		80
8	file cabinet	520	2	175		350
9	vehicles	520	2	4700		9400
10	recording equipment	520	2	450		900
11	dictation equipment	520	1	1200		1200

BRU: Regulating and Licensing of Professions BRU CODE 08-53-5-07-00-00 REVISED

Continued -

The concept, of course, is not new, since the purpose of licensing acts is preventive public protection. Historically, however, the emphasis has been on demonstrating a minimum level of competence prior to licensure. Enforcement of standards of practice after licensure has been, for the most part, delegated to private institutions or associations.

Although the obvious intent of this bill is to reduce the incidence of malpractice actions, the real purpose is to help assure an adequate supply of health care delivery personnel, an occupational group which is threatened by soaring malpractice insurance premiums. If this package of bills is enacted, it will not last long if the state is ineffectual in its efforts to reduce malpractice.

To accomplish this, the boards will need a highly sophisticated investigative staff capable of responding quickly to complaints and monitoring the activities of in excess of 8,795 licenses. Unfortunately, there is little data available upon which to base projections of the probable work load. The Anchorage Daily Times, in two separate articles last summer, enumerated some 55 Alaska malpractice cases from 1957 through 1974. This is an average of three known cases per year and represents .034% of Alaska's total licenses in the health care delivery industry.

It should be noted that only one half or 4,398 of these are active licensees, the remainder being in an inactive or lapsed status. They are included because for the majority, reactivating the license is primarily an administrative function which does not require additional demonstration of competency.

Compiling the data necessary to sustain a disciplinary action in this industry in accordance with the Administrative Procedures Act is estimated to require an average of one half man month per case. The above statistics would indicate staffing needs of 1 1/2 man months per year. Assuming the boards responsibilities would require investigative actions on 1% of the active licensees per year raises the number to 47 cases or 23 man months. Two full-time investigators will generate clerical work expected to require the services of one full-time clerk typist III. It cannot be over-emphasized that these projections are based on assumptions which have very little basis since statistical data is almost entirely unavailable.

It has been assumed that this bill will be effective July 1, 1975. Expense projections allow for 10% inflation factor only.

I. REQUEST

Bill No. "An act relating to liability for the provision of health care
Title: services; chagning Alaska Sup. Court's Rules of Civil Procedur
Requested by: Office of the Governor Date: December 31, 1975
Return Date Requested: January 12, 1976
Agency: Commerce & Economic Dev. Program: Insurance

II. FISCAL DETAIL

Budget Request Unit(s) Affected: none

A. EXPENDITURES: (Thousands of dollars)

	OBJECT	FY 76	FY 77	FY 78	FY 79	FY 80	FY 81
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
	TOTAL						

B. FUNDING: (Thousands of dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						

C. POSITIONS:

PERMANENT/TEMPORARY	/	/	/	/	/	/
MAN MONTHS (P./T.)	/	/	/	/	/	/

III. ANALYSIS (See Fiscal Note Preparation Instruction , Section III)

No fiscal Note impact

IV. ATTACHMENTS

V. DATE: 1/[illegible]/76 PREPARED BY: [signature]

Approved: [signature]

Adopted

A M E N D M E N T #1 suggested by Revisor of Statutes

TO: CS FOR HOUSE BILL NO. 574

Page 2, line 2: after "demonstrated" insert "lack of"

Page 2, line 25: after "demonstrated" insert "lack of"

Page 3, line 18: after "demonstrated" insert "lack of"

Page 4, line 28: after "demonstrated" insert "lack of"

Page 5, line 21: after "demonstrated" insert "lack of"

Page 6, line 14: after "demonstrated" insert "lack of"

Page 7, line 7: after "demonstrated" insert "lack of"

Page 7, line 29: after "demonstrated" insert "lack of"

Page 8, line 22: after "demonstrated" insert "lack of"

Page 9, line 23: after "demonstrated" insert "lack of"

A M E N D M E N T #2

Adopted

TO: CS for HOUSE BILL NO. 574

Page 4, line 3: after "him" insert "from the ~~corporation~~" Healthcare Providers Indemnity Corp.

A M E N D M E N T #3 Adopted

TO: CS for HOUSE BILL NO. 574

Page 4, lines 15 - 20: delete all material and insert:

(b) Before a license may be renewed the licensee shall submit evidence to the board that ~~the~~ continuing education requirements prescribed by regulations adopted by the board have been met.

A M E N D M E N T #4 Failed

TO: CS for HOUSE BILL NO. 574

Page 4, between lines 10 and 11: insert the following:

(c) This section does not apply to persons licensed under this chapter who are employed ~~full-time~~ by the federal, state, or local government and do not ~~practice~~ provide healthcare practice outside this employment.

A M E N D M E N T #5

TO: CS for HOUSE BILL NO. 574

Page 5, line 10: delete "$200,000" and insert "$100,000"

Page 5, line 10: delete "$600,000" and insert "$300,000"

A M E N D M E N T #6

Adopted

TO: CS for HOUSE BILL NO. 574

Page 13, line 8: after "proving" insert "by a preponderance of evidence"

A M E N D M E N T #7

Adopted

TO: CS for HOUSE BILL NO. 574

Page 14, between lines 26 and 27, insert:

Sec. 09.55.554. ORAL CONTRACTS. No cause of action against a health care provider arises for breach of an oral contract to provide a cure or achieve a specific medical result.

A M E N D M E N T #8

Adopted

TO: CS for HOUSE BILL NO. 574

Page 15, lines 16 and 17: after "circumstances" and before "used" delete all material

A M E N D M E N T #9

Adopted

TO: CS for HOUSE BILL NO. 574

Page 23, lines 21 - 24: delete all material and insert the following:

(g) Members of the board of governors receive $100 a day when the board meets, and travel ~~and per diem~~ expenses allowed by law.

Page 24, lines 20 and 21: delete all material

A M E N D M E N T #10

Adopted

TO: CS for HOUSE BILL NO. 574

Page 25, line 15: after the semi-colon insert "and, at the option of the health care provider," that... "(B)

A M E N D M E N T #11

Adopted

TO: CS for HOUSE BILL NO. 574

Page 27, between lines 6 and 7, insert the following:

(6) negotiate for and enter into contracts for management services for the corporation;

Renumber remaining paragraphs

Wilson

February 18, 1976

Suggested changes to CS HB 574
by Rodman Wilson, M.D.

Page 4, after line 10 insert:

1 OK "(c) Physicians in full-time, exclusive municipal, state, or federal employment are exempted from the requirement in (a) of this section."

#1 Adopted Page 10, line 24: Delete "physically or orally examine the parties" and replace with "interview and physically examine the injured person if alive"

2 #2 Adopted the parties

3 Page 10, line 28: After "records" add "or materials"

4 Page 13, following line 29:

OK If interest is paid on periodic payments then lump sum payments should be discounted for having the money in hand.

5 Page 15, lines 15-21: Change to read:

OK "(4) The health care provider, after considering all of the attendant facts and circumstances and consulting with the family if any, used reasonable discretion as to the matter and extent to which the alternatives or risks were disclosed to the patient because he believed that full disclosure would adversely affect the patient's condition."

6 #3 adopted Page 17, line 1: After "recommendations of" add "~~the~~ its medical staff,"

#4 adopted 7 Page 23, line 4: Delete "attorneys," change l.5 "affiliated with the insurance industry."

~~8~~ ~~Page 25,~~ line 2: At what date is insurance required?

9 Page 25, lines 16-20: Change to read:

See Block #10 "(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 at the time retroactive insurance is purchased."

10 Page 27, line 30: "gross medical revenue" better left out of statute. Can be negotiated with the profession by the director. Also the profession worries about the confidentiality of individual gross income figures.

OK

Ana

A M E N D M E N T

Adopted

TO: CS for HOUSE BILL NO. 574

ARTICLE 3. LOAN FUND.

Sec. 21.88.110. FUND ESTABLISHED. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) Loans from the fund ~~may~~ shall be made to the corporation ~~when~~ upon cert. by Director ... necessary for the ~~fund~~ corporation to maintain adequate ~~minimum capital and surplus~~ reserves. If a loan is made to the corporation from the fund, the corporation shall issue a note to the fund pledging the premiums collected in the future as security for the loan.

(c) Loans from the fund shall be repaid by the corporation within four years at an annual interest rate of seven per cent.

(d) The director may sell or transfer at par value to the Department of Revenue the notes held by the Department of Commerce and Economic Development as security for loans made under this section. The Department of Revenue shall purchase all the notes offered until the current principal amount of the notes purchased and held by the Department of Revenue equals $5,000,000.

TABLE OF CONTENTS

INTERPROFESSIONAL CODE

Colorado Medical Society — Colorado Bar Association

Foreword

The cause of good interprofessional relations should be well served by this code jointly developed by committees of the Colorado Medical Society and the Colorado Bar Association. The code is intended to be an instrument for better understanding of the problems existing between attorneys and physicians with reference to medical testimony. For those with years of experience in either profession, portions of the code may seem elementary. An occasional reminder, however, is never unimportant when it relates to fundamentals. More significant is the long-range purpose of the code: to prepare the new practitioner of either law or of medicine for matters in interprofessional relations of which he would be almost entirely unaware until he encountered them as problems in his practice. Forewarned, the practitioner may be able to avoid the problems altogether.

This Interprofessional Code constitutes the further recognition that with the great developments in the science and art of both medicine and law, it is inevitable that the physician and the attorney are drawn into steadily increasing association, as the law calls with increasing frequency upon medicine for its scientific knowledge and for its evaluation of facts so that the rights of individuals and of the government may be appropriately determined before various tribunals.

Each of the professions has the duty to develop an enlightened and tolerant understanding of the other. Each profession is vitally essential to the very preservation of society. The aims of the two professions are essentially parallel in their services to society, and this necessitates a full understanding at all times and full cooperation when that is called for.

It is an obligation which each profession owes to the other in the best interests of the public as well as in the best interests of the separate reputations of the two professions. Each must keep in mind the differences in the capacities and characteristics of the practitioner of both professions, and that while law and medicine may each be termed a science, each is an inexact science; and such inexactness is and always will be accented by the human limitations of its practitioners.

General Principles

Doctors of medicine and attorneys at law, as members of two professions possessing a close personal relationship with those they serve, have established principles of ethics applicable to the traditions and requirements of their respective callings.

The physician has responsibility for the care of the individual, in health as in disease. He must minister to his patient's needs to the best of his ability and in accordance with the high precepts of the Hippocratic oath.

The attorney is an officer of the court, sworn to support the Constitution of the United States and of the state or states in which he is admitted to practice. As is the physician, he also is pledged to maintain the confidence and to preserve inviolate the secrets of his client. He will not reject, from any consideration personal to himself, the cause of the defenseless or oppressed, nor delay any man's cause for lucre or malice.

Interprofessional Relations

Each profession is obligated by its own stature to respect and honor the calling of the other. Neither the fact nor the appearance of incompetence, corruption, dishonesty, or unethical conduct on the part of individual members of either profession can be tolerated. It follows then that each profession must vigorously support within its own ranks, as well as in the ranks of the other, those ethical concepts which each has found necessary in the public good. One who has chosen to be a physician or an attorney and has been found competent to be such by appropriate authorities, is vested with high responsibilities and privileges to enable him to serve the public with honor, with dignity, and with effectiveness.

1. The Attending Physician and His Patient

In situations where a patient's legal rights are at stake, the patient's physician should promptly furnish the patient's attorney with the medical facts and data pertinent to the case. The physician should accept the further responsibility of explaining such facts in such a manner that the attorney understands them and can determine their relationship to his client's cause. There should be complete cooperation between the physician and the attorney, each assuming his proper responsibility.

It is for the physician to determine the actuality or probability of fact pertaining to his patient's condition. It is for the attorney to determine how and under what circumstances such facts are to be appropriately presented.

Because of the large number of occasions when medical facts are intricate and difficult to understand, the physician should always provide the attorney with a written summary of them for his study. The physician should carefully preserve his own original records, although with express consent of his patient permitting their physical inspection by, or making a copy of relevant portions available to, his patient's attorney.

A physician should never advise on the amount of damages a patient should

seek to recover. The proper province of his professional advice is the extent, degree, or percentage of illness, injury, disability, or similar judgments based upon his professional knowledge of the case. He is not expected to understand technical rules of legal liability, of evidence, or of trial techniques. The latter are the exclusive province of the attorney.

2. The Attorney and His Client

It is part of the attorney's oath on his admission to the bar of this state that he will not counsel or maintain any suit or proceeding which shall appear to him to be unjust, or any defense, except such as he believes to be honestly debatable under the law of the land. He will employ, for the purpose of maintaining the causes confided to him, such means only as are consistent with truth and honor and will never seek to mislead the judge or jury by any artifice or false statement of law or fact.

In discharge of that oath, it becomes the attorney's responsibility to marshal the facts and to obtain professional and other opinion which, in his judgment, are necessary for his client's case and in a manner consistent with his oath and the ethics of his profession.

It is important that the physician understand that legal proceedings in this country are conducted under what is known as the "adversary system." Under that system the attorney occupies a dual position. He is not alone an officer of the court but also the single-minded advocate for his client. He does not and cannot properly represent both sides to a dispute.

This system has developed in recognition of the truth demonstrated countless times that justice can usually be satisfactorily accomplished if the two or more contestants can present their points of view to some neutral third person who can weigh the opposing claims. Such claims are usually presented in the form of testimony which is offered in question and answer form. The judge of a court, the jury, or the officer presiding before an administrative tribunal is the referee who weighs the opposing points of view and the conflicts in testimony. In a sense the judge or administrative officer much more nearly approximates the physician in objectivity. The physician well knows, however, that in some situations it is also possible for medical men to vary honestly and sincerely in their physical findings, their treatment, and their evaluation of illness or injury.

3. Conferences

The physician and the attorney should always confer relative to the common problems presented in a particular case. Such conferences should be arranged in advance of a court or other hearing at the mutual convenience of each, in full appreciation that to each profession, time is of the utmost importance. No physician and no attorney should be required to spend unnecessary time in arranging or attending such a conference. The attorney who knows and understands the progress of his client's case, the conflict, if any, of its medical aspects, and the probability of settlement or trial should determine the necessity of a conference. The physician shall feel obligated to point out anything which he believes will be helpful in presenting the patient's case as well as the weaknesses in the opposing medical theories or testimony.

It is unfair to the patient-client, the physician, and the cause of justice to present a medical witness who has not first conferred with the attorney and who, therefore, may lack a full appreciation of the significance to the case of the particular evidence he is being asked to give. It is equally obvious that the attorney is less able to represent the full interest of his client where he has not had the advantage of full conferences with the physician in advance of presenting the case.

4. Reports to Attorneys

Physicians must appreciate that promptness in providing a patient's attorney with such information as may be available is of importance to the patient's legal rights. Many matters can be settled out of court to the mutual satisfaction of the parties involved. Undue delays in providing medical reports, bearing on a patient's legal rights, may prejudice the patient's opportunity, either as to settlement or disposal of the problem, and thus create possible further expense, worry, and even the loss of important testimony. Witnesses may die or facts become obscure as the time elapses.

As a minimum a physician's reports to his patient's attorney should include the following:

a. History as related by patient
b. Examination
c. Diagnosis
d. Treatment
e. Progress and prognosis

5. The Physician and Court Arrangements

It is the physician's obligation to be in court at the time requested. Timing is not only important for the orderly and advantageous presentation of the patient-client's case, but also for the convenience of the Court, other witnesses, the jury, the attorneys and other litigants. Courts and the attorneys must appreciate, however, that the physician has continuing and often unpredictable responsibilities to his patients. It must therefore be anticipated that at times courtroom procedure must give way to humanitarian considerations and the physician be permitted to testify "out of turn" or at another time. Courts and attorneys should undertake in every way to determine when and approximately how long the doctor of medicine will be needed in court. The doctor should be given as much advance notice as is reasonably possible, so that he can arrange his professional affairs accordingly.

When an emergency arises which calls for the services of a physician witness, judges and attorneys should promptly release such witness or postpone his appearance until the emergency has first been cared for.

6. The Attending Physician on the Witness Stand

The attending physician is a witness. As such he should never assume the role of the advocate. His patient is represented by an attorney who serves in that capacity. The counsel should not engage in examination of the physician as a hostile witness but as a provider of facts. The physician should show respect and consideration to the court and to the attorneys. Such also is the obligation of courts and attorneys to the physician.

If a physician believes that an attorney is omitting an important point in the course of presenting the case or that he is underestimating the importance of medical testimony which is being offered by the other side, he should tell the attorney so, preferably in writing.

7. The Attending Physician and His Charges for Services in Connection with Litigation

The medical profession has long accepted its responsibility to serve the health of the people without regard to race, religion, rank, or ability to pay.

But when the financial circumstances of the patient justify, the physician is entitled to reasonable compensation, as are others who provide such an individual with personal services or commodities. "Reasonable compensation" should include consideration of time spent by the physician in conferences, preparation of required or requested reports, travel costs, and court or other appearances. The attorney must do his full part in explaining that fact to his client.

It is proper and not unusual for an attorney to represent on a contingent fee basis a client who is not in a position to pay a per diem fee irrespective of the

outcome of the case and the attorney may acquire a lien upon the proceeds of the action. The medical profession neither has, nor seeks, any similar arrangement. The charges of a physician should not in any way be based upon a percentage of the patient's financial recovery. Any other practice might lead to a charge that the physician witness had an interest for being partial in his testimony.

8. The Attorney and His Direct Payment of Medical Fees

An attorney under his canons of ethics cannot stir up strife or litigation, and neither can he reward those who may persuade others to seek his service. He cannot "maintain" a suit or other proceeding. This standard presents every practicing attorney with difficult questions. Is he permitted, for example, to advance costs of litigation on behalf of his client? He may do so ethically where such advances constitute a charge to the client, and their collectibility is not contingent upon the outcome of the case. Such advances may be made by the attorney only with the understanding that he is to be reimbursed by his client.

It should be remembered that an attorney, in seeking the services of a physician in connection with a medical-legal matter, acts only as an agent for the client-patient, and incurs no legal obligation on his own behalf for the services of the physician. Nevertheless, professional courtesy on the part of the attorney requires that he exert his best efforts to insure that the client pays for such medical services with reasonable promptness. The attorney, at the time of settlement of a claim in behalf of his client, should, if possible, take steps to make certain that any unpaid medical charges due from his client are paid at that time.

9. Cooperation by Attorney to Assure Physician Payment

Misunderstandings between the two professions sometimes arise in those court cases or administrative proceedings in which it appears that the attorney protects his own fee without making any corresponding effort on behalf of the physician whose treatment in advance of the litigation and whose advice and testimony during the course of it are essential.

There are cases in which the attorney does not advance the fee for the physician's testimony, either because the amount is beyond his means or because he has no reasonable expectation of reimbursement by his client and is therefore not ethically warranted in making such advance.

Still another complication is presented when a physician takes care of a patient who asserts that his injury or illness arose out of or during the course of employment. It may ultimately be determined by an administrative body or a court that the injury did not arise out of employment. In such situation there will be no workmen's compensation award and the physician may remain unpaid. The attorney may then bring civil action and make a recovery with or without the testimony of the original treating physician. Or the physician may have prepared opinion evidence which was for some reason not acceptable to the patient or to his attorney and which, despite the time required and the careful preparation by the physician, may not have been used. In still other cases the testimony of the physician may have been ready, but the case may be settled out of court.

In any of the above situations and in others not here enumerated, the physician may have no protection for his earned professional fee, although it may have been included in the financial settlement. The attorney should, as a matter of fairness and interprofessional courtesy, do everything reasonably possible to assure payment of the services rendered by another professional man in a matter in which he is concerned. It has been held "professionally reprehensible" for an attorney to make a settlement of a case without providing for the physician's fee after he had made such an agreement with the examining physician witness with the client's approval.

10. Expert Testimony

The attorney should understand that in a very real sense, and one recognized by law, every physician is relatively "expert" in the field of medical testimony. The thoroughness and high quality of his training entitles him to this status as does his unlimited license. There is another degree of expertness recognized alike by courts and the profession which comes with specialized training and experience in a particular branch of medical science. It is in this latter sense that the term "medical expert" is more commonly understood and used.

An expert medical witness may or may not have treated the patient. He may or may not have examined the patient. The testimony of an expert must in part depend, then, on the facts of his relationship to the particular patient. His testimony, if he has not treated the patient, cannot be expected to be the same as if he had treated the patient "in the nakedness of his distress." Expert testimony will be still more limited if the physician, even though an acknowledged expert, has never examined the patient but has been limited to X-rays, observations, the reports of other physicians, or to hypothetical questions.

The attorney should take into account the difference between these situations and should not expect a medical expert to offer opinion evidence which exceeds the factual relationship of such expert to the patient, or which exceeds the facts contained within hypothetical questions put to him as the basis for his opinion.

11. Subpoenaed Expert

There are situations in which the attorney subpoenas the medical expert, either because a physician has been uncooperative or the attorney has thought

him so, or the physician has said, for example, that he does not wish to testify, or that he has no opinion. This presents complications from the standpoint of the physician. There is no question of the obligation of the physician to answer to a subpoena like any other citizen, except where grave emergency prevents his doing so. An emergency can never be a matter of mere convenience to the physician. It must always involve the genuine professional needs of a patient, and the physician takes the risk of convincing the Court that the emergency was of sufficient gravity to justify his ignoring the order of the Court.

The most obvious complications presented by a subpoena are: first, it is unlikely to take the demands of the physician's practice or his professional convenience into account; second, the physician is frequently not given enough time to prepare to respond to a subpoena; third, the compensation which accompanies a subpoena is nominal and does not reflect the reasonable value of the professional services involved in preparing or offering court testimony, or the time taken away from a physician's practice.

A physician subpoenaed as a medical expert cannot reasonably be held to special study, review of the authorities and medical literature, or to other specialized preparation in such circumstances.

No medical expert can be compelled to form an opinion, although he may be required to state the substance of his observations if he observed the patient. If he does not have a professionally adequate basis for an opinion as to a particular litigant whom he did not observe, he cannot be compelled to offer an opinion before a court or administrative body. If he has an opinion, he is obliged to state it.

If an attorney is insistent that a medical expert offer an opinion under these circumstances, the physician should be careful to state for the record that he has been subpoenaed, that he has not observed the patient, if such is the case, and that he has an insufficient basis upon which to form a professional opinion.

When a physician who has not observed a particular individual is subpoenaed as a medical expert, he will be confronted with the problem of the hypothetical question. If he can answer that question, he must do so. If he cannot answer it without special study or the question does not contain sufficient facts upon which to form an answer, he should so state.

12. Statements by Physicians to Both Sides

Attorneys are under ethical obligations first, not to handle both sides of a case, and second, not to deal with the parties to the other or adverse side except through the latter's attorney. The principle of adverse interests is not always well understood by the physician who is trained to think only in terms of patient interests. The result is that in some situations physicians may offer observations or opinions to both sides in a particular proceeding or lawsuit or may submit to interviews by attorneys for both parties, and that variations in their opinions may result which can be embarrassing and difficult to explain at a later time.

It is self-evident that a physician's integrity and judgment are among his most precious assets, and that neither should ever be "purchased." On the other hand, when a physician has been asked to offer his testimony on behalf of a patient or as an expert on behalf of a particular claimant, he should not needlessly complicate the case by making himself available to representatives of the other side or by offering apparently inconsistent viewpoints to two or more parties or their attorneys.

When a physician who has agreed to offer testimony on a case is approached by attorneys or other representatives for other parties with adverse interest, he should be frank about his prior commitment, notify the attorney for the party for whom he has agreed to testify, and thereafter be guided by the advice of the latter's attorney.

13. Ethical Limits of Medical Testimony

It is hard to set down in words the proper limits of medical testimony. If a physician has treated a patient on whose behalf he is offering testimony, he must offer the facts of his diagnosis, his treatment, and his prognosis honestly and simply. He should not indulge in speculation unless the case unavoidably requires such indulgence, and in such situation he must clearly label his own testimony as speculative or his "best estimate" or "best judgment."

Under no circumstances is a medical witness justified in suppressing medical evidence or in "taking sides" as such. First, such an attitude goes to the very credibility and usefulness of the testimony. Second, it is an unwarranted usurpation of part of the attorney's function.

If the physician is testifying as an expert, he should offer no opinion beyond the facts of the case or which is not otherwise in the court record or which goes beyond his personal knowledge or runs counter to his professional training and judgment. Violation of these fundamentals is not excusable by claiming that an attorney forced him into the making of an improper statement. His professional judgment and his own conscience must mark the limits of his testimony, including his opinions.

14. Efforts by Attorneys to Influence Medical Testimony

It is improper for an attorney to seek to color the professional opinion of the physician. He may properly point out the kind of medical evidence he needs to establish his case and the reasons for it, but this does not excuse him for trying to force or shape the physician's testimony. It must be remembered that any improperly presented medical testimony is almost always a bilateral product and one which is professionally unworthy of both the physician and the attorney.

As is well stated in Canon 15 of Legal Ethics: "The office of attorney does not permit, much less does it demand of him for any client, violation of law or any matter of fraud or chicane. He must obey his own conscience and not that of his client."

Finally, no ethical attorney is justified in abusing, badgering, or browbeating any witness, including a physician, whether it be one he called or a witness for the other side. Such actions are beneath the dignity of the attorney and are equally in violation of the dignity of the physician. Established rules of evidence give ample opportunity for testing the competence or credibility of a medical witness and make unnecessary and unjustifiable a resort to any of the above devices on the part of the cross-examining attorney. The same holds of examination of a physician who is in fact, or who is believed to be unfriendly to a particular viewpoint and is therefore examined as a "hostile witness."

No judge or other presiding official should tolerate such tactics, but where they do not act promptly, the physician should inquire of the person conducting the hearing whether he is required to submit to such treatment. Rarely will an administrator or judge fail to restore the hearing to a proper level after such a request is made.

15. The Problem of Conflicting Medical Evidence

One of the most common criticisms of medical testimony arises from conflicts between the testimony of two or more physicians with reference to the same case. Physicians are themselves critical of this situation under some circumstances. It is an extremely troublesome matter and one which may be partially solved by the observance of several principles, largely within the control of each of the professions.

The first is that an attorney can reduce the area of misunderstanding out of which conflicting testimony frequently comes by thorough preparation of his case, by a careful use of words, and by a carefully worked out purpose in having certain testimony offered. The second is that the physician can and should explain that medicine is as much an art as it is a science; that in many situations alternative treatments are available, any one of which may be appropriate; that judgment values are not exact but at best fall within rather substantial ranges; that certain risks attend a given procedure; that some cases will not have a successful outcome;

that many diagnoses are limited by the subjectivity of the symptoms and are complicated by the mental outlook of patients; and finally, that diagonsis and treatment must both be evaluated as of the time they occurred rather than in the light of a later day.

16. Choice of Language by Medical Witness

A medical witness testifying before an administrative body, such as an industrial commission, may ordinarily use technical language with relative freedom and confidence. The reason for this is that such bodies become relatively expert in the understanding of his medical vocabulary. That is true in varying measure of judges. It is not true, however, of a jury. It is possible for medical testimony to be so worded technically that its meaning is entirely lost upon a jury or is so completely misunderstood that the jury finds differently than it would if it had known the true import of the testimony.

When this situation occurs, it may be the responsibility of either or both the physician and the attorney. To make his professional testimony clear, both for the record and for physicians and attorneys on the other side, a medical witness should first express his findings and opinion in medical terms. He should then translate those terms as accurately as possible into language intelligible to the court, attorneys, and the jury. He should also put into intelligible language the effect of particular injuries. The latter is frequently easier than the technical statement of a diagnosis or of the treatment rendered.

The medical witness should remember that his testimony is not intended to impress or edify, but to explain. If it does not help explain and does not clarify the issues of a particular case, it has failed in the sense that it was not useful to the determination of the case.

17. Proper Use of Professional Associations

When an attorney is of the opinion that another attorney in the case or a medical witness has acted improperly or has offered improper testimony, he should first seek to remedy the matter during the course of the hearing or litigation itself. Failing that, and if he continues to be of the opinion that a genuine wrong has been done he should refer the case objectively, and without indulgence in personalties to the professional organization of which either the attorney or the physician is a member.

In like manner, a physician, if he is satisfied as a matter of conscience and professional judgment that an attorney has exceeded the limits of propriety in his handling of medical witnesses or in his efforts to introduce improper medical testimony, should report his opinion to the bar association to such effect. He also has the clear obligation of reporting to the appropriate medical organizations one of his own profession who has, in his opinion, acted with apparent impropriety in the course of appearing as a witness.

The making of such a report either against a member of one's own profession or against the member of another profession is one of great delicacy and seriousness. Professional reputation is the most precious and at the same time the most fragile asset of any professional man. Subjecting it to question must be done with fairness, candor, and without rancor, and in the excercise of sound judgment and conscience.

By the same token, merely because of the gravity of the step, no member of either profession should abstain from reporting what he believes a substantial misconduct. At least as much harm can be done from such abstention as from making a groundless charge.

18. A GUIDE FOR MEDICAL LEGAL CHARGES

From Colorado Bar Association Interprofessional Committee: Note/Increases in costs and fees have occurred. Attorneys and doctors are encouraged to settle the amount and manner of payment in advance. Efforts are being made to review, revise and update medical-legal charges but the Interprofessional Code was out of print and it was decided to make reprints available without further delay leaving blanks to insert fees later.

1. This schedule is intended as a guide for the charging of reasonable medical-legal fees. Where the circumstances warrant, greater or lesser charges may be justified and charged by a physician in any particular fact situation.
2. TESTIMONY. One-half day or less — $ _____ .to $ _____ .
   Factors to be considered:
   a. Specialization or not;
   b. Disruption of patient scheduling and office procedure;
   c. Time in preparation;
   d. Advance notification;
   e. Time away from office;
   f. Time actually testifying.
3. REPORTS. $ _____ to $ _____ .
   Factors to be considered:
   a. Form report versus short summary report versus detailed narrative lengthy report.
4. PRE-TRIAL CONSULTATION WITH ATTORNEY. $_____ to $ _____ per hour.
   Note: The sub-committee believes that consultations are desirable in that they work to the establishment of a better relationship between the testifying physician and the patient's attorney and that, in general, consultations result in a shorter trial time and a more lucid explanation of the medical problem involved.
5. CANCELLATIONS. For the physician who receives less than twenty-four (24) hours notice of the cancellation of his time for testifying, he may, in his discretion, charge a fee, not to exceed $ _____ to $ _____ which fee should bear a reasonable relationship to actual financial losses, if any.
6. ADVANCE PAYMENTS. Within twenty-four (24) hours prior to the actual time of testimony, the testifying physician is entitled to receive upon his request a reasonable witness fee paid in advance.
7. MEDICAL SERVICES. The amount charged for medical services is entirely discretionary with the examining physician. This charge is always the sole responsibility of the patient, subject to the guidelines set forth in paragraph 8 of the Interprofessional Code.
8. DISCOVERY DEPOSITION OF MEDICAL EXPERT. Where a medical expert is deposed by either party to an action, the party causing the taking of the deposition may be charged by such expert witness a reasonable fee for the time involved, such fee to be based upon the same hourly rate as might be reasonably charged for a pre-trial consultation as suggested in paragraph 4 hereof.
9. RESPONSIBILITY FOR PAYMENT. The attorney who has caused the incurring of any medical-legal charge shall be ethically responsible to assure the payment of such charge, where such charge does not exceed the maximum suggested by this schedule, to the physician who makes any such charge. The attorney is never responsible for the payment of any charge incurred by a patient for medical treatment but ethically should withhold, with his client's permission, such charge or medical expense from any recovery obtained through the attorney's efforts.

Joint Medico-Legal Plan

for Screening Professional Liability Cases

Colorado Medical Society
Colorado Osteopathic Association
Colorado Chiropractic Association
Colorado Dental Association
Colorado Hospital Association
Colorado Bar Association

1. PURPOSES

The fundamental purpose of this Plan is two-fold: on the one hand, to prevent where possible the filing in court of actions against physicians, chiropractors, dentists, hospitals, health care facilities or their agents or employees for alleged breach of professional duty in situations where the facts do not permit at least a reasonable inference of such breach; and, on the other hand, to make possible the fair and equitable disposition of such claims against physicians, chiropractors, dentists, hospitals, health care facilities or their agents or employees as are, or reasonably may be, well-founded.

2. REPUTATION AND LEGITIMATE GRIEVANCES

The participating groups recognize that the mere filing of an action in court, however unjustified medically it may be, causes substantial harm to the reputation and practice of the concerned physician, chiropractor, dentist, hospital, health care facility, or their agents or employees. The participating groups recognize also that persons having legitimate and meritorious grievances against physicians, chiropractors, dentists, hospitals, health care facilities, or their agents or employees have heretofore often encountered the greatest difficulty in substantiating their claims with expert testimony in court.

3. PANEL IMPARTIALITY

All members serving on the Hearing Panel provided for hereunder must realize that they are appointed for their impartiality, integrity, and judicial temperament, and must not allow personal prejudice or bias to influence their findings or determinations.

4. COMPOSITION OF PANELS

To carry out the purposes of this Plan, the Colorado Medical Society, the Colorado Osteopathic Association, the Colorado Chiropractic Association, the Colorado Dental Association, the Colorado Hospital Association and the Colorado Bar Association shall each designate from its association a member thereof to serve as its Representative. Such Representative shall be responsible for the general supervision and administration of this Plan, and each shall appoint from the membership of his respective association members to serve on each Hearing Panel. The six groups, medical, osteopathic, dental, chiropractic, hospital, and legal (hereafter referred to as the participating groups) shall have equal representation at all times on such Hearing Panels. The Chairman of each panel shall be a member of the Bar Association, and shall be designated by the Bar Association Representative. The Hearing Panel shall consist of six members, three attorneys designated by the Colorado Bar Association Representative, and three Representatives of the participating group whose member is the subject of the claim of malpractice for which the Hearing shall be convened, unless more than one participating group is involved, or unless all parties to the hearing agree to a lesser or greater number.

Where more than one participating group is involved, each such group shall have no fewer than two representatives on the Hearing Panel and the total number of bar

Association panelists shall be equal to the total number of other panelists convened for the Hearing. In such cases, Bar Association panelists shall be, by appointment prior to the hearing, specifically designated by the Bar Association representative to deal with the liability and damage questions of a specific participating group, and shall vote only on questions of such specific group, i.e., in the ultimate questions an attorney designated as an "osteopathic panelist" votes only on questions dealing with the liability of the osteopathic physician concerned.

The specific occupation or profession of Colorado Hospital Association panelists may vary from case to case based upon the particular area of hospital responsibility at issue. Thus, among others, administrators, nurses, records personnel, physicians, or therapists may be panelists. The administrative representative of the Colorado Hospital Association shall consult with the administrative representative of the Bar Association in selecting the specialization of panelists for particular cases involving hospitals.

5. SUBMISSION OF CASES

The screening procedures outlined herein shall apply only to claims of alleged breaches of professional duty commonly referred to as "malpractice" and shall not apply to claims arising out of the maintenance and use of premises or vehicles and other similar claims in negligence or contract.

An attorney may submit a case for the consideration of a Hearing Panel by addressing a request in writing to the Colorado Bar Association, signed by both himself and his client. This letter request shall contain the following:

A. A brief statement of the facts of the case as asserted by the Claimant, showing the persons involved, the dates and the circumstances, so far as they are known, of the alleged breach of professional duty.

B. A statement authorizing the Hearing Panel, through its Chairman, to obtain all medical and hospital records and information pertaining to the incident, and, for the purposes of its consideration of the matter only, waiving his client's privilege as to the contents of those records and information. Nothing in that statement shall in any way be construed as waiving such privilege for any other purpose or in any other context, in or out of court.

C. An agreement that the evidence received or offered at the hearing and the deliberations, discussions and conclusions of the Hearing Panel and of the members thereof will be confidential within the Panel and privileged as to any other person, and that no member of the Hearing Panel or any person attending the hearing will be asked in any action or proceeding to testify concerning the evidence received or offered or the deliberations, discussions, conclusions, or proceedings of such Panel.

D. A request that the Hearing Panel consider the merits of the claim and render its report to him.

E. A list of witnesses, both lay and expert, who may be called by the Claimant's attorney to testify before the Hearing Panel. The purpose for this requirement is to allow the parties in good faith to give notice to the panelists so that any prospective panelist may have an opportunity to disqualify himself if a relationship exists between him and a prospective witness which may affect such panelist's fair and impartial deliberation. Counsel for the respective parties may be free to call additional witness as justice requires, subject to approval by the Chairman of the Hearing Panel.

F. A statement that the attorney has read, understands, and subscribes to this Plan for screening claims against physicians, chiropractors, dentists, hospitals and health care facilities and has advised his client thereof, and that the Claimant and his attorney agree to the submission of the facts pursuant to the Plan. Without such agreement, no action shall be taken on the request for review.

G. At the option of the parties, the letter request may also contain a written statement

by the Claimant and his attorney that such provisions of Rule 109, Colorado Rules of Civil Procedure, as the parties may select in writing shall control disposition of the liability issues of the claim or claims. Such agreement shall not be binding unless all parties to the hearing and their attorneys elect in writing so to be bound.

6. CONSENT OF RESPONDENT

Appended to such request shall be the signed statement of the Respondent physician(s), chiropractor(s), or dentist(s) involved, or authorized representative of the respondent hospital, health care facility, or their agents or employees involved, and of the attorney or attorneys representing such physician, chiropractor, dentist, hospital, health care facility, or their agents or employees, containing the following:

A. Acknowledgement of the receipt of a copy of such request.

B. An agreement that the matter be submitted for the consideration of a Hearing Panel in accordance with this Plan. Without such agreement, no action shall be taken on the request for review.

C. A list of witnesses, both lay and expert, who may be called by the Respondent's attorney to testify before the Hearing Panel. The purpose for this requirement is to allow the parties in good faith to give notice to the panelists so that any prospective panelist may have an opportunity to disqualify himself if a relationship exists between him and a prospective witness which may affect such panelist's fair and impartial deliberation. Counsel for the respective parties may be free to call additional witnesses as justice requires, subject to approval by the Chairman of the Hearing Panel.

7. JURISDICTION

Cases which the Hearing Panel may consider may include any case involving any alleged breach of professional duty by any member of the Colorado Medical Society, Colorado Osteopathic Association, Colorado Chiropractic Association, Colorado Dental Association, Colorado Hospital Association, their agents or employees; provided, however, that nothing herein shall prohibit the Panel from also hearing a claim against any other practitioner of medicine, chiropractic, dentistry or hospital if the parties, the Bar Association, Medical Society, Osteopathic Association, Chiropractic Association, Dental Association, or Hospital Association Representatives, and the members of the Hearing Panel unanimously consent thereto.

8. SCHEDULING—QUORUM

Requests for review submitted as above shall be scheduled for hearing as promptly as possible before a panel constituted as above set forth; provided, however, in no instance shall the date assigned be more than 45 days after the receipt by the Bar Association Representative of the request for review. In any hearing a quorum of the Hearing Panel for the purpose of deciding the issues submitted to it shall consist of a majority of those members of the Hearing Panel who have attended all hearings of the issues.

9. AFFIDAVITS OF PANEL MEMBERS

Each member of the Hearing Panel selected shall be advised of the names of the parties, their addresses and occupations in the case of each claimant and respondent. There also shall be tendered to each member of the Hearing Panel an affidavit to be signed by the member of the Hearing Panel and returned to the designated Chairman of the Hearing Panel no later than five days prior to the hearing date. Such affidavit shall contain the following:

A. That the Hearing Panel member is either not acquainted with the claimant or the respondent, or that such acquaintanceship is on such a basis that it will not interfere with an objective and fair evaluation of the issues to be presented.

B. The affiant has no knowledge of the facts of this claim other than those contained in the claimant's submittal letter or that any prior knowledge will not in any way

prejudice his objective determination of the issues to be resolved herein.

C. That the affiant has no preconceived or inalterable opinion or conclusion concerning the subject matter of the Claimant's submission and knows of no impediment to his being a fair and impartial member of the Hearing Panel.

D. That the affiant endorses and supports the Joint Medico-Legal Plan as a method of resolving or attempting to resolve such claims.

E. That the affiant will not hesitate to render a true and just determination of the issues to be presented and will not be governed or influenced by sympathy or prejudice for or against any party in the case, nor will the affiant be influenced by fear of criticism by other members of his profession.

The attorneys for the parties may not orally question the members of the panel as to their qualifications at the commencement of the hearing, except for good cause shown to prevent manifest injustice. Objection to any member of the Hearing Panel must be made by the parties or their attorneys before evidence is presented at the hearing or such objections shall be deemed to be waived.

10. OPENING STATEMENTS

At the time set for hearing of the case, the Claimant's attorney shall be present and shall state his case, including a resume of the facts constituting the alleged breach of professional duty which he is prepared to prove and the legal theories on which he expects to base such proof. The Respondent and his attorney may be present and should also make a statement of his case, including the legal theories on which he expects to base his defense. No statement by the attorneys or the parties shall preclude the Hearing Panel from consideration of other areas pursuant to the provisions of Paragraph 19 of this Plan; however, if the members of the Hearing Panel do consider other areas, such members of the panel shall inform the parties and their attorneys that such areas are being considered, and an opportunity shall be provided to the parties and their attorneys to present additional testimony if the parties or their attorneys so desire.

11. WITNESSES–ISSUES

Each party may present such testimony and other evidence as may be proper under the provisions hereof relating to rules of evidence to be followed, and any witness called shall be subject to cross-examination by the opposing party and to interrogation by members of the Hearing Panel. The monetary damages, if any, shall not be the subject of inquiry or discussion. The hearing will be conducted informally, and no official record shall be kept. Rules of evidence and procedure applicable to informal administrative proceedings shall be followed. Hospital records and summaries may be reviewed and considered by the Hearing Panel. Written statements of treating physicians may also be received by the Hearing Panel; however, the Panel shall not consider any opinions as to ultimate issues of liability which may be contained in such reports. Relevant medical texts, journals, studies, or other pertinent material may be reviewed and considered by the Panel if the Panel deems such material to be appropriate.

12. RULES OF EVIDENCE–FAILURE OF PROOF

It is the purpose and intent of this Plan that the Panel informally consider all matters relevant to the issues presented, and to this extent formal rules of evidence shall not be followed. The Chairman of the Hearing Panel shall rule on all objections and procedural matters, subject to being overruled by a majority vote of the Panel members. If the parties shall fail to present sufficient evidence to enable the members of the Hearing Panel to make a decision on any issues involved, then the Hearing Panel shall have no obligation to reach any conclusion whatever and the Chairman of the Panel shall submit his written report pursuant to Paragraph 21 of this Plan, designating the issue involved and advising that the Panel has deemed the evidence presented on such issue to be insufficient to

render any decision on the merits. Subject to the provisions of Paragraph 15 of this Plan, in the event that the Hearing Panel does deem the evidence presented on such issue to be insufficient to render any decision on the merits, the parties shall be deemed to have honored their commitments to be bound under the submission agreements signed by the parties and their attorneys, and shall thereafter be fully released and discharged from all commitments contained in such submission agreements. At their option, the parties may thereafter agree to resubmit their case to a Hearing Panel. If such option is exercised, the parties to the case and their attorneys shall submit new submission agreements in writing consistent with the requirements of this Plan.

13. EXPERT WITNESSES

The Hearing Panel itself shall have the power to call such experts as it, in its discretion, may deem necessary or desirable. No expert witness who is not a party to the hearing shall be permitted to testify as to ultimate issues of liability except by consent of all parties in writing at least five days before the hearing. Any party may present testimony by a consulting or treating physician who has examined the Claimant for purposes other than to appear as a potential witness in litigation, so long as such testimony does not contain opinions as to ultimate issues of liability.

14. CLOSING STATEMENTS

At the close of the presentation of evidence by the parties, the Claimant's attorney may state his resume of the evidence and its relation to the legal theories on which such evidence is based. The Respondent's attorney may then state his resume of the evidence and its relation to the legal issues relied upon by Respondent. The Claimant's attorney may then present brief rebuttal of those facts or issues discussed by the Respondent's attorney.

15. ADVISEMENT–SUPPLEMENTAL HEARINGS

When the parties present have been heard, the Hearing Panel may take the case under advisement, or it may request that additional evidence be obtained and presented to it at a supplemental hearing, which shall be set for a date and time certain, not longer than 15 days from the date of the original hearing, unless the attorney bringing the matter for review shall in writing consent to a longer period. Any second or subsequent hearing shall be held in the same manner as the original hearing, except that the opening statements of the attorneys for the parties which were given at the commencement of the initial hearing will not be permitted at any subsequent hearing. The parties and their attorneys may be present at any second or subsequent hearing.

16. DELIBERATIONS

In each case taken under advisement, the Hearing Panel shall consider all of the evidence admitted and the statements of counsel, and may also consider expression of opinions of the medical members of the Hearing Panel relating to any medical questions involved, and the legal opinions of the lawyer members of the Panel relating to any questions of law involved.

17. QUESTIONS TO BE DETERMINED

The Panel shall make its findings on the following questions:

A. Whether there is a reasonable probability that there exists a claim for relief against the Respondent based on breach of professional duty, regardless of the legal theory on which it may be predicated, and if so,

B. Whether there is a reasonable medical probability that the Claimant was injured thereby,

C. Whether the evidence presented as to questions A and B has been sufficient to allow the Hearing Panel to render its decision on the merits.

18. DAMAGES NOT ASSESSED

The Hearing Panel shall make no findings respecting the quantum of damages in the case, if any there be, and shall make no effort to settle or compromise any claim, or express any opinion as to the monetary value of any claim.

19. ALTERNATE QUESTIONS AND THEORIES

Subject to the provisions of Paragraph 18 above, nothing herein shall be construed as prohibiting the Panel from considering other areas involved or answering questions other than those stated in A and B, in Paragraph 17 hereof, in the interest of disposing of all matters which the parties or the Panel may consider relevant to the case. If the Panel, in considering its findings on Questions A and B contained in Paragraph 17 above, determines that more than one theory should be discussed on either question, the Panel may, in its discretion, include in its findings the conclusions reached by the Panel as to each theory considered.

20. VOTING

The decisions on the above three questions, and any other matters which the Panel may decide, shall be reached by a majority vote of those members of the Panel present who have attended all hearings on the issue. The Chairman of the Panel shall be a voting member in the determination of such questions, if such Chairman has attended all hearings on the issue. The votes on such questions shall be by secret ballot, and shall be tallied and announced by the Chairman of the Panel.

21. WRITTEN REPORT OF FINDINGS

Its answers to these questions shall be submitted in writing to the parties, and copies shall be furnished to the Bar Association, Medical Society, Chiropractic Association, Osteopathic Association, Dental Association, or Hospital Association Representatives concerned with the issues presented to the Hearing Panel. A copy of each report shall be retained in the permanent files to be maintained by the Bar Association Representative. The deliberations of the Hearing Panel shall be and remain secret. The written report shall be signed for the Hearing Panel by its Chairman, and shall contain only the conclusions reached by a majority of its members, provided, however, that any member of the Panel may request that his dissent from the conclusions of the Panel be noted in the official records of the Hearing Panel. The opinion reached in any case shall be treated in every respect as confidential between the Hearing Panel and their respective members on the one hand and all persons directly concerned in the case on the other. Subsequent to the written report herein referred to, to the extent practicable, the Chairman of the Panel and one medical member thereof shall meet informally with counsel for all parties to discuss the findings and determinations of the Panel.

22. CLAIMANT'S VERDICT—DUTIES

In any case where the Hearing Panel has determined that there is a reasonable probability that there exists a claim for relief against the Respondent based on breach of professional duty, regardless of the legal theory on which it may be predicated, and further finds that there is a reasonable medical probability that the Claimant was injured thereby, then the Panel and the society of the participating group whose representative has been designated as the Respondent will cooperate fully with the Claimant's attorney in procuring an expert witness qualified in the field of health care involved. Such witness shall consult with and testify on behalf of the Claimant, upon arrangement by the Claimant with said witness for payment for his services to the same effect as if the said witness had been employed originally by the Claimant. A physician, chiropractor, or dentist who has been called before the Hearing Panel in an advisory capacity or any member of the Hearing Panel shall not be precluded thereby from serving as such witness,

provided that he shall not be asked to testify concerning the evidence received or offered, or the deliberations or proceedings of the Hearing Panel, or as to any information given or acquired by him at the hearing.

23. RESPONDENT'S VERDICT—DUTIES

In a case where the Hearing Panel has determined either that there is no reasonable probability that there exists a claim for relief against the Respondent based on breach of professional duty, regardless of the legal theory on which it may be predicated, or that there is no reasonable medical probability that the Claimant was injured thereby, the Claimant's attorney shall refrain from filing any court action based upon such claim, unless personally convinced that strong and overriding reasons compel such action to be taken in the interest of his client, and that it is not done to harrass or gain unfair advantage in negotiation for settlement.

24. TIE VOTES

In a case where the secret ballot of the Hearing Panel has resulted in a tie vote either on the ultimate issue of whether there is a reasonable probability that there exists a claim for relief against the Respondent based on breach of professional duty, regardless of the legal theory on which it may be predicated, or on the ultimate issue of whether there is a reasonable medical probability that the Claimant was injured thereby, the Chairman of the Panel shall submit a written report pursuant to the provisions of Paragraph 21 of this Plan. Such report shall designate the ultimate issue on which the tie vote resulted, and shall designate the ultimate issue, if any, on which a majority vote of the Panel resulted and the answer to such ultimate issue determined by such majority vote. Upon submission by the Chairman of the written report announcing the tie vote, to the extent practicable the Chairman of the Panel and one panelist from the participating groups shall meet informally with counsel for all parties to discuss the findings and determinations of the Panel. After submission of such report by the Chairman announcing such a tie vote on one or more ultimate issues, the parties shall be deemed to have honored their commitments to be bound under the submission agreements signed by the parties and their attorneys, and shall thereafter be fully released and discharged from all commitments contained in such submission agreements. At their option, the parties may thereafter agree to resubmit their case to a new Hearing Panel. If such option is exercised, the parties to the case and their attorneys shall submit new submission agreements in writing consistent with the requirements of this Plan.

25. RECONSIDERATION

The parties or their attorneys shall have ten days from the date that the written report signed by the Chairman of the Hearing Panel has been served upon the attorneys for the parties within which to request the Hearing Panel to reconsider any issue which has been presented to the Hearing Panel for its determination. Failure to file such a request for reconsideration, specifying with particularity the issue or issues for which reconsideration is requested, within the ten days provided or within any extension of time which may be granted by the Chairman of the Hearing Panel shall cause the findings of the Hearing Panel to become final. Upon receipt of such a request for reconsideration, the Chairman shall poll the Hearing Panel and shall determine whether the majority of the members of the Hearing Panel wish to reconsider such issue. If by majority vote the members of the Hearing Panel decide that they wish to reconsider any such issue, the Hearing Panel by majority vote may reconvene for additional testimony or for additional argument by the attorneys for the parties. If such additional testimony or argument is received by the Hearing Panel, a supplemental report shall be signed for the Hearing Panel by its Chairman pursuant to the requirements of Paragraph 21 of this Plan.

26. COURT OF ACTION

It is not intended that the submission of any case to the Hearing Panel shall be considered as a waiver by the Claimant or his attorney of their ultimate right to decide for themselves whether the case shall be filed in court, except in those cases in which the parties have agreed to be bound under the provisions of Rule 109, Colorado Rules of Civil Procedure. However, any attorney who brings a case before the Hearing Panel shall weigh its conclusions in the greatest professional good faith.

1-20-76

Suggested Rewording of Questions for
Expert Advisory Panel
HB 575 Sec 09.55.536(e)(1)-(5) p5-6

(1) What was the condition for which the person sought medical care?

(2) Was the care appropriate and skillful?

(3) Is there an injury which arose from the medical care?

(4) What is the injury?

(5) Is the injury stable, or will it improve or become worse?

Members file on Malpractice

ALASKA DENTAL SOCIETY

OFFICE OF THE PRESIDENT

January 10, 1976

Mr. Langhorne Motley
Commissioner
Pouch D.
Juneau, Alaska 99811

Dear Commissioner Motley:

The Alaska Dental Society wishes to reaffirm it's position in relation to the Malpractice Insurance Commission's proposed legislation.

We object to mandatory inclusion in a joint under-writing association and adhere closely to the points and reasoning brought out in a report to the legislature made by Dr. H.S. Denenberg.

Sincerely;

Robert R. H. Sutherlin DDS

R.H. Sutherlin
President
Alaska Dental Society

cc: All legislators
All Health Care Associations
Governor
Director of Insurance

Introduced: 1/14/76
Referred: Health, Education
and Social Services

IN THE SENATE BY CROFT, KERTTULA AND RODEY

SENATE BILL NO. 507 am

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act establishing risk management in hospitals; and providing for an effective date."

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

* Section 1. AS 18.20 is amended by adding a new section to read:

Sec. 18.20.075. RISK MANAGEMENT. (a) To be eligible for a license each hospital shall have in operation an internal risk management program which shall

(1) investigate the frequency and causes of adverse incidents in hospitals which cause injury to patients;

(2) develop and implement measures to minimize the risk of injury to patients from adverse incidents, giving due regard ...; and over

(3) analyze patient grievances which relate to patient care.

(b) The department shall adopt by regulation and submit to the legislative administrative regulation review committee prior to implementation, standards for risk management programs in hospitals in the state which may vary according to the size of the hospital, the type of care offered by the hospital, and other factors found relevant by the department.

* Sec. 2. This Act takes effect July 1, 1976.

TELEGRAM

RCA ALASKA COMMUNICATIONS, INC.
PHONE: 586-6440
JUNEAU, ALASKA 99801

Copies for Members files
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PMS TERRY GARDINER CARE HOUSE JUDICIARY COMMITTEE 1976 JAN 27 AM 10 57

JUN" 0919

AS PRESIDENT OF THE ALASKA CHIROPRACTIC SOCIETY
I HAVE BEEN DIRECTED BY ITS MEMBERS TO REQUEST
YOUR ASSISTANCE IN EXCLUDING (TOTALLY)DOCTORS
OF CHIROPRACTIC FROM SB522 MALPRACTICE CLAIMS ARE NOT
A PROBLEM WITH OUR PROFESSION AND OUR MEMBERS ARE
ADEQUATELY INSURED THROUGH OUR NATIONAL CHIROPRACTIC
AS ORGANIZATION FOR OUR PATIENTS PROTECTION

CECIL S MCLEOD DR

1. Dept of Rev be obligated to make investment

~~F~~ to Corp. - certification of fund deficiency by Director of Div of Insurance to Com of Revenue

Be able to

"private group" + "hospitals"
"private clinic"

Sec. 21.88.080. REQUIRED INSURANCE; CANCELLATION. The corporation shall provide insurance to all health care providers otherwise eligible for licensure under AS 08.64 and AS 18.20. The corporation may provide for installment payment of premiums in which event each installment is due by the date specified. The corporation may cancel any of its policies in the event of nonpayment of any premium or installment on a premium or other charge by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice stating when, not less than 10 days after notice is received by the insured, the cancellation is effective.

ARTICLE 3. LOAN FUND.

Sec. 21.88.110. FUND ESTABLISHED. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) Loans from the fund shall may be made to the corporation when necessary for the ~~fund~~ Corporation to maintain adequate reserves.

(c) Loans from the fund shall be repaid by the corporation within four years at an annual interest rate of seven per cent.

ARTICLE 4. GENERAL PROVISIONS.

Sec. 21.88.300. DEFINITIONS. As used in this chapter,

(1) "corporation" means the Health Care Providers Indemnity Corporation;

(2) "director" means the director of the division of insurance for the State of Alaska;

(3) "fund" means the medical malpractice liability revolving loan fund;

(4) "health care provider" means a physician licensed under AS 08.64 and a hospital as defined in AS 18.20.130, including a hospital [illegible] state facility owned or operated by the state or one or more of

its political subdivisons;

(5) "occurrence basis insurance" is insurance against claims arising during the period of the policy coverage.

* Sec. 24. AS 08.64.365 is repealed.

* Sec. 25. This Act takes effect 30 days after enactment.

Alaska State Legislature

REPRESENTATIVE
TED SMITH
2616 SORBUS CIRCLE
ANCHORAGE, ALASKA 99504

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811

COMMITTEES
RESOURCES
BUDGET & AUDIT
LABOR & MANAGEMENT

House of Representatives

February 10, 1976

Terry Gardiner
Chairman
House Judiciary

Dear Terry,

These comments are directed to the Work Draft Copy of CSHB 574 marked 2nd Version of Draft #2.

Sec. 18.20.075 starting at line 23 on page 16 deals with risk management. I recommend that this be changed to loss management and be a function of the Health Care Provider Indemnity Corporation. Many of the functions listed are already accomplished and/or provided for under the provisions for review organizations starting on page 17. It should be a function of the HCPIC to provide professional expertise to its insureds in the area of lost prevention.

The definition of function of a review organization on page 21 under Sub. Sec.(H) includes acting as an arbitrator or mediator. Some of the immunities provided to the review organizations are not appropriate in this context. Specifically I do not believe that the privilege of confidentiality in a physician-patient relationship should be waived for this function. Accordingly I recommend that on page 17 at the end of line 21 you add the phrase "except a review organization acting under authority of Sec. 70(5)(H) of this chapter." I also do not believe that the immunity from discovery is appropriate for such organization and on page 19 after line 13 I recommend that you add the following:"(d) The immunities of this section do not apply to a review organization acting under Sec. 70(5)(H) of this chapter."

It is my understanding that the remainder of the bill starting on page 22 does not express committee intent so I will withhold comment on that portion of the bill.

Sincerely,

Ted Smith
Chairman
House Labor & Management

TS:hk

Representative Gardner,

Comment on C S - Bill 574
by the House Judiciary Committee.

Our first reading is favorably impressed by the many good features.

We would like to suggest that one very important factor it needs and which would strengthen it considerably - to make insurance companies & their cost more predictable is a strict Statute of limitations as in Indiana - see attached copy.

Such statute of limitations would make a "late Claims fund" unnecessary. In the absence of this type of statute of limitations - then a late claims fund becomes more needed.

Thanks.

R. Witt, MD.

Indiana – April 2, 1975 (Reprint)

or his insurer to or for the plaintiff, or any other person, may not be construed as an admission of liability for injuries or damages suffered by the plaintiff or anyone else in an action brought for medical malpractice.

Sec. 4. Evidence of an advance payment is not admissible until there is a final judgment in favor of the plaintiff, in which event the court shall reduce the judgment to the plaintiff to the extent of the advance payment. The advance payment shall inure to the exclusive benefit of the defendant or his insurer making the payment. In the event the advance payment exceeds the liability of the defendant or the insurer making it, the court shall order any adjustment necessary to equalize the amount which each defendant is obligated to pay, exclusive of costs. In no case shall an advance payment in excess of an award be repayable by the person receiving it.

Sec. 5. A patient's claim for compensation under this article is not assignable.

Sec. 6. Financial responsibility of a health care provider under this chapter may be established only by filing with the commissioner proof that the health care provider is insured by a policy of malpractice liability insurance in the amount of at least one hundred thousand dollars ($100,000) per occurrence.

Chapter 3. Statute of Limitations.

Sec. 1. No claim, whether in contract or tort, may be brought against a health care provider based upon professional services or health care rendered or which should have been rendered unless filed within two (2) years from the date of the alleged act, omission or neglect except that a minor under the full age of six (6) years shall have until his eighth birthday in which to file. This section applies to all persons regardless of minority or other legal disability.

Minor
In jail
In military service
Mentally incomp

Sec. 2. Notwithstanding the provisions of IC 1971, 16-9.5-1-7, any claim by a minor or other person under legal disability against a health care provider stemming from professional services or health care rendered, whether in contract or tort, based on an alleged act, omission or neglect which occurred prior to the effective date of this article, shall be brought only within the longer of

(a) Two (2) years of the effective date of this article, or

(b) The period described in section 1 of this chapter.

Chapter 4. Patient's Compensation Fund.

Sec. 1. (a) There is created a patient's compensation fund to be collected and received by the commissioner for exclusive use for the purposes stated in this article. The fund and any

Additional Coverage Made available
Excess / Coverage

States full faith & credit

~~Page 22 line 20~~

Page 23 — statistics
Provisions for Suit info to go to licensing Board

Page 24, line 25

include Retroactive portion

check required reserves requirement
Commission Recommendation said
retrospectively lower premiums in future

Page 27, line 12 - check "indemnifying"

→ allow both retrospective adjustment
+ returning premiums

2 years

Plaintiff

- Informed consent
- Continuing Education
- Risk Management SB 507
- clearing + convincing

Yes

Yes

Medical Board set standards
4 year time period
Subject to reexamination if not complied

1. additional assured by Hosp.
language Page 51, line 21

Check Court Rule change on
Discovery Clause page 19

Cause of Action for triggering mechanism

N ☐ 400,000
500,000

Chris Beardsley - Providence

20,000 for $20 million coverage
increased cost under M.I.C.

Bar Assoc Endorse } Court ?
AMA Endorse } Approve

~~Endorsed~~

Require MIC to contract to
— Per Diem
Page 21, line Retro-active clause

Page 22 (6) umbella language - does it make sense

Pending Contingent liability

Rewrite fund for Revenue not Appropriation

Reasonable Rates for fund in Gov bill

Mechanism on Doctors Rates for New ones

Hospital Insurance Rate Determination

Page 21 line 8 ? why this

Page 21 (b) rewrite

Mandatory section on Management of MIC

Experts in Medical Mal/Practice Risk Management

allow internal Risk Managers To impose

Introduced: 1/14/76
Referred: Health, Education and Social Services

IN THE SENATE BY CROFT, KERTTULA AND RODEY

SENATE BILL NO. 507 am

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act establishing risk management in hospitals; and providing for an effective date."

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

* Section 1. AS 18.20 is amended by adding a new section to read:

Sec. 18.20.075. RISK MANAGEMENT. (a) To be eligible for a license each hospital shall have in operation an internal risk management program which shall

(1) investigate the frequency and causes of adverse incidents in hospitals which cause injury to patients;

(2) develop and implement measures to minimize the risk of injury to patients from adverse incidents; and

(3) analyze patient grievances which relate to patient care.

(b) The department shall adopt by regulation and submit to the legislative administrative regulation review committee prior to implementation, standards for risk management programs in hospitals in the state which may vary according to the size of the hospital, the type of care offered by the hospital, and other factors found relevant by the department.

* Sec. 2. This Act takes effect July 1, 1976.

1

1. Socialized Medicine
2. State fund Docs contribution
3. State trust fund - people pay
   A. limit docs liability 100,000

John Ale

			New
58-152	Commissioners	—	28-58
3	Boards & Bureaus		~~1~~ 2
	Administration		
	legal (ratify dismissal Michigan)		Some
	Advisory panel		Unpredictable
	Reserves for future		

(1) 1974 5,000 av. 300 docs — 1.5 million premium

(2) Scale of doctors incomes

(3) Breakdown of premium dollar
St. Paul ~~&~~ Aetna

(1.) What % of Alaskan cases go to court

(2) ~~W~~ How many cases for plaintiff in jury cases

What's trial de novo

~~B~~ 40 - defense expense of litigation
12 - plaintiff
12 - broken
17

to difficult to refute expert testimony

impartiality & credibility is strength of Advisory Board

1st./claims Made - Single fund

Premiums based on gross receipts

70% of doctors pay 1,000 or less

9% of doctors pay high risk

Only 5% of claims are ever actually are filed

Att won't take cases unless case a minimum cost of #10,000 out of pocket expenses

Why less in front of Adjudication Board

1. & Expert Advisory Board reduces costs because of their expertise & credibility

1. Selection of jury - 2 days
2. instruction of jury - ½ day
3. presenting evidence to jury - complicated

Never been jury award against doctors

W

≤8% of cases settled out of court

Justification for state Participation

1. ~~(1)~~ insurance Co. have such low surpluses they can't buy any insurance anyway

(2.) Only operates in state will be interested because they are captive and subject to JUA

(3.) Insurance co. have had bad experience with Malpractice and would be very conservative in any bid + high risk - want high profits

(4) Cheaper Cost because no profit required by state
15% for insurance co.
+ additional savings of Commission etc. in proposed MIC

(5)

1. limit contingent fees
2. eliminate ad Damnum clause - in bill?

Denneberg

1. Consumer on Boards in bill?

2. Ohio & Wisconsin continuing education
have Rick get these
give more authority to Board?

3. Florida set up internal Risk management
procedure - Com. recommendation
set aside 10% of premiums to fund this?

Working Committee
1. Block
2. Smith
3. Carpenetti
4. Rob Koshas ?
5. Rick

Malpractice

Ins. ~~Incr~~ payments

Legal – losing att pay fees

Medical – dispiriary

Ask Block – about losing Att pay fees
Talk to Malpractice Att in Calif
Dennenberg
College Legal Prof

Suits are winning ! therefore would anything discourage good suits ?

What % of suits filed win anything ?

~~" " " losing suits~~

What do ins Co. pay out in suits they ~~lose~~ win in terms of legal and defense costs

Is SB113 contained in Gov. package

Contract Co. to Manage & Write policies
to do paper work Similar to Alaska U.F. Grp.
1. policy % of income
2. premium gaged to experience ± 10% (example) – Mechanism to space over years in increase – excess in reserve fund to build up – State to invest state loans etc.

put in reserve fund until education program developed of do both education – loss control State Medical education program & ~~&~~ on going

Can you write one standard policy

1. Alt to admit other groups by com.
   but only if all of group joins

Premiums include ① cost of program - go to gen fund
② losses
③ reserve
④ Education fund

state sets standards of policies as set by advisory bd of group insured - use ~~staff~~ existing licensing bd

~~So~~ Bradley Bill $5 million to set up fund to be paid back to general fund over ~~10~~ 10 years at 7½% - Dir of Ins can suspend to insure solvency of fund

add = employees to Division of Ins to Manage

1 Part
2. Cotton

deduct costs of state

1. state ins plan : Ass does by gross income
2. ~~losing~~ att pay court costs - provide exception
3. State Medical care
4. Policing of Doctors

~~att can only charge on hourly basis~~

Save Money of administering program

1. total premiums paid in Alaska now
2. average Mal practice settlement now
3. State funds paid for State Medicare
4. Cost of state administration of Ins.

III set up adjudication board to cut systems cost

breakdown of premium dollar

Medical Malpractice

Act Snowden

1. Adjudicatory Board
2. Advisory panel ~~to~~ Superior Court

No. 7 recom.

difficult to administer Adjudicatory

→ Was submitted as a court rule change

Dr. Wilson - Advisory Committee

Rejection of Advisory panel concept by Supreme Court will be outlined in letter

Statistics

'66 Malpractice suits 18 years
3.7 suits per year
2.8 million payed in settlement
500,000 settlement in 1974

Because 100 of 370 insured less suits ?

13-~~25~~¢ of premium dollar goes to

Roy Box Optometrist

Umbrella insurance available

SVA - disadvantage - tax on insurance companies therefore all consumers in Alaska

MIC - take advantage of re-insurance experience & expertise on Mal-practice

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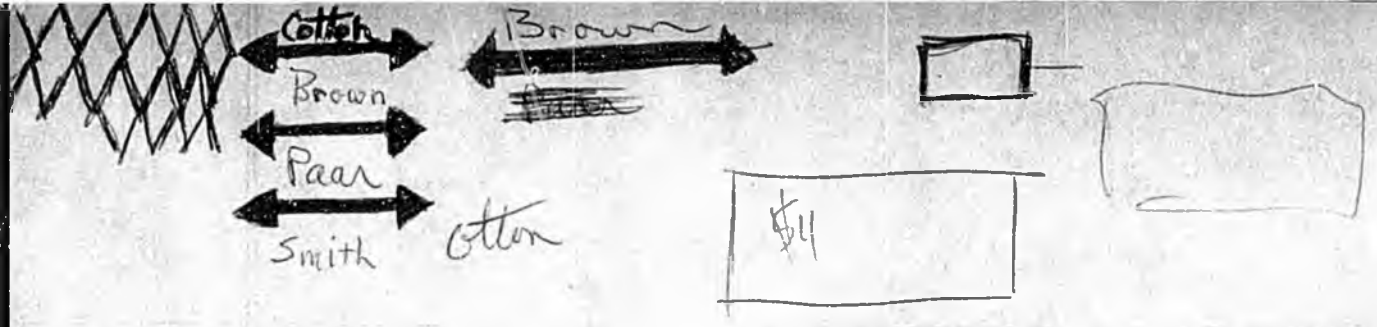
Late Claims Fund

statute of limitations (2 year) doesn't apply

no personal liability with the fund

thus allows more recovery

higher burden of proof though



Insurance Co. don't care what the experience is in Alaska

AIPAC - "Hale" $5 million capitalization

Feb 11 - Reinsurance People

(1.) No History on Alaska - Don't believe we have a problem

(2.) Patients go out of state for treatment
Who is responsible

Insolvency pickup problems - other ~~cancel~~

Dollar Volume of Claims - 90% payment in 1st 3 years.

Inclusion of other groups - Nurses etc
1. Cut cross complaints - Multiple defendants
common defense
2. different rights for different folks
3. Concern for how each other function in health care system.

" include Medical Health Care Group "

Cost (1.) Continue existing occurence rates
SUA has to be self supporting
" retrospective adjustment "

AS 8.64.107 - .366 limitation of liability

MIC - ~~Title~~ Insurance Co. don't have surpluses to write and pick up our insurance

Dick Block

1. Controllable Progam - control cost
transfer uncontiolable risk to someone else

OCCURENCE - never used to be a problem

1974 - Stock Market crash
up to 1972-1973 lucrative insurance profits
Made a lot of investments in stock market
∴ lots of $ lost
At the same time high Medical care inflation
Companies didn't sell stocks instead drove
surpluses down — ∴ cut back premiums

Get NAIC Report

50% come in 1st year claims
later claims are big ones

excess costs in Alaska because 5 programs
spread over 315 doctors

Adverse selection if not Mandatory inclusion

Plan 1 1. Mandatory — exclusive; controllable program
Plan 2 2. Now ready to sell insurance through MIC
each years calculations of ratio passed on to
next years rates - MIC not Mandatory

Plan 3 Back up SUA

Plan 4 Late Claims Fund - don't collect
- some Medic on Cash basis

Insurance
Medical
legal

Medical Mal-practice

1. overall cost is uncontrollable (legal reduced)
2. mechanism for spreading cost is inefficient

1-13 recommendations - legal control cost

liability system 40%-60% → distribution to individual
other collateral system 85%-95% → " " "

Separation of speculative cost to control cost of insurance

Recom 12 - Pay for damages periodically

9+10+11 - Adjudication Board — small claims aren't being paid of filed

23-27 - Prevent Malpractice from occurring

13-23 - Distribution of Cost.

(1.) By including all physicians you actually include all patients

(2.) Indemnity Corp needs all members to function

One source for Ins & Private Ins can manage program better than State

Because of controllable Cost in 1-13 Indemnity Corp will be able to find ins. in private sector

Stand By facility - JUA

Late Claims fund - No obligation for 3 years

Enforcement Mechanism - doctors all belong to insurance pool

1st 3 years you can quantify/cost

94% of Claims in 1st 3 years

Robert Whaley - Alaska State Medical Assoc

1. No longer have radiation service in Alaska
2. losing some experts
3. Ultra-conservative in attitude of risk

No-fault coverage - commission didn't feel appropriate

Agree with Den. recommendation on strengthening Comm.

2/3's of cases 1. wrong choice 2. bad luck

Ask what Medical Assoc pos on all phys. being included

Blue Cross - John Hopkins
support commission proposal even though has SUA

Dr. Kim Fairbanks
240- of 300 belong to competet groups.

100 physicians without insurance today

Blocks - Calif broker for hosp Assoc.

set aside $700,000 instead of $4 million per periodic payment - this is the savings

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Henry Pratt - opposed mandatory inclusion
Dentist insurance is National + includes all kinds of coverage

Vic Dunbar - Hosp Assoc.

two exceptions
1. #14 Mandatory inclusion
2. #22 All Health Care Providers

Assoc. split on this issue

Joe Josephson - Alaska Medical Assoc.
Use Commission bills as a base

1. discipline
2. retroactive coverage - ask Dick Block

AMERICAN MEDICAL

JANUARY 12, 1976

Physicians' liability protest widens in Southern California

With the holidays over, hospitals in Southern California began to feel the full force of a work slowdown by physicians protesting increasing professional liability insurance premiums.

A check by the Southern California Hospital Council of the 160 hospitals in Los Angeles County showed 64 had experienced some restrictions in services by Jan. 5. Elective surgery had been cut back in all 64. Effected to a lesser degree were obstetric-gynecological procedures, emergency room services, and outpatient care.

Hardest hit was the northwestern area, in Encino and the San Fernando Valley, where 20 out of 30 hospitals reported slowdown actions. Almost all orthopedic and neurosurgical services were halted there. Only eight Southern California hospitals outside Los Angeles County were affected. The job action, however, was expected to continue to build.

IN RESPONSE to the survey, the Los Angeles County Medical Assn. activated its 24-hour referral service on Jan. 6 to help patients needing medical care.

Meanwhile, a last-minute proposal by the governor's office submitted on Dec. 29, was turned down by the medical societies and other physician groups, although parts of it may be salvagable.

The plan, "California Malpractice Reform Act of 1976" would establish a physician-controlled fund to pay claims.

Florida hospitals yield on insurance rules, page 10

Average cost to physicians would be $4,000—one-third more than average 1975 rates, but considerably lower than newly proposed increase.

The catch is that physicians could no longer refuse to treat Medi-Cal patients. MDs with less than 10% Medi-Cal patients also would have to provide up to 20 days of free services annually. The plan also would require the medical profession to operate a "peace corps" in the underserviced areas of the state.

California Medical Assn. (CMA) governing council, meeting in special session Jan. 5, endorsed only those parts of the plan not dealing with the "peace corps" or Medi-Cal treatment. Those portions approved include a limit on physician liability and a check on legal merits of a suit before it can be filed.

The council also voted to support actions of physicians involved in the slowdown. It called for reforms that would establish compulsory arbitration, screening panels, and "specialty courts" for malpractice claims; allow filing of counterclaims; eliminate pain and suffering awards; provide a schedule of awards in wrongful death actions; grant absolute immunity for physicians rendering emergency care and for those on peer review panels; and set up a catastrophic health insurance plan for all Californians.

LATER THAT EVENING, the Los Angeles County Medical Assn. council

(See Liability . . . , p. 10)

Liability slowdown widens in California

(Continued from page 1)

agreed to back up the CMA recommendations on the administration's plan. Agreement between the two societies may signal a halt to the infighting that has characterized the liability dispute in recent months. Members of the various splinter groups that have criticized organized medicine also have indicated during meetings with the societies they will begin to coordinate efforts aimed at halting runaway premium costs.

The 327% increase in premiums, scheduled to go into effect in Southern California on Jan. 1, has been delayed at least for a month, although it may be made retroactive. The company plans to appeal the decision against its requested 486% increase and will put off billing physicians until next month. It has assured physicians in the plan that they will be covered during that time.

Survey shows liability law gains in '75

An *American Medical News* survey of the country's medical societies indicates that during 1975, at least 31 states approved legislation aimed at controlling the crisis in medical liability.

As a result of these activities, availability of insurance is no longer a serious problem in many areas. Some 20 states passed laws allowing for formation of a pooling mechanism, such as a joint underwriting association, or of a physician-owned insurance company. Sixteen have put those pools into operation; seven have physicians' companies.

Premiums, however, continue to escalate, with little relief in sight. Physicians in at least 13 states experienced premium increases of 100% or more and another five reported increases beyond 500% during 1975. One exception to this is Indiana, first state to approve sweeping regulations on malpractice claims. Physicians there received only a small increase during the year, and may have no increase during 1976.

A type of patients' compensation fund, similar to that passed in Indiana, was approved in four other states, and seven medical societies hope to interest their legislators in the legislation during the coming year. The system generally sets a limit on physicians liability and establishes a fund to pay costs beyond that amount.

Seven states approved a limitation on awards and 15 more will try to do this during 1976, although the constitutionality of such laws is being disputed.

Attempts to police the medical professional have led nine states to strengthen their boards of medical examiners; nine more plan to introduce similar measures during this year. Two states, Washington and Wisconsin, approved continuing medical education requirements, and Minnesota hopes to have this passed in 1976.

Details on each state's situation appear on page 13.

Survey shows gains in liability legislation, but problems remain

Alabama

The Alabama Medical Liability Act was passed in September, 1975. It provides for a statewide JUA, reduces the statute of limitations, repeals the ad damnum clause and establishes a malpractice claims reporting system. There are no plans for further legislative action in 1976.

According to the Medical Society of the State of Alabama, physicians are not having difficulty getting coverage. However, the society-sponsored carrier, Wausau, has expressed a desire to terminate its activity in July. The society says it is in the initial planning stages of a physician-owned insurance company. According to a society spokesman, the incidence of claims reported in the last year has increased 75%. Premiums have increased approximately 50%.

Alaska

Alaska physicians continue to experience a serious problem with availability of coverage. New policies are available only through the medical society plan with Mutual Fire, Marine, and Inland, which writes only claims-made policies up to $300,000 limits. A July survey by the medical society showed that 22% of physicians had no insurance and 40% had unsatisfactory coverage. Delivery of care has been seriously affected. Many patients have had to travel to other states for treatment.

The legislature has approved a joint underwriting association, but the plan was vetoed by the governor who has established a committee to investigate alternatives. The medical society favors a state-run pool to guarantee coverage. Family practitioners covered by Mutual Fire and Marine had premiums increased from $400 to $6,000; rates for orthopedic surgeons went from $2,000 to $12,000.

Arizona

The state will lose its only carrier, Travelers, on April 1, when the company terminates its program with the medical society. Before then, the society hopes to have legislators approve a temporary joint underwriting association and physicians' mutual company. It also is working with the hospital and bar association on various reforms modeled after Indiana's Patient Compensation Fund. Travelers received a 107% increase this year, putting premiums at between $1,595 and $9,119 for $1-million limited coverage. The Insurance Service Office has recommended rates in the state be raised an average 300% during 1976.

Arkansas

The Arkansas State Legislature passed during its 1975 session legislation that makes mandatory the reporting of all claims filed to the medical examining boards, sets up a JUA, and establishes a voluntary arbitration panel whose results are admissible in court as evidence. Since the legislature only meets every other year, there is no legislation on the agenda. However, according to a medical society spokesman, efforts to amend the state's constitution will begin to clear the way for legislation similar to the "Indiana package."

Liability coverage is available in Arkansas, if a physician accepts St. Paul's claims-made policy. St. Paul is the state's only carrier. Premiums have increased a total of 80% over the last year. Society officials say there has been a "marked increase" in the number of claims filed against physicians.

California

Legislation passed following a month-long job action in mid-1975 includes a limit on awards for pain and suffering, sliding scale for contingency fees, strengthening the board of medical examiners, and a reduced statute of limitations. The mechanism is available for a joint underwriting association, and mutual companies have been formed in the San Francisco area, in other parts of Northern California, and in the Los Angeles area.

None of these measures, however, promises any effect on the soaring costs of premiums that increased up to 327% in parts of Southern California on Jan. 1. Northern California MDs received increases of 341% on Nov. 1 last year. High-risk physicians pay $36,000 in the south and $22,000 in the north for coverage of up to $1 million/$3 million.

Colorado

No malpractice legislation was passed in 1975. For the coming session, however, the medical society and other groups have made it known that there will be a number of bills submitted. A society spokesman says that the society's bill will address itself to the statute of limitations and strengthening the Board of Medical Examiners. Groundwork for a JUA is expected to be laid.

Availability of insurance does not seem to be a problem. The society-sponsored carrier, Hartford, is the predominant carrier in the state, and Empire and St. Paul also are active. Premiums have, as elsewhere, been on the rise. As of last June, the premium on policies offering $100,000/$300,000 coverage has risen 15%. $1-million coverage has increased 40%, while $3/$5-million coverage has increased 39%. A medical society official said 44 claims were filed last year, 38.9% more than a year earlier.

Connecticut

With 90% of the state's physicians covered by Aetna Life and Casualty Co., Connecticut reports there is no problem in obtaining adequate coverage. However, the number of liability cases by specialty more than doubled from May 1, 1974, to May 1, 1975, prompting a 40% increase in premiums.

Although the state medical society has no plans to start a JUA or physician-owned company and although there was no remedial legislation passed in the past year, the society will pursue a broad legislative program in 1976, including sliding contingency fees, a ceiling on awards, and a study of arbitration.

Delaware

When the Delaware General Assembly convenes Jan. 13, the Medical Society of Delaware will push for tort reform, limitation on awards, and creation of a JUA. It does not intend to create a physician-owned firm. The medical society reports its agreement with Aetna, which insures about 70% of the state's physicians, has one year to run, and that, "For now, physicians who are our members can still get insurance—for a price."

During the past year, premiums in Class I increased 66.7% and the Class III premiums jumped 74.8%. The society said it could not ascertain if there had been an increase in the number of claims.

District of Columbia

The medical society plans to continue to work on several bills introduced but not passed last year, which include a $500,000 limit on awards, establishment of mandatory review panels, and a reduction in the statute of limitations. It also is working with the insurance commission on plans for a joint underwriting association, although availability is not a problem at this time.

Coverage is available through the society-sponsored plan with Hartford, now in its third year of a five year plan. St. Paul and U.S.F. & C. also write policies. Hartford received an 83% hike in premiums during 1975. Coverage on $1-million/$3 million policies costs between $200 and $1,000. The society, however, predicts a significant jump in rates this year.

Florida

The Medical Malpractice Reform Act of 1975 established in Florida a mandatory mediation panel—now being challenged for its constitutionality in a Florida court — and a statewide JUA. Further legislation concerning medical liability is expected in 1976, particularly in the area of tort reforms. The Florida Medical Society-sponsored insurance trust, which offers $500,000 basic liability coverage for the same rates Argonaut charges for $100,000 coverage, has attracted over 4,000 participants.

A society spokesman told *AMN* that during the period of 1963-74 the rate of claims filed rose from 3 per 100 physicians per year to 16 per 100 per year. Under the JUA, the premium for basic coverage for a Class I physician in Dade and Broward County, for example, is $2,930. For a Class V, it is $24,247. Under the trust (claims-made), a Class I doctor pays $1,313 and a Class V pays $8,243.

Georgia

Georgia's legislature in 1975 passed a law that permits the insurance commissioner to set up a joint underwriting association, if and when physicians are no longer able to get liability coverage.

For the time being, the state's physicians have no trouble, except in getting excess coverage over $1 million. Some 95% of the state's physicians are insured under the Medical Assn. of Georgia's program with St. Paul, on a claims-made basis, and overall premiums were actually reduced this year by 11%. Malpractice claims this year are up 40%, but many of these are nuisance claims generated by publicity, say medical association officials.

Hawaii

A feared Jan. 1 pullout by the major carrier, Argonaut, was postponed pending legislative action. The medical society is working with the administration to develop an omnibus bill containing various tort reforms. A joint underwriting association, not favored by the society is available to physicians should the need arise.

Rates increased only 11% for basic coverage and 13% for excess coverage last year. Physicians now pay between $668 and $4,343 for $25,000/$75,000 coverage and between $1,046 and $13,010 for $1 million. The incidence of claims rose sharply in 1974 and again during the first part of 1975, but dropped off the second part of last year.

Idaho

The Idaho state legislature passed in 1975 the Hospital-Medical Liability Act, which placed a limitation on liability and created a statewide JUA. The concept of limiting liability has since been tested in the courts and found to be unconstitutional and some have questioned the constitutionality of JUAs. Because the Liability Act was a non-severable bill, many of the other items that were passed along with the JUA and liability limitation clauses will be reconsidered during the 1976 legislative session.

Coverage is available. When Argonaut, which covered 500 of the state's physicians, pulled out last year, St. Paul, with its claims-made policy, stepped in. On Aug. 1, the Insurance Service Organization recommended companies in Idaho institute a 287% across-the-board premium increase. According to a spokesman for the Idaho Medical Society, a feasibility study is under way to consider the possibility of a physician-hospital-owned insurance company.

Illinois

The Illinois Supreme Court will decide this month the constitutionality of two new laws—a limit on awards and mandatory screening panels. Legislators also approved a lowered statute of limitations and provided the mechanism for a joint underwriting association during 1975. The medical society plans for 1976 include various tort and judicial reforms.

Physicians have no trouble obtaining adequate coverage through one of eight carriers in the state, including a society-sponsored program with Hartford. Premiums rose an average of 49% to 69% during the past year, putting premiums at between $368 and $5,084 in the Chicago area, and between $344 and $2,868 in the less populated areas for $100,000/$300,000 coverage. Claims rose 42% last year in the Chicago area.

Indiana

In April legislators approved a precedent-setting measure that established a $100,000 liability limit on physicians, a catastrophic fund to pay awards beyond $100,000 up to an additional $400,000, a risk manager system to guarantee coverage, mandatory screening panels, a limit on attorneys' fees, and a shortened statute of limitations. During 1976, the medical society plans to seek revision of portions of the law, such as adding a $100,000 limit on cases involving more than one physician, and possibly legislation allowing individual physicians to insure themselves.

Medical Protective of Ft. Wayne, insurers of 52% of the physicians, did not seek an increase during 1975 and likely will not do so during the first part of 1976. Rates of other firms—Aetna, Hartford, and Continental—went up 18% in September. A pull-out by major carriers has halted; only St. Paul, which insures 200 MDs, will leave. A few physicians are covered by the risk manager system, whose rates range from $1,629 to $13,250. Medical Protective charges between $508 and $3,269 for $100,000/$300,000 coverage. Other firms charge between $822 and $6,913.

Iowa

Laws enacted during 1975 to establish a joint underwriting association, define informed consent, allow the courts to rule on contingency fees, and reform other torts laws were just a beginning, according to the state medical society, which plans to press for passage of an eight-point package during the year. Included would be a possible limit on physician liability plus a state fund for excess awards, a ceiling on awards for pain and suffering, a system for arbitration, strengthening of the board of examiners, and other tort changes.

Basic coverage is available, at rates ranging from $621 to $3,825 for $200,000/$600,000, but excess protection is difficult to obtain. Coverage is available with Medical Protective; St. Paul, which writes only claims-made; and Aetna. Older physicians, however, especially those with claims against them, are often not renewed.

Kansas

Only one law on liability passed the legislature last year; it required insurance companies to report claims. The medical society plans an extensive campaign for 1976 in attempt to get approval for an Indiana-type compensation fund that would limit liability to $100,000 and establish a fund to pay excess awards up to $500,000. Plans also call for voluntary arbitration, screening panels, revising the board of medical examiners, and establishing a temporary JUA.

Insurance now is available to most physicians, but at high costs that vary greatly. Basic coverage for Class I ranges from $500 to $2,000 and for Class V from $3,000 to $6,000. Carriers include Medical Protective, which writes 55% of physicians; St. Paul, which writes 35%; and Aetna and Hartford.

Kentucky

The Kentucky legislature did not meet last year. This year, it will consider reforms recommended by a governor's task force, among them a type of JUA.

Insurance is available to physicians through Medical Protective, which writes 65% of policies, Aetna, which writes 15%, and other companies. Some new physicians have experienced difficulties obtaining coverage. Rates increased last year about 60% to between $1,823 and $3,304 for $100,000/$300,000 coverage. Incidence of claims rose 33%.

Louisiana

A package of reforms based largely on the American Medical Assn.'s model legislation won approval in 1975. These include a $500,000 limit on awards, contractual binding arbitration, informed consent definition, and a shortened statute of limitations. Also approved was a limit on physicians' liability of $100,000/$300,000, and a patients' compensation fund to pay awards for over that amount up to $500,000. The medical society has opposed either a JUA or a mutual company, although coverage may soon become a problem as Hartford, which covers 75% of physicians, continues to cancel some physicians.

Most of the remaining physicians have insurance through St. Paul, which will not write new policies. Rates increased 91% in July and went up another 75% this month. Premiums for $100,000/$300,000 coverage cost between $695 and $5,247. The medical society estimates the number of claims rose 300% last year.

Maine

Reporting its premiums increased "too much" (from $400 to $1,800 annually for some internists; from $1,600 to $4,000 for the higher-risk specialties), the Maine Medical Assn. sponsored 1975 legislation for creation of a JUA and formation of a malpractice study commission.

Both were adopted, and the society now awaits the commission's recommendations to plan its 1976 legislative program.

Coverage is difficult to obtain only for new physicians, those who are foreign-trained, and those who have suits pending. The society has no plans to start its own company, and reports it has no way of obtaining data on claims filed.

Maryland

In 1975, the legislature in Maryland passed bills which established a JUA, changed the statute of limitations to three years from discovery, and provided for the creation of the society-sponsored Mutual Liability Insurance Society, which went into existence June 1, 1975, and has been writing policies since July 1. A governor's task force is looking at other proposals which come before the legislature in 1976.

At present, Hartford Insurance Co., is the only carrier that continues to renew policies. Other companies have withdrawn and are no longer renewing policies. No company is accepting new risks. Premiums have been rising; Mutual Liability Insurance Society's have risen 200%.

Massachusetts

The legislature enacted a joint underwriting association programmed to self-destruct by the end of 1977. To date, the JUA has written policies on 900 physicians; coverage is available up to $1 million/$3 million.

Legislation supported by the medical society also established a study commission to review the tort system and recommend changes, and established a medical screening tribunal and medical disciplinary board. The medical society is studying the feasibility of establishing a captive company to insure its members.

Michigan

Last year, laws allowing binding arbitration, a shortened statute of limitations, immunity for peer review board members, extension of the Good Samaritan Act, establishing a state insurance pool, and requiring insurance companies to report claims were passed. This year, the medical society would like to see considered a limit on awards, further shortening of the statute of limitations, and provisions requiring all suits to have an affidavit of merit. The Brown-McNeely state fund has been activated with rates at about $2,000 to $12,000 plus surcharge. It covers some 1,500 MDs.

Medical Protective writes about 65% of physicians' policies and charges between $1,185 and $7,863 for $100,000/$300,000. The company received a 126% premium increase in October. Both St. Paul and Shelby Mutual are leaving the state. Excess coverage generally is not available in the state. The society hopes to have its required $3 million in capitalization collected within the next few months so it can begin issuing policies for its mutual company.

Minnesota

The state society is recommending a legislative package including: reinstatement of the collateral source rule, strengthening the policing powers of the state board of medical examiners, continuing education requirements for relicensure, and tort reforms.

St. Paul, which insures 90% of the state's physicians in a program based on an agreement with the society, switched to claims-made this year, so some of the low-risk groups experienced a decline in premiums. Any large jumps will come in subsequent years.

St. Paul projects 348 claims for 1975, based on midyear statistics; 305 claims were filed in 1974; 199 in 1973.

Mississippi

Mississippi physicians have had no liability premium increase this year—though all policies are now on a claims-made basis, since the only carrier in the state is the medical-society-sponsored plan under St. Paul.

Physicians have as yet had no trouble getting new coverage, and comparatively few malpractice suits have been filed (80 this year, compared to 60 last year). However, the Mississippi State Medical Assn. is backing a nine-part reform package to be introduced in next year's legislature, including screening panels and a joint underwriting association.

Missouri

In 1975, the legislature approved a law allowing the medical society to form a mutual insurance firm. This year legislative plans include measures to control contingency fees, establish a JUA, increase the powers of the licensing board, establish review panels, and provide numerous tort changes.

The state still has several carriers, but only one or two write new business. The medical society has formed Missouri State Medical Insurance, Inc., a for-profit insurance firm that writes about 400 policies. Rates range from $500 to $30,000 for $100,000/$300,000 coverage. Medical Protective, which insures 50% of physicians, received a 50% rate increase in October. Other carriers' rates went up 300% to 400% last year. The Insurance Service Office has recommended another 100% increase for this month.

Montana

The state legislature did not pass any liability measures in 1975 and will not meet at all this year. The medical society has established an ad hoc committee to consider future changes in tort laws.

Aetna writes 80% of policies in the state through the medical society and St. Paul covers others. Premiums increased 72% during 1975 and will go up another 76% this month. Class I physicians pay $1,560 and Class V pay $13,270 for $1 million coverage.

Nebraska

The medical society plans to introduce legislation in 1976 patterned to some degree after legislation passed this year in Indiana. It will include a medical screening panel, limit on awards, a patient reimbursement fund, medical evaluation commission, and modification of the contingency fee.

About 40% of physicians are insured under a society-sponsored program with St. Paul, which recently switched to claims-made. Rates increased 25% July 1, when the switch was made, and probably will double Jan. 1. Medical Protective, the state's other major insurer, is writing no new policies, and other companies are moving out of the

Nevada

During 1975, the legislature approved formation of a JUA, extended the Good Samaritan Act to hospitals, established mandatory screening panels, increased authority of the licensing board, and made several changes in tort law. No session will be held this year, but an interim study commission is at work on additional reforms.

The JUA has gone into effect and covers some 150 physicians. Other carriers include Argonaut, which is being selective about new business and may pull out altogether in May, and Imperial, which will take no new business. Argonaut did have an eight-year contract with the medical society. It has pulled out of this, though continues to write some new coverage. The society did not have figures on rates, which vary considerably from individual to individual. Rates for most did go up considerably.

New Hampshire

Confronted with a doubling of liability premiums, the New Hampshire Medical Society obtained the creation of a JUA and establishment of a state commission to study all facets of the medical injury reparations system. The commission's recommendations are due on or before Jan. 1, 1977.

The NHMS reports the state's physicians "generally have no trouble" obtaining adequate coverage, primarily with Hartford, which has 80% of the business. Increase in claims was described as substantial.

New Jersey

No legislation made it through the New Jersey General Assembly during 1975. A number of bills are expected to be submitted in 1976. Among the state medical society's legislative suggestions are measures dealing with the statute of limitations, res ipsa loquitur, informed consent, collateral source requirement, limiting amount of liability required, and mandatory panels for screening. New Jersey physicians are presently able to get coverage. The society-sponsored carrier, Chubb and Sons, covers almost all state society members.

Premiums are rising. For 1976, they will increase on an average of 50%. Class I physicians will note a rise of nearly 75%, while Class V physicians will see their premiums increase by 30%. According to a spokesman for the medical society, the rate of claims filed is up markedly. Figures for calendar 1974 showed a 60% increase.

New Mexico

No legislation was passed in 1975, but a study commission was formed to recommend reforms. With the announced pull-out of the only carrier, Travelers, on March 1, measures will have to be approved quickly to guarantee coverage. Plans for both a JUA and a physicians' mutual have been readied for immediate consideration. Other measures to be introduced include a state-operated patient's compensation fund, a limit on liability and on awards, mandatory screening panels, tougher laws to discipline physicians, and several tort reforms.

Rates increased 74% last May, putting premiums at between $913 and $5,781 for $1 million coverage.

New York

Last year, the legislature approved establishment of a JUA, and a physicians' mutual, passed reforms on physician discipline matters, allowed recommendations of mediation panels to be admissible in court, and granted other tort reforms. This year, the medical society plans to introduce its Patients' Indemnification System, which will take suits out of the court room into an arbitration process. Also planned to be introduced are measures limiting awards and contingency fees, and calling for numerous tort reforms. Both the JUA and physicians' mutual have been put into effect.

Some 15,500 physicians are covered by the mutual, 3,500 by the JUA. Rates increased about 20% during the year. High-risk physicians in New York City pay about $17,000 as of July 1. The society reported 2,000 claims in 1974 and 1,324 for the first part of 1975.

North Carolina

State legislators approved a reinsurance exchange that has been challenged in the courts by involved insurance carriers. All companies except the society's own mutual have received injunctions exempting them from participating. Other laws passed in 1975 strengthen the board of medical examiners and establish a study commission. The medical society is recommending the commission consider establishment of a patients' compensation fund, a limit on liability, a mechanism for easier filing of counter-claims and several tort reforms.

Coverage in the state is available only through the physicians' mutual or through the St. Paul claims-made program. A premium increase of 570% was approved in October. Physicians in the mutual pay between $967 and $7,872 for $100,000/$300,000 coverage. Claims have increased about 67%.

North Dakota

Most physicians can obtain solid coverage and with conversion to a claims-made policy, some North Dakota physicians actually experienced a slight decrease in their premiums for the first year, the state medical society reports. However, the occurrence policies doubled and umbrella coverage jumped 100-200%. Without required reporting of claims, the society notes, it is difficult to determine if claims increased.

During 1975, the NDMA was successful in having the statute of limitations amended to two years after discovery, with a maximum of six years; protecting medical society and hospital review records from discovery and making them inadmissible as evidence; and gaining authority to establish a mutual liability insurance company. Next year, the society will sponsor a comprehensive bill, including tort reform, screening panels, and arbitration.

Ohio

Through the efforts of Ohio physicians an extensive package of reform measures passed the legislature in 1975. These included a limit on awards for pain and suffering, limit on contingency fees, establishment of JUA, provisions for binding arbitration, strengthening of the medical board, and numerous tort reforms. The society hopes to modify the JUA plan this year and to introduce other reform measures. The JUA has gone into effect. The society also is investigating formation of a mutual company.

Six carriers currently write coverage, including Medical Protective, Buckeye Union, Shelby Mutual, St. Paul, Travelers, and Hartford. Aetna began pulling out of the state this month. Rates increased as much as 700% in the state. Physicians pay between $900 and $7,500 for basic coverage.

Oklahoma

Oklahoma physicians remain in a relatively good position, with comparatively low rates under two medical-society-sponsored plans—though basic coverage premiums ($100,000-$300,000) increased 35% and excess coverage increased 200% this year. Basic coverage under the sponsored Insurance Company of North America plan ranges from $273 to $1,594, and excess coverage under CNA to $1 million also ranges from $273 to $1,534.

Though there are no other active carriers in the state, physicians do not as yet have trouble getting coverage. There have been no new legislative reforms this year, but the Oklahoma State Medical Assn. plans to introduce a package of several bills, including a measure to provide for written warranty and a redefinition of the statute of limitations.

Oregon

The medical society has asked the state court to rule on the constitutionality of a new law that limits physicians' liability and sets up a state excess fund. Also passed by the legislators last year were measures to limit contingency fees, permit creation of a physicians' mutual company, strengthen the medical practice act, and reform various tort laws. The legislature will not meet this year, but a state task force will study additional reforms.

The society has a group plan with CNA that charges between $1,116 and $7,240 for $100,000/$300,000 coverage. CNA has just requested an increase for the coming year of about 20%, which will put rates for the basic coverage at between $1,340 and $8,692. Protection is available up to $5 million at a cost of between $2,540 and $15,796, under the newly requested rates.

Pennsylvania

The Pennsylvania Medical Society last year reluctantly backed a new liability law in that state, creating a joint underwriting association only for those physicians who can't get coverage elsewhere, plus mandatory pretrial screening panels —but the society hopes to win some more effective changes in this year's legislature. The physicians hope to bolster the new law by reducing the statute of limitations, improving the composition of screening panels, and banning pain and suffering awards.

Private insurance is available from Medical Protective, Argonaut, and Aetna, and from the joint underwriting association for those refused by the private companies. Meanwhile, the medical society is studying formation of a captive insurance company. Private coverage rates jumped substantially this year—from 67% to as much as 476% higher than last year—from a Class I low of $538 (Medical Protective) to a Class V high of $15,277 (Argonaut).

Rhode Island

Rhode Island adopted a joint underwriting association plan this year, so that physicians have no trouble obtaining coverage—though rates increased 200% this year. The legislature has not passed any liability reform laws, though the Rhode Island Medical Society is planning to develop and introduce a comprehensive malpractice reform package next year.

Officials estimate malpractice claims increased 50-60% this year over last.

South Carolina

The legislature created a joint underwriting association that went into effect July 1, and a study commission to propose legislation to the governor by March.

The state medical society is working for a package bill similar to the AMA model, including: reduction of statute of limitations, limit on damages, binding arbitration, limit on contingency fees, and elimination of the ad damnum clause. The society also plans to introduce a bill that would set up a new medical discipline system.

Current premium for Class I for basic $100,000/$300,000 coverage is $250 and for Class V, $1,400, a 100% increase over 1975. No claims have been filed under the JUA; earlier figures are not available.

South Dakota

In South Dakota, physicians backed measures granting peer review immunity and a reduction in the statute of limitations this year; and the state medical association will probably introduce a package of 10 bills next year, including voluntary binding arbitration and a joint underwriting association. The legislative push was prompted by a change from occurrence to claims-made coverage in the state, plus a big increase in premiums.

Premiums range from $550 to $12,356 (last year, the range was $164 to $8,650). Though St. Paul, Aetna, USF&G, Hartford, Western Casualty & Surety, and Western Fire & Casualty all write policies, state society officials report that new physicians in solo practice have difficulty finding insurance—though, so far, all have been able to find acceptable coverage. The society hopes to get a joint underwriting association approved by next year's legislature; a similar measure failed this year.

Tennessee

The Tennessee legislature passed a comprehensive package of liability reform bills last year, creating a joint underwriting association, malpractice review boards, plus major changes in tort law, including reduction of statute of limitations, limits on contingency fees, and allowance of counterclaims by physicians. Further improvements in the legislation are being planned by the Tennessee Medical Assn.

However, high premiums for coverage under the joint underwriting association remain a serious problem—rates for the highest category of coverage rose from ISO's $897 in September, 1974, to $12,509 under the JUA this fall. Class I coverage rose from $176 in September, 1974, to $1,532 as of the end of this year. The JUA was implemented when Shelby Mutual, the state's biggest insurer, announced it would withdraw coverage next April, and other firms started phasing out as soon as the JUA went into operation. The medical association approved plans to start a physician-owned company, but the firm must be capitalized for $4 million before it will be approved by the state insurance commissioner.

Texas

In 1975, bills were passed allowing formation of a JUA, establishing a study commission, regulating insurance rate increases, and lowering the statute of limitations. The medical society has put together a 22-point plan for the commission recommending such reforms as a limit on awards and on contingency fees, establishment of arbitration boards, strengthening of the board of examiners, and other tort reforms.

Excess coverage in the state is not written through the JUA and is difficult to obtain. Medical Protective writes 60% of the policies. Other carriers include Hartford, Aetna, and St. Paul. Travelers pulled out of a group plan in Harris County on Nov. 1. Increases in rates of 600% to 800% were the norm last year. Many increases were even higher.

Utah

The Utah State Legislature will meet in 1976 for a 20-day session during which a malpractice bill, sponsored by several groups including the Utah Medical Society and the Utah Bar Assn., will be introduced. The bill will likely include a $250,000 cap on awards, reform of the statute of limitations, a requirement of a 90-day notice of intent to serve, elimination of the ad damnum clause, and a requirement of disclosure of collateral sources. A companion bill is expected to be introduced that will call for strengthening of the state's Medical Practice Act. Two measures will involve strengthening licensure laws and, increasing the size of the physician's examining committee.

Coverage is available to physicians in Utah. Aetna, the primary carrier, is in the last year of a five-year contract, but has indicated it will extend coverage for at least another year. Premiums increased in 1975. For 1976, they will rise an additional 70%. Class I physicians, for $100/$300,000 coverage, have seen premiums rise from $769 to $1,260. Neurosurgeons, for $250/$500,000 coverage, have seen premiums go from $6,186 to $10,603.

Vermont

Faced with a proposed 163% increase in premiums for next year, the Vermont State Medical Society is backing a package of four bills and a resolution to be submitted in the next session of the state legislature—the first sortie into liability reform.

Physicians as yet have no difficulty obtaining coverage, either through the medical society's sponsored program with Aetna, or with Hartford or St. Paul. Society officials estimate claims against physicians were up 50% last year over 1974, and if proposed premium increases are approved, physicians will pay from $1,400 (Class I) to $11,950 (Class V) for coverage.

Virginia

The state medical society plans to introduce a comprehensive package in the 1976 session of the legislature. A physician-owned reciprocal exchange is being organized, with no connection to the society.

St. Paul insures 90% of physicians in a society-sponsored plan. Basic premiums remained the same this year, though $1-million excess coverage jumped 100%.

Claims for the first six months of 1975 were 50% higher than for the same period in 1974.

Washington

Members of the Washington State Medical Assn. who do not have an adverse malpractice litigation record have no trouble obtaining coverage—90% of the business through Aetna—and the medical society does not plan to seek either a JUA or its own company.

During the past year, WSMA obtained passage of a standard of care bill, an expanded Medical Disciplinary Act, an amendment to the Medical Practice Act to provide for continuing education, and passage of a Good Samaritan Act. In 1976, the society will pursue a broad legislative program, including limitations on awards and contingency fees, screening panels, and various reforms in tort law.

The society estimates claims increased about 12% and premiums 70%.

West Virginia

The medical society is supporting legislation for 1976 that would establish a joint underwriting association and effect a number of tort reforms.

Aetna Life and Casualty is the only company writing new policies, and only under the society-sponsored program. Aetna received a 48% premium increase for basic coverage in 1975 and is seeking a similar increase for 1976.

Wisconsin

After a full year of legislative battles, Wisconsin physicians won several reforms of liability laws, including limits on liability, joint underwriting association, patients' compensation fund, and pretrial screening panels.

Physicians no longer have trouble getting insurance, though the State Medical Society of Wisconsin is investigating a physician-run liability program. Medical Protective, St. Paul, and Wisconsin Health Care Liability Insurance Plan all continue to write new policies, though St. Paul is limited to claims-made and Medical Protective is largely restricting new coverage to low-risk specialties and rural areas. Medical Protective's rates increased 10%-30% this year, to a high of $3,411 in Class V, while ISO's rates increased about 70%, to a high of $2,274. Figures on number of malpractice claims filed this year have not been compiled.

Wyoming

Obtaining adequate coverage is not a major problem, according to state medical society executive director Robert Smith. St. Paul withdrew from the market, but a society-sponsored plan with Aetna, which covers 80% of the state's physicians, took all those who lost coverage. The remaining 20% are covered by Hartford.

The society is proposing legislation for 1976 that would include: a two-year statute of limitations; disabled physician act; state reporting law; expanded immunity for persons involved in review; informed consent legislation; joint underwriting association; and a patient compensation act.

Information is not yet available on the size of premium increases for 1976. Except for one $200,000 loss, the highest in the state's history, awards for 1975 are lower, so far, than last.